Putting Health Care Spending On a Sustainable Path

Statement of

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For the Committee on the Budget

United States Senate

February 29, 2012

Washington, DC

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Chairman Conrad, ranking Member Sessions, other distinguished members of this Committee, it is an honor and a privilege to offer my thoughts on sustainable health spending. My name is Len M. Nichols. I am a health economist, Professor of Health Policy, and Director of the Center for Health Policy Research and Ethics in the College of Health and Human Services at George Mason University in Fairfax, Virginia. My other affiliations relevant to the subject of today's hearing include: Editor-in-Chief of the online Payment Innovation Community, a project jointly sponsored by the American College of Cardiology and the American Journal of Managed Care[1]; Board member of the National Committee on Quality Assurance,[2] Academy Health,[3] and the Arkansas Center for Health Improvement;[4] member of the National Committee on Vital Health Statistics;[5] and recently I was selected, along with 72 other health professionals from around the country (out of 920 applicants), to be an Innovation Advisor to the Center for Medicare and Medicaid Innovation.[6] I do want to make crystal clear at the outset, however, my written testimony and spoken views are mine and mine alone and that I do not speak for any organization, public or private, nor any other person, living or dead.

I am certain you know the CBO projections on health spending and deficits as shares of GDP at least as well as I do, so I will not belabor the obvious first point in any hearing with this title: we cannot afford the health care system we have, and therefore we cannot afford projected health care cost growth for our major public programs along with the anticipated tax expenditure for employer-sponsored health insurance.

But the fundamental point is that we cannot afford our current health care system, for it is that system that casts our most sacred Medicare promises into doubt at the moment. Therefore any

[1]http://paymentinnovations.cardiosource.org
[2]http://www.ncqa.org
[3]http://www.academyhealth.org
[4]http://www.achi.net/index.asp
[5]http://www.ncvhs.hhs.gov
[6]http://innovations.cms.gov/innovation-advisors-program

humane and sustainable Medicare solution must center on system-wide reform. As a consequence, I am continually surprised when I see that the loudest proponents of "structural reform" of Medicare are even more vigorously opposed to the Patient Protection and Affordable Care Act (hereafter, the ACA), because it is the most promising and closest thing to comprehensive health system reform our county has ever tried. But I learned a long time ago not to waste time trying to understand why some people prefer partisan posturing over logical consistency and factual analysis.

"Structural reform" of Medicare has become a rallying cry and litmus test of those who judge others (and all things, really) by the metric of commitment to deficit reduction. Unfortunately, the term is often misused, or at least oddly misplaced. The problem with the mindless use of the term "structural reform," from my perspective, is that it is too-often used to actually mean guaranteed public spending limits, with all remaining financial risk shifted to beneficiaries, providers, private plans and employers. To some prominent commentators today, if your preferred solution does not include "spreadsheet economics" assertions that Medicare cost growth will somehow be forced to be no higher than X per cent per capita and therefore Y trillions will be saved over the next Z years, then you are deemed just not serious about Medicare reform.

Nothing could be further from the truth. My criticism of spreadsheet health economics is fair when applied to the Ryan budget and Roadmap,[7] but also to the various so-called bi-partisan commissions that have weighed in in very broad terms about health costs recently.[8] In general, most, but not all, proposals of premium support suffer from the fatal flaw of essentially just telling all beneficiaries they must join private health plans and then telling health plans that we

[7] http://cbo.gov/ftpdocs/121xx/doc12128/04-05-Ryan_Letter.pdf

[8] I say "so-called" because most had far more conservative than liberal members, and their solutions overemphasized spending cuts rather than a balanced consideration of modest tax increases, i.e., they by and large accepted the partisan and dubious premise that we are as a nation grossly overtaxed. It is hard for me to square that premise with the facts that: (a) our taxes take 10 percentage points less from our GDP than the OECD average, 15 or more percentage points less than 11 countries, including the Netherlands, Norway, Austria, and France, countries often governed by conservative parties; (b) we have a military budget and worldwide obligations that exceed all others nations' combined; and therefore (c) we do far less income redistribution than any other advanced nation on the planet. So to propose deficit reduction that is 2:1 spending cuts to revenue increases, or worse, is to effectively reduce an already thin social safety net in the richest nation on earth. This is not my idea of biblical justice, which requires balance and sustainability, among other things. Senators and other readers might find the following short books helpful for perspective on setting social priorities: C. Marshall, *Little Book of Biblical Justice*, Good Books, 2005; W. Brueggemann, *The Prophetic Imagination*, Fortress Press, 2001; M.D. Meeks, *God the Economist*, Fortress Press, 1989.

(the government) will pay this much and no more for health insurance and we expect you (the plans) to figure out how to make this work for beneficiaries and providers. This common version of premium support is essentially a system of hiring plans to fix our health care woes while containing the financial risk to the government. Indeed, for some advocates, our only serious health care woe IS the financial risk for our government in keeping current promises to the elderly and the poorest among us. The only thing "structural" about the kind of Medicare (and Medicaid) reform they propose is that it would re-structure aggregate government payments to grow at an arbitrary and fixed rate. It does nothing to change the fundamental structure of the delivery system and its currently counterproductive incentive structures.

Therefore, it cannot and will not work. Not because plans wouldn't try (and some have more potential than others, to be sure) but because they do not have sufficient market power. If they could do this alone, don't you think they would have already? Knowledge about the importance of local provider market power is not as widespread as it should be, but scholarship is starting to make clear that this problem is real and growing and will make the shrinking premium support voucher (in real terms) worth less and less over time in many areas of our country.[9] So the net effect of a "plans only" voucher approach to "structural reform" will be to significantly curtail access to needed and effective care for all but the highest income beneficiaries. This may or may not be the goal; I try hard not to attribute motives. But in any event this approach is manifestly not sustainable, since providers with market power will simply shift public program underpayment for real costs to private insurers and self-insured employers, thus worsening, not improving, our international competitiveness for high value added jobs, the ones we had better develop strategies to keep if we are going to remain a mostly middle class society.

I want to offer a different vision of structural and sustainable Medicare reform for your consideration today.

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[9]Nichols, Len M. "Making Health Markets Work Better With Targeted Doses of Competition, Regulation, and Collaboration," *St. Louis University Journal of Health Law and Policy* 5(7):7-26; Paul B. Ginsburg, http://hschange.org/CONTENT/1162/1162.pdf ; Nichols et al, "Are Market Forces Strong Enough to Deliver Efficient Health Care Systems? Confidence is Waning," *Health Affairs* March/April 2004. *Competition in the Healthcare Marketplace: Hearing Before the Subcomm. on Consumer Prot., Product Safety, and Ins. Of the Comm. On Commerce, Science, and Transp.*, 111th Cong. 85-99 (2009) (statement by Len M. Nichols).

True Structural Reform

"Structural reform" should mean addressing the fundamental problem with our health care system, and that is this: our underlying incentive structures are all wrong. Today, health plans make bigger profit margins segmenting the healthy from the sick than from finding and coordinating high quality care options for all enrollees. At the same time, fee-for-service payment arrangements – plus over 8000 CPT codes and byzantine layers of opaqueness when it comes to device and drug costs to patients – have long encouraged volume growth and penalized the highly coordinated care we now know can improve care and health while lowering the total cost of care in many instances.

So, "structural reform" ought to mean changing the underlying incentives of insurers, physicians, hospitals, and patients to align their self-interest with our common interest in reducing cost growth per capita while expanding access to high quality care, so that all Americans can reach their productive potential and propel our economy to sustainable economic growth. The good news is, structural reform of -- and incentive realignment within -- our health care system is actually what the ACA is all about.

Imagine a health system in which insurers made more money helping to coordinate care toward more efficient health production and maintenance – with consumer engagement -- than in discriminating against the unhealthy. Imagine a health system in which every clinician-patient encounter had, to support its joint decision making process, complete information on the patient along with current best practice information about diagnostic and therapeutic options for that kind of patient with these symptoms and with that particular history and family risk factors. Imagine a health system in which primary care physicians were able to be better compensated while seeing fewer patients per day than they do today because primary care teams become co-managers with the patient of the patient's specific pathway to health restoration or maximization, given their possibly multiple chronic conditions. Imagine a health system in which many specialists and hospitals cooperate with primary care teams and post-acute facilities and *patients and their families* to reduce unnecessary utilization while improving quality, and health outcomes because all could share in the savings off our currently unsustainable baseline to incentivize them to help us make it so. THIS would be a health system that had been structurally reformed, and this would be a health system in which we can afford to strengthen Medicare and

Medicaid going forward, while extending access to health insurance and high quality care for all Americans. This is the health system that the ACA – with help from the health information technology and meaningful use investments pursuant to the ARRA – is trying to give us the tools to create.

The single biggest change that will take place if the ACA remains the law of the land in 2014 is this: for the first time ever in these United States it will be less profitable for insurers to segment risks than to discover and coordinate high quality care for all enrollees, especially for the sickest among us. Thus, the necessary but targeted use of federal power to change the rules of insurance markets will fundamentally alter the business model of every health insurer, and that in turn will unleash health plans on a vigorous search for value in our health care delivery system, exactly what patients (and taxpayers) need. In anticipation of this happy day, the search has already begun, with promising early results.[10]

The Medicare Advantage analogue to this insurance market incentive realignment is the ACA's required shift from formulaic overpayment of private health plans to a payment system that will increasingly be based on competitive bidding while rewarding quality performance and patient satisfaction. Early results on this score are promising as well.[11]

But the structural reform that matters most for the long run affordability of our health care system, for families and governments alike, in the ACA and in the real delivery system where millions of health professionals improve patients' lives every day, is the structural reform of incentives for providers within the delivery system as a whole. Here the ACA takes a multi-pronged approach that is worthy of attention and praise, which I will follow with specific suggestions to improve on it in the spirit of what has already begun.

The first key thing the ACA did for delivery system incentive realignment is to signal, through the market basket update reduction,[12] that "business as usual" is over, because we cannot afford it. That provision, already in effect, lowers the growth factor of Medicare hospital payments by

[10] Higgins, Aparna et al, "Early Lessons from Accountable Care Models in the Private Sector: Partnerships Between Health Plans and Providers," *Health Affairs* 30, No. 9 (2011):1718-27; and "Transforming Care Delivery," *AHIP Issue Brief* January 2012; Zirui Song, Dana Gelb Safran, Bruce E. Landon, Yulei He, Randall P. Ellis, Robert E. Mechanic, Matthew P. Day, and Michael E. Chernew, "Health Care Spending and Quality in Year 1 of the Alternative Quality Contract," *New England Journal of Medicine,* 2011; 365:909-918.
[11] http://www.hhs.gov/news/press/2011pres/09/20110915a.html.
[12] Section 3401.

a percentage equal to economy-wide productivity. Thus, our collective signal to hospitals, and to all providers really, is that we are no longer going to pay more each year automatically without demanding that hospitals become at least as much more efficient as the economy as a whole. I think this is one of the main reasons Medicare spending growth was so low last year,[13] and why the search for efficiency in hospital operations is at least as intense as the health plan search for ways to engender more value for their enrollees.[14] Reductions in the overpayment to Medicare Advantage health plans, while enabling some to do better through superior quality performance, sent a parallel signal, as did corrections to mispriced physician procedures, also called for in the ACA. One good thing the Ryan Budget did, since it retained all the ACA Medicare savings proposals, was to buttress this signal in an important way: it apparently does not matter who wins the upcoming elections, the federal government is going to become a much more demanding buyer of health care for Medicare enrollees, either through health plans alone as hired proxy for the government -- the Ryan Budget / spreadsheet economics way -- or through creating tools for providers and patients and private plans together to implement and act upon improved incentives, the ACA way.

The ACA vision for becoming a more demanding buyer points to the heart of structural delivery system reform. The overarching goal is the three part aim: better health, better care (including wider access to high quality care), and lower cost, but the focus of today's hearing (and most discussion in budget contexts) is about lower spending. At the end of the day, there are only four basic sources of lower health spending: (1) reduced utilization; (2) lower prices; (3) higher quality which can help lower use and/or prices but may also increase cost in some areas over current baseline; and (4) better underlying health in the patient population. We need to pursue all of them, since there are no silver bullets, contrary to a lot of wishful thinking.

Sources of Spending Reduction

Use could be reduced from higher quality, e.g., better coordination of care in transitions between hospitals and other settings, including home, or through better ongoing co-management – including patient engagement – of patients with complex and multiple chronic conditions. These

[13] Martin, Anne B., et al. "Growth in US Health Spending Remained Low in 2010; Health Share of Gross Domestic Product Was Unchanged from 2009," *Health Affairs* 31 No. 1 (2012):208-219.
[14] http://www.optuminsight.com/resources/browse/articles/innovations-from-optuminsight-flexibility-critical-in-building-acos/.

quality improvements, as well as reductions in inappropriate use -- tests and procedures that the existing evidence base does not support for some of the patients who are getting them -- are incentivized in the ACA through the care transitions benefit, the penalty for hospitals with unreasonable re-admission rates, and the myriad pilots that finance infrastructure and/or reward the achievement of utilization reductions through better care.[15]

Prices could come down as a result of government fiat, but note also that government price cuts could lead to necessary price increases quoted to private payers, so this is not as simple a lever as some might think (especially in Medicaid, which already often underpays for services). Prices could also come down as a result of process improvements, if transaction prices are determined in competitive environments. Both process redesign (e.g."Lean" production techniques, as Virginia Mason Medical Center uses in Seattle, Washington and Denver Health uses in Denver, Colorado) and administrative simplification (in particular, standardizing claims adjudication algorithms) can lead to this kind of price reduction.

The largest potential source of price reductions is probably input price reductions, specifically, labor costs, device costs, and drug costs. Physicians and nurses do earn more here in relative terms than in most countries, and more optimal scope of practice and care delivery arrangements could achieve net input price reductions as well. A little used but possibly major source of price reductions would be physician and hospital collaboration to drive device and drug prices and spending to their minimum efficient levels, if traditional incentive arrangements between manufacturers and some physicians can be superseded by service payment contracts. The final source of price reduction is countervailing market power against those hospitals and physician groups – or integrated systems – that charge private payers considerably higher than their patients' costs today. These circumstances are more common than is widely known. In the limit, countervailing buying power in these markets might be applied through community-wide negotiation with local and specific anti-trust immunities, or all payer rate-setting as a last resort. Only Medicare, or all payers acting in concert, has enough countervailing market power to be effective in some markets today.

[15] These include: the three ACO models (shared savings, Pioneer, and Advanced Payment); the four bundled payment models; medical home projects (Multi-payer Advanced Primary Care Practice demo, the Comprehensive Primary Care Initiative, the FQHC Advanced Primary Care Practice demo, and the Independence at Home program).

Quality could be improved through better patient engagement, better adherence to evidence based best practices, and better care coordination. Care coordination might raise costs relative to baseline in many cases. So "savings" to be shared must be net of these quality-enhancing cost increases.

Finally, health itself could be improved from behavioral changes (diet, exercise, smoking cessation, etc), in the short, intermediate and long runs. Behavior can be channeled by wellness programs sponsored by employers or community entities like schools or churches, by value based insurance design and decision support to optimize health maintenance and the balance between self-care and health service use, and by community public health resources like nutrition education plus exercise- and fresh food-friendly environments. All of these health enhancing strategies are encouraged and incentivized in the ACA as well.

ACA and Private Sector Reform Specifics

All of the new payment model initiatives in the ACA that were mentioned above are designed to start and then accelerate physician and hospital collaboration and our collective transition away from FFS/pay for volume health care at the point of service. The really good news is that the private sector is organizing similar types of incentive realignment pilots as well. This is essential because every clinician and clinician manager I have ever met, and I am old enough and have given enough hospital association and medical society keynote addresses to have met quite a few over the years, every single one always expressed a strong preference for one set of incentives from payers, one set of quality metrics, one set of patient acuity adjusters and feedback loops, etc., rather than the byzantine plethora they labor under today. Indeed, without new incentives in place for a majority of patients in a given practice or hospital, it is highly unlikely that care delivery will change from the current focus on volume and uncoordinated care.

And while the ACA may be responsible for the type and scope of interest in payment and delivery reform models being tried now in the 49 states which AHIP recently reported on,[16] similarly the spread of these initiatives within the private sector is surely also driving more plans and provider groups to consider the public-private partnerships that CMMI is trying to create

[16]Martin et al, op cit, footnote 13.

around the Comprehensive Primary Care Initiative,[17] the Multi-Payer Advanced Primary Care Practice Demonstration,[18] and through both Pioneer and Advanced Payment ACOs.[19] When providers see the federal government, state government programs, and private payers all focused like a laser beam on reducing costs while better measuring and improving care quality, patient experiences and outcomes, structural reform is not only possible, it becomes likely.

It is fair to say that many were disappointed with the initial shared savings ACO proposed rule,[20] but since then interest in CMMI pilots has been increasing, from 32 full speed Pioneer ACOs to 8 states coordinating large multi-payer collaborations to transform physician practices into patient centered medical homes, 5-7 sets of private plans providing incentives to transform primary care with 75 physician practices each within defined local markets and the as yet unreported but expected (and rumored throughout delivery system circles) very high interest in both the 4 bundled payment models about to be tested and the open ended innovation challenge grants which were submitted near the end of January.[21] Based on what I'm hearing from applicants to that grant opportunity from around the country, interest is very high in this unique opportunity to tell CMMI/CMS what new payment and care delivery arrangements make sense to particulars set of providers, plans, and employers who are indeed willing to pursue the three part aim (better health, better care, lower cost) on the ground in the real world. This is not your father's "one size fits all" Medicare demo from decades past.

Suggestions for Improving the Chances for Real Structural Reform

So what tools and approaches could be added to the ACA/CMMI array that could solidify and even turbo-charge our transition to a sustainable – and structurally reformed – health care system and by extension, Medicare program? There are many, but I will emphasize two in the remainder of my testimony.

First, malpractice and SGR reform: This may seem an odd pairing into one suggestion, especially since malpractice is currently a state prerogative, like clinician licensure. But as twin devices to

[17] http://innovation.cms.gov/initiatives/cpci
[18] https://www.cms.gov/DemoProjectsEvalRpts/MD/ItemDetail.asp?ItemID=CMS1230016
[19] http://innovations.cms.gov/initiatives/aco/pioneer; and http://innovations.cms.gov/initiatives/aco/advance-payment/
[20] http://www.commonwealthfund.org/Newsletters/Washington-Health-Policy-in-Review/2011/May/May-9-2011/Model-ACO-Health-Centers-Skeptical.aspx
[21] http://www.innovation.cms.gov/documents/pdf/CMMIreport_508.pdf.

re-earn physician trust and engagement in the reform enterprise, they are similar and complementary nonpareils indeed.

Malpractice reform should have been part of the ACA. I believe and perhaps some of you know that it could have been if all Republicans had not decided to unanimously oppose the ACA, despite the fact that it is analytically similar to the Chafee-Dole proposal of 1993, which also had 17 other Republican Senator co-sponsors who wanted to provide a constructive Republican alternative to solve the uninsured and affordability problems addressed by President Clinton's Health Security Act and now by the ACA.[22] Alas, here we are. I am no malpractice expert, and I know some states' clinicians are satisfied with their current systems and so they should not be changed without giving them a chance to preserve what works from clinician perspectives. But I also know that most physicians are not happy with their local malpractice system and so providing concrete reform options and incentives for the system to work better both from their and from their patients' perspectives would go a long way toward proving to physicians that the federal government wants to be a better partner in delivery system restructuring than it has been in the past. I am certain that it will be much easier to engender physician buy-in to the payment and delivery reforms we need if we can reduce their fear of being sued for not doing unnecessary tests and procedures. The amount of money actually saved from malpractice reform is not nearly as important as is the fear of being sued in holding back practice pattern transformation and the fruition of incentive realignments that we need.

But even malpractice pales in comparison to our ongoing SGR saga as "proof" that the Congress and the Medicare program cannot be trusted to be good partners with physicians. Imagine if there was some kind of national internet referendum on congressional salaries and that in the absence of a majority vote to the contrary -- to be held on some pre-determined website on some random day between Christmas and New Year's each December – your salaries for one year would be cut by 20% or more. Then imagine the people could also vote to preserve your salary levels one

[22] That proposal had an individual mandate, re-organized individual and small group markets, subsidies for the low income population, and was paid for with Medicare savings and reductions in the open-ended tax preference for employer sponsored health insurance. See http://www.kaiserhealthnews.org/Stories/2010/February/23/GOP-1993-health-reform-bill.aspx; http://www.kaiserhealthnews.org/Graphics/2010/022310-Bill-comparison.aspx. The Republican co-sponsors included current senators Grassley (IA), Hatch (UT), Bond (MO), and Lugar (IN), and former senators Bennett (UT), Cohen (ME), Danforth (MO), Dominici (AZ), Durenberger (MN), Faircloth (NC), Gorton (WA), Hatfield (OR), Kassebaum (KN), Simpson (WY), Specter (PA), Stevens (AL), and John Warner (VA).

month at a time, instead of for 12 months. This is how the SGR debate looks to many physicians. One month reprieve? Two months? Twelve months? Forever? Never? I know it costs real money to fix the SGR problem. And I agree it is a contrived problem, bequeathed to us by former Ways and Means Chairman Bill Thomas, who put the SGR provision in the Balanced Budget Act of 1997 in expectation that the specter of draconian physician payment cuts would force our nation to have a structural Medicare reform conversation. For what it's worth I'm pretty sure Chairman Thomas never intended that we would postpone that conversation this long. But the good news is, we're having a structural Medicare reform conversation now, so the crying need for the annual or monthly SGR kabuki dance has passed. Just fix it, MEDPAC has recently given you at least a starting point to move forward,[23] winding down the wars in Iraq and Afghanistan might lessen the budget pain as well, so just do it and clear away another obstacle to adult conversations on structural delivery system reform along the way.

But by far the most important enhancement which Congress could now give Medicare, the CMS and the CMMI in particular, to turbo-charge genuine structural reform in our health care system, would be to encourage or require openness to accepting, supporting, and joining community wide, multi-payer and multi-stakeholder delivery and payment reform proposals that are developed on the ground in the real world, not in Washington or Baltimore. I have had the privilege to watch and even participate a bit as Rochester, New York and Grand Junction, Colorado have developed true community-wide visions of how to achieve the three part aim for *all* patients, not just public or private sector or currently insured patients. Their local consultative processes include all relevant hospitals, physician groups, health plans including Medicaid, consumer advocates, social service providers (in Rochester's case) and even behavioral health providers (in Colorado's case). Each of these communities, in their own way, promises to achieve structural transformation of their health system if their proposals are implemented. Basically, they just need Medicare to say yes, share relevant data in real time and join the party (and help finance the 3 year transition to a sustainable system). They have each applied for Innovation Challenge grants, and are awaiting formal word on that opportunity, so we shall keep our fingers crossed on their behalf, and on behalf of what our nation could learn from them.

[23] http://www.medpac.gov/documents/10142011_MedPAC_SGR_letter.pdf.

I would strongly recommend that you consider directing CMMI to create a specific major initiative or grant-making window on community-wide payment and delivery reform. You could call it, an "Accountable Community" program. A pre-condition would be what Rochester and Grand Junction have demonstrated: the ability to assemble all relevant stakeholders, including consumers, at the planning table, so that true multi-payer payment reform could make providers' transitions smoother and thereby better health, quality, and cost outcomes occur must faster. Of course community proposals have to be rigorously reviewed and judged to credibly reduce public sector cost growth, in addition to their local goals.

But what I am trying to emphasize in this entire testimony is that Medicare is more likely to perform well and achieve "structural reform" type results in the long run if the underlying health system – in the real communities where all people live and all providers work and all patients actually seek care – is transformed to be more efficient, more patient-centered, and more focused on quality measurement and less on volume and financial protection of the status quo. That is, the federal government needs to recognize that many communities' local goals are goals we all share. In my opinion and experience, we are far more likely to succeed if the entire health community in a given area has similar incentives, commitment, and feedback loops, than if Medicare or Blue Cross or The Local Grand Hospital Where All Our Children Were Born and All Our Grandfathers' Died tries to do this on their own.

One final point on structural reform: Spreadsheet economics does have one seductive feature which attracts support, particularly among those who don't study the health system for a living; it "guarantees" a particular cost growth path for Medicare or Medicaid, or at least purports to, whereas my approach to structural reform has no such guarantee. I will argue that guarantees of this sort are not good things, and here's why.

Hard target growth rates carved in stone are by definition inflexible. They do not allow program managers to ask or care why targets cannot be met, whether because more people enrolled than anticipated or because costs could not be lowered as fast as desired for any reason. They simply enforce (or at least would try to enforce) cuts or growth limits in voucher or overall spending amounts to meet the spending target. I grant you this may be the only way to guarantee that federal taxes never collect more than the 18% of GDP that they do today, and if you really think

that's the most important priority for our nation, you can stop reading now, if you haven't already.

Whereas, targets growth rates like those embedded in the ACA, which also empowers a group of experts, appointed by the President and confirmed by the Senate to the Independent Payment Advisory Board to recommend specific and credible alternative policies if the current law provisions do not work as planned, are a much wiser alternative to inflexible targets. First of all, with proper delivery system reform incentives, actual savings may exceed growth rate reduction targets. Indeed, the CBO really only scored the payment cuts in the ACA: the market basket update reduction, the MA payment cuts, and the revisions of mispriced procedures account for the great bulk of anticipated savings over the first 10 years of the ACA. If *any* of the payment reform initiatives like Pioneer ACOs, comprehensive primary care, bundled payments, or even more creative ideas emerging from Innovation Challenge grants work and then spread, savings from the ACA could be much greater than the targets already set to more than offset anticipated subsidy costs. Second, if the anticipated savings do not materialize, or if subsidy costs or private health care spending exceeds expectations, then the IPAB would be empowered to think broadly and creatively about how best to achieve the overall health spending growth targets set in the law. But here's the key difference in an IPAB-like situation and a hard target from spreadsheet economics: *Congress would have the ultimate authority about what to do in the IPAB-like case.*

If the Congress, in its collective wisdom, did not like what the IPAB proposes, it could enact alternative policies to hit the targets, or it could decide to change the targets and raise taxes if indeed costs exceed the targets for reasons the Congress judges to be worth asking the American people to pay for. By contrast, the hard target approach attempts to take accumulated political judgment and a balanced approach to our fiscal options out of the decision, and would therefore remove authority from Congressional hands and thereby lock us into a health spending pathway that can never be altered. I must infer some proponents of this approach simply do not trust Congress to exhibit fiscal discipline. A better way to fix that problem is to hold regular elections, not constrain health policy once and for all time to live out the wishful thinking of a spreadsheet exercise completed in the absence of ongoing input from real communities where health providers and patients actually work and live.

In summary, it is far better to get the health spending growth rate you are willing to incentivize by empowering clinicians and patients and by inducing plans to help them achieve it, rather than to hit the growth rate you could (try to) force with hard budget caps on payments to health plans alone.

Thank you again for the opportunity offer thoughts today. I would be glad to answer any questions my testimony may provoke, today or in the future.