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TESTIMONY OF DAVID M. CUTLER
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Before the
Committee on the Budget
United States Senate

Summary

The United States spends far more than is needed on medical care. At least one-third of medical spending is not associated with improved health, implying waste of about $750 billion annually. Thus, cost containment is a central economic issue.

There are two important rules that need to guide any discussion of cost containment. First, we need to eliminate wasteful spending, not valuable spending. Second, we need to reduce the overall level of spending, not simply shift costs from one payer to another.

The question that faces policy analysts, therefore, is finding areas where money can be saved while simultaneously improving care quality. The health policy literature suggests six avenues for cost savings: reducing unnecessary services; efficiently providing necessary services; improving prevention; reducing administrative costs; lowering prices that are too high; and reducing fraud. The Affordable Care Act has a number of provisions addressing these areas of cost savings, but more can be done.

To address the costs of inefficient care delivery, Congress should commit to a path of replacing fee-for-service payment in Medicare with bundled payment systems. Such a policy would start by expanding on the Acute Care Episode demonstration program and the recent Accountable Care Organization program, and extend those payment methodologies to all conditions and providers within a few years.

To reduce administrative costs, Congress should require specific actions including integration of clinical and administrative systems, electronic interchange of information, and centralized credentialing systems. In addition, Congress should establish an administrative simplification agency within the Department of Health and Human Services that would be tasked with realizing administrative cost savings of one-third or more in the next five years.

Together, these polices would significantly slow the growth of medical spending and provide significant relief to the federal budget.

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Chairman Conrad, Ranking Member Sessions, and members of the Committee, thank you for giving me the opportunity to appear before you today to discuss the topic of "Putting Health Care Spending on a Sustainable Path." My name is David Cutler, and I am the Otto Eckstein Professor of Applied Economics at Harvard University. I have appointments in the Department of Economics, the Kennedy School of Government and the School of Public Health at Harvard. I am a research associate at the National Bureau of Economic Research, and a member of the Institute of Medicine. I have studied the health care industry for over 20 years and have written extensively about the economic and fiscal consequences of health care reform.

The high level and rapid growth of medical spending in the United States is an enormous policy challenge. High medical costs have an immediate effect on family budgets, by reducing the amount that families can spend on housing, clothing, education, and other important goods and

services. In addition, high costs for businesses lead to a variety of labor market impediments,[1] including people feeling locked into their current job, reduced business startups, and reduced employment, especially of lower wage workers. Further, high medical spending poses a strain on budgets at all levels of government. As this committee knows, the long-run budget situation of the federal government is very significantly determined by the growth of medical spending. Thus, policy must focus on reducing that spending growth.

That said, not all policies to lower medical spending are the same. There are two important rules that need to guide any discussion of cost containment:

o *We need to eliminate wasteful spending, not valuable spending.* Cutting spending without consideration to what is cut is not a good policy unless measures are put in place to ensure that the provision of valuable care is enhanced and that the most vulnerable members of our society are protected from the adverse effects that could result from indiscriminate cost reductions.

o *We need to reduce the overall level of spending, not simply shift costs from one payer to another*. It would be easy for governments to reduce their spending on medical care; they could simply pay less for medical care and make beneficiaries pay more. While this would lower government spending, it would raise spending by families. It is, in short, a shift of costs, when we need to reduce the overall level of spending.

[1] Jonathan Gruber, "Health Insurance and the Labor Market," in Anthony J. Culyer and Joseph P. Newhouse, eds., *Handbook of Health Economics*, Volume 1A, Amsterdam: North-Holland, 2000; Janet Currie and Brigitte Madrian, "Health, Health Insurance and the Labor Market," in Orley Ashenfelter and David Card, eds., *Handbook of Labor Economics*, 1(3), Amsterdam: North-Holland, 1999, 3309-3416.

OPPORTUNITIES TO REDUCE MEDICAL SPENDING

The question that faces policy analysts and this Congress, therefore, is finding areas where money can be saved while simultaneously improving care quality. The health policy literature shows that this is possible and suggests six areas where money can be saved and quality simultaneously improved. These areas are shown in Table 1, along with estimates from the Institute of Medicine (IOM) of the *lower bound* of excessive spending associated with each area.

Table 1: Excessive Medicare Care Spending (Lower Bound Estimates)

Area	Dollars* (billion)	Percent of medical spending
Poor care delivery		
Unnecessary services	$210	8%
Inefficiently delivered services	$130	5%
Missed prevention opportunities	$55	2%
Excessive administrative costs	$190	8%
Prices that are too high	$105	4%
Fraud	$75	3%
TOTAL	$765	31%

* Estimates are for 2009. Data are from the Institute of Medicine.[2]

Several categories of spending are associated with *poor care delivery*. This includes unnecessary service use (care beyond clinical guidelines, defensive medicine, and unnecessary choice of high cost services when lower cost services are available), inefficient delivery of services (mistakes, errors, and operational inefficiencies), and missed prevention opportunities. The IOM estimates that these categories together account for 13 percent of medical spending, or nearly $400 billion annually.

[2] Institute of Medicine, *The Healthcare Imperative: Lowering Costs and Improving Outcomes: Workshop Series Summary*, Washington, D.C.: Institute of Medicine, 2010, Box 21-1.

Excessive administrative costs includes costs that insurers incur for billing and claims processing, as well as the costs of billing and bill collection in physicians' offices, clinics, and hospitals. The total cost of excessive administration is nearly $200 billion annually, or 8 percent of total health spending.

Excessively high prices is use of products and services that are more expensive than need be. The recent move by Medicare to implement competitive bidding for durable medical equipment shows the extent to which prices can be lowered without reductions in quality. The IOM estimated that 4 percent of medical spending could be eliminated by lowering prices to competitive levels.

Fraud is the final category of excess costs, and accounts for an estimated 3 percent of medical spending.

All told, the IOM estimates that at least $750 billion in medical spending is wasted annually, amounting to over 30 percent of the total national health bill. To put this in perspective, this is near the entire spending of the American Recovery and Reinvestment Act of 2009. Thus, the United States wastes approximately a stimulus bill every year on medical spending that is not associated with improved health. The IOM further estimates that implementation of known effective strategies to reduce waste could save nearly three-quarters of this amount, reducing medical spending by $550 billion annually. It is therefore worth considering what changes are necessary to realize these savings. I focus particularly on the costs of poor care delivery and administrative expenses.

POOR CARE DELIVERY

The costs of poor care delivery are manifest in several ways. Overtreatment is relatively common and reflects use of expensive care when less expensive care is just as effective. The well-known studies from the Dartmouth Atlas highlight the degree of overused care.[3] Mistakes and clinical errors are a particularly malicious form of poor care delivery, since they simultaneously increase medical spending and harm health. About $30 billion dollars is spent annually treating hospital-acquired infections.[4] Similarly, missed prevention opportunities drives up acute care costs while worsening population health.

A good deal of research has examined the causes of poor care delivery. There is not a single cause of this inefficiency. It would be nice if we could attribute the excessive spending to a handful of doctors who are not up to date or to a malpractice system run amok. But that is not the case. Rather, the problem is interwoven throughout the health care system.

The characteristics of poor care can be seen with reference to high quality care providers. There are a number of health systems that deliver care that is superior and cheaper to that in general practice. The journal *Health Affairs* recently profiled 15 such organizations.[5] The Institute of Medicine has reported on several more.[6] Organizations such as the Cleveland Clinic, Geisinger Health System, Group Health Cooperative, Intermountain Health Care, Kaiser Permanente, the

[3] Elliott S. Fisher, David E. Wennberg, Thérèse A. Stukel, Daniel J. Gottlieb, F. L. Lucas, and Étoile L. Pinder, "The Implications of Regional Variations in Medicare Spending. Part 1: The Content, Quality, and Accessibility of Care," *Annals of Internal Medicine*, 2003; 138; 273-287; Elliott S. Fisher, David E. Wennberg, Thérèse A. Stukel, Daniel J. Gottlieb, F. L. Lucas, and Étoile L. Pinder, The Implications of Regional Variations in Medicare Spending. Part 2: Health Outcomes and Satisfaction with Care, *Annals of Internal Medicine*, 2003; 138: 288-298.
[4] R. Douglas Scott II, *The Direct Medical Costs of Healthcare-Associated Infections in US Hospitals and the Benefits of Prevention*, Washington, D.C.: Centers for Disease Control and Prevention, 2009.
[5] Profiles of Innovation in Health Care Delivery, *Health Affairs*, March 2011.
[6] Institute of Medicine, *The Healthcare Imperative: Lowering Costs and Improving Outcomes: Workshop Summary*. Washington, DC: The National Academies Press, 2010.

Mayo Clinic, and the Virginia Mason Medical Center all have achieved high quality, lower cost outcomes. Consider just a few examples. The University of Pittsburgh Medical Center reduced its hospital-acquired infections (HAI) rate by 85%; Geisinger cut its readmission rate down to 3.8%; Parkland, a public hospital in Dallas, reduced readmissions for Medicare heart failure patients by about 40 percent in 2010-11; and Denver Health, a safety-net institution, has cut its rate of fatal and expensive cardiac arrest rates more than in half.[7,8]

These organizations are not concentrated geographically, nor do they share particular demographic characteristics of enrollees. Rather, they have three other features in common: (1) they use information technology to learn what works and what does not; (2) they have removed themselves from the fee-for-service payment grid and instead use volume-neutral or value-based compensation systems; and (3) they have freed up employees to do the right job, by training leaders who facilitate quality improvement and empowering employees to make the right care the heart of their mission.

These examples can be replicated nationally. There is no reason why every doctor, hospital, and health system could not implement care processes equal to the best in the country. But policy is needed to make it happen. Two policy components are particularly important. One part is the so-far successful push to disseminate information technology throughout the medical system. The HITECH Act passed as part of the American Recovery and Reinvestment Act of 2009 is

[7] Paul Barr, "Cutting readmissions: Index allows hospital to track high-risk patients," *Modern Healthcare*, 2011; July 25:10.
[8] Patricia A. Gabow and Philip S. Mehler, A Broad And Structured Approach To Improving Patient Safety And Quality: Lessons From Denver Health, *Health Affairs*, 2011, 30(4), 612-618.

succeeding in its goal to facilitate the adoption of universal health IT. Congress should rightly celebrate this accomplishment and keep pushing for organizations to do more.

The next step is to create incentives to use those systems appropriately and change the delivery model for health care services. The Affordable Care Act took some steps in this direction with a series of changes to the Medicare program. These include: *direct payment innovations,* including higher reimbursement for preventive care services and patient-centered primary care, bundled payment for acute and post-acute medical services, shared savings or capitation payments for accountable provider groups that assume responsibility for the continuum of a patient's care, and pay-for-performance incentives for Medicare providers; *increased funding for comparative effectiveness research*, to enhance our knowledge of what medical care is helpful, and what is not; *distinguishing medical care providers on the basis of cost and quality*, making that data available to providers, consumers, and insurance plans, and providing financial incentives for relatively low-quality, high-cost providers to improve their care; an *Innovation Center* at CMS to sponsor and encourage innovative care delivery models; and *increased emphasis on wellness and prevention*, through lower cost sharing for preventive care, mandatory nutrition labeling at chain restaurants, employee wellness discounts, and dedicated funding for prevention and public health.

But the Affordable Care Act did not go far enough. To achieve meaningful savings, we need to commit to more systematic payment reform, and in particular a move from fee-for-service reimbursement to bundled payments. A variety of payment methodologies fall into the bundled care heading. Some bundled payments will be at the episode level. For example, primary care

physicians might receive a bundled payment for services delivered in the primary care setting, with bonuses for reducing emergency department and inpatient costs. Similarly, specialists may receive a bundled payment for the services related to the problems they treat – a hip replacement bundle for patients that have a broken hip, for example. In the Congressional Budget Office's recent review of programs that reform the payment and delivery system, the single reform that demonstrated reduced spending was bundling services, which CBO estimated saved 10 percent.[9]

Other payments will be at bundled at the patient level for an entire year. The Accountable Care Organization (ACO) model that Medicare is pioneering is an example of such a payment system. Evidence from a similar program in Massachusetts shows that a global payment model saved 2 percent in just the first year.[10]

Recommendation 1: Congress should facilitate cost savings by undertaking three payment reforms in the Medicare program:

1. Adopt nationally the 37 bundles in the Acute Care Episode (ACE) demonstration for cardiac and orthopedic procedures combined with rehabilitation services.

2. Introduce and disseminate bundles for chronic conditions, such as treatment for cancer, coronary artery disease, and diabetes.

3. Establish a date certain, perhaps 5 to 7 years from now, when the vast bulk of payments by Medicare and Medicaid – 80 percent or more – would be bundled episode payment or global patient-based payment.

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[9] Lyle Nelson, *Lessons from Medicare's Demonstration Projects on Value-Based Payment*, Washington, D.C.: Congressional Budget Office, 2012.

[10] 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.

Ideally, CMS would work with private insurers on the design of each of these steps. Many private insurers are moving in this direction already but are waiting for CMS to take the lead. Together, these policies would send a clear market signal that fee-for-service payment is ending and would incentivize investment in the infrastructure and technology that is necessary for more widespread implementation of bundled payments.

REDUCING ADMINISTRATIVE COSTS

Spending on administration is much higher in the United States than in other countries, and is much greater than any analyst suggests is needed. For every office based physician in the United States, there are 2.2 administrative workers; in Canada, there are half as many. U.S. hospitals have 1.5 administrative workers per bed; that is 40 percent more than in Canada.[11]

The overall cost of this administrative expense is staggering. The Institute of Medicine estimated that providers and payers in the United States spend $361 billion on billing and insurance-related administrative costs, of which about half are not associated with improved system operation.[12] The McKinsey Global Institute, the Medical Group Management Association, the American Medical Association, and the association of America's Health Insurance Plans also suggest that administrative costs are excessive.[13] Some of these costs are

[11] David Cutler, and Dan Ly, "The (Paper)Work of Medicine: Understanding International Medical Costs," *Journal of Economic Perspectives,* 2011, 25(2), 3-25.
[12] Institute of Medicine, *The Healthcare Imperative: Lowering Costs and Improving Outcomes: Workshop Summary.* Washington, DC: The National Academies Press, 2010; James G. Kahn, et al., "The cost of health insurance administration in California: estimates for insurers, physicians, and hospitals," *Health Affairs,* 2005; 24(6), 1629-39.
[13] McKinsey Global Institute, *Accounting for the Cost of US Health Care: A New Look at Why Americans Spend More*, Washington, D.C.: McKinsey Global Institute, 2008; Medical Group Management Association, "Administrative Simplification for Medical Group Practices," MGMA Position Paper, June 2005; Stephen J. Ubl and others, Letter to President Obama, May 11, 2009, available at http://www.whitehouse.gov/assets/documents/05-11-09_Health_Costs_Letter_

paid by insurance companies in their billing and claims processing departments, but this is not the bulk of the costs. Rather, a larger share is paid by providers, in the form of excess personnel and time investment. The typical U.S. hospital spends 10 cents out of every dollar raised just collecting that dollar.[14]

Table 2 provides examples of these costs, including credentialing processes that differ for each insurer and care organization; claims submission and payment processes that are not standardized; and eligibility verification that is needlessly complex.

Table 2. Administrative Complexity Through the Provider Revenue Cycle

Stages	Examples of Administrative Costs
Providers Negotiate with Insurers Contracting and Credentialing	Time spent negotiating various contracts and filling out redundant credentialing forms; Lost clinical time due to long approval process for credentialing applications.
Patient Schedules Appointment Eligibility Verification	Patient effort to contact appropriate office personnel and negotiate insurance approval; Providers, insurers, and patients contend with retroactive additions and terminations of employee coverage that complicate eligibility verification process; plan customization and carve-outs add confusion to determinations of covered services.
Patient Visit/Treatment	Prior authorization requirements for treatments and services are often ambiguous and arduous to complete; process for referrals is time-consuming and often does not add value.
Billing and Claims Submission	Variation in claims requirements, lack of standardized codes, lack of uniform operating rules, insurance company companion guide changes, and complexity in identifying the primary insurance company responsible for payment due to lack of standardized identifiers.
Claims Status Inquiries Collections, Remittance, Payment Posting	No verification process in place to determine whether claim was successfully received from provider in the format desired by insurance companies and other payers.
Denials	Variation in use of denial codes across payers creates

to_the_President.pdf;

[14] Bonnie B. Blanchfield, James L. Heffernan, Bradford Osgood, Rosemary R. Sheehan, and Gregg S. Meyer, "Saving Billions Of Dollars--And Physicians' Time--By Streamlining Billing Practices," *Health Affairs*, 2010, 29(6):1–7.

Reconciling Over-and Under-Payments	challenges for provider offices; Insurance company systems are outdated and often lack capabilities to identify important data in provider claims; Uneven adoption of electronic capabilities creates room for human error.
Appeals	Processes vary across insurers and many conducted manually, which is costly and time consuming.
Reporting	Inconsistent requirements across insurers, agencies, hospitals, and other programs.

Note: This analysis is drawn primarily from research conducted for the Employers Action Coalition on Health Care.[15]

There is no doubt that these costs can be reduced. Credentialing has been partially streamlined in some areas, and could be streamlined further. There are proposals for standardizing claims submission, payment notification, and eligibility verification, and statewide examples in Massachusetts and Utah that could be expanded. The major impediment to reducing administrative waste is not lack of knowledge, but instead lack of authority and willpower.

The Affordable Care Act took some steps to streamline these costs. In particular, Sections 1104 and 10909 of the ACA establish uniform operating rules for claims submission, adjudication, and other communications between providers and insurers. This complements operating rule requirements enacted as part of the Health Insurance Portability and Accountability Act of 1996. But there is more to be done in this area. In particular, Congress can take two vital steps to further administrative savings.

Recommendation 2: Congress should mandate several steps to reduce administrative costs to occur within the next three years, including:

1. Requiring EMR vendors to integrate electronic clinical records with claims and bill processing functions;

[15] Employers Action Coalition on Healthcare Steering Committee. *Analysis of Administrative Simplification.* 2003; Mark Merlis, *Simplifying Administration of Health Insurance*. Washington, D.C.: 2009.

2. Requiring providers and payers to implement the electronic exchange of eligibility, claims, and other administrative information; and

3. Requiring all payers, hospitals, and physicians to use a single, centralized physician credentialing system.

The first of these requirements would simplify the transfer of information from clinical systems to billing systems. Since a good share of administrative costs come from the need for clinical documentation in the billing transaction, this would save significant amounts of time and money. The second requirement ensures that payers have mutually compatible billing systems and that providers respond by adopting similarly compatible electronic submission systems. The third requirement specifies that credentialing would be standardized into a single system.

The most efficient way to implement these changes would be to have HHS, in consultation with payers and providers, set national standards. Because the government is such a large share of the medical system, there is no way to achieve administrative simplification without public sector involvement. Private collaboratives are a second alternative, but they lack integration with the public sector and might vary needlessly from locality to locality.

Administrative simplification is very technical, and public sector expertise in these areas is often lacking. As a result, HHS has been slow to use authority given to it to reduce administrative costs. For example, the HIPAA measures on administrative simplification were not fully implemented until well over a decade after the legislation was passed. To address this, Congress should elevate the importance of administrative savings within the health care agencies:

Recommendation 3: Administrative simplification measures should be allocated to a new office or agency within the Department of Health and Human Services tasked with the specific goal of reducing administrative costs by one-third over the next five years.

The new agency would promote consensus where such consensus exists, and have the authority to mandate some actions if consensus cannot be reached. Given the level of scrutiny now being placed on administrative costs and the need for savings in this area, I am confident that most such savings will be realized through a consensus process.

SUMMARY

In sum, the need for cost savings in health care is critical. Fortunately, we have the ability to address the problem. Both poor care delivery and administrative cost simplification are feasible within the next few years. Also fortunately, many of the needed changes are not partisan in nature; efforts to improve care delivery and reduce administrative costs have crossed party lines. Thus, the issue for this Congress is how to start with bipartisan support for delivery system reform and administrative simplification and use that to achieve real cost savings. By working together with the industry participants, experts, and the administration, this Congress can help set the path for an era of health reform that is valuable for our economic health as well as our personal health.

Thank you again for the opportunity to meet with you. I would be happy to answer any questions that you might have.