TESTIMONY BEFORE THE COMMITTEE ON THE BUDGET
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Thank you, Chairman Conrad, Ranking Member Gregg, and Members of the Committee for this invitation to testify before you. My name is Sherry Glied. I am a health care economist and serve as the Chair of the Department of Health Policy and Management at Columbia University's Mailman School of Public Health in Columbia University. I have studied health care reform issues for the past 15 years and greatly appreciate the opportunity to share my thoughts with you today.

The urgent need for health care reform in the United States today stems from five failings of our health care system.

First, and far and away most important, some 47 million Americans lack health insurance. Lack of coverage means that people do not get valuable preventive care, that their health deteriorates, and that they face financial crises. More than that, without health insurance, the pain, suffering, and fear that all of us face when we are ill or hurt is compounded by the indignity of being forced to beg or borrow or forego solace that is readily available to the rest of us. The idea that American citizens regularly experience this indignity – whether because of poverty, ignorance, or even incaution -- is simply shameful. We deserve a health care system that provides coverage to all Americans.

Second, even among the insured, the technical quality of care is not nearly what it should be. The inadequate quality of our care shows up in one comparative study after another – our system doesn't do as well as it should and could in terms of the processes of care and, in consequence, we do not live for as long or in as good health as we should and could.

The poor performance of our health care system in all of these studies stands in sharp contrast to our perception that America has the best health care in the world. And it is true that our very best hospitals and doctors offer services that are unparalleled. But these state-of-the-art practices are isolated pockets in a sea of mediocrity. Patients discharged from these exceptional settings typically return to the weakly coordinated, poorly managed system that is our norm. Some of the excellence of the best in our system does trickle down, but it does so slowly and unsystematically.

Third, our health care system performs poorly in providing patients with quality service. In this era of 24-hour internet banking, TV screens at every airliner seat, and drive-through everything, nearly 1/3 of American doctors don't offer ANY weekend or evening hours[1]. If their patients want to see them, even for a regular health maintenance appointment, they have to take time off work. And when they get to the doctor, American patients – the same people who can now check out their own groceries to avoid standing in line – typically spend nearly half an hour just waiting until the doctor sees them. In some cities, the average patient routinely waits as long as 45 minutes. Few Americans have a copy of their own health record, virtually none of them in a form they can understand. One of the most common complaints among people enrolled in high deductible health savings accounts plans is that they can't even comprehend their health care bill. We need a health care system that offers Americans at least the level of service they routinely expect in other sectors.

Fourth, our health care system fails to protect people from the financial consequences of illness, the principal function of health insurance. Even among insured Americans, getting sick takes a substantial financial toll. Illness means days lost from work, for both patients and family members; it means additional expenses incurred for transportation, food, care-giving, health-related appliances, and so on; it can even mean the permanent or temporary loss of a job. Many Americans just do not maintain a sufficient cushion of savings to withstand the unanticipated shocks to income and spending that come with illness, even when they have adequate health insurance. If their health plan fails to cover some medical expenses, or their co-payments and deductibles are too high for them to manage, financial disaster is likely to be imminent. That failure can be financially devastating in itself – for patients, families, and creditors too. We need a health care system that protects people from the financial consequences of ill health.

Fifth, this system, which leaves out so many and offers inadequate service to the rest, is also shockingly expensive. Governments already pay for about half of our health care spending, and the other half comes from private sources. Even so, government spending per person on health care in the United States is as high as total spending per person in several other major OECD countries![2] It's almost as if half of our health care spending bought us nothing at all.

Our health care system is so expensive not because it's better than other systems, not because we use more services than people in other places, not even because we get those services quicker than people in other places. It's expensive because we pay more for the same – and sometimes worse – quantity, quality, and timeliness of services as exists in other countries with better functioning systems. We need a health care system that is affordable – today and fifty years from now – and that gives us value for our money.

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[1] Cathy Schoen, Robin Osborn, Phuong Trang Huynh, Michelle Doty, Jordon Peugh, and Kinga Zapert. On The Front Lines Of Care: Primary Care Doctors' Office Systems, Experiences, And Views In Seven Countries. *Health Affairs*, November/December 2006; 25(6): w555-w571.

[2] Tabulations of SourceOECD. Public costs per capita in the US exceed or are about the same as total costs per capita in Denmark, Finland, Greece, Ireland, Italy, New Zealand, Portugal, Spain, Sweden, and the UK.

None of these failings come about because of venality or malice. The men and women who work in our health care system – even in our insurance companies -- are, by and large, exceptionally bright, dedicated, and hard-working. This is a systems problem, and so, Members of the Committee, it falls into your court.

NEW DIRECTIONS

You have asked me to comment on three possible directions for moving forward with health care reform: Medicare for all, an employer mandate, and an individual mandate. I'm going to address these in turn.

I want to preface my remarks by noting that, in my view, any of these options would be an improvement over the present mess. At the same time, not one of them does or could represent a comprehensive, all encompassing solution to the five problems I've described above.

That's not surprising. When you look around the world at health care systems that have existed for half a century or more, you see your counterparts – legislators the world over – endlessly tinkering with the systems, modifying them, introducing new elements and withdrawing old ones. Much as I am sure you would like to put the health care problem behind you, the one forecast I am comfortable making is that someone like me will be sitting here talking to someone like you about these same problem 50 years from now. So let's consider the options on the table today as foundations on which we will build a system into the future.

Medicare for All

Let me begin with the general notion of "Medicare for All". The very best thing about this plan is that it builds on something that already exists. Although Medicare has many serious flaws, it may be easier to bear the ills we have than flying off to others.

Medicare has three other important virtues that come about because it is a "single payer" type plan. First, everyone would be insured through the same financing, which means that healthier and sicker people would be forced into the same pool. The system wouldn't waste resources, and deny people appropriate coverage, in trying to sort people between these groups.

Second, as a single payer, the Medicare program would have tremendous clout to drive hard bargains with health care providers. Since high prices are the main contributor to high health care costs in the United States, this capacity to bargain hard is very important and Medicare for all would do it better than any other plan could.

Third, coverage under Medicare – at least under part A-- is automatic. It's the same for everyone and everyone is entitled to it.

But Medicare also has some serious flaws as a base for universal coverage. These fall into three categories: benefit design, financing design, and organizational design.

The Medicare benefit package was designed in 1964. We should all be very grateful to the wise legislators of the 88th Congress who did the heavy lifting at that time. But they were legislators and not fortune tellers. In 1964, the Surgeon General had just released the landmark report on cigarette smoking and health. The Framingham study, the big longitudinal study which identified the main heart disease risk factors, had just released its first major findings. Of the top ten procedures that Medicare beneficiaries underwent in 2003, only 3 were in routine medical use in 1964 and the majority had not yet been developed. Average length of stay in a hospital for those 65 and over was 12.6 days – it's about 5.6 days today.

No policy wonk, in his or her wildest imagination, would dream up the Medicare benefit design today. The state of the art of benefit design has evolved, but Medicare has not evolved along with it. Today, plans don't separate the insurance for inpatient hospitalizations from that for physicians – but Medicare was written before there was such a thing as outpatient surgical and diagnostic centers. Today, plans don't usually include a mental health benefit with a 50% co pay – but Medicare was written in the era of Freudian psychoanalysis, not SSRIs and short-course cognitive behavioral therapy. And no one could possibly invent the Medicare cost-sharing design today – but Medicare was written fifteen years before the RAND health insurance experiment taught us about efficient cost-sharing design.

The second feature of Medicare that makes it an awkward fit for universal coverage is the financing. Medicare operates by drawing a great deal of the money in to the Federal government, in a variety of ways, and then dispersing it. A big chunk of Medicare's financing comes from a payroll tax that is supposed to fund a trust fund to provide today's contributors with benefits in the future (not that it actually does). Many economists worry about the labor market impacts associated with a big expansion of the payroll tax to pay for an insurance expansion. Another chunk of Medicare's financing is deducted from people's social security checks to pay the part B premium. There is no comparable way to collect the same funds from working-age people. Retrofitting Medicare to the under-65 population would be more complicated than it sounds.

The third feature of Medicare that could pose difficulties is its organizational design. Medicare already pays for care for over 42 million people. That makes it among the largest health insurance programs in the world. By contrast, for example, the largest single payer program in Canada, the one that is operated by the province of Ontario, serves only 12 million people.

The enormous potential size of a universal Medicare program creates two related risks. First, a single financing program of this type creates a set of tremendously powerful incentives for health care providers. As we have learned throughout the history of the program, providers will organize their practice patterns, consciously or unconsciously, around the incentives provided by the financing system. A single financing system, in

which all money flows in the same way, necessarily creates stronger incentives than a mixed payment system. That would be fine, even desirable, if we were all knowing and could design a perfect payment system. But we can't and so we should approach this problem with some humility, designing a system that allows for some variation and experimentation.

Second, the response to those same incentives generates a system that is institutionally and organizationally committed to the preservation of the status quo. The reason that the design of the Medicare program hasn't evolved over the past 40 years is that over the past forty years all the players in the system have adapted to it, so that it is against their interest to let it change. We need to design a system that will generate creative destruction, transforming itself over time as new technologies transform the delivery of medical care itself.

Employer Mandate

What about an employer mandate? While I may be the only existing fan of the employer-based health insurance system, I have grave misgivings about extending its reach through a mandate. Employer-based coverage has existed for about 80 years, pooling risks for individuals over time and across groups, with remarkably little government interference. Indeed, nearly half of all those covered by employer-based insurance are in self-insured plans, which, because of ERISA, operate virtually without any substantive regulation whatsoever. These plans are innovative, flexible, and efficient. Benefits change with the times; new strategies for cost containment are adopted and abandoned; and, when they're allowed to do it, as in the mid-1990s, private employer-based plans can have nearly as much bargaining clout as a single payer plan. For full-time, middle income, working people employed by all but very small firms, and for their households, job-based coverage is a great system. That group constitutes about ½ of all Americans under 65. And despite all the rhetoric about the sky falling, rates of private employer-sponsored coverage for have barely budged over the past twenty years. In 1987, 66% of Americans under 65 held private insurance under an employer-based policy. In 2006, the figure was 63%[3].

The problem with an employer mandate comes when you try to stretch that very effective system to cover people who don't naturally belong to it. That includes part-time workers, workers who change jobs frequently, low wage workers, and workers in small firms. They're the ones whose job-based coverage has been eroding most. Unfortunately, just describing the category illustrates the problems with an employer pay-or-play mandate. It doesn't make sense to force part-time workers, multiple job holders, or workers in small unstable firms to get their coverage through their jobs. Often they and their job will have gone their separate ways before the coverage even becomes effective. If so, an employer mandate becomes nothing more than a disguised payroll tax on low wage workers in small firms.

[3] Sherry Glied. The Employer-Based Health Insurance System: Mistake or Cornerstone? In Policy Challenges in Modern Healthcare, ed. Mechanic, Rogut, Colby, and Knickman. NJ: Rutgers University Press, 2005 and Current Population Survey.

Individual Mandate

The third option is an individual mandate. I am going to assume that when we talk about an individual mandate, we are talking about an option that includes enough financing to ensure that everyone can afford to buy a reasonably generous health insurance package. Requiring people to buy coverage without putting that kind of subsidy program in place would be adding injury, in the form of penalties, to the insult that people already experience by being uninsured.

With that adequate subsidy element in place, an individual mandate can be a useful tool. It can help persuade people of the importance of obtaining coverage and give them the resources to do it, addressing the problems of poverty, procrastination, and incaution that contribute to lack of insurance. It can force people to make their priorities –in terms of buying health insurance or using their resources in other ways – conform to national priorities. It allows universal health insurance to be financed without requiring the flow of substantially more funds through the Federal government. But an individual mandate isn't a panacea.

Many of the people who do not have coverage now don't have a natural place to obtain coverage. They have no natural way to bargain with providers and obtain good prices and, they have no natural way to pool their risks with others, especially if they've already had health problems. One way to address this problem is to set up group purchasing arrangements – call them coalitions, alliances, connectors, helpers or whatever.

A temptation in doing this is to allow for voluntary participation in these organizations, or to allow them to compete with one another, or to allow voluntary organizations to serve as groups. Unfortunately, history suggests that any such voluntary scheme is unlikely to work. In fact, voluntary fraternal organizations offering health insurance did exist in the United States for a brief period in the early part of the 20th century, but they failed rapidly, for just the reasons we can expect voluntary groups to fail today. It's too easy for people to join a group – a fraternal organization, church, or alliance – and to leave that group –on the basis of their own health status and the prices offered by the group. Voluntary groups can even crowd out employer sponsored coverage by drawing the best risks out of the job-based group. Ultimately, under voluntary pooling, like will sort with like, and pooling will evaporate.

To work well, an individual mandate has to compel participation in defined and pre-specified purchasing groups and those groups need to be able to take active steps, such as risk adjustment, to ensure the viability of the plans that participate in them. In my view, it should also operate so as to minimize disruption of the existing employer-based system, which already contains viable purchasing pools. To do that, people should be permitted to use income-related subsidies to buy coverage and meet the requirements of the mandate through their employers' plans.

An individual mandate also faces profound administrative challenges. Individual mandates currently operate in two countries: the Netherlands and Switzerland. These countries offer valuable lessons, but care needs to be taken in the translation. Even the Netherlands, which is twice the size of Switzerland, has a population smaller than that of the New York City metropolitan area. Both countries share a tradition of a more intrusive state than we are used to here. Each also operates their health insurance programs in ways that make it easier to enforce the mandate. For example, in both countries, all coverage runs over a calendar year, so that a check of insurer records in January reflects all new policies.

The need for taking appropriate steps to monitor and administer a mandate becomes even clearer when you look at a profile of uninsured people in the US today. An individual mandate would be relatively easy to manage for the 55% of uninsured spells that last for at least a year or more. But the individual mandate would be harder to operate for those people who spend only brief periods uninsured. About 45% of episodes of uninsurance last fewer than five months – yet illness and accident don't always wait for coverage to start again. An individual mandate needs to be designed in conjunction with a system that addresses these transitions.

WHERE TO GO FROM HERE

In my view, the best design for a health care system would combine elements of all three of these options. It would incorporate the automatic coverage element of the Medicare program, so that people who faced unexpected crises or had difficulties in managing their lives, could be assured of coverage. It would incorporate an individual mandate so that people who can afford it would purchase coverage for themselves and their families. And it would allow employer-based coverage to continue to operate where that system is most effective.

There are many possible ways to combine these elements and I don't have a favorite. The key will be to maintain both a focus on flexibility and effective bargaining power -- to deal with the changing health care system and the strength of providers -- and an affordable, accessible, compassionate system to deal with the needs of everyday Americans.