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TESTIMONY OF DAVID M. CUTLER
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Before the
Committee on Energy and Commerce
U.S. House of Representatives

Summary

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 there are three areas where costs can be saved: (1) improved management of acute and post-acute care; (2) greater attention to prevention; and (3) reducing excessive administrative spending. At least one-third of medical spending is not associated with improved health, implying waste of about \$750 billion annually.

The Affordable Care Act has a number of provisions designed to address these areas of cost savings. These include direct payment innovations such as higher reimbursement for preventive care services, 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 in comparative effectiveness research; an Independent Payment Advisory Board and an innovation Center in the Center for Medicare and Medicaid Services to test and disseminate new care models; an excise tax on high cost insurance plan; increased emphasis on wellness and prevention; and standardization of costly and burdensome administrative practices.

The effect of these change on medical spending, federal and state budgets, and job growth are profound. I estimate that over the next decade, the Affordable Care Act will reduce national medical spending by over \$500 billion, reduce the federal budget deficit by over \$400 billion, and lead to the creation of 250,000 to 400,000 jobs annually. The urgent need is for this Congress and administration to work together to ensure that the Affordable Care Act is as successful as it can be.



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Mr. Chairman, Mr. Pallone, and members of the committee, I appreciate the invitation to appear before you today to discuss the topic of “The True Cost of the Patient Protection and Affordable Care Act (the Affordable Care Act).” 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 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, and understanding how the Affordable Care Act affects those costs is extremely important. 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 These include people feeling locked into their current job,² reduced business startups, and reduced employment, especially of lower wage workers.³ Further, high medical spending, when combined with constant or falling tax collections, pose a strain on budgets at all levels of government. Thus, policy must focus on constraining medical spending.

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 payments across-the-board 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. Those measures are included in the Affordable Care Act, as described below.

- o *We need to reduce the overall level of spending, not simply shift costs from one payer to another.* It would be easy for businesses to reduce their spending on medical care; they could simply stop providing health insurance and let their employees buy individually. While this would lower business costs, it would raise spending by families. Indeed, family spending would

¹ Gruber, Jonathan, "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.

² Brigitte Madrian, "Employment-Based Health Insurance and Job Mobility: Is There Evidence of Job-Lock?," *Quarterly Journal of Economics*, 1994, 109(1), 27-54.

³ Neeraj Sood, Arkadipta Ghosh, José Escarce, "Employer-Sponsored Insurance, Health Care Cost Growth, and the Economic Performance of U.S. Industries", *Health Services Research*, 44(5), October 2009, 1449 -1464; Katherine Baicker and Amitabh Chandra, "The Labor Market Effects of Rising Health Insurance Premiums", *Journal of Labor Economics*, 24(3), July 2006, 609-634.

likely increase by more than business spending fell, since the administrative costs of individual insurance are many times greater than the administrative costs of group coverage. Similarly, governments could reduce their liability for medical care by shifting costs to individuals – requiring higher premiums for Medicare beneficiaries or restricting eligibility for Medicaid. But this too is a shift of costs that may lead to an increase in the overall level of medical spending, not a reduction in expenses.

OPPORTUNITIES TO REDUCE MEDICAL SPENDING

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 there are three areas where money can be saved and quality simultaneously improved:

- o *Improved management of acute and post-acute care.* When people develop acute illnesses, they receive care that is uncoordinated, frequently inappropriate, and provided in settings that are more expensive than needed. For example, the Dartmouth Atlas shows that Medicare beneficiaries who live in areas of the country that spend more receive more medical care, but their health is no better.⁴ The magnitude is such that nearly one-third of Medicare spending could be eliminated by bringing spending in more expensive areas to the level of less expensive areas. Another study shows significant unnecessary hospital readmissions, again in the Medicare population. Nationally, about 20 percent of Medicare beneficiaries are readmitted

⁴ Fisher, Elliott, et al., “The Implications of Regional Variations in Medicare Spending. Part 1: The Content, Quality, and Accessibility of Care.” *Annals of Internal Medicine* 2003a, 138: 273–87; Fisher, Elliott, et al., “The Implications of Regional Variations in Medicare Spending. Part 2: Health Outcomes and Satisfaction with Care.” *Annals of Internal Medicine* 2003b, 138: 288–98.

to a hospital within one month of a previous discharge.⁵ In the best health systems, the rate is close to 5 percent.⁶ The difference between these rates is tens of billions of dollars annually, and needless suffering for many families.

Improvement in acute and post-acute care management has been demonstrated numerous times. The journal *Health Affairs* recently profiled 15 successful organizations.⁷ The Institute of Medicine has reported on several more.⁸ Organizations such as the Cleveland Clinic, Geisinger Health System, Group Health Cooperative, Intermountain Health Care, Kaiser Permanente, Massachusetts General Hospital, the Mayo Clinic, and the Virginia Mason Medical Center all have achieved high quality, lower cost outcomes. 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 payments; 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. All of this would be possible to replicate nationally, but not without major changes in how medical care is structured.

⁵ Stephen F. Jencks, et al., "Rehospitalization among Patients in the Medicare Fee-for-Service Program," *New England Journal of Medicine*, 2009; 360: 1418-1428.

⁶ Maureen Bisognano and Amy Boutwell, "Improving Transitions to Reduce Readmissions," *Frontiers of Health Services Management*, Spring 2009, 25(3), 3-10.

⁷ Profiles of Innovation in Health Care Delivery, *Health Affairs*, March 2011.

⁸ Institute of Medicine, *The Healthcare Imperative: Lowering Costs and Improving Outcomes: Workshop Summary*. Washington, DC: The National Academies Press, 2010.

o *Increased attention to prevention.* Prevention extends lives, and in many cases lowers medical spending as well.⁹ Thus, preventing acute illnesses is a second way to lower medical costs and improve the quality of care. There are several aspects of prevention: primary prevention (mammograms, colonoscopies, obesity reduction programs, and the like), secondary prevention (medication for diabetes, high cholesterol, and other chronic diseases to prevent acute events), and tertiary prevention (reducing the risk of hospital readmission, as noted above). Primary, secondary, and tertiary prevention are all poor in the United States. For example, only 43 percent of diabetic patients in the United States report receiving recommended screening for diabetes.¹⁰ That is about average internationally, but far below the best countries. Two-thirds of diabetics in the United Kingdom and nearly 60 percent of diabetics in the Netherlands report having received all recommended screenings. Thus, we know we can do better.

There are several features of the British and Dutch health care systems that likely contribute to their better prevention. First, providers in these countries regularly use information technology. Eighty-nine percent of British physicians and 54 percent of Dutch physicians have extensive access to electronic medical records and decision support systems, compared to only 26 percent of U.S. physicians.¹¹ Physicians cannot help patients manage their care if they do not know what care their patients have and have not received. Second, both the United Kingdom and the Netherlands encourage a team-based approach to care provision. In the Netherlands, physicians have established after-hours cooperatives to provide care on nights and weekends. The United

⁹ Dana P. Goldman, et al., “The benefits of risk factor prevention in Americans aged 51 years and older,” *American Journal of Public Health*, 2009, 99(11), 2096-101.

¹⁰ Cathy Schoen, Robin Osborn, Sabrina K.H. How, et al., “In Chronic Condition: Experiences of Patients with Complex Health Care Needs, in Eight Countries, 2008,” *Health Affairs*, 2009, 28(1), w1-w16.

¹¹ Cathy Schoen, Robin Osborn, Michelle M. Doty, et al., “A Survey of Primary Care Physicians in Eleven Countries, 2009: Perspectives on Care, Costs, and Experiences,” *Health Affairs*, 2009, 28(6), w1171-w1183.

Kingdom has national call centers for the same purpose. Third, physicians are rewarded for care coordination in both countries. Performance on quality measures has been an important part of physician compensation in the United Kingdom since the early 2000s, and the same is true – though to a more limited extent – in the Netherlands. Neither care coordination nor good outcomes are rewarded in the U.S. health care system, especially Medicare. Fourth, nurses are allowed to play a key role in organizing care in the United Kingdom and the Netherlands. While neither the United Kingdom nor the Netherlands have more nurses than the United States, both countries allow nurses greater autonomy in helping care for patients. The United States could well implement a system like that in these other countries. But will require significant change in the way that medical care is delivered.

o *Eliminating excessive administrative costs.* Spending on administration is much higher than in the United States than in other countries, and is much greater than any analyst suggests is needed. For example, 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

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_

Excessive administrative costs are a result of several factors: credentialing processes that differ for each insurer and care organization; claims submission and payment processes that are not standardized; and eligibility verification that is needless complex. There is no doubt that these costs could 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 willpower. The Health Insurance Portability and Accountability Act gave the Department of Health and Human Services the authority to streamline administrative costs, but this was pursued only haphazardly. The Affordable Care Act provides additional authority and the means to carry this out.

Summary. All told, the amount of excessive medical spending is staggering. A rough consensus among experts, including a recent consensus document from the Institute of Medicine, is that at least one-third of medical spending is not associated with improved health. This implies waste of about \$750 billion annually.¹⁴ Many experts in medical care delivery suggest that the amount of excessive spending is even higher. To put this in perspective, the lower bound is about 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.

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¹⁴ Institute of Medicine, *The Healthcare Imperative: Lowering Costs and Improving Outcomes: Workshop Summary*. Washington, DC: The National Academies Press, 2010.

THE IMPACT OF THE AFFORDABLE CARE ACT ON COST SAVINGS

The Affordable Care Act has provisions that address each of these three areas of excessive spending. Before highlighting these areas, it is important to note that the Affordable Care Act builds upon the HITECH Act passed as part of the American Recovery and Reinvestment Act of 2009. The HITECH Act provided the funding and incentives to make medical records electronic. The next step is to create incentives to use those records appropriately and change in the delivery of services to promote better care, not just more expensive care. Together, the two pieces of legislation bring the medical system to the point where significant productivity improvements are possible.

Many provisions of the Affordable Care Act will affect costs in the areas of noted above. For example, Accountable Care Organizations will have incentives to both limit hospital readmission rates and to prevent episodes of illness through better chronic care management. They will also streamline administrative costs within the systems. For simplicity, I delineate the provisions of the Affordable Care Act in two groups: those that are primarily designed to affect the provision of medical services; and those that are primarily related to administrative simplification.

Provisions related to the delivery of medical services. The Affordable Care Act begins the process of a wholesale restructuring of how Medicare and private insurers pay for medical care, moving away from payment-for-volume and towards payment-for-value. Within the Medicare and Medicaid programs, the specific provisions of the Act 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 Independent Payment Advisory Board to recommend structural changes to Medicare, along with an Innovation Center in CMS to sponsor and encourage innovative care delivery models;

An excise tax on high-cost insurance plans, to provide incentives for firms with high spending to lower those costs; 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.

Together, these provisions should have a profound effect on the delivery of medical services. They bring to Medicare the same management tools and incentives that underlie the care delivered in the best medical systems in the country, and in the best businesses outside of medical care.

Additional provisions affecting administrative simplification. One of the least noted features of the Affordable Care Act are the provisions addressing administrative simplification. In particular, Sections 1104 and 10909 of the Act establish uniform operating rules for claims submission, adjudication, and other communications between providers and insurers. They also extend the areas where standardization is sought. In combination with the transformation to electronic medical records, these provisions will lay the foundation for a major reduction in the administrative burden of medicine.

THE FISCAL AND ECONOMIC IMPACTS OF THE AFFORDABLE CARE ACT

Estimating the impact of any reform bill on medical spending and the economy is difficult, let alone one with as many pieces as the Affordable Care Act. Partly as a result of this uncertainty, the Congressional Budget Office and the Office of the Actuary assume only minor savings from the delivery system provisions in the legislation. For example, CBO estimated that the parts of the law noted above will cost \$10 billion over the 2010–2019 period, while the Office of the Actuary determined savings of only \$2 billion.

Other estimates, however, suggest that an aggressive approach to changing the delivery of medical services could result in significantly greater cost reductions. Consider, for example, the

30 percent or more of medical care that is estimated to be wasteful. How rapidly would an improved system be able to eliminate this waste? If the waste could be eliminated in 10 years, the implied reduction in costs relative to trend is 3 percent annually. An efficiency initiative that took 20 years would lower costs relative to trend by 1.5 percentage points annually.

Studies of the American economy as a whole suggest that information intensive industries have productivity growth of 1.5 percentage points annually above other industries.¹⁵ However, medical care is more complex than most industries. Thus, cost savings in medical care may be somewhat slower. For this reason, I consider savings of 1.0 to 1.5 percentage points annually a reasonable expectation for the impact of the type of reforms included in the Affordable Care Act.¹⁶ Relative to cost savings of this magnitude, the Business Roundtable suggests a larger potential reduction in spending,¹⁷ as do health care groups such as the American Medical Association and American Hospital Association.

The impact of cost savings of this magnitude are profound. Figure 1 shows the effect on national medical spending of a reduction in cost growth of 1.5 percentage points annually. I project that **national spending on health care will decline relative to trend** by over \$500 billion in the first decade, by \$3.5 trillion in the second decade, and by nearly \$5 trillion in the third decade. These

¹⁵ Stephen D. Oliner, et al., "Explaining a productive decade," *Brookings Papers on Economic Activity*, 2007, 1: 81–137.

¹⁶ David M. Cutler, Karen Davis, and Kristof Stremikis, *The Impact of Health Reform on Health System Spending*, Center for American Progress and the Commonwealth Fund, May 2010; Melinda Beeuwkes-Buntin and David Cutler, *The Two Trillion Dollar Solution: Saving Money by Modernizing the Health Care System*, Center for American Progress, June 2009; David Cutler, "How Health Care Reform Must Bend the Cost Curve," *Health Affairs*, 2010, 29(6), 1131-1135.

¹⁷ Hewitt Associates, *Health Care Reform: Creating a Sustainable Health Care Marketplace*, Washington, D.C.: Business Roundtable, 2009; 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_to_the_President.pdf;

savings would translate into enormous savings for the federal budget. In comparison to the Congressional Budget Office estimates that the Affordable Care Act will save about \$130 billion over the next decade, assuming reasonable savings from the provisions noted above suggests **budgetary savings of over \$400 billion over the first decade.** The savings in subsequent decades would be even greater, as cost savings cumulate.

If the Affordable Care Act were repealed, the ability to achieve cost savings would be very significantly reduced, even were tight constraints on Medicare and Medicaid substituted instead. The Affordable Care Act will save money not by mandating any specific level of savings, but by incentivizing better care.

Insurance premiums would decline with reductions in overall medical spending, and this would lead firms to hire more workers. **Improving the productivity of the medical sector by 1 to 1.5 percent per year would create 250,000 to 400,000 jobs annually over the next decade.** Jobs would be created in virtually all industries with the exception of health care, where more efficient production should allow for some reduction in administrative staff. Estimates from other groups suggest job creation along the same lines. The President's Council of Economic Advisers used a different methodology but reached a similar conclusion.¹⁸ And a recent Urban Institute study agrees that long-term cost savings are the major determinant of the employment effects of health reform, though they do not provide a specific jobs estimate.¹⁹

¹⁸ Executive Office of the President, Council of Economic Advisers, "The Economic Case for Health Care Reform," June 2009; Executive Office of the President, Council of Economic Advisers, "The Economic Case for Health Care Reform: Update," December 2009.

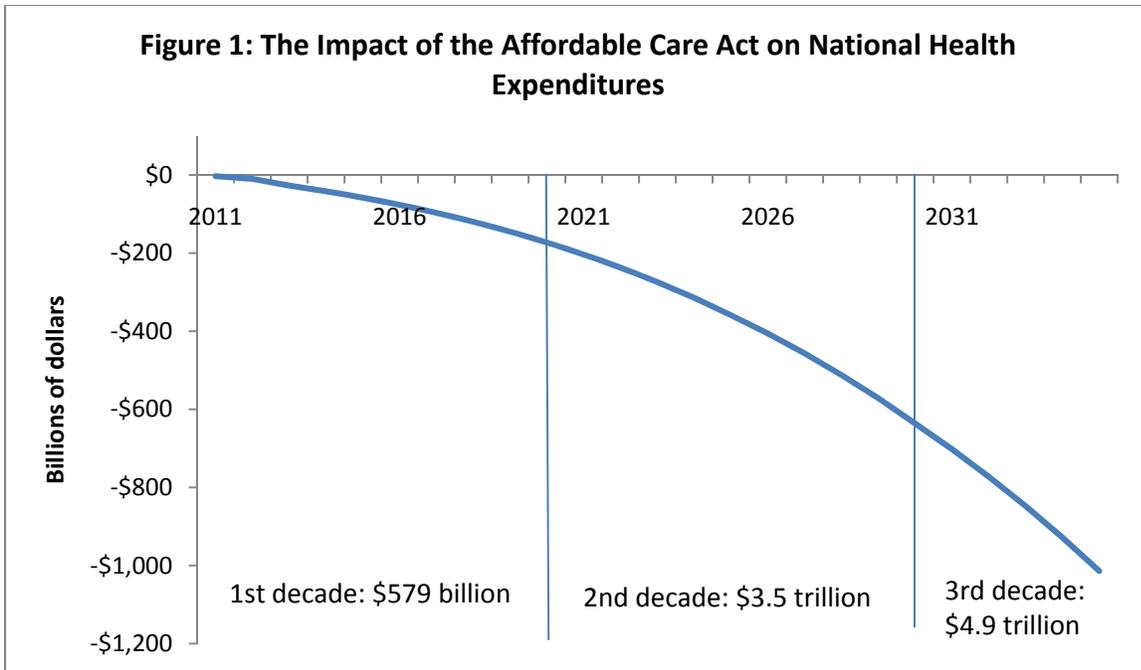
¹⁹ John Holahan and Bowen Garrett, "How Will the Affordable Care Act Affect Jobs?" Washington D.C.: The Urban Institute, March 2011.

Of course, other provisions of the Affordable Care Act will affect employment as well. But those provisions will affect employment in different directions and on net have a minor impact on job creation. Expanded insurance coverage will increase demand for health care workers, while reductions in Medicare and Medicaid spending will lower demand. Universal coverage will increase the ability of workers to change jobs or leave the labor force entirely, while reductions in costs for small firms and some large firms will boost employment there. As virtually all analysts note, these effects will roughly cancel out. The major impact of the Affordable Care Act on employment will stem from its impact on overall medical spending.

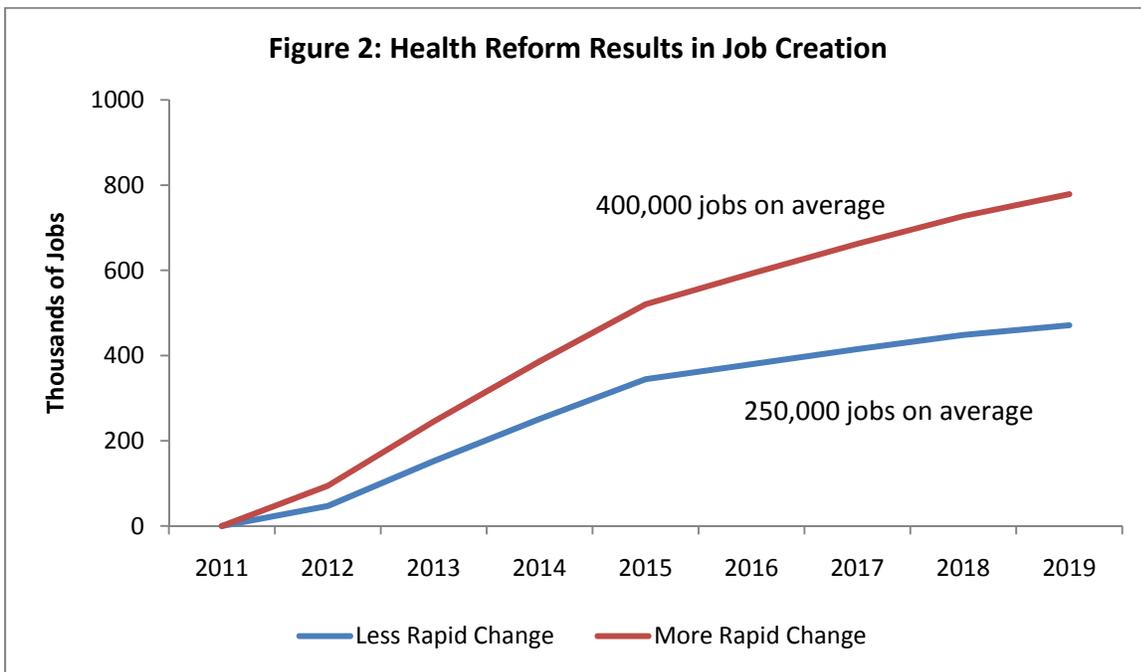
SUMMARY

In sum, economic research on the potential impact of the Affordable Care Act is clear: the Affordable Care Act creates an opportunity for changes in the way that medical care is delivered that will cut the growth of medical care costs; improve the fiscal situation of federal, state, and local governments; and spur job creation. The issue for this Congress is how to strengthen the Affordable Care Act. There are many provisions of the Act that could be stronger, and some that ought to be reconsidered. In the former category are provisions to speed new program models in all parts of Medicare and Medicaid. There are steps to address this in the Affordable Care Act, but they could and should be strengthened. By working together with 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.



Data are from David Cutler, "How Health Care Reform Must Bend the Cost Curve," *Health Affairs*, 2010, 29(6), 1131-1135.



Data are from David Cutler and Neeraj Sood, "New Jobs Through Better Health Care," Washington, D.C.: Center for American Progress, 2010.