

An Economic Case for Making Health Reform Work

Statement of

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An Economic Case for Making Health Reform Work

Chairman Keiser and other distinguished members of the Committee, I am humbled to come before you today to offer my thoughts on the theory, likely effects and risks of health reform and of doing nothing in the United States and in North Dakota. My name is Len M. Nichols, and I am a Professor of Health Policy and the Director of the Center for Health Policy Research and Ethics at George Mason University in Fairfax, Virginia. I am also a health economist who has been studying the health system and health reform proposals for over 20 years.

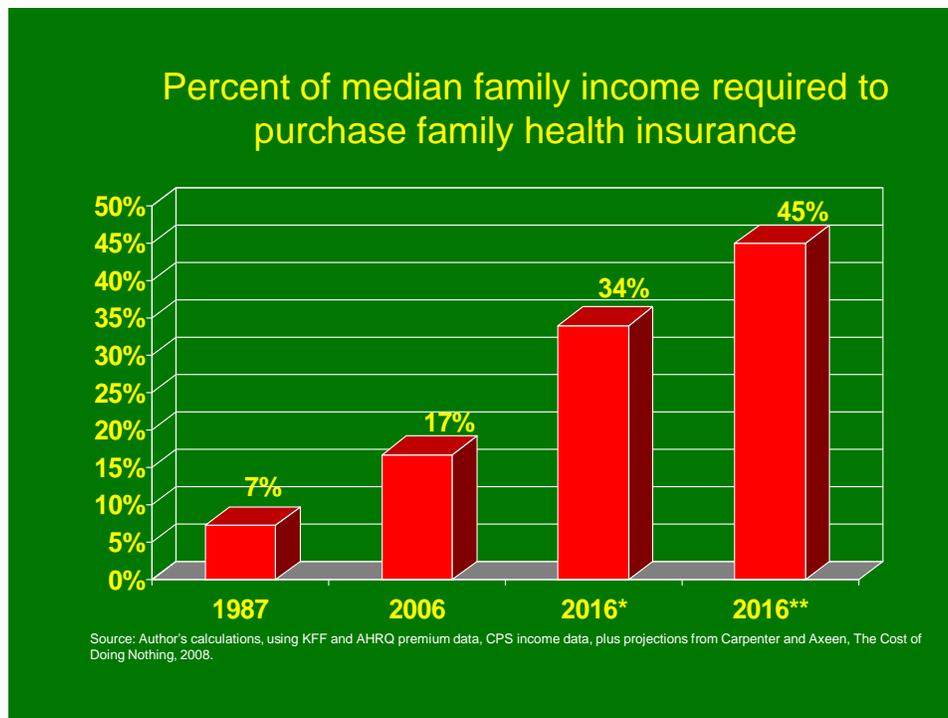
My overall assessment is that the legislation recently passed by the Congress and signed by the President is an imperfect but good start in the direction we need to head, toward making our health system sustainable for all Americans. Frankly, we do not really have a choice. We cannot afford the health system we have built, for even though parts of it are truly outstanding and the envy of the world, we get very low clinical value for our many dollars on average and we exclude too many from care that most of us still take for granted. We are on a path that will force us to either improve our system's overall quality and efficiency, or else look away as more and more Americans go without care that is expected and widely available to the entire population in every other industrial country in the world.

I have lived in or near Washington, DC for 19 years. I have had the privilege of testifying before and meeting with members of congress and presidents for almost two decades. Most of the ones I have met in both houses and on both sides of the aisle are good and decent people who love their families and country and are trying to figure out the right thing to do against great odds and with many conflicting pressures. I can also assure you, most of them do not really want to take up health reform as a legislative matter, because apparently you cannot even talk about health reform without making about half the population very angry. Most politicians do not like to make large groups of people angry. So why did they do this?

Why is health reform necessary?

Figure 1 is the beginning of my answer to this question.

FIGURE 1

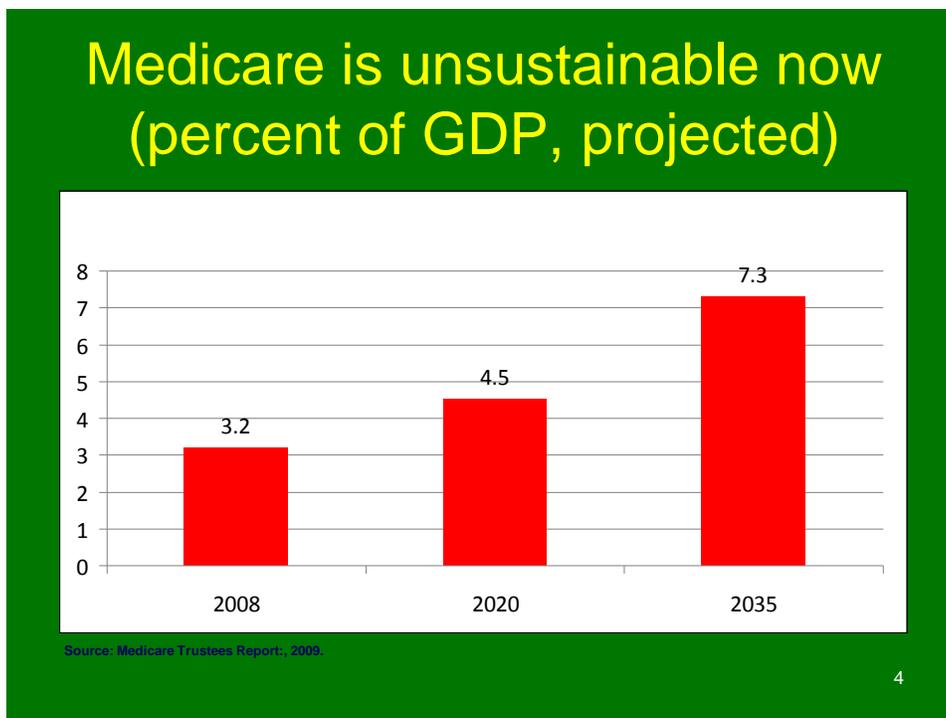


It shows the ratio of average family premium to median family income in the United States over time. I start with 1987, a year for which trusted, nationally representative historical data exists. Premiums claimed 7% of median family income then. Next move to 2006, when the presidential candidates for 2008 had to make a go/no-go decision about whether to run. They'd all been to Iowa many times and learned to talk to farmers (or so they thought). And virtually every primary candidate, all except Tom Tancredo (R-CO), 20 candidates in both parties, felt compelled to develop and offer a health care plan of some consequence. The bar graph for 2006 explains why: family premium had jumped up to 17% of median family income. The focus groups and polling that inform candidates' positions were unambiguous in both parties: the middle class had become quite worried about paying for health insurance and health care. What happened between 1987 and 2006 is that our health care costs per capita grew so much faster than economy-wide productivity, more and more Americans every year found health insurance to be unaffordable. Seventeen percent of median family income means that half the population does or would have to pay *more* than 17% to purchase health insurance for their family. That is hard to do for most people, and the single largest reason the number of uninsured in this country continues to grow.

Then I do a simple forecast, assuming that premium and median income trends continue out 10 more years just like they did in the 10 years that ended in 2006. The graph presents a choice about what you believe about economics. If you believe what economists say, that in the long run, employer contributions to health insurance have to be paid for with productivity and therefore actually come out of what would be wages, then you should count the employer share as part of income (as I do in the 1987 and 2006 calculations), and ten year trends will take us to *only* 34% of median family income as the cost of family health insurance in 2016. If you believe what some union advocates claim, that employer contributions come out of profits and should not be counted as part of income, then premiums will be 45% of median income by 2016. Now truth is of course somewhere in between (closer to the economists' view, to be sure), but the larger point is, neither of these numbers is equilibrium. We are not going in six short years to a world in which half our population will be paying *more* than 1/3 of their income for health insurance. Our current trajectory is unsustainable. Leaders have to lead us out of this wilderness.

Figure 2 is another reason Congress stuck with health reform despite the political pain this year. It shows the single greatest threat to our long run fiscal balance, the Medicare program's cost growth trajectory.

FIGURE 2



Medicare, our current promises to the elderly, will claim larger and larger shares of our GDP over time if we do nothing to alter the path it is on. I do not know how you can begin to get

Medicare cost growth under control unless we reform the health care system in which Medicare purchases services for our seniors.

Still, the legitimate question remains, can we really afford to do health reform with our debt and deficit situations as bad as they are? Figures 3 and 4 can help address this question.

FIGURE 3

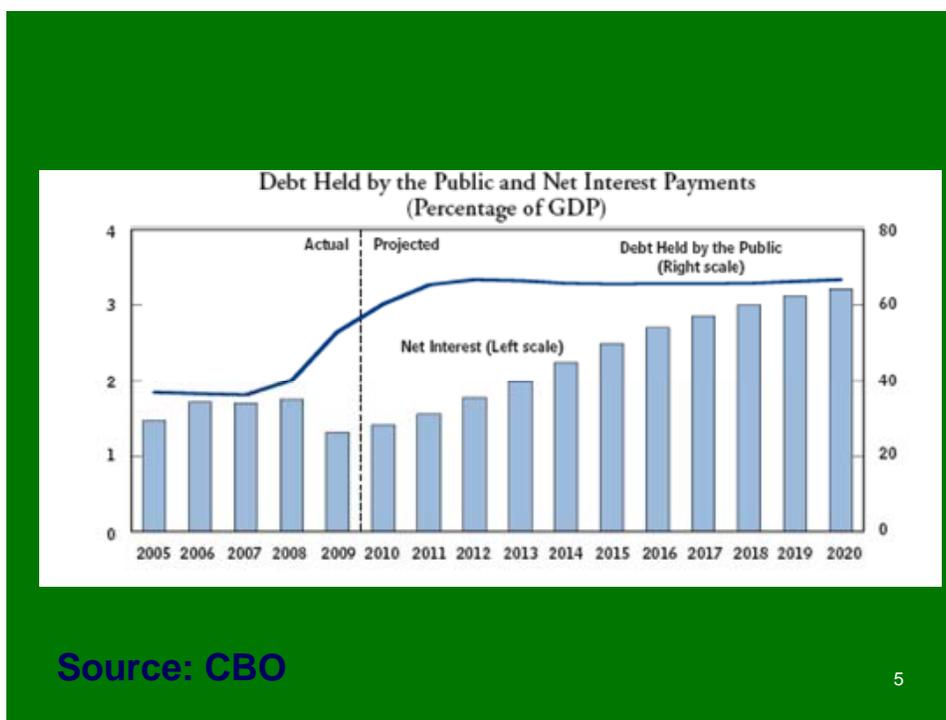


Figure 3 illustrates two concepts. The first to focus on is the line graph, the ratio of debt held by the public (and the Chinese) to GDP. This is the most important barometer of our long run fiscal situation; it shows what we owe as a percentage of what we produce. Its level is read against the right hand scale. Notice from 2008-2010, debt jumped from about 40% of GDP to over 65% of GDP. This is why serious people are nervous. Then note that even as the economy is expected to recover (all of 2010-2020 is from CBO's most recent forecast), debt/GDP is expected to continue to rise, albeit slowly, but still inexorably.

Now consider the second concept in Figure 3, the bar charts. They show the fraction of GDP we have to spend on interest (read against the left hand scale). Interest claims jump from roughly 1% of GDP in 2008 to over 3% in 10 short years. Now 2% of GDP may not get non-economists as excited as it does me, but trust me, 2% of GDP is a big deal. It's partly a big deal because this represents money we are spending through government that is not providing useful services to anyone who needs them. To put this in perspective, it would cost 1% of GDP to cover all 46 million of the uninsured, not just thirty + million of them. So because we cannot get our fiscal

house in order, we are squandering twice what it would cost to cover the uninsured and buying our people, who are fighting two wars in hard places and some of whom are needful as you all know, exactly nothing in productive and useful services. This is partly why some serious people are angry at Washington right now.

To put this lack of stewardship in proper historical perspective, now consider Figure 4. I love history, it can teach us a lot, if we will but take a little time to reflect and remember.

FIGURE 4

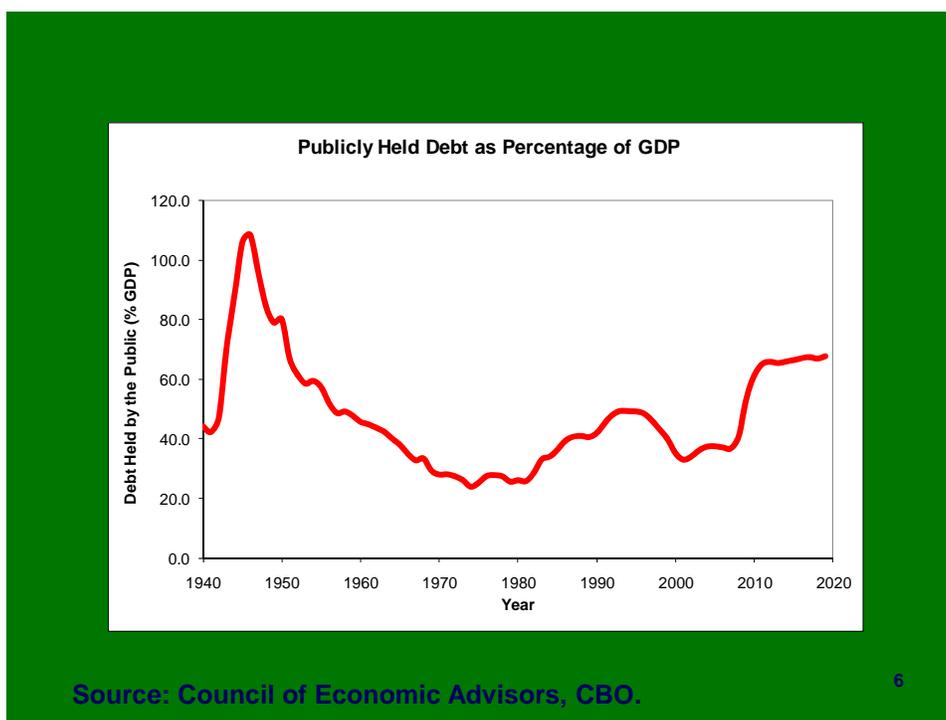


Figure 4 shows debt/GDP since WWII. I go back to the WWII era because we were better stewards then. Note debt/GDP jumped from 40% in 1940 to over 110% by 1946. We had to borrow to build those battleships and B-29s that we used to defeat fascism and tyranny around the world, and that was a very good idea. We faced an existential threat to our way of life, and we met it, the way prudent families do. We borrowed in times of crisis, and then we paid it back when we could. Note that after the war ended, from 1946 on, rather smoothly for many years thereafter, debt/GDP fell. Now sure, part of the reason is that economic growth gave us more GDP, but the point is we had a bi-partisan consensus not to spend more than we took in, unless we had to. In fact, we had a bi-partisan consensus to pay back the debt over time, and it had fallen to the low 20% range by 1980.

Then what happened? I would argue that our bi-partisan consensus broke down with the election of Ronald Reagan. Now some people loved him, and he was an inspiration to many more, but the truth is in his time our bi-partisan consensus broke down: we cut taxes, but we did not cut spending commensurately. As an economist, I will tell you; you can have any size government you want, but eventually you will have to pay for it. The people who loan you the money, be they from China or New York, will make you. So, by the time of the 1992 election, a non-politician named Ross Perot made a major contribution to our Republic by buying TV time with his own money and showing us very simple power point slides and explaining that our rising debt had been ignored too long. Perot certainly helped elect Bill Clinton. And Clinton, with some not entirely happy collaboration from Newt Gingrich and the Congress, managed to reform a new bipartisan consensus to get our fiscal house in order. They balanced the budget together, and look back at Figure 4 in the late 1990s, debt/GDP started to fall back toward pre-Reagan levels. By the time Clinton left office, in 2001, we had a \$200B budget surplus.

What the heck happened? The Bush tax cuts are what happened, along with two wars and the Medicare drug bill, and we lost our bi-partisan consensus about fiscal sanity once again. And debt/GDP turned up again.

Then what happened? Well, the financial crisis of 2007-8 turned into the economic crisis of 2008-10, and debt/GDP soared. Mostly, let us not forget, because the economy tanked and GDP actually fell. Two-thirds of the run up in debt/GDP since 2007 is due to the deep recession we fell into. Remember when Treasury Secretary Paulson and Fed Chairman Bernanke went to Capitol Hill together in October of 2008? They told the assembled leaders of both houses of Congress and the relevant committees, correctly, that we were extremely close to a financial meltdown, for General Electric could no longer float commercial paper overnight to meet payroll. Our financial and economic systems had ground to a halt. We were precariously close to another Great Depression, which was the single most important cause of WWII, I'm sure you all recall. In that circumstance, virtually every macroeconomist on the planet offered the same advice Paulson and Bernanke were giving: we have no choice but for the US government to borrow and spend to jump start the economy and prevent another depression. And so the TARP and then the stimulus package were born. Now of course, designed and implemented by humans in a powerful hurry, these were imperfect vehicles for our macroeconomic will. But I submit to you that we faced an existential threat to our way of life just as threatening as WWII was. As we faced it, in October of 2008 anyway, we had something close to a bi-partisan consensus that we had no choice but to borrow and spend, and that put the last 1/3 on the increase in our current debt/GDP level.

Now of course the details of how the TARP was spent, the bitter post-election breakdown of bi-partisanship on Capitol Hill, none of this was pleasant to live through or see up close. But my point is this: the sin was not to borrow in the short run to spend and prevent an economic meltdown like we had in the 1930s. The sin is the absence of a bi-partisan consensus to get the

debt back down as the economy recovers, as it did after WWII, as it is beginning to do once again. We had no choice but to run up more debt in the short run. But it is way beyond counterproductive to act as if there is no way to ever agree on anything about how to bring it down again.

So let's review the bidding. We have to get our deficits and debt/GDP down. Medicare cost growth is the single greatest fiscal problem we face. The last three CBO Directors could not be clearer on this point. And Medicare cost growth is inexorably tied to our health system's inefficiency. So we are back to, we have no choice but to reform our health care system, if we are truly serious about reducing debt/GDP in the long run.

But wait, surely given all this it would be far wiser to reduce cost growth first and expand coverage a decade or so from now? This question too is eminently sensible. But it ignores a fundamental, if little known, reality: $\frac{3}{4}$ of hospitals today lose money on Medicare.¹ All of them lose money on Medicaid. So do you really think they could or would tolerate (and let their politicians feel safe with) serious public program payment reform unless we also cover the uninsured and stop the drain on their cash flow, cash flow they need to invest in new information systems and process reorganization? Covering the uninsured, in my view, is a moral responsibility of our society,² but it also an economic imperative, a kind of payoff we need to buy time so hospitals (and physicians) can learn how to thrive economically in a new world of re-aligned incentives and best-practice information, so they can learn how to help us transform our health system into a sustainable one that serves us all.

What Reform is *Really* About

After all the political drama of the last 17 months (and still counting) of our national health care debate, it may seem odd to pose such a simple question, but my observation is that the answer is not widely understood. Reform is really about using policy to reset the rules governing key markets so that incentives change, so that ultimately individual self-interest is channeled into serving the social interest of maintaining a health system that works better for all of us at an affordable cost, affordable for families and for society as a whole. Reform is really about changing the two obsolete business models that are holding us back.

The first business model that must change is that of risk selection by insurers. Right now, they profit by excluding the sick, by discriminating against those who are unlucky in the lottery of

¹ March 2010 MEDPAC report.

² Len M. Nichols, "Stewardship," in *Connecting American Values with Health Reform*, Hastings Center, http://www.thehastingscenter.org/uploadedFiles/Publications/Primers/Connecting_American_Values.pdf

serious health problems. They do this to protect the healthy, who they happily insure at a price higher than the cost of covering the healthy. We have a fairly decent insurance system for the healthy. This is hardly the point of a health system. Insurance market reform is about reducing the profitability of discrimination against the unlucky and increasing the profitability of helping *all* enrollees find clinical and health value in our complicated health delivery system. The new insurance business model will indeed reward competition on price and quality of patient and enrollee experience, not competition based on risk selection. If you change what is profitable, insurer behavior will change. At some level, insurance reform is as simple as that.

But the economics of insurance reform does not stop here. You cannot make insurers ignore health status and take all comers unless everybody comes. You must insure that the risk pool is indeed the population, not a select few, else premiums will rise in a destructive spiral. The truth is the only way to make insurance markets work for all is to require everyone to participate. A mandate is not some plot to reduce freedom; it's a necessary tool to make sure everyone pays their fair share, to make sure insurance markets work. But you cannot mandate that individuals buy insurance if you're not prepared to provide subsidies for the lower income population. This is why health reform is not simple or possible with small incremental steps. Successful health reform is lumpy, or actually more like an integrated circuit. Remove one part, and the whole thing will not work. That is the clear goal of those who would remove the individual mandate with dubious constitutional arguments, I am sure you understand.

The second business model in our health care system that must change is fee-for-service payment, or "pay for volume" as it has come to be known in analytic circles. Fee-for-service was not a bad idea when it was invented, when doctors were as likely to kill you as help you get better (before roughly 1910). Patients did not want financial incentives to get between their clinician and effort that might help them. But now we know that fee-for-service has led us to spend 17% of GDP while delivering mediocre system performance in terms of the health of our population and even the average quality of care delivered, and of course we now have cost growth trajectories we simply cannot afford. So the second piece of health reform, the part that will make high quality health care and health insurance affordable if anything can, is to move clinicians, patients and payers from pay for volume to pay for value, pay for clinical value, health improvement and actual health, and no longer for the volume or complexity of services delivered per se.

There are quite a few emerging models for how to do this, but the main theme I want to emphasize in the remainder of this testimony is that the reform law actually includes many tools and building blocks from which a sustainable health care system can be built, if we will but build it. Let me hasten to add that Washington cannot do this alone. Successful health reform is a participation sport. But the argument that the law contain "nothing" about cost containment or that it is woefully inadequate on this front is quite simply and dangerously false. Dangerous because it confuses us and distracts us from what is actually in the bill and from engaging as we

all should to make sure we build sustainable health systems all over the United States, regardless of how people vote most often.

The delivery reform part of the bill takes two related and major steps. First, as prelude, the new law signals that business as usual will end. These signals are sent to the provider community in three main ways. First, through reducing the known overpayment to Medicare Advantage plans and linking future payment to quality, not risk selection. Second, through reducing automatic Medicare payment updates for hospitals, incentivizing productivity ongoing improvements rather than reliance on unending pay inflation. Third, again within Medicare, adjusting a host of obviously mis-priced procedures (e.g., imaging) and linking payment to quality across all provider types. Before long there will be no Medicare payment that is not somehow adjusted for quality performance, and that may be the most important signal of all.

These signals are also illustrative of why reform passed. Did you ever wonder why the major provider lobbies – the American Hospital Association, the American Medical Association, the Pharmaceutical Manufacturers Association, the Federation of America’s Hospitals (for-profit hospitals) – supported reform this time around when they very much opposed reform in the Clinton era? It is not because they suddenly felt their hearts strangely warmed for the access problems of the uninsured. The main reason, in my view, is because the leadership of these organizations, and a critical mass of their Boards and members, came to understand that cost growth containment is an economic imperative for this country, that it will happen regardless of who controls Congress down the road, and they would rather have cost growth containment arrive with coverage expansion coupled with incentive realignment than to fail again as a nation and end up with draconian price controls in 5-7 years. They fear, like I do, that price controls will be seen as the only viable option if we fail this time. Therefore, in their minds and in mine, as was famously uttered during the stress of bringing the Apollo 13 crew home, “failure is not an option.”

The second step within the new law is to use payment policy, where the federal government has jurisdiction, to drive providers toward pay for value and away from pay for volume. Once again, there are three basic mechanisms. A new Center for Medicare and Medicaid Innovation is charged with developing, testing, and evaluating a host of specified and unspecified incentive and information structures that can transform care delivery. The specified models include variations of accountable care organizations, bundled payments, medical homes, patient empowerment models (including shared decision making, navigators, home care for the chronically ill, prevention and health promotion), and rural community health integration models. The Secretary of HHS has the authority to spread payment and delivery reform innovations coming out of that are shown to improve quality or lower cost without Congressional approval, a reform strongly supported by analysts and stakeholders with long experience with Congressional interventions that overturn more evidence-based decisions. Second, the

Independent Payment Advisory Board (IPAB) is charged with taking an annual system level look at performance on cost as well as quality and health outcomes and with making recommendations that would become law fairly quickly or be replaced by measures designed by Congress that would be expected to be equally effective. Their recommendations and subsequent policy changes would only be binding where the federal government has sole payment policy jurisdiction, i.e., in the Medicare program, but could end up being catalytic if the private sector also thinks the recommendations have merit. Finally, a major incentive change will be effectuated by the excise tax on high cost plans when it comes on line in 2018. This will, as if the business model changes and medical loss ratio limits were not enough, force private insurers to focus like a laser beam on delivering clinical value per dollar to all their enrollees, for plans that fail and remain high cost will be penalized quite substantially.

How will all this payment innovation and signaling work to actually lower costs? First of all, it is telling that the Congressional Budget Office, an institutionally conservative skeptic (and we need them to be) of legislative “savings” proposals has concluded with their best analysis that the health reform bill will lower the deficit in each of the next two decades.³ This is particularly important to understand, since so much has been made of the argument that there are only 6 years of coverage expansion but 10 years of savings and revenue enhancements within the basic cost estimate framework required by the law. Second, the independent Office of the Actuary (OACT) at CMS, if anything too dismissive (in my view) of the private sector’s ability to react to incentives that are present in the legislation, actually scores the bill as achieving a little more savings than CBO found, and goes on to express their worry that the reforms are so strong they actually threaten the viability of roughly 15% of hospitals and other institutional providers.⁴ So some serious people are convinced the cost-containment provisions in the law are quite serious.

The key point I want to make is that virtually all of the savings that CBO and OACT attribute to the bill as written come from the first tack, the signals that business as usual is over. While important precisely for the money they raise and the signals they send, those provisions are mostly about just reducing payment levels in the current and flawed payment system. The really interesting and possibly transformative provisions, i.e., all the payment innovation and IPAB activity, is not scored as delivering and is therefore not relied upon to finance the bill. Therefore, IF the payment reforms work to transform care delivery and “bend the (cost growth) curve” as quite a few analysts think they will,⁵ those savings will be “gravy,” i.e., unexpected by construction and therefore can (and should) contribute to deficit reduction and debt payback.

³ CBO cost estimate.

⁴ OACT memo.

⁵ D. M. Cutler, K. Davis, and K. Stremikis, *The Impact of Health Reform on Health System Spending*, Center for American Progress and The Commonwealth Fund, May 2010.

How might this all affect North Dakota?

High quality data confirm what Senator Conrad and his staff have long taught me, North Dakota has lower than average insurance premiums, lower than average per person health costs, as well as lower than average percentage uninsured, along with higher than average quality of care. So if you are happy enough to be better than average, you can be proud. But if you want to deliver more value over time as best practices and incentive structures evolve, you might want to engage various dimensions of the reform payment pilots and make them work for North Dakota communities. After all, according to the 2008 National Quality Report from the Agency for HealthCare Research and Quality, North Dakota ranks 31st in colorectal cancer deaths per capita, 37th in suicides, 40th in kidney dialysis quality and 49th in the treatment of congestive heart failure. So even better than average states have plenty of room for improvement. And while you do have lower premiums than average, I doubt you have many employers who think the pay too little for health care. According to AHRQ data, your premiums are growing faster than the nation's, at least since 2000.⁶ Paying less over time, relative to baseline, and achieving higher quality and more access for lower income North Dakotans will always be a good and popular idea.

The larger initial impact on North Dakota is likely to be more purely economic from the cash flows attendant to coverage expansion. Much has been made about the cost to the states of Medicaid expansion. An analysis released yesterday by one of the foremost non-partisan, public policy research institutions in the country, the Urban Institute, which has a well-deserved reputation among policy analysts as the group most adept at understanding and modeling the Medicaid program, will shed some light on this question that you may find relevant. The Urban Institute team estimates that to fund North Dakota's obligation under the Medicaid expansions, North Dakota will have to raise and spend \$32-57 million over the 6 years 2014-2019.⁷ (The range of estimates is due to reasonable variations in assumptions about how many Medicaid eligible individuals will enroll). In exchange for this, North Dakota would receive between \$595-709m in federal dollars. This 12-19 fold- injection of new spending will have a positive economic effect far beyond the initial health care services it will buy and that will dwarf the negative economic drain from raising the \$32-57m in local taxes. Health care spending multipliers are much larger than general spending (or taxation) multipliers,⁸ since so much of the

⁶ Author's calculations based on AHRQ data downloaded May 26, 2010.

⁷ John Holahan and Irene Headen, "Medicaid Coverage and Spending in Health Reform," Kaiser Commission on Medicaid and the Uninsured, May 2010, <http://www.kff.org/healthreform/upload/Medicaid-Coverage-and-Spending-in-Health-Reform-National-and-State-By-State-Results-for-Adults-at-or-Below-133-FPL.pdf>

⁸ See Len M. Nichols et al, "The Future of Colorado Health Care," Colorado Health Foundation and Colorado Trust, November 2009, for an explanation of the relative sizes of health and non-health spending multipliers.

initial round of spending remains in the state, so the net impact of raising all the money for a coverage expansion within North Dakota would still be positive for the economy of North Dakota. But factoring in the proportion that would come from the federal government, especially when you add in the 100% federal subsidies for those with incomes between 133% of poverty and 400% of poverty who would be eligible for premium subsidies through the exchange, and the fact that North Dakota only pays 60 cents in taxes for each dollar of federal revenue it gets,⁹ and this coverage expansion will add up to something like another stimulus package as providers of health services spend the money they receive from newly covered individuals in the myriad of professional and personal ways. Local businesses might consider this net economic impact when deciding whether to support implementation or repeal.

Three (and a half) final points

I would not want to leave the impression that I think the reform law is perfect by any means. It should have seriously addressed malpractice reform, and it should have lowered regulation and legal barriers to provider incentive re-alignment (e.g., antitrust safe harbors). Both of these would have been easier if the bill had attracted the bi-partisan support it deserved, in my view, since the bill is so similar in structure – insurance reforms, individual mandate, premium subsidies and Medicaid expansion -- to what Massachusetts passed under Republican Governor Romney's leadership, to what Gov. Schwarzenegger proposed in California a few years back, to what the bi-partisan Blue Ribbon Commission recommended in Colorado about the same time, and, going back further in time, to what Senator John Chafee proposed in 1993 that had 15 Republican co-sponsors, including current Senators Grassley, Hatch, Bennett, and Gregg and then-Majority Leader Dole. The Chafee bill also used Medicare savings to partially finance the premium subsidies. But I digress.

Specifically, the delivery reform sections of the bill would be stronger if the IPAB started within one year and not have to ignore hospitals for a few years, the excise tax on high cost plans should also start sooner, and if the Center for Medicare and Medicaid Innovation started immediately and not in 2011, for no set of tasks and responsibilities is more important to the ultimate success of the reform enterprise. In short, while good, the delivery system reforms are a bit timid around the edges for my taste. However, those who argue in the abstract for much more vigorous reforms in this regard often stop short when you point out what they are really calling for is a price control regime that will lower short run payments perhaps but stifle the very innovation we need to link provider and patient self-interest to a more sustainable health system.

⁹ See the Tax Foundation, <http://www.taxfoundation.org/research/topic/48.html>

As I have stated repeatedly, the point of reform is to make our health systems in real communities around the country both high quality and economically sustainable. For this to occur, CMS and the Administration need to work hard to signal an openness to creative and innovative proposals from communities and the private sector to become full partners in incentive re-alignment. The best way to do this would be to clarify, in regulation, in appointments of personnel, and in public statements, that the goal of payment reform pilots is not to improve Medicare or Medicaid efficiency but to improve the entire health care system. It seems obvious to this simple country health economist that the best way to do this would be to develop community wide, multi-payer payment pilots, not to keep the public program incentive changes cordoned off from the private sector. Clinicians need one set of incentives, information systems and feedback loops, not 40 or 200 or 1300 (nationwide). In my speaking and learning since the bill passed, I have been pleasantly surprised at how many hospital systems, physician groups, health plans, and communities warm to this message and would like to participate in making their local health systems work better for all, but need a little direction and welcoming to become CMS' partner, not its observer or guinea pig.

Finally, it bears repeating that we actually have no choice. We have to lower our health cost trajectories, and I believe we will. Preferably by making the tools of this reform effort take on the flavor of the great diversity and creativity of the best health providers and communities around the country, and by making the incentive and information tools envisioned by the law come into being. If we fail, I fear we will be forced to adopt price controls to meet short run budget targets as dictated by future financial markets. That is a fate to be avoided if we can, and we can, if we put down our unnecessarily toxic politics and pick up our innate pragmatism. I am of course just guessing here, but I doubt anyone knows the wisdom of this suggestion more intimately than the good people of North Dakota.

Thank you for the opportunity to speak with you this morning. I would be glad now or at your own convenience later to answer any questions my testimony may have triggered.