Testimony Presented to the Senate Health, Education, Labor, and Pensions Committee:

"Identifying Opportunities for Health Care Delivery System Reform: Lessons from the Front Line"

James C. Capretta
Fellow, Ethics and Public Policy Center and
Visiting Fellow, American Enterprise Institute

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Senator Whitehouse, Ranking Member Enzi, and members of the committee, thank you for the opportunity to participate in this very important hearing on health care delivery system reform.

I would like to make three basic points in my testimony today:

1. The source of many of our problems in health care delivery is the dominant Medicare fee-for-service (FFS) program. It will be nearly impossible to move to a high-value, low-cost delivery system if Medicare FFS continues to operate as it does today.

2. The 2010 health care law's efforts at "delivery system reform" — most of which fall within Medicare — are very unlikely to be the solution people are hoping for because the federal government is not good at fostering a high-value, low-cost provider network.

3. A more reliable approach to higher-quality and lower-cost patient care is strong competition in a functioning marketplace.

Medicare's Role in Dysfunctional Health Care Delivery

Let me begin with what I think is a point of agreement: Medicare fee-for-service (FFS), as the program is currently constituted, is a primary cause of the systemic deficiencies in health care delivery that we all want to see addressed.

Why do I think this is a point of agreement? By looking at the 2010 health care law. The key "delivery system reforms" that are being pushed and promoted by the administration are mainly in the Medicare program. In effect, the administration is hoping to change how health care is delivered for everyone in the United States by changing how Medicare buys services for its enrollees.

Although I am skeptical of the policy prescription, I agree that changes in Medicare are the right place to start.

American health care has many virtues. The system of job-based insurance for working-age people and Medicare for retirees provides ready access to care for most citizens (although access is more problematic for the poor through Medicaid). We have the most advanced network of clinics and inpatient facilities found anywhere in the

world. And U.S. health care is also open to medical innovation in ways that other health systems around the world are not.

But there is no denying that health care in the United States is all too often highly inefficient. The system is characterized by extreme fragmentation. Physicians, hospitals, clinics, labs, and pharmacies are all autonomous units that are financially independent of one another. They bill separately from the others when they render services to patients; what's worse, there's very little coordination of care among them, which leads to a disastrous level of duplicative services and low-quality care in too many instances. The bureaucracy is maddening, the paperwork is burdensome and excessive, and there is very little regard for making the care experience convenient and pleasant for the patient.

At the heart of this dysfunction is Medicare — and more precisely, Medicare's dominant FFS insurance structure.

In a June 2009 article in *The New Yorker*, Atul Gawande contrasted the high-use, high-cost care provided in McAllen, Texas, to the less-costly and higher-quality care provided in other cities, such as El Paso, Texas, and at institutions such as the Mayo Clinic.[1] However, as Robert Book later pointed out, the real lesson from the Gawande study may be quite different from what most assumed initially.[2] At the time, President

[1] Atul Gawande, "The Cost Conundrum: What a Texas Town Can Teach Us About Health Care," *The New Yorker*, June 1, 2009, at *http://www.newyorker.com/reporting/2009/06/01/090601fa_fact_gawande*.
[2] Robert Book, "Medicare Variation Revisited: Is Something Wrong with McAllen, Texas, or Is Something Wrong with Medicare?" The Foundry, December 14, 2010, at *http://blog.heritage.org/2010/12/14/medicare-variation-revisited-is-something-wrong-with-mcallen-texas-or-is-something-wrong-with-medicare/*.

Obama and others cited the article as an example of how physician culture and practice patterns have run amok in certain regions of the country and why "bending the cost curve" would require addressing these problems.

Yet upon closer inspection, it became clear that the cost differences between McAllen and El Paso were largely confined to Medicare. For the non-Medicare population, the cost differential between the two cities is practically nonexistent.[3] As Book explained, this suggests that Gawande uncovered a problem with *Medicare* in McAllen, not a problem with medical *practice* in McAllen.

Indeed, Gawande's article never really explained who was paying for McAllen's overbuilt system. It turns out it was Medicare FFS, with its emphasis on an expansive, volume-driven delivery structure. Without Medicare FFS payments for every physician-prescribed diagnostic test and surgical procedure, the expensive infrastructure in McAllen would never have been viable.

Medicare's FFS insurance is the largest and most influential payer in most markets. As the name implies, FFS pays any licensed health care provider when a Medicare patient uses services — no questions asked. Nearly 75 percent of Medicare enrollees — some 37 million people — are in the FFS program.[4] Physicians, hospitals,

[3] Luisa Franzini, Osama I. Mikhail, and Jonathan S. Skinner, "McAllen and El Paso Revisited: Medicare Variations Not Always Reflected in the Under-Sixty-Five Population," *Health Affairs*, Vol. 29, No. 12 (December 2010), pp. 2302–2309.
[4] 2012 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Insurance Trust Funds, April 2012, Table IV.C1.

clinics, and other care organizations most often set up their operations to maximize the revenue they can earn from Medicare FFS payments.

For FFS insurance to make any economic sense at all, the patients must pay some of the cost when they get health care. Otherwise, there is no financial check against the understandable inclination to agree to all of the tests, consultations, and procedures that could be possible, but not guaranteed, steps to better health.

But Medicare's FFS does not have effective cost-sharing at the point of service. Of course, the program requires some cost-sharing, including 20 percent co-insurance to see a physician. But the vast majority of FFS beneficiaries — nearly 90 percent, according to the Medicare Payment Advisory Commission (MedPAC) — have additional insurance, in the form of Medigap coverage, retiree wraparound plans, or Medicaid, which fills in virtually all costs not covered by FFS.[5] Further, Medicare's rules also require providers to accept the Medicare reimbursement rates as payment in full, effectively precluding any additional billing to the patient.

In the vast majority of cases, then, FFS enrollees face no additional cost when they use more services, and health care providers earn more only when service use rises. It is not at all surprising, then, that Medicare has suffered for years from an explosion in volume of services used by FFS participants.

[5] Joan Sokolovsky, Julie Lee, and Scott Harrison, "Reforming Medicare's Fee-for-Service Benefit Design," Medicare Payment Advisory Commission, February 23, 2011, at *http://www.medpac.gov/transcripts/benefit%20design%20jsjl.pdf*.

CBO reports that the average beneficiary used 40 percent more physician services in 2005 than they did just eight years earlier.[6] Spending for physician-administered imaging and other tests was up approximately 40 percent in 2007 compared to 2002, according to MedPAC.[7]

Medicare's dominant FFS design also stifles much-needed innovation in service delivery. As Mark McClellan, former Administrator of the Centers for Medicare and Medicaid Services (CMS), put it:

> *In traditional FFS Medicare, benefits are determined by statute and cannot easily include many innovative approaches to benefit design, provider payment, care coordination services, and personalized support for beneficiaries.... When providers are paid more when patients have more duplicative tests and more preventable complications — as is the case in FFS payment systems — it is more challenging to take steps like adopting health IT or reorganizing practices in other ways to deliver care more effectively.*[8]

[6] Congressional Budget Office, "Factors Underlying the Growth in Medicare's Spending for Physician Services," June 2007, Table 3.
[7] Medicare Payment Advisory Commission, Healthcare Spending and the Medicare Program: A Data Book, June 2009, p. 102.
[8] Mark McClellan, testimony before the Committee on the Budget, U.S. House of Representatives, June 28, 2007, at *http://www.allhealth.org/briefingmaterials/mcclellantestimony-818.pdf*.

The Limitations of Government-Led Delivery System Reform

The Obama administration is trying to address these problems caused by Medicare in the delivery system with initiatives being championed by the Centers for Medicare and Medicaid Services (CMS). I am very skeptical that these efforts will solve the problem.

The most prominent delivery system reform now being pursued is the effort to move more care delivery into accountable care organizations (ACOs)**.**

An ACO allows doctors and hospitals to join voluntarily with others in new legal entities that are responsible for providing care across institutional and outpatient settings. The idea is to put physicians and hospitals in new organizational arrangements in which they share Medicare revenue and keep the savings if they provide quality care at less cost than FFS Medicare would normally pay. The physicians and hospitals participating in an ACO would keep a substantial portion of the resulting savings. In effect, ACOs are the latest in a long series of efforts to persuade physicians and hospitals to form provider-run — as opposed to insurance-driven — managed care entities.

Interestingly, a five-year pilot project on ACOs has already come up well short of the high hopes placed upon it. According to a 2011 story in *The Washington Post*, "In 2010, the final year, just four of the 10 sites, all long-established groups run by doctors,

slowed their Medicare spending enough to qualify for a bonus, according to an official evaluation not yet made public."[9]

Moreover, the Congressional Budget Office (CBO) has systematically examined many demonstration initiatives carried out by CMS over the past decade or so, all of which were aimed at carrying out, in various ways, "delivery system reform" so that costs would moderate and patient care would improve.[10] The results have been terribly disappointing. As CBO Director Douglas Elmendorf put it:

> *The demonstration projects that Medicare has done in this and other areas are often disappointing. It turns out to be pretty hard to take ideas that seem to work in certain contexts and proliferate that throughout the health care system. The results are discouraging.*[11]

I believe there are two reasons to be skeptical that the health care law's efforts will turn out differently. First, Medicare FFS looks and operates as it does for a reason, which is that it is much easier for government-run insurance models to impose across-the-board payment rate cuts than it is to makes distinctions among providers based on quality and cost data. (This might be thought of as the CMS's version of the "Lake

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[9] Amy Goldstein, "Experiment to Lower Medicare Costs Did Not Save Much Money," *The Washington Post*, June 1, 2011, at *http://www.washingtonpost.com/national/experiment-to-lower-medicare-costs-did-not-save-much-money/2011/05/27/AG9wSnGH_story.html*.

[10] Congressional Budget Office, "Lessons from Medicare's Demonstration Projects on Value-Based Payment," January 2012, at *http://www.cbo.gov/sites/default/files/cbofiles/attachments/WP2012-02_Nelson_Medicare_VBP_Demonstrations.pdf*.

[11] Cited in Merrill Goozner, "Rising Health Care Curve Won't Bend, Even for Obama," *The Fiscal Times*, July 13, 2011, at *http://www.thefiscaltimes.com/Articles/2011/07/13/Rising-Health-Care-Curve-Wont-Bend-Even-for-Obama.aspx*.

Wobegon effect": to the government, all providers of medical care are "slightly above average.") Repeated attempts over the years to steer patients toward preferred physicians or hospitals have failed miserably because politicians and regulators have never been able to withstand the uproar that comes when some providers are favored over others.

The private-sector delivery models that are rightly admired — such as Geisinger, the Cleveland Clinic, and Intermountain Health Care — operate very differently. They do not take just any licensed provider into their fold. They operate highly selective, if not totally closed, networks, which allows them to control the delivery system. Low-quality performers are dropped or avoided altogether, and tight processes are established to streamline care and ensure some level of uniformity. *Most importantly, these models have succeeded despite Medicare's perverse incentives, not because of them*.

A second flaw can be seen clearly in the ACO design. The name Accountable Care Organization begs the key question: accountable to whom? Because in the ACO design the beneficiaries are really not part of the equation. Initially at least, the beneficiaries are to be assigned to ACOs based on their use of physician services. They won't be asked up front if they want to join them. Moreover, the beneficiaries will share in none of the supposed savings from the ACOs. If the ACO effort is found to cut costs, the savings will be shared among the providers and the government. What incentive do the beneficiaries have to enroll in what will very likely be seen as "managed care"?

In short, the ACO model is built around a flawed understanding of accountability. The ACO will be accountable to the government with data and other requirements. But the ACO concept is not intended to give the beneficiaries a choice of competing plans and models. This is a very shortsighted way to look at delivery system reform. ACOs will be effective at reducing costs only by becoming more integrated and closed networks of providers who follow data-driven protocols for care. It would far more effective if beneficiaries voluntarily signed up with such delivery models because it would reduce their costs too. As matters stand, the beneficiaries will have no financial incentive to give up complete autonomy in the choice of providers.

Moreover, for the ACO model to work, some high-cost, low-quality providers must be excluded from the ACO networks. As soon as that becomes evident, and provider revenue is threatened, the government will come under intense pressure (as it has in the past) to loosen the ACO concept and allow virtually all licensed providers to become "preferred ACO providers." When that happens, the only way to control costs will be the old-fashioned way: with blunt, across-the-board payment rate reductions in Medicare (which is exactly what the 2010 health care law did to hit its budget targets).

Relying on a Functioning Marketplace

The alternative to relying on a CMS-led delivery system reform effort is a functioning marketplace with cost-conscious consumers.

In 2003, Congress built such a marketplace, for the new prescription-drug benefit in Medicare. Two features of the program's design were important to its success. First, there was no incumbent government-run option to distort the marketplace with price controls and cost shifting. All private plans were on a level playing field. They competed with each other based on their ability to get discounts from manufacturers for an array of prescription offerings that are in demand among beneficiaries and their physicians.

Second, the government's contribution to the cost of drug coverage is fixed and is the same regardless of the specific plan a beneficiary selects. The contribution is calculated based on the enrollment-weighted average of bids by participating plans in a market area. Beneficiaries selecting more expensive plans than the average bid must pay the additional premium out of their own pockets. Those selecting less-expensive plans pay a lower premium. With the incentives aligned properly, participating plans know in advance that the only way to win market share is by offering an attractive product at a competitive price because it is the beneficiaries to whom they must ultimately appeal.

This competitive structure, with a defined contribution fixed independently of the plan chosen by the beneficiary, has worked to keep cost growth much below other parts of Medicare — and below expectations. At the time of enactment, there were many pronouncements that using competition, private plans, and a defined government contribution would never work because insurers would not participate, beneficiaries would be incapable of making choices, and private insurers would not be able to

negotiate deeper discounts than the government could impose by fiat. All of those assumptions were proven wrong.

What actually happened is that robust competition took place, scores of insurers entered the program with aggressive cost-cutting and low premiums, and costs were driven down.

The result has been a strong record of success. In 2012, the average beneficiary premium is just $30 per month for seniors.[12] Over the six years that the program has been operating, the monthly premium has gone up an average of about $1 per year.[13] Overall, federal spending has come in roughly 30-40 percent below expectations.

Similar changes — what might be called a defined contribution approach to reform — must be implemented in the non-drug portion of Medicare, as well as in Medicaid (excluding the disabled and elderly) and employer-provided health care.

In Medicare, that would mean using a competitive bidding system — including bids from the traditional FFS program — to determine the government's contribution in a region. Beneficiaries could choose to enroll in any qualified plan, including FFS. In some regions, FFS might be less expensive than the competing private plans. But in some places, it almost certainly would not be, and beneficiary premiums would reflect the cost

[12] Department of Health and Human Services, "Medicare Prescription Drug Premiums Will Not Increase, More Seniors Receiving Free Preventive Care, Discounts in the Donut Hole," press release, August 4, 2011, at *http://www.hhs.gov/news/press/2011pres/08/20110804a.html*.
[13] For the average premium in 2006, see Medicare Payment Advisory Commission ,"A Data Book: Healthcare Spending and the Medicare Program," June 2007.

difference. This kind of reform could be implemented on a prospective basis so that those already on the program or nearly so would remain in the program as currently structured.

Moving toward a defined-contribution approach to reform would allow for much greater federal budgetary control, which is of course a primary objective and tremendously important for the nation's economy and long-term prosperity. But this isn't just a fiscal reform. It's a crucial step toward better health care too because it would put consumers and patients in the driver's seat, not the government. With consumers making choices about the kind of coverage they receive as well as the type of "delivery system" through which they get care, the health system would orient itself to delivering the kind of care patients want and expect.

Conclusion

I commend the committee for holding this hearing today because it gets to the heart of the matter. To slow the pace of rising costs, we do need delivery system reform. But I do not think the federal government has the capacity or wherewithal to make it happen. Like other sectors of our economy, if we want higher productivity and better quality, we are going to need to rely on the power of a functioning marketplace.