



Six Ways Not to Reform Health Care

By John E. Calfee

The Senate and House have both passed health care reform bills, but the two bills differ in important respects. Attempts to reconcile these differences have been forestalled by the election of Republican Scott Brown (Mass.) to fill the Senate seat long held by Ted Kennedy. Whether the Obama administration and congressional leaders can resurrect this legislation in some form remains to be seen. The fact remains, however, that Congress came very close to passing legislation that would change myriad components of the health care system. Unfortunately, both reform bills involved nearly unfathomable complexity, invited a variety of adverse consequences, and failed to address key problems in the health care system. Instead of taking the time to create common-sense legislation to address shortcomings in the U.S. health care system, Congress proceeded under the mistaken assumption that any bill to fundamentally reform the health care system is better than no bill at all.

Congressional Democrats and the Obama administration came very close to passing legislation that would radically transform our health care system. Democrats continue to seek a path to sweeping reform even as they and others debate the political dynamics that undergirded the unexpected defeat in Massachusetts. These debates, however, miss the point. Instead of proposing legislation that would improve health care quality and offer real relief to struggling Americans, Congress is demonstrating, sadly, how *not* to transform health care. Thus far, Congress has made many mistakes in constructing its proposals for health care reform. The balance of this *Outlook* will examine some of the ways health care reform has gone wrong.

Do Not Change Everything at Once

Despite its manifest problems, including high costs and incomplete insurance coverage, the American health care system provides exceptionally good care and is highly rated by the vast

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majority of consumers. This suggests taking an incremental approach to reform. Instead, Congress has embarked upon sweeping reforms that touch upon or even completely revamp much of health care. These reforms would fundamentally alter the operation of private insurance, regulate insurance firms' spending and profits, require

Key points in this *Outlook*:

- An attempt to change all aspects of the health care system at once has led to complex legislation that is difficult to understand or measure effectively.
- The health care legislation ignores important consequences and fails to address key problems in the health care system, such as cost control, in any meaningful way.
- A faulty assumption that any health care reform bill is better than no bill may result in health care reforms that do more harm than good for American consumers.

nearly everyone to buy insurance or pay a fine, promise massive taxpayer insurance subsidies, provide for the biggest Medicaid expansion in recent decades, launch federal long-term care insurance, dismantle most of the Medicare Advantage program that covers roughly one-fourth of Medicare beneficiaries, establish untested mechanisms for cutting future Medicare reimbursements to providers, implement numerous smaller changes in Medicare to reorganize much of the practice of medicine, create a federal Independent Payment Advisory Board to cut Medicare spending (unless Congress quickly intervenes) and to recommend cuts in private health care, and create a federal “Innovation Center” to develop and promote new ways to cut costs throughout the health care system. And this list represents only a sample of the many changes proposed in the Senate bill’s two-thousand-plus pages.¹

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Even if one grants the need for fundamental health care reform, making so many fundamental changes all at once vastly increases the complexity of legislation and opens the door to provisions designed mainly for the benefit of specific constituencies. Some of these legislative earmarks have become well known. For example, the Senate bill cuts back on Medicare Advantage programs (health maintenance organizations for Medicare beneficiaries) except in New York, Pennsylvania, and Florida, and, at the same time, provides special Medicaid funding for Nebraska, Louisiana, and Vermont, and allocates \$100 million for hospital construction at a public university in Connecticut (presumably the University of Connecticut).

Do Not Change So Quickly

Congress constructed much of its plan for revamping health care at lightning speed, but essential parts of the House and Senate bills were revised over and over again. In the last ten or so days before the final series of floor votes began on December 20, 2009, some senators amended the Senate bill extensively—in private.² Most senators

(Democrats as well as Republicans) learned the contents of the final, huge amendment to the reform bill while it was being read out loud in the Senate chambers, as lobbyists and journalists pored over what they had just downloaded from the Internet. Almost no one with a vested interest—that is, anyone who is sick or ever will be sick—can possibly understand what the legislation would actually do. The bills are too complicated for anyone to make a quick assessment, including members of Congress themselves. Too many interconnections among components of the bills plus myriad effects on diverse parts of the health care system and the larger economy (most of which are not even mentioned in the legislation) render the bills nearly incomprehensible.

Uncertainties about the Senate bill were particularly vivid in the Senate infighting over a “public option,” in other words, the creation of publicly financed alternatives to private health insurance. In a brief but vigorous debate over a Medicare buy-in for those age fifty-five and older, a chief issue was whether subsequent political dynamics would lead to a relentless expansion of Medicare to replace much or all of private insurance. Who knows for sure? As it happened, the Senate replaced the proposed Medicare buy-in with a system of multistate, private-sector insurance plans under the supervision of the federal Office of Personnel Management, but reliable predictions of how this will work are unavailable.

Do Not Rely on CBO Scores

Throughout the process of creating the health care reform bills, Congress has had to wait for the Congressional Budget Office (CBO) to score (assess the budget implications of) the latest versions of the bills. This focus on CBO scores is misguided for four reasons. First, CBO models are often unreliable for assessing ten years’ worth of effects from legislation as complex as these reform bills. In its November 13, 2009, analysis of the current version of the Senate reform bill, the Office of the Actuary at the Centers for Medicare and Medicaid Services (CMS), whose methods are similar to the methods the CBO employs, noted:

The actual future impacts of H.R. 3962 on health expenditures, insured status, individual decisions, and employer behavior are very uncertain. The legislation would result in numerous changes in the way that health care insurance is provided and paid for in the U.S., and the scope and magnitude of

these changes are such that few precedents exist for use in estimation. Consequently, the estimates presented here are subject to a substantially greater degree of uncertainty than is usually the case with more routine health care proposals.³

Second, CBO scores are typically the result of repeated back-and-forth communications between the drafters of congressional bills and CBO modelers. If initial estimates are unfavorable—if they show too much spending or too little revenue—the bill’s provisions are revised and resubmitted until a satisfactory result is achieved. Given the innate uncertainty of CBO modeling, some scores will underestimate actual costs and others will overestimate costs. But it is underestimates, rather than overestimates, that are most likely to survive this process because they lead to more favorable scores to accompany the amended bills.

Third, the CBO is required to assume explicit spending cuts will actually take place regardless of political circumstances. A widely noted example is the CBO assumption that Medicare “sustainable growth rate” (SGR) reimbursement cuts of more than 20 percent for physicians and other providers—set in current law and maintained in the Senate reform bill—will occur as planned. This disregards the fact that Congress has overturned these same cuts for the past seven years. The administration obviously expects Congress to continue this practice, notwithstanding the content of the reform bills. We know this because the president touted the American Medical Association (AMA) endorsement of the Senate bill even though the AMA explicitly stated that its endorsement would be withdrawn if Medicare reimbursement cuts were not offset by separate legislation.⁴ Aside from SGR cuts, however, the Senate reform bill contains other cuts of comparable or greater scale involving hundreds of billions of dollars. For example, the bill assumes Medicare reimbursement and spending will be forced to decline roughly in parallel with annual productivity improvements in the nonhealth sector. The CBO incorporates these massive cuts into its spending scores, but, as the CMS Office of the Actuary has noted, there is little reason to expect such productivity gains to occur in hospitals, clinics, and other places where these cuts are planned.⁵ The planned Medicare cuts are unlikely to survive the next decade of Medicare politics in Congress.

Finally, the CBO focuses only on federal spending and revenues, ignoring the most important effects of reform. The CBO scores ignore nearly every essential aspect of

private insurance; health care organization; and the nature, quality, and efficiency of health care itself.⁶ In particular, the CBO has paid scant attention to total health care spending—although it had ample time to do such expansive analyses, the fevered haste with which current reform proposals have been constructed notwithstanding.⁷

Congress tends to rely on CBO scores because they represent easy-to-grasp support and offer respite from the difficult task of generating sound estimates of the most important effects of reform legislation.

The obsessive focus on CBO projections is one of the most destructive aspects of the entire health care reform debate; it has contributed to an entirely unjustified confidence in CBO scores as a reliable guide to the most important effects of health care reform. A flood of editorials and political statements, including the president’s own December 19, 2009, celebration of the final Senate bill, demonstrates reliance on CBO numbers. The president said, “Because it’s paid for and gets rid of waste and inefficiency in our health care system this will be the largest deficit reduction plan in over a decade. In fact, we just learned from the Congressional Budget Office that this bill will reduce our deficit by \$132 billion over the first decade of the program, and more than one trillion dollars in the decade after that.”⁸ It is rather like the old saying about looking for lost car keys in the well-lit area under the streetlight instead of in the darkened regions where they most likely slipped out of your pocket. Congress tends to rely on CBO scores because they represent easy-to-grasp support and offer respite from the difficult task of generating sound estimates of the most important effects of reform legislation.

Do Not Assume Imminent Solutions to the Most Challenging Problems

Will the proposed health care reform work as designed? Not unless problems that have stumped everyone are solved soon after the reforms are launched. Unsolved problems loom large. The most obvious dilemma the health care reform legislation does not address adequately is cost. The reform bills contain numerous measures that will increase both public and private costs, such as

requirements that insurance plans accept all applicants regardless of preconditions and charge everyone the same premium (partly adjusted for age), combined with penalties for noninsurance and massive federal subsidies to keep premiums affordable.⁹ The CBO's scores probably underestimate many of these costs. Even seemingly technical details could have large practical consequences on cost; this is especially true of insurance mandates and penalties. For example, the Senate bill will penalize consumers for failing to purchase insurance, but the penalties will often be so much lower than the premiums individuals would have to pay for insurance that many consumers will choose simply to pay the penalty. This would negate the primary goal of those penalties, which is to rope in enough healthy, low-cost insurance buyers to hold premiums down for higher-risk consumers. Further, lower-income employees and their employers will discover that subsidized premiums in the insurance "exchanges" are so low that employers and employees would both gain if employees switched to the exchanges, which would leave federal subsidies responsible for paying most health care costs.¹⁰ Instead of controlling costs, reform legislation would suppress potent cost-reduction tools such as high-deductible plans and substantial copayments. The success of health care reform depends on cost control. It is no surprise, therefore, that the absence of proven cost-control measures has attracted critical comments from nearly all observers regardless of political persuasion.¹¹

The confidence that anything will be better than nothing is grievously misplaced.

The response from congressional Democrats and the Obama administration has been to say the legislation includes dozens of measures that will eventually bring costs down.¹² These measures range from pushing Medicare costs down in high-spending regions and penalizing inefficient care to curtailing fee-for-service reimbursements and encouraging the creation or expansion of integrated-care systems, modeled after organizations such as Kaiser Permanente, and so-called accountable-care organizations.¹³ Most of these measures require the resolution of problems that either currently defy solution (such as regional disparities in Medicare spending) or for which solutions consist of activities that have shown little promise when attempted in practice or examined in the research literature. Integrated-care organizations, for

example, have failed to expand market share when competing against traditional fee-for-service organizations. Another cost-cutting tool is funding for comparative effectiveness research, wherein treatments would be compared for clinical effectiveness. The results would feed into decisions to reduce costs by discarding relatively ineffective treatments. A recent detailed case study found that this approach can easily increase spending, however, because it tends to discount individual differences in response to therapy.¹⁴ For the most part, proponents of reform are simply assuming events will defy evidence-based expectations. It is yet another depressing example of the triumph of hope over experience.

Do Not Ignore the Impact on Medical Technology

Perhaps the most unreal aspect of the entire debate over health care reform has been the near-complete neglect of research incentives for drugs and medical devices.¹⁵ International experience demonstrates that when health care costs surpass expectations it is common for countries to cut reimbursements for devices and, especially, medications. We can expect the same tendency here when health care costs escalate and cost-control mechanisms fail. State and federal officials will be tempted to resort to price ceilings or other brute-force controls. The reform bills already contain some price controls, such as increasing mandatory drug-price rebates in Medicaid, and these may be only a sample of what is to come. Because recent advances in medical technology are the prime source of the health benefits reform is designed to make more widely available, the absence of explicit attention to incentives for research and development is alarming. If research firms believe more price and usage controls are on the way, investment will suffer, and the pace of technological advance will slow. If this happens, there will be no way to know what will be lost; no one will ever know what new cures were not developed.

Do Not Assume Any Reform Is Better Than No Reform

The confidence that anything will be better than nothing is grievously misplaced. Yet even as massively complex legislation moves forward with scant time for critical scrutiny, prominent Democrats have declared that any bill that contains a few core elements—such as guaranteed issue regardless of preexisting conditions—is bound

to do more good than harm. Former president Bill Clinton was quoted as saying, “The worst thing to do is nothing.”¹⁶ This sentiment arises from a political calculation that if changes were sought piecemeal or at a more thoughtful and deliberate pace, the entire reform movement would fail. Polling data compiled by my colleague Karlyn Bowman show that support for the Democrats’ reform plans has consistently run from about 35 percent to 45 percent;¹⁷ as the November 2010 elections draw near, many in Congress may be reluctant to vote for such unpopular legislation. The political imperative toward haste—the idea that Congress must pass reform as quickly as possible before the political environment deteriorates—is about to give us comprehensive reform whose essence has yet to be clarified by anyone. If this happens, there are compelling reasons to expect reform and its unintended consequences to increase costs and worsen care. Sadly, far simpler reforms could achieve the most important goals without setting the nation on such a dangerous course. That will be the topic of another *Health Policy Outlook*.

Notes

1. For the full text of the Senate bill as it passed (with amendments), see *Patient Protection and Affordable Care Act*, S 3590, 111th Cong., 1st sess. (December 24, 2009), available at www.opencongress.org/senate_health_care_bill (accessed January 19, 2010).
2. For the massive “Manager’s Amendment,” see “Amendment No. IIII, Calendar No. III,” an amendment to *Patient Protection and Affordable Care Act*, 111th Cong., 1st sess., available at <http://democrats.senate.gov/reform/managers-amendment.pdf> (accessed January 19, 2010).
3. Centers for Medicare and Medicaid Services (CMS), Office of the Actuary, “Estimated Financial Effects of the ‘America’s Affordable Health Choices Act of 2009’ (H.R. 3962), as Passed by the House on November 7, 2009,” November 13, 2009, 4, available at www.cms.hhs.gov/ActuarialStudies/Downloads/HR3962_2009-11-13.pdf (accessed January 19, 2010).
4. American Medical Association (AMA) to Harry Reid, Washington, December 21, 2009, “AMA Letter of Support for Senate Reform Bill HR 3590,” available at www.ama-assn.org/ama/pub/health-system-reform/ama-supports-hr-3590.shtml (accessed January 19, 2010).
5. CMS, Office of the Actuary, “Estimated Financial Effects of the ‘Patient Protection and Affordable Care Act of 2009,’ as Proposed by the Senate Majority Leader on November 18, 2009,” December 10, 2009, 8, available at http://enzi.senate.gov/public/index.cfm?FuseAction=Files.View&FileStore_id=85899a92-a646-4bca-87b6-81ae629e7533 (accessed January 19, 2010).
6. Congressional Budget Office (CBO) to Max Baucus, Washington, October 30, 2009, “Different Measures for Analyzing Current Proposals to Reform Health Care,” 1, available at www.cbo.gov/ftpdocs/106xx/doc10689/hr3962ClarifyMeasuresBaucusLtr.pdf (accessed January 19, 2010).
7. *Ibid.*, 7.
8. White House Office of the Press Secretary, “Statement by the President on Health Care and Climate Change,” news release, December 19, 2009, available at www.whitehouse.gov/the-press-office/statement-president-health-care-and-climate-change (accessed January 19, 2010).
9. See John E. Calfee, “We Already Know Why Healthcare Overhaul Will Fail,” *American.com*, December 16, 2009, available at <http://american.com/archive/2009/december-2009/we-already-know-why-healthcare-overhaul-will-fail>.
10. James C. Capretta, “The Senate Health Care Bill’s ‘Firewall’ Creates Disparate Subsidies,” *Heritage Foundation Web Memo 2730*, December 11, 2009, available at www.heritage.org/Research/HealthCare/wm2730.cfm (accessed January 19, 2010).
11. For example, see David S. Broder, “A Budget-Buster in the Making,” *Washington Post*, November 22, 2009; and Alain C. Enthoven, “Would Reform Bills Control Costs? A Response to Atul Gawande,” *HealthAffairs.org*, December 22, 2009, available at <http://healthaffairs.org/blog/2009/12/22/would-reform-bills-control-costs-a-response-to-atul-gawande> (accessed January 19, 2010).
12. Peter R. Orszag, “A Leap Forward to Better Care,” *Washington Post*, November 20, 2009.
13. See a brief list of cost-control provisions in John E. Calfee, “We Already Know Why Healthcare Overhaul Will Fail.”
14. Anirban Basu and Tomas Philipson, “The Impact of Comparative Effectiveness Research on Health and Health Care Spending” (Working Paper 16533, National Bureau of Economic Research, Cambridge, MA, January 2010).
15. John E. Calfee, “Stop Taking R&D for Granted,” *Forbes.com*, December 24, 2009, available at www.aei.org/article/101468.
16. Nirit Weiss, “No Hasty Health Care Reform,” *Forbes.com*, December 14, 2009, available at www.forbes.com/2009/12/14/health-care-reform-politics-opinions-contributors-nirit-weiss.html (accessed January 19, 2010).
17. Karlyn Bowman, “More Health Care, but Less Government,” *Forbes.com*, December 14, 2009, available at www.aei.org/article/101424.