

What Should Our Next President Do About Health Care Costs?

The Public Policy Institute sponsored a Solutions Forum on June 13, 2008, to look at policy options for dealing with rising health care costs. Julie Rovner of National Public Radio moderated a discussion among John Rother, executive vice president of AARP; David Cutler from Harvard University, an advisor to the Barack Obama campaign; and Tom Miller from the American Enterprise Institute, an advisor to the John McCain campaign.

Opinion polls that track the public's views on health care reform, including those sponsored by the Kaiser Family Foundation, have found that health care costs are among Americans' top economic problems, affecting their financial well-being and their family's health care. The Foundation also has found that health care costs are affecting family budgets: Nearly four in ten (37 percent) report financial troubles over the past five years as a result of medical bills. Because this issue resonates deeply with the public, AARP's Public Policy Institute held a forum to focus on health care costs and solutions the presidential candidates' advisors propose to address them.

The Sources of Cost Growth

Economic and policy researchers have identified three most important drivers of health care costs:

- New technology
- Third-party insurance (which makes people insensitive to cost)
- An increase in chronic disease, particularly obesity

Dr. Cutler agreed with these three as the most important sources. He added that another important area to target is

administrative expenses—in the U.S. health care system, these expenses have grown with health care costs, rather than becoming a smaller share of them, as one might expect. He also noted research from Dartmouth researchers that shows a dramatic geographic variation in health care spending and that higher spending does not buy better quality of care. This finding suggests that between a third and half of all medical spending is not buying anything useful.

Mr. Miller agreed on the factors, but switched the order—he said that the most important factors are third-party insurance, which means that patients are largely insensitive to the costs, and how we pay providers (for volume rather than value). Third-party insurance also stimulates the supply of technology—which raises costs, because it gives its producers the promise of payment. He added that providers who are delivering health care and incurring costs for patients and payers need to be more accountable for the outcomes and costs of the care. Mr. Miller emphasized the importance of the larger issue of population health—because we will be paying for the consequences of poor health for a very long time, it is important to change the behaviors and invest in better health of the young. Education is a more powerful

factor in shaping and improving long-term health than how we insure Americans and finance their health care.

Proposals for Controlling Costs

There is widespread agreement among policymakers and the public that the rise in health care costs is affecting government budgets, business, and families. Both presidential candidates have proposals for slowing the rise in health care costs and getting better value out of the dollars we already spend.

Mr. Miller called for better measurement of performance for groups of accountable health care providers and for development of measures that capture outcomes of care. To do this, we should think creatively about how to link doctors in individual practice, so they work together toward the same goals. He also called for prioritizing health improvement among younger people, since we will pay for their health care over time. At the same time, we need to figure out better ways to treat chronic conditions. Mr. Miller also supports the design of cost sharing to create incentives for people to see better providers and get the right type of care.

Dr. Cutler emphasized three policies to control costs. First, he agreed with Mr. Miller on the importance of improving prevention and care management and called for innovative models of prevention and chronic care management that reach out and actively engage people to improve their care. Second, he called for investment in “knowing more and paying smarter,” that is, learning which providers have the best performance, which treatments are the most effective, and which services are really needed in a particular case. Once we build this evidence base, we should design payment systems to encourage providers and patients to use the best and most effective care. Complementing this

evidence base will be more use of health care information technology (IT); Senator Obama’s health care plan proposes \$50 billion for health care IT. The third area for cost containment programs to target is administrative expenses. Senator Obama’s proposal would promote insurance exchanges that can pool risk and administrative functions, much as a large firm does. These exchanges will help small firms and people who buy individual insurance by reducing administrative expenses.

Dr. Cutler and Mr. Miller disagreed about whether consumer-directed health plans deter consumers from using preventive services. While Dr. Cutler pointed out that this was a concern, Mr. Miller stated that a McKinsey study found that consumers in these plans use information more aggressively and use more preventive care.

Mr. Miller also noted that although he supports learning more about what works, the success of comparative effectiveness research will depend on how different organizations and practitioners translate this information into practice. How efficiently care is delivered can have a larger effect than determining which services are theoretically the most effective.

Finally, Mr. Miller noted that the Obama approach would raise spending by expanding coverage and recycling its savings into investments in additional health care services, and he said it is not possible to control costs of public programs while expanding them.

Dr. Cutler argued that a high priority of the Obama plan is to integrate policies to improve value with offering coverage to the nearly 50 million people uninsured entirely during the year and that number again uninsured at some point during the year.

Health Care Information Technology and Privacy

Many believe that health care IT has the potential to improve the quality of care and to reduce paperwork in the health care system. Analysts have pointed to a number of reasons for the relatively slow diffusion of health care IT, one of which is concern that computerizing this information may compromise patient privacy.

While Dr. Cutler agreed that there are privacy issues to be resolved in health care IT, he felt that they are not insurmountable. One way to address them would be an “opt out” provision that would allow people to remove themselves from a database. He noted that the bigger issue to be resolved before IT is more widely adopted is developing a model that delivers better care more efficiently; once that model is found, people will invest in health care IT. Mr. Miller agreed that issues around privacy can be resolved through “opt out” strategies. Senator McCain is very optimistic about the potential for health care IT to save money and feels that it is important to get agreement on interoperable standards. Speaking as a general expert, Mr. Miller pointed to some limits to the analyses that claim large savings from IT.

Addressing the Cost of Prescription Drugs and Costs Associated with End of Life

People are aware of two factors affecting the cost of care—the high costs of prescription drugs and the high costs of care at the end of life. Prescription drugs are a relatively small share of total health care spending—about 10 percent. Health care spending at the end of life is estimated to make up a quarter of all health care spending.

Dr. Cutler remarked that the out-of-pocket cost of prescription drugs is higher than for other services, which is why it is more noticeable to consumers. The Medicare Part D program is a good model for providing drug coverage, though it needs work. One issue in end-of-life care is that the care provided does not have an enormous amount of value. That said, we have not developed interventions that work very well. There are emotional issues to take into account. Investing in learning more about what works will help us to discern what care is of value and what is not.

Mr. Miller pointed out that prescription drug spending has slowed in the last couple of years, thanks in part to the increased use of generic drugs. Moving to biosimilar drugs for biologics is an important area, but it is more complicated than for other drugs. Senator McCain has been in favor of reimportation. Mr. Miller also pointed out that profits and patents drive innovation and that reducing profits could stifle innovation. With respect to end-of-life care, the challenge is predicting when someone is at the end of life, and he agreed that this is a complex emotional area.

Health Care Workforce and Cost Containment

The Institute of Medicine and others have pointed to the need for the capabilities of the health care workforce to change with the growing aged population and to the shortages in primary care, nursing, and direct care workers. At the same time, when the number of providers grows, service use and costs tend to grow.

Mr. Miller noted that more physicians do not necessarily result in higher quality of care. He also remarked on the challenge of attracting and keeping physicians in rural areas. Ideally, integrated care teams

would evolve to make the most out of the resources available, loosen up on the scope of practice, use senior nurses and physicians more creatively, and allow health care providers to immigrate into the United States. It is important to create incentives to produce the right outcomes at a lower cost, regardless of kind of what label providers have.

Dr. Cutler noted that Senator Obama's plan devotes a fair amount of space to changing the mix of the workforce—not just primary care providers, but all types of personnel who work in primary care. Very frequently, that will not be a physician; it will be an advanced practice nurse. He pointed out that integrated teams tend to do the best jobs on prevention, care coordination, and use of IT. Advanced practice nurses also do a lot of outreach and prevention, which can result in good outcomes.

In response to a question from the audience, both speakers expressed interest in learning more about the nursing and nursing faculty shortage.

Where Medicare Fits into Reform and Cost Containment

An important question for the future president is whether to integrate Medicare into health care reform, introduce policies to reform Medicare first, or introduce policies targeted at the private sector first.

Dr. Cutler said that we need Medicare changes and a big commitment to IT and preventive initiatives, and we will need a big effort to restructure the private health insurance market to allow individuals and small businesses buy as a large group. The Obama plan would move forward on all these initiatives as fast as possible; now is the time to do so. Dr. Cutler pointed out that the public sector buys half of medical care, so it is important to think about large-scale changes in

medical systems in public programs. At the same time, we see important and interesting innovations in health care around the country in spite of the government. Those innovators report that their innovations would have been easier if government did not create barriers. Medicare, the whole federal government, and state and local governments should be part of the solution.

Mr. Miller said that Senator McCain would emphasize using Medicare as an important laboratory for change— Medicare will have to take the lead in creating incentives for accountability. Mr. Miller agreed that initiatives will have to go through Medicare to have leverage. But at the same time, innovations in Medicare have been difficult. At the end of the day, some changes will have to be made wholesale with the best design possible; we cannot wait for all the innovations to be tested piecemeal through the demonstration process. Senator McCain supports income-related Part D premiums.

On the Role of Malpractice Reform in Controlling Costs

Many physicians point to defensive medicine and high personal liability insurance as contributors to health care costs.

Mr. Miller noted that damage caps work to bring down costs. They are, however, a crude approach to what he called “a very crude system,” which doesn't work well. Creative ideas that have some value, though they may not end up being tried, are medical courts, early offers, and alternative dispute resolution.

Dr. Cutler said that in a much better medical care system, malpractice would be rare. We need to have fewer mistakes and fewer things that go wrong and to intervene beforehand so we get the data we need, the right preventive care in

place, and the environment to encourage admitting mistakes without facing a penalty for them. Today's environment, by contrast, encourages providers to conceal mistakes. Caps on damages are expected to save 2 percent of spending on medical care. Focusing on preventing bad outcomes in the first place would have a much larger impact.

How Reform Proposals Would Save People Money

Since most Americans view the cost problem through their own experience, rather than through perspective of the system or the payer, it is important to understand how the reform proposals would affect the American pocketbook.

Dr. Cutler estimates that Senator Obama's plan would save the typical American family about \$2,500 a year through reduced out-of-pocket expenses associated with better coverage and less unnecessary care, lower premiums that employers face, and savings in public-sector programs. Some families, particularly those that purchase coverage in the individual market, will see even greater savings. The Obama plan would offer a guaranteed level of benefits that is roughly equivalent to a Medicare plan or the federal health benefits program but would have more medical management. The plan would prevent people from having to spend tens of thousands of dollars a year on health care.

Mr. Miller disagreed with the estimate for the Obama plan and argued that the Obama plans shifts costs around and does not reduce them. In particular, he said the reinsurance provisions are a new form of subsidy. Mr. Miller also disagreed with the potential for administrative savings in the Obama plan. He made a general criticism of the Obama plan, saying that elements of the proposal—a national plan option and a national health insurance exchange—

would encourage people to take up public coverage because it would increase regulatory burdens on private plans and would provide financial incentives for people to enroll in the national plan option. By contrast, the McCain plan would save individuals money by giving them more control over their health care dollars through tax credits that would go directly to them and their families. The McCain plan also would provide protections for people who have high-cost preexisting conditions and difficulty in finding affordable insurance, through substantially subsidized "guaranteed assistance plans" that cap the degree to which their premiums can exceed "standard" rates and subsidize them beyond that level. The plan also would reward more affordable, higher value care. The McCain plan does not have a cap on out-of-pocket spending, although Mr. Miller thinks it could be structured in a reasonable way.

On the "Physician Fix" under Debate for Medicare

Mr. Miller said we should start paying physicians ultimately on a value basis, not a fee basis. He noted that the reimbursement system for physicians rewards them for doing more. Dr. Cutler agreed that the current approach to setting physician payment rates each year is bankrupt.

Financing Health Reform

Dr. Cutler stated that one of the biggest differences between the candidates is that Obama is willing, in the short term, to put more money into medical care. The funds for that will come from the expiration of the high-income tax cuts. Obama's plan also calls for Medicare advantage savings. These sources would pay for tax credits for people to purchase insurance and for other new investments, such as health care IT.

Mr. Miller noted that we have a health care system that costs too much and delivers poor value, so it does not make sense to put more money into it. The only way to really pay for changes to health care is to have an evidence-based approach to reform that squeezes out waste and pays for care that is worthwhile. We need evidence that initiatives really work before indefinitely investing in them. If reforms do not actually deliver, we should not advance them.

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