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A Cure Worse than the Disease

Obama Care Won't Cut Costs, But May Cut Quality

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With Democratic support coalescing around Sen. Max Baucus's (D-Mont.) health care reform proposal, passage of a comprehensive overhaul now appears more likely than ever. One reason is the Congressional Budget Office's (CBO) preliminary cost estimate for the bill suggesting that it would cost $829 billion over the 10-year budget window, but actually *reduce* the federal deficit by $81 billion.[1]

On paper, the plan looks affordable, because it contains several features intended to reduce long-term health care costs. However, there is good reason to believe these proposals will not cut costs substantially, and could reduce the quality of care for patients. Most of the alleged cost-cutting measures merely shift costs from the federal government onto the states or private payers, without affecting long-term health care inflation. The only measures that could reduce the annual rate of growth in health care costs would erect government barriers between patients and their doctors, while jeopardizing long-term medical innovation.

Bringing millions of currently uninsured Americans into public or private health plans will not be cheap. That is why White House Chief of Staff Rahm Emanuel has said that the administration's first priority is "getting health care costs under control."[2] And, in an August *New York Times* op-ed, President Obama wrote that the Democratic proposals "will finally bring skyrocketing health-care costs under control" by cutting "hundreds of billions of dollars in waste and inefficiency in federal health programs like Medicare and Medicaid."[3]

In order to keep the bill's reported net costs down, Sen. Baucus's plan relies on $397 billion of new taxes and other expected revenue and on accounting and cost-shifting gimmicks. For example, to help increase health care coverage, the bill would expand Medicaid eligibility, a

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move that shifts an estimated $33 billion of spending to the states. The CBO's analysis notes this, but because it is not a federal expenditure, does not account for it in the bill's budget score.[4]

Dubious Cost Cutting Proposals. The Baucus bill also counts on dubious cost-cutting proposals, such as a $245-billion reduction in Medicare spending by enforcing a Sustainable Growth Rate (SGR) in annual payments to physicians.[5] Under the SGR, fees paid to doctors and hospitals for performing given procedures would increase every year at set rate that is lower than health care inflation. The mechanism is not new, however; it has been part of Medicare since 1998. But, in every year since 2002, Congress has prevented the SGR from actually triggering the scheduled fee cuts, which are hugely unpopular with physicians and patients.[6] The bill's cost estimate is based on proposed 24-percent physician payment cuts, but the CBO itself suggests that these savings are unlikely to materialize.

In his report to Sen. Baucus, CBO Director Douglas Elmendorf wrote that, "the sustainable growth rate (SGR) mechanism…has frequently been modified (either through legislation or administrative action) to avoid reductions in those payments," but that the cost projections had to assume the proposals would be enacted and enforced. "The long-term budgetary impact could be quite different if those provisions were ultimately changed or not fully implemented."[7] Missing even two or three years of these scheduled cuts would eliminate the projected deficit reduction and inflate the plan's total costs. Nevertheless, if the cuts *are* enforced, reducing payments for Medicare beneficiaries merely requires physicians and hospitals to charge higher rates to those with private health insurance.

These proposed changes result in an on-budget 10-year price tag for the Senate Finance Committee's health care reform proposal that is lower than those for the bills in the Senate Health, Education, Labor and Pensions Committee[8] and in the House of Representatives. However, none of the three bills contain the sort of fundamental changes in health purchasing that would reduce the annual rate of growth in health spending—that is, they do not "bend" the slope of the cost-curve in a downward direction.

Indeed, some alleged cost-cutting measures are more likely to increase long-term health care expenditures. For example, each of the bills would require every health insurance plan to pay for preventive care services, which, it is argued, would simultaneously reduce costs by improving health and permitting early diagnosis and treatment of potentially costly conditions.[9] While there are opportunities for preventive care to reduce costs by, for example, encouraging better diet, fitness, and smoking cessation, and by better managing certain health conditions such as diabetes, most comprehensive studies suggest that, on balance, preventive care services increase, rather than reduce, health care costs.[10]

The costs of the added screening inherent in preventive care coverage are substantial, and, ironically, they often tend to cause more money to be spent on costly treatment than would otherwise be the case. As Dartmouth University Professor of Medicine Gilbert Welch notes, "Screening for heart disease, problems in major blood vessels and a variety of cancers has led to millions of diagnoses of these diseases in people who would never have become sick."[11] And, according to a comprehensive review of the cost and benefits of preventive care published in the *New England Journal of Medicine*, "[S]creening costs will exceed the savings from avoided

treatment in cases in which only a very small fraction of the population would have become ill in the absence of preventive measures."[12]

The preventive care mandate is of a piece with other health care reform proposals. Each of the bills would set a minimum level of benefits that every health insurance plan must cover, and they would require plans to shield patients from many forms of cost-sharing, such as co-payments and high deductibles. But isolating patients from the cost of their care tends to result in over-consumption of health services.

Cost Control through Government Meddling. The only significant cost-cutting proposals on the table are those for the creation of federal intermediaries between doctors and their patients to restrict the amount of care patients receive. One such proposed program is an Independent Medicare Advisory Council (IMAC), or what the Senate Finance Committee bill calls a Medicare Commission,[13] to make recommendations about Medicare payment rate reductions and other reforms. The other is greater reliance on comparative effectiveness research to steer physicians away from high-cost, low-value treatment options. Yet even these proposals are of dubious value and are more likely to reduce the quality of patient care than to reduce the growth rate of health care costs.

There is no doubt that much health care spending is wasteful and unnecessary. By some estimates, Americans spend tens of billions of dollars every year on health services of questionable or non-existent value.[14] Consequently, the ultimate goal of programs such as the IMAC and comparative effectiveness research is to examine the usefulness and expense of various medical treatments and decide which ones should be covered by health care plans and how much government should pay. In an April *New York Times* interview, President Obama suggested that such a group, working outside of "normal political channels," should guide decisions regarding that "huge driver of cost...the chronically ill and those toward the end of their lives."[15]

In theory, the IMAC would be empowered to make tough choices about physician payment practices and technology purchasing, but in practice, it would be designed in a way that would subject it to immense political pressures. According to Office of Management and Budget Director Peter Orszag, members would be "appointed by the President, confirmed by the Senate, and [would serve] for five-year terms. The IMAC would issue recommendations as long as their implementation would not result in any increase in the aggregate level of net expenditures under the Medicare program."[16] Still, it would be up to the "President to approve or disapprove each set of the IMAC's recommendations," and "Congress would then have 30 days to intervene with a joint resolution before the Secretary of Health and Human Services is authorized to implement them."[17]

Ironically, the IMAC has been proposed in order to replace the existing Medicare Payment Advisory Commission (MedPac), a congressional advisory body that is widely perceived as ineffective because its recommendations are too easily ignored by Congress.[18] The new proposal would nevertheless require Congress to affirmatively vote to reject the IMAC recommendations, but it would give both Congress and the president an opportunity to prevent the implementation of unpopular cost-cutting recommendations. As with the Sustainable Growth Rate mentioned

above, relying on bodies like MedPac to cut politically popular benefits usually does not work. On the other hand, if the proposed IMAC were successful at reducing the use of expensive medical technologies, such cuts too often would come at the expense of patient care.

No Easy Choices; No Average Patients. President Obama and supporters of his proposals have tried to oversimplify the ability to cut costs while making complex treatment decisions. In a July 2009 interview, Obama said, "If there's a blue pill and a red pill, and the blue pill is half the price of the red pill and works just as well, why not pay half price for the thing that's going to make you well?"[19] Yet the choice is not always that easy.

For many years, such research, on what is also known as evidence-based medicine, has been conducted by the U.S. National Institutes of Health, the Agency for Health Care Research and Quality, and by numerous other public and private sector investigators.[20] In theory, research on clinical effectiveness can help doctors better understand the likely benefits of the medicines they prescribe and improve the quality of care they deliver. In practice, however, experience with evidence-based medicine in the U.S. and abroad shows that, while such research produces incrementally useful information, it has failed to systematically change the practice of medicine.[21]

Patients vary substantially in their individual physiology, their response rates to drugs and surgical procedures, and their willingness to tolerate side effects. So, for many conditions, from cancer and cardiac care to asthma medicines and antidepressants, the choice of appropriate treatment requires doctors and patients to carefully balance the benefits and drawbacks of individual interventions. But, in order to produce statistically significant results, the clinical research conducted to compare different treatments must evaluate groups of patients who are highly similar and who therefore are not representative of the population at large.

According to former FDA official Henry I. Miller, "[F]or many classes of drugs—among them statins, anti-hypertensives, pain-relievers and antipsychotic medicines—the selection of the appropriate drug among many possibilities requires a delicate balancing of effectiveness and acceptable side effects in each patient."[22] In the end, comparative effectiveness review is too crude a method to produce results that are broadly generalizable across all patients suffering the same illness. Consequently, if research results serve merely as treatment *recommendations*, there is little reason to believe they would have much effect on physician behavior, or be effective in cutting costs.

A September 2009 RAND Corporation study indicates that, "it is uncertain that the research will lead to reductions in spending and waste or improvements in patient health." That study also concluded that, because producing meaningful comparative effectiveness data is hugely expensive, "at least in the near term, any reduction in spending…would be offset by the up-front cost associated with generating, coordinating and disseminating the research findings."[23] Similarly, the CBO estimates that "voluntary" implementation of comparative effectiveness recommendations would reduce federal spending by just 1/100th of 1 percent over the 10-year budget window.[24]

Forcing a Square Peg into a Round Hole. The program will result in savings only if legislation or subsequent implementation tries to force the square peg of comparative effectiveness research results into the round hole of clinical practice by requiring physicians to always pick the treatment deemed best for average patients. Some congressional advocates support the comparative effectiveness program specifically because it could, in the words of former Democratic Sen. Tom Daschle, "have teeth" because "all federal health programs would have to abide by [its recommendations], and those programs account for 32 percent of all health spending and insure roughly 100 million Americans."[25] Daschle has also recommended conditioning the tax exclusion for private sector health insurance on compliance with federal comparative effectiveness recommendations.[26]

In the February 2009 stimulus bill, Congress and President Obama allocated $1.1 billion to fund a Federal Coordinating Council for Comparative Clinical Effectiveness Research in order to centralize and analyze results of this research for use by federal health programs.[27] Although its authorizing statute forbids the Coordinating Council's recommendations from setting treatment limitations, each of the congressional Democratic health reform proposals rely to some extent on the outcomes of such research for projected cost savings.

The Baucus bill would establish a Patient-Centered Outcomes Research Institute to "compare the clinical effectiveness, risk and benefits of two or more medical treatments, services or items."[28] It is not clear exactly what powers the proposed institute will have, but the only conceivable point of centralizing comparative effectiveness research in this way is to guide federal reimbursement practices. Eliminating genuine waste and inefficiency from government programs is a laudable goal, but centralized programs for comparative effectiveness, or "patient-centered outcomes research," run a substantial risk of becoming tools to control the practice of medicine in a way that puts patient health at risk.

The current proposals are modeled on a British government program called the National Institute for Health and Clinical Excellence, known by the ironic acronym NICE. That program denies British citizens access to many expensive breakthrough drugs for debilitating and life-threatening conditions like cancer, multiple sclerosis, Alzheimer's disease, and macular degeneration because those medicines are not sufficiently effective for every patient who takes them. As Karol Sikora, a leading UK cancer specialist, observes, "The real cost of this penny-pinching is premature death for thousands of patients."[29]

Stifling Innovation. Adopting comparative effectiveness research results into health programs as mandatory treatment guidelines would very likely result in inappropriately denying many patients access to useful treatments. It could also stifle the development of innovative new treatments that tend to be hugely expensive when first discovered, but which eventually become far less costly after they are introduced and doctors begin using them more broadly.[30]

Often, the medical condition for which a new drug is initially approved turns out to be only one small part of its eventual use because more important applications are discovered only after the drug is approved and doctors begin testing it for other conditions. This was the case for the therapeutic protein interferon alfa-2a, sold under the brand name Roferon-A. First approved for a rare blood condition called hairy cell leukemia—for which it is now seldom used—Roferon-A

was later found to be effective for a number of other far more prevalent conditions, including chronic hepatitis C and chronic myelogenous leukemia.[31] Had the prescribing and reimbursement of the drug been blocked by government bureaucrats early on, its additional uses likely would have never been discovered. There are many other such examples.

Research on the next generation of treatments for cancer, heart disease, and countless other serious conditions would slow to a snail's pace if every new medicine were required, immediately upon gaining regulatory approval, to be effective and cheap enough to get the support of bureaucratic bean counters. Adopting comparative effectiveness as a cost-cutting tool would, in effect, freeze medical science in its current form. But, with countless billions of dollars spent on existing treatments of little or no value, taxpayers would continue to pay sizeable bills.

Perhaps paradoxically, expensive new treatments with higher per-unit prices can lower overall treatment costs by keeping small problems from turning into larger ones, or by speeding recovery times for certain illnesses. However, because it would be a government program, subject to the same political machinations as other government bodies, the comparative effectiveness council could recommend denying coverage for expensive treatments that are effective for only a small number of patients while rubberstamping approval for politically popular, but ineffective treatments.

For example, in May 2009, the NICE program recommended that the UK's National Health Service pay for acupuncture for the treatment of lower back pain,[32] despite copious evidence showing that acupuncture works no better than random pin pricks.[33] While each new expensive medicine to treat rare cancers would benefit only a small number of patients, many millions of people suffer from lower back pain and support the use of acupuncture. Therefore, it is no wonder that the former are not covered by the UK's NHS, but the latter are.

Conclusion. Despite claims that the Senate Finance Committee's health care reform bill will rein in costs and eliminate waste from the system, the proposal will actually lead to higher health care costs and an exploding budget problem for the federal and state governments. The only features of that bill, and the other congressional Democratic proposals, that could reduce the growth rate in health care costs are not structured to work adequately. It is far from clear that decisions made by an Independent Medicare Advisory Council or Medicare Commission would genuinely rein in health care spending in a way that makes sense for patients. Nor is voluntary reliance on comparative effectiveness research likely to bring down U.S. health care costs, even in the short-run. Both, however, could very likely lower the quality of patient care and wreak havoc on long term medical innovation.

Currently, there are hundreds of innovative and expensive medical technologies in the research pipeline. These include highly sophisticated imaging and diagnostic tools, as well as promising new treatments for cancer, heart disease, Alzheimer's, and many other life threatening or debilitating conditions. There will be no roving "death panels" to decide which patients should live and which should die. But, if each new medical product must pass a population-wide cost-benefit test before a critical mass of patients could get access, there will be little incentive for investors to finance the next generation of technologies that could provide the cures Americans will expect in coming years. This would be the logical, but unfortunate, outcome of the kinds of

decision-making envisioned by cost-cutting advocates in Congress's Democratic majority and in the administration.

Notes

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