



US HEALTHCARE REFORM:
MONUMENTAL HEALTH SYSTEM
TRANSFORMATION, OR FATALLY
FLAWED COMPROMISE?

Alan M. Garber MD PhD

17th Annual Lecture 2010

About the Author

Alan M. Garber, MD, PhD, is the Henry J. Kaiser Jr. Professor, and also a Professor of Medicine, Professor of Economics, Professor of Health Research and Policy, and Professor of Economics in the Graduate School of Business (courtesy), at Stanford University. He is the founder and director of the university's Center for Health Policy and the Center for Primary Care and Outcomes Research at the School of Medicine. He is also a Staff Physician at the VA Palo Alto Health Care System, where he is the Associate Director of the VA Center for Health Care Evaluation.

A summa cum laude graduate of Harvard College, he received his PhD in economics from Harvard and an MD with research honours from Stanford, and completed his residency in Medicine at Brigham and Women's Hospital in Boston. He is a member of the Panel of Health Advisers to the Congressional Budget Office, the Institute of Medicine, the American Society for Clinical Investigation, and the Association of American Physicians. He is a Fellow of the American College of Physicians and of the Royal College of Physicians. He served as Chair of the Medicare Evidence Development and Coverage Advisory Committee (CMS) and directed the Health Care Program of the National Bureau of Economic Research (NBER) for 19 years.

Dr. Garber's research is directed toward methods for improving health care delivery and financing, particularly for the elderly, in settings of limited resources. His work addresses such issues as technology evaluation, comparative effectiveness, the causes of health expenditure growth, and health care productivity.

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By Alan M. Garber, MD, PhD
Director of Stanford University School of Medicine
Center for Health Policy and the Center for
Primary Care and Outcomes Research

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The Royal College of Physicians
St Andrews Place
London



Office of Health Economics
12 Whitehall London SW1A 2DY UK
Tel: +44 (0)20 7747 8850
www.ohe.org

US Healthcare Reform: Monumental Health System Transformation, or Fatally Flawed Compromise?

I am going to give you my punch line right now: the answer to the question posed by my title is of course, “yes”.

I would like to take this time to give you an overview of US health reform with a little bit of background explaining how we got there, without going into too much detail.

Some people would say that the creation of Medicare in 1965 was the defining moment in US health reform in modern times, i.e. in the second half of the Twentieth Century and beyond. Ex-President Harry Truman became the first registered Medicare beneficiary. He signed his Medicare enrolment form as then President Lyndon Johnson signed the bill into law.

Medicare is, of course, the universal health insurance programme for the elderly, along with the disabled and individuals with end-stage renal disease. One fact buried in the history of the creation of Medicare is that it was originally intended to be a universal health insurance programme. There was strong resistance, particularly from organised medicine, and, as a result, the benefits were pared back and coverage was limited, primarily to the elderly.

With 40 years of hindsight, one of the comments that President Johnson made soon after Medicare was enacted may strike those of you who are familiar with Medicare as ironic. He said: “The benefits under the law are ... varied and broad. If it has a few defects – such as the method of payment of certain specialists – then I am confident those can be quickly remedied and I hope they will be”. These problems were never completely remedied and this is one of the reasons why Medicare remains a huge challenge for the US.

Another significant chapter in the history of American health reform involved the next major modification to Medicare. When Medicare was created, drugs constituted a very small part of health expenditures in absolute terms. The absence of a prescription drug benefit was viewed as a minor defect that was likely to be remedied soon. However, not until 1988 did Congress address this gap in Medicare, in the Medicare Catastrophic Coverage Act. In addition to its drug coverage features, the Act extended coverage for catastrophic illness and enhanced Medicare’s long-term care provisions. But from the perspective of many Medicare beneficiaries, the Act replaced voluntary private supplemental insurance for Medicare with compulsory public insurance.

At the time, the legislation was required to be budget neutral. In other words, it could not add to federal expenditures. In order to meet that requirement, it was financed by a steeply progressive tax. For the highest income group the tax was estimated to reach about 17 times the actuarial value of the additional benefits. Thus for high-income Medicare beneficiaries, the tax was far more costly than what they paid in premiums for the private supplemental insurance

plans that the Medicare enhancements were designed to replace. The legislation was passed into law, but the elderly rebelled, and the law was repealed before it was fully implemented.

Although most of the people serving in Congress today were not in politics then, the political memories of this episode are long and legislators kept this in mind when thinking about any kind of subsequent health care reform.

Five years later, major reform was on the agenda again, when a recently elected President Clinton introduced a complex and ambitious plan for health reform that would have led to universal health insurance coverage. There was insufficient congressional support in 1993 for the President's plan and, following the failure to agree on a compromise plan, health care reform again receded as a legislative initiative.

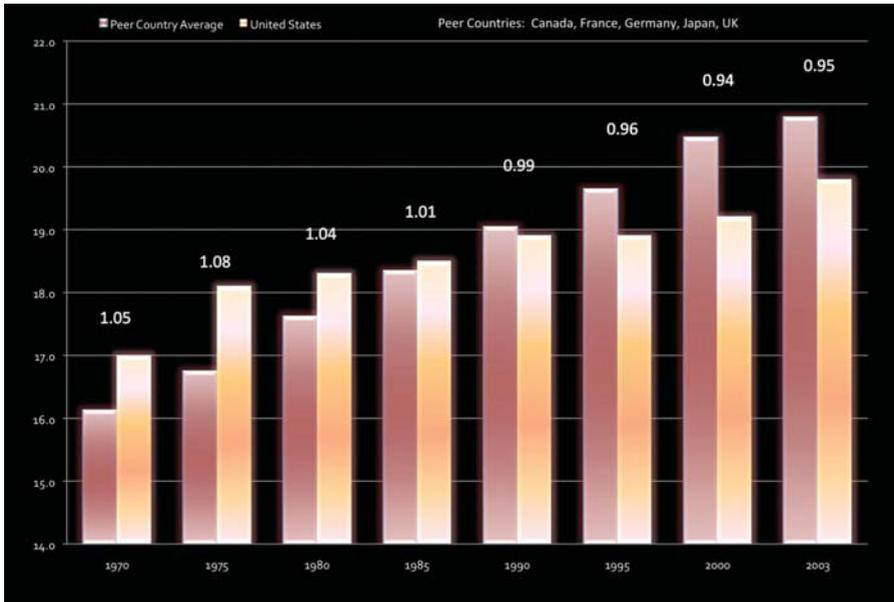
President George W. Bush was able to push through a reform that only affected Medicare and resulted in the creation of a drug benefit. This took an unusual form, with a benefit schedule that included a gap in coverage commonly referred to as the "doughnut hole." That is, insured individuals were responsible for all prescription spending after reaching an initial coverage limit (about \$2,400 in 2007) in total drug expenditures but before reaching a catastrophic limit of \$3,600 in out-of-pocket expenditures. The benefit might not have followed textbook descriptions of insurance design, but it met the political requirements for passage, which included very little Democratic support at the time. The law did not fundamentally alter the overall structure of Medicare but by committing the government to larger ongoing subsidies it exacerbated Medicare's long-term budget shortfall.

In the spring of 2008, Barack Obama released the plan for health reform that was to be a centerpiece of his presidential campaign. There are a couple of things to keep in mind. First, US health reform was fundamentally a Democratic issue. Public opinion polls consistently suggested that the public trusted the Democrats more than Republicans on the subject of health care. Secondly, at the time Hillary Clinton, not Barack Obama, was the leading Democratic presidential candidate. Health reform was something of a treacherous issue for her, despite her commanding knowledge of the issue, since it would draw attention to her prominent role in the failed Clinton health reform effort. Thus health reform was more politically attractive for Obama than for the other leading presidential candidates. He proposed that health reform include the following elements: health insurance exchanges, comparative effectiveness research, increased regulation of the health insurance market, and ways to save on administrative costs.

After President Obama's election, reform remained a leading issue for the US public. The most obvious reason, of course, was concern about access to health care. We all know about the uninsured in the US. However, health reform was unlikely to be endorsed by Americans solely on the basis of covering the uninsured. This might not be true in the UK or other wealthy nations, if they did not already have a system that guaranteed care to all its citizens. But in the US, this argument by itself would not sway the electorate, as President Clinton's attempt at reform suggested.

Perhaps a more important motivation was one I call the value deficit. Most of you are familiar with this so I am just going to give you one example. This bar chart shows female life expectancy at age 65 and compares the US to peer countries: the UK, Canada, France, Germany and Japan - large, wealthy nations that are most like the US in many respects.

Female Life Expectancy at 65

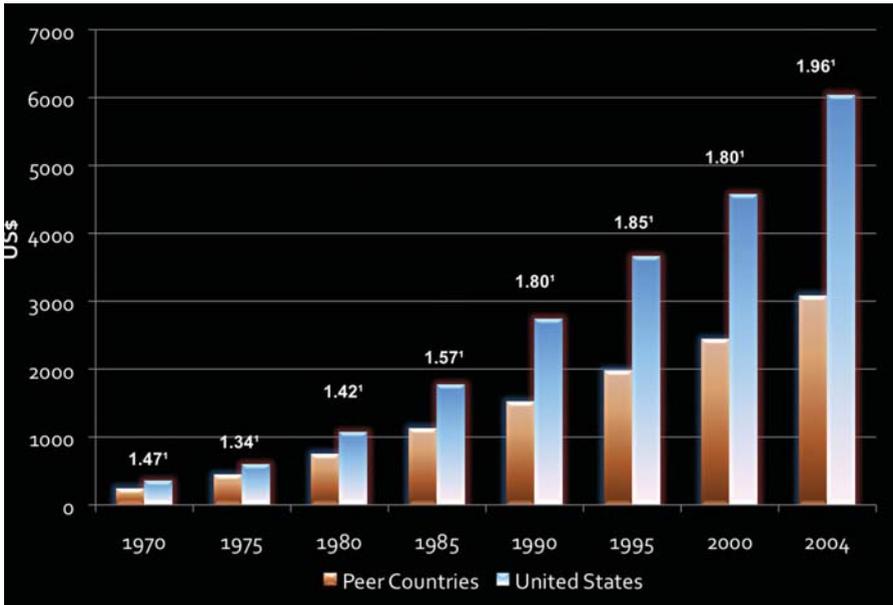


Source: Author's calculations from: OECD Health Data 2008

Remaining life expectancy at 65 years of age in 1970 was actually longer for US females (17 years) than in the peer countries where it was just over 16 years. Life expectancy improved over the next 33 years in the US, increasing to nearly 20 years in 2003, but it improved more rapidly in the other countries. The US moved from 105 per cent of the peer group life expectancy to 95 per cent. One of the reasons I chose to look at women aged 65 is that in the US Medicare covers essentially everyone age 65 and older, so health insurance is universal at these ages. In addition, life expectancy at advanced age is arguably less affected by factors outside the healthcare system, compared to life expectancy at birth, for example, where all of the factors contributing to neonatal mortality have a substantial impact. The main point of this figure is that although this measure of health improved in the US, it did not improve as much as in other countries.

The next graph shows PPP adjusted per capita health care expenditure in the US compared to the peer countries

Per Person Health Care Spending



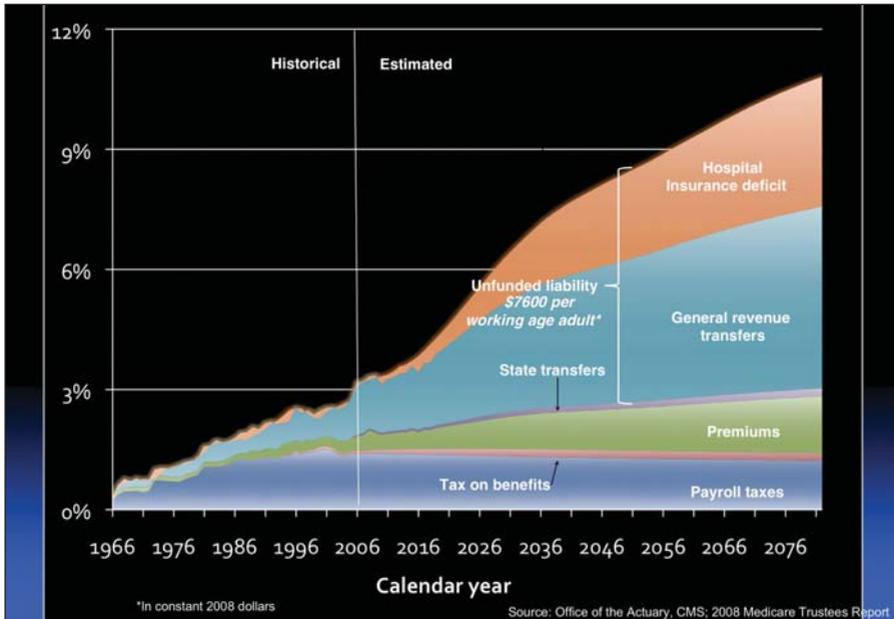
Note: 1. Ratio of per capita spend in US to average per capita spend in the UK, Canada, France, Germany and Japan
 Source: Author's calculations from: OECD Health Data 2008

It shows the US spent 47 per cent more per capita in 1970 (almost half as much again), and 96 per cent more in 2004 (almost twice as much). Putting all this information together, we see a higher growth rate in per capita expenditures as compared to the peer group countries at a time when there was a lower rate of improvement in life expectancy.

We all know that there are many caveats that go along with any analysis of this sort. I am not going to claim that we know the precise reasons for variation in life expectancy or that it is easy to control for factors such as underlying disease in the population, health behaviours, and so on. But there is no simple, obvious aggregate metric that says that greater health expenditures in the US were producing better aggregate health outcomes.

For reasons like these, I long believed that the principal driver for health reform was the issue of value. In the past few years I have had reason to change my view. Although value remains important, I now believe that it is also about the absolute level of expenditures.

Medicare Sources of Non-Interest Income and Expenditures as a Percentage of Gross Domestic Product



Source: Office of the Actuary, CMS: 2008 Medicare Trustees Report

For Americans, this is the graph that should make us worry. In the US, the factors that are most threatening to our long term economic health are funding deficits for Social Security and Medicare.

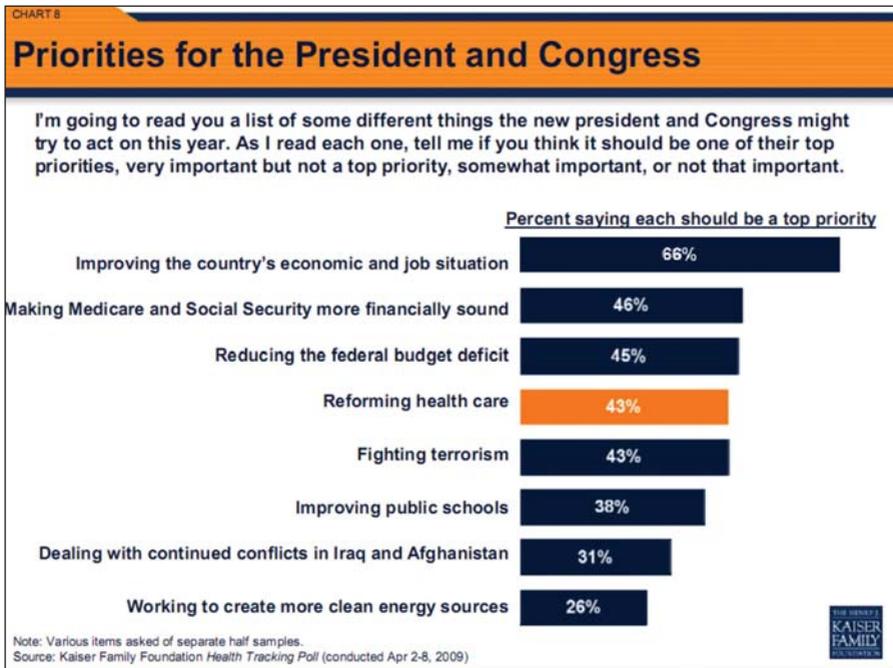
According to many budget experts, Social Security is relatively easy to fix, but Medicare is not. This graph shows projections of Medicare expenditures as a percentage of GDP. Medicare currently accounts for only a small part of health expenditures. Data from the Office of the Actuary at CMS, the agency that runs Medicare, show that Medicare only accounted for 3% of GDP in 2006. Beyond 2006 are projections of Medicare expenditures as a percentage of GDP. These estimates, according to a number of sources, including the Congressional Budget Office, are conservative.

The areas under the Medicare expenditures curve show revenues from dedicated sources of programme funding under pre-health reform rules. Starting from the bottom up, the first source of funding is a payroll tax, or the Medicare tax. Next are premiums for optional programmes. There are several parts to Medicare. Essentially all elderly citizens enroll in the hospital insurance component, Part A. There is no premium. However, enrolment in both Parts B and D requires payment of a premium. Part B covers physician services and a variety of outpatient products and services. Part D is the prescription drug benefit. The graph shows a gap because the total revenue generated from the payroll tax does not cover the increasing costs of hospital insurance.

This presentation of the hospital insurance shortfall reflects the way that the federal government accounts for Medicare revenues and expenditures. The Hospital Insurance Trust Fund is where the revenue generated from the payroll tax goes first and is then paid out as Medicare incurs expenditures.

This fund was projected to go bankrupt sometime between 2017 and 2019. As it stands, there is a deficit (in orange) that general revenue transfers cover. Without a designated source of funding, you might think of the budget shortfall as simply adding to the federal budget deficit. Going forward, if you cannot continuously increase federal debt, you might think the solution is to raise taxes. By 2050, however, this deficit will make up 6% of GDP and, by my calculations, the unfunded liability that year would amount to \$7,600 (2008 dollars) per working age adult, which is more than \$1,000 greater than the average personal income tax. In other words, covering this projected deficit from general taxation would require the equivalent of more than doubling the income tax. We do not know exactly how we are going to cope with the rising Medicare deficit. Presumably we will not continue on this path. The question is, how we will get off it?

This set of predictions predates the health reform law and the Office of the Actuary has not yet issued updated projections. The importance of these figures is that this budget imperative is behind everything that Congress is thinking about when they talk about health reform. There are strong pressures to resist adding to the federal budget deficit.



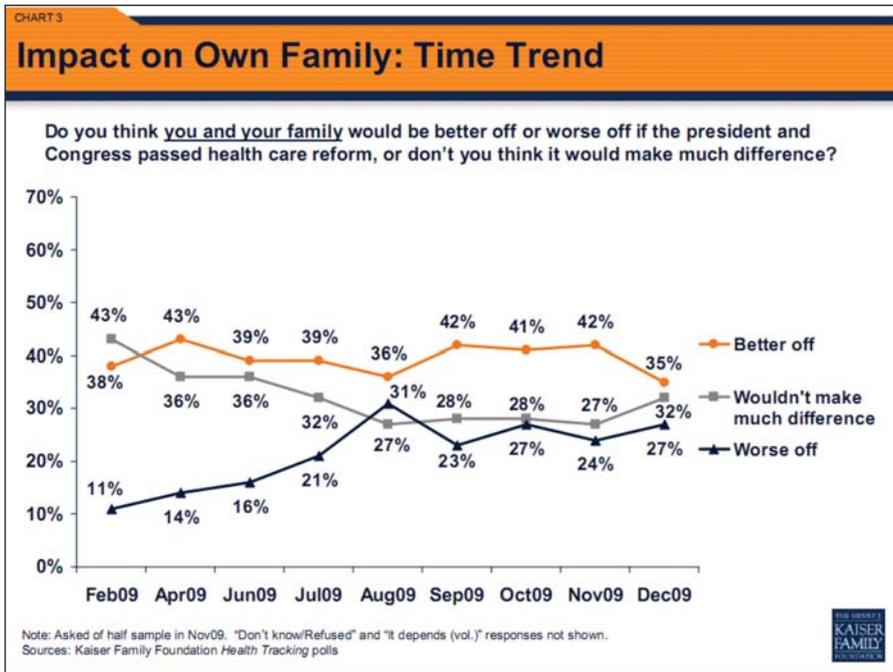
Source: Chartpack: Kaiser Health Tracking poll – April 2009, (#7893) The Henry J. Kaiser Family Foundation

Let us return to April 2009. Candidate Obama is now President Obama and is making good on his promise to pursue comprehensive health reform. How strong was public support for this? The Kaiser Family Foundation conducted a national survey that asked a sample of Americans about their top priorities for the President and Congress to address. In April 2009 the economy was still viewed with great concerns despite some signs of recovery. In this context, reforming health care is a top priority for 43% of people.

You could argue that the “economic and job situation” is related to health reform, as are Medicare and Social Security concerns and reducing the federal budget deficit. But a large minority identify health reform per se as a top priority.

Against this was an emerging vocal minority vehemently opposed to health reform. Many Democrats in 2008 were elected in districts that had traditionally voted Republican and thus did not have very safe seats. Further, Representatives serving in the House have two-year terms and are constantly under pressure to look to the next election – often described as the constant campaign cycle.

The Kaiser Foundation’s tracking poll showed that overall support for reform was mixed throughout 2009:



Source: Chartpack: Kaiser Health Tracking polls – February 2009 to December 2009, The Henry J. Kaiser Family Foundation

When you ask people if they think that health reform will make their family better off or worse off, we see that responses had changed between February and December. The rate of “better off” responses declined slightly, from 38% to 35%. However, there was evidence of growing negativity, as the percentage of people responding that they would be made worse off more than doubled – rising from 11% in February to 27% in December.

Responses to the question “is health reform good for the country as a whole?” reflect similar trends. Thus when health reform was being formulated and debated in 2009, it was hardly a political “slam dunk”. However, President Obama and the Democratic leadership were convinced it was too late to turn back.

Obama, along with many of his colleagues in Congress, had staked so much on this issue that he made the decision to proceed with reform efforts despite the political risk to the Democratic Party. Indeed, some strategists argued that capitulation to the Republicans on health reform posed greater political risk to the Democrats than pushing forward with health reform, after the President and congressional Democrats had invested so much energy in crafting a plan and making the case for health reform to the public.

In the months that followed, events took one unexpected turn after another. Perhaps the most notable surprise was the election of a Republican during a special election to replace the late Senator Ted Kennedy in Massachusetts. The loss of what had been long considered a safe Democratic seat deprived the Democrats of a filibuster-proof majority. Suddenly Democrats were unable to pass legislation in the Senate without Republican votes. Arguably the election in Massachusetts expedited the passage of health reform legislation, albeit by unconventional manoeuvres. The loss of a 60-seat majority in the Senate meant that the House Democrats needed to pass the Senate Bill in its entirety instead of engaging in a potentially lengthy bargaining process as part of Conference deliberations, with only a restricted set of changes possible under a less-frequently used reconciliation process. The Senate and House Democrats were able to reach a compromise by this means, and Obama’s health reform plan was signed into law at the end of March 2010.

The Congressional Budget Office estimates that, as a result of health reform, 32 million people will become newly insured over a ten year period. Sixteen million of them will be enrolled in Government insurance programmes such as the State Children’s Health Insurance Program (SCHIP); Medicaid, the federal-state health insurance programme for low-income Americans; and 24 million more people will be enrolled through exchanges. Although the insurance expansion does not guarantee every American health insurance, it substantially reduces the number of uninsured.

The exchanges are mainly designed to make health insurance available for people who do not qualify for Medicaid and who cannot obtain health insurance at favourable rates through their employers. But they are also intended to change the way that health insurance is purchased and sold, giving individuals and small businesses the opportunity to obtain insurance on more favourable terms than traditional individual health insurance markets. Furthermore, extensive comparative information will enable individuals to make informed decisions when they enrol in a health insurance plan.

Subsidies for health insurance purchase are available to individuals and families whose yearly income is above 133% of the federal poverty level (FPL), making them ineligible for Medicaid, and less than 400% of the FPL. Just below 400% of the FPL, individual and family contributions to health insurance premiums are capped at 9.5% of income. At the lower end insurance premiums can only make up 2% of income.

The largest costs of the health reform legislation come from these subsidies and from increased expenditures on Medicaid. The total increase in health outlays estimated to result from the health reform plan is about \$930 billion over ten years. The subsidies to purchase health insurance on exchanges will account for about \$360 billion of this total. The new plan also includes \$106 billion for a reinsurance programme which will reimburse insurers for the high-risk individuals they enrol. Government programmes have been projected to cost \$434 billion and a variety of smaller programmes add to that cost.

In a nation facing massive and growing government debt, the long-term fiscal consequences would be of considerable interest to the public. But the budgetary consequences of legislation received tremendous attention for another reason as well: the US Congress has pledged to operate under pay-as-you-go rules. In principle, this means that Congress needs to find savings or revenues to offset the costs of any legislation that increases federal expenditures. Thus Congress was under great pressure to find savings to offset the costs of this piece of legislation. According to the Congressional Budget Office, Congress succeeded. According to their estimates, the Patient Protection and Affordable Care Act will reduce the federal budget deficit by \$124 billion over ten years.

Some of the savings come from offsetting reductions in government programmes, taxes on device manufacturers, pharmaceutical companies and insurers, and an increase in the Medicare Part A tax for high income individuals.

Complementing the subsidies intended to expand the numbers of Americans with health insurance are a number of new regulations placed on health insurers. They are designed to protect consumers who have to purchase insurance on their own or as part of a small group. There are also changes in payment mechanisms under Medicare and an emphasis on prevention and primary care. For example, insurers are obliged to automatically cover any form of preventive care that is recommended by the US Preventative Services Task Force and to provide higher payments for primary care physicians, that is, to assist with recruitment to what has been a less well-paid part of the profession. The new plan also includes a set of provisions to encourage different health care providers to work together better, such as the creation of Accountable Care Organizations (ACOs).

Promoting more efficient care

Most of what I have been discussing concerns the mechanics of financing: what the financial implications are and how you get more people covered. I now want to talk about the so-called “game changers,” the aspects of the reform legislation that are intended to change one or more of: (1) the rate of growth of health care costs; (2) how we practice care; and (3) the quality of care.

There is a broad set of health care delivery and payment reforms. The Medicare programme in particular is currently an example of a traditional fee for service health insurance programme, where a physician is paid according to a set fee schedule for each service that he or she provides. A physician can increase revenue by delivering a higher volume of services. The goal of several of the reforms is to change the payment mechanism so that providers get paid for actually making their patients better rather than simply delivering more services. An important part of the approach is giving physicians more financial responsibility.

The health insurance exchanges are intended to facilitate this change. The exchanges are a market oriented idea, modelled after the Federal Employees Health Benefits Programme (FEHBP). Because they can purchase their insurance through FEHBP, federal employees can choose among a large number of health insurance plans, and are provided with extensive information about each. The information includes descriptions of the services each plan covers as well as premiums and out of pocket costs. This version of a health insurance market or exchange operates with a very low overhead and tends to work well.

Multiple health reform plans have included a variant of market exchanges, though not necessarily by that name. Examples include Health Insurance Purchasing Co-operatives and Purchasing Pools. These arrangements build on the idea that if consumers have information about the different health plans, health plans will compete not only on premiums, but also on the quality of the care, and also on the breadth of choice of physicians and hospitals available through the health plan's network. Participating plans, like health insurance plans in general, are subject to regulatory controls. In this case, the legislation specifies what the health exchange plans need to cover. Much more is going to be spelled out in the next phase of rule-making. There will be bronze, silver, gold and platinum plans. To qualify for the subsidies mentioned earlier, you have to be enrolled in a silver plan or higher.

What about the public insurer idea which was dropped from the initial proposals? In most of the public discussion there was little detail about what a public insurer would look like. Would it resemble traditional Medicare and use the Medicare fee schedule, or would it just be a public agency providing insurance similar to that of commercial plans? There was also little discussion of how a public plan would set provider payments. Would a public plan act like a commercial insurer except be publicly owned? The public option became an ambiguous and highly ideological issue.

One possible scenario is that the public insurer might use the Medicare fee schedule, but because its reimbursement rates would be so much lower than the commercial health insurance payment, physicians would avoid seeing patients enrolled in the public plan. An alternative scenario is an equilibrium in which everybody enrolls in public insurance. In alternative scenarios, nobody could enrol. Without knowing details that were lacking in the debate, it is impossible to say what impact a public plan would have.

The Affordable Care Act includes many programmes that change how doctors and hospitals are paid. A few of them merit special attention. One is the Center for Medicare and Medicaid Innovation, which will be set up within the Centers for Medicare and Medicaid Services (CMS). It will have a billion dollar annual budget to help develop new ways to pay for

care and organise providers. The dramatically increased budget for such activities has the potential to change the way that CMS approaches demonstration and pilot projects, and to promote more fundamental change in care delivery than has been possible in recent years.

The second is the Medicare Shared Savings Program which will enable hospitals and physicians to come together and legally share the savings if they come up with plans to successfully lower the costs of care. The third is a Hospital Readmissions Reduction Programme which includes a financial penalty for hospitals that have high rates of preventable events like certain types of hospital acquired infections.

Another feature of the legislation is something that many of us thought was a political impossibility. It is the creation of a largely independent agency that will have the ability to propose changes in federal health programmes and have them take effect with only limited modification by Congress, if health expenditures grow too rapidly.

Historically, Congress has been deeply involved in setting policy for Medicare. When I was on the Medicare Coverage Advisory Committee, we held a meeting to consider the use of PET scanning, a very expensive test that was not covered routinely in the same way that CT and MRI scanning were. At the time perhaps the most powerful member of the Senate was Ted Stevens, a senator from Alaska. Ted Stevens wrote a letter to the then Secretary of Health and Human Services, Donna Shalala, recommending that Medicare cover PET scans. Secretary Shalala insisted on evaluating the requested coverage through regular channels, including the Medicare Coverage Advisory Committee. Following our committee's evaluation, there was only a limited extension of coverage for PET. Under other circumstances, however – if the Secretary of HHS had not been so committed and steadfast about maintaining an evidence-based process for coverage decision making – there could easily have been nearly unlimited coverage for PET scanning.

The reform legislation, in addressing the appropriate ways in which Congress might interact with officials in government agencies was also cognisant of an important advisory committee called MEDPAC, the Medicare Payment Advisory Committee. MEDPAC was created by Congress and its work is well respected. Its members have a very deep understanding of how the programme works, they understand policy, economics and medicine, and they have broad representation. They routinely issue recommendations for ways to make Medicare more efficient. However, when they make controversial recommendations – and any recommendation that has large effects on Medicare spending is controversial – their advice is seldom followed by enabling legislation. The idea this time was to create some political insulation for a MEDPAC-like body to be able to make recommendations that had a better chance of being implemented.

Despite being politically unpopular, this component of the health reform bill survived the legislative process, although its scope became more limited as the legislation moved forward. Starting in 2014 the Independent Payment Advisory Board can make efficiency recommendations, and if certain cost targets are not met, that is if Medicare expenditures grow at too rapid a rate, their recommendations take precedence and by-pass standard

Congressional committees. Under such circumstances, their recommendations cannot be amended without a 60 per cent majority vote by Congress. The default approach is to adopt the recommendations; if the legislators do not like the recommendations, they have to undertake action to overcome them. That procedural change is significant, especially if you realise how difficult it is to pass any legislation through Congress. Ultimately, this changes the entire game in terms of how things are done.

Another feature that was added is that, while the new advisory body cannot dictate policy for the entire health system, they can collect data and report on health system performance generally. However, the board cannot make any recommendations before 2019 that will reduce payments to physicians and hospital services, which together account for the majority of Medicare expenditures.

A final major “game changer” I want to talk about is comparative effectiveness research. The idea is not only to do technology assessments, i.e. structured literature reviews and modelling efforts, but to actually collect new kinds of data.

Comparative effectiveness research was partly funded before the health care reform legislation in the stimulus bill that was passed in the wake of the economic crisis, the American Recovery and Reinvestment Act. \$1.1 billion was set aside for comparative effectiveness research (CER) for two years. The health reform plan institutionalised it in a new private organization called the Patient Centered Outcomes Research Institute. Recall that the US Congress had divided views about certain issues. Although the legislation passed, it included features that might seem inconsistent. For example, the agency cannot make coverage decisions using a cost-effectiveness threshold. It can only provide information, and some people claim that it may not be able to report health outcomes in quality adjusted life years. So there are significant limitations on how federal programmes can use the research.

With all of these limitations, how exactly will CER affect health care? The Congressional Budget Office had issued a report two and half years ago about savings from comparative effectiveness research. The version of comparative effectiveness research they examined was defined in a bill that was being considered at the time. The bill prohibited federal agencies from using the results directly. Unsurprisingly the report concluded that it would have no effect on health expenditures, though the report also stated that CER implemented in a different way might have substantial effects.

How might CER be used effectively? Gail Wilensky, who formerly headed the Health Care Financing Administration (HCFA, the former name for the agency that administers Medicare), said: “...the information from comparative clinical effectiveness needs to be paired with financial incentives to encourage their more appropriate use...”. In other words, when there is good clinical evidence for treating a disease in a certain way, there should be a financial incentive such as low co-payments for patients, and higher out-of-pocket payments when the available evidence suggests that a procedure or treatment pathway is not effective.

One of the prominent voices during the health reform debates was that of Glenn Steele, a prominent surgeon and head of a provider group that also runs an insurance programme in rural Pennsylvania called the Geisinger Clinic. Glenn Steele frequently testified before Congress about aspects of the reform bill. During one session he described how Geisinger developed a new approach to pay for care that was built upon “best practice steps” – a product of CER. They developed such steps for cardiac surgery patients using the American Heart Association and American College of Cardiology guidelines for surgery. They “hardwired” the best practice steps into their electronic health record and then established a package price for this bundle of services. The clinic bears the full financial risk. If the costs for any one patient are higher than expected, the clinic will have to make it back with patients whose costs are lower than expected. This is the model for some of the payment reform features that are in the Accountable Care Act.

Thus the purpose of CER is not to use it for coverage decision making, although commercial health insurance plans will be unlikely to ignore it when setting coverage policy. Instead, it may be used to construct bundled payments and other types of payment innovations designed to promote better outcomes and better care. The Lewin Group, a private consulting group that carries out forecasts similar to those of the Congressional Budget Office, has estimated that combining CER with this type of innovative programme could save \$368 billion over ten years.

I want to close with just a few thoughts and an explanation for why I answered the question I posed the way I did.

Many of my colleagues are sceptical about the effects of the reform legislation. We are frequently asked the simple question: “Is it a good thing or is it a bad thing?” One can argue either way so I want to start out with how reform could go wrong. The states play a major role in implementing the reform and making it work. For example, the exchanges and high risk pools have to be set up by the states. Medicaid, the insurance programme for the poor, is mainly administered by the states, although it is a joint federal/state programme. If the states refuse to play ball in any one of these areas, the reforms won’t deliver the promised benefits. Do not be surprised if you see that it works very well in California and poorly in Louisiana. It all has to do with the support from the state governments. Similarly, there are basic issues of having enough people with the right kind of skills to help roll out these reforms. Whether it is a lack of people or a lack of will, the states have a huge role to play and can influence how smoothly implementation proceeds.

The savings that are projected to occur in government programmes are, in large part, due to reductions in the growth rate of Medicare and Medicaid payments. The danger here is that at some point a physician can say: “I am earning \$75 for this office visit for a Medicare patient and \$300 for a commercially insured patient; I am just going to stop seeing Medicare patients”. This is a real risk if Medicare payments are set too low because Medicare and Medicaid are not the only payers in this system.

There is a similar risk for hospitals. Several demonstration projects have been authorised, under the new legislation, to come up with new forms of organisation of care and payments. What if they are unsuccessful? What if they are successful but only in small hospitals or in unique areas, and they simply do not generalise to the rest of the country? Might we end up with more risk selection? If the subsidies are too low the only people who will purchase health insurance are those who know they are going to need a extensive medical care. The result would be an increase in the cost of purchasing insurance.

Health insurers say their rates are going to increase for two reasons: 1) hospital and physician groups are charging them more; and 2) they are insuring a higher risk population. They are covering more and more people who have costly health conditions, especially in their individual insurance products.

Another much talked about aspect of health reform is the individual mandate and the requirement that people purchase health insurance or face financial penalties. Initially, the penalties are going to be quite low, especially if you are a low income person. For a relatively healthy 25 year old who does not make much money, the cost of enrolling in health insurance may be high relative to the size of the penalty for not purchasing coverage. It becomes evident that this aspect of the mandate may not work as planned if the penalty for non-purchase is too small. This will drive up costs by removing low cost enrollees from the risk pool.

A somewhat obscure issue, but very important in California, is monopolies, in particular highly concentrated markets of providers. In the US we do not have fixed prices for payments from insurers to providers, so when there is monopoly power prices may be very high. There are features in the new law that could increase market concentration, especially as physicians in hospitals join together into integrated groups.

The rising costs might lead to increased regulation. For example, when insurers in Massachusetts increased their premiums, the Governor stepped in and the State Health Insurance Commissioner was not allowed to authorize the increase in premiums that insurers were demanding. The difficulty that the health plans then faced, or at least that they claimed, was that their revenues would fall below their costs.

A final way in which things could go wrong is the possible repeal of the excise tax on high cost health plans. The excise tax addresses what economists typically view as the fundamental cause of excess health expenditures in the United States – the favourable tax treatment of health insurance. The excise tax does not take effect until 2018 and could easily be repealed before then.

Now a few words about the other side of the coin, i.e. how reform could turn out well. First of all there are many incentives for physicians and hospitals to integrate care better. It is clear that hospital leaders get the message, and many of them are already working on this even before the law goes into effect, or at least the parts of the law that would incentivise them to do this.

The payment incentives to improve health outcomes might work. The emphasis on prevention in primary care might work. We may actually see an unprecedented level of innovation in medical technology that is designed to achieve better outcomes at lower cost. This will require a shift in the goals and behaviour of medical technology innovators. Many of them already see this as a profitable opportunity, but not without an element of risk.

Ultimately, whether the reform is successful or not will be dependent on the following:

- 1) Implementation. This will be immensely complex and will require the right leadership to succeed. Leadership can determine whether ambiguities and other problems in the legislation become major challenges or are readily overcome;
- 2) The legislation itself;
- 3) How providers behave, as well as employees and individuals.

Congress is unlikely to repeal this legislation anytime soon. At this point you would need bipartisan consensus. What we may see are other congressional modifications such as increased payments to doctors under Medicare that will undo the cost saving features of the current reform plan.

I believe that Congress, sometime over the next four to six years, will be less amenable to increases in provider payments, due to rising federal budget deficits. Although Congress cannot be counted on to restore Medicare payment cuts in several years, in the near-term they likely will. But Congressional behaviour, particularly two or three elections into the future, is not easily predicted, and the state of the economy at the time will weigh heavily in their thinking.

One other point: those who think that the legislation is a step in the wrong direction need to remember that the alternative is not the status quo, because the status quo is not stable: we had rising numbers of uninsured people and Medicare and other government programmes increasingly weighed on the economy. The alternative was never going to be perpetuation of health care as it existed two or three years ago. The alternative was likely to be characterised by rising costs and worse health outcomes. Perhaps that set the bar a little bit lower for health reform but for many of us that is why, despite its shortcomings, this kind of legislation is indeed a step in the right direction.

Office of Health Economics

The Office of Health Economics (OHE) was founded in 1962. Its terms of reference are to:

- Commission and undertake research on the economics of health and health care;
- Collect and analyse health and health care data from the UK and other countries;
- Disseminate the results of this work and stimulate discussion of them and their policy implications.

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