



# FACING FACTS QUARTERLY

A Report about Entitlements & the Budget  
from The Concord Coalition

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## Targeting 'Waste and Abuse' Won't Bend the Health Cost Curve

In stressing the urgency of reform, the President has repeatedly warned that runaway health-care spending poses a grave threat to the nation's fiscal and economic future. "Our health-care problem is our deficit problem," he pronounced in his address to Congress last month. "Nothing else even comes close." Yet the reform strategy that the President outlined and all of the bills that Congress has produced focus on expanding insurance coverage, not controlling costs. Indeed, to the extent that they would save any money at all, it is merely to offset the extra budgetary cost of more—not less—health-care spending.

Defenders of the legislation now taking shape in Congress maintain that this striking mismatch between problem and solution is not really a mismatch at all. They acknowledge that reform may not save much within the ten-year budget window. They insist, however, that new investments now being made in outcomes research, electronic medical records, and prevention will in the long term painlessly "bend the health cost curve" by increasing the efficiency of the entire health system. Vast savings will be easy to achieve because, as the President underscored in his address, our health system "is currently full of waste and abuse."

No one disputes that a great deal of health-care spending is either ineffective or inefficient. But it is wrong to suppose that we can painlessly bend the health cost curve by just identifying such "waste" and zeroing it out.

It is wrong because, as we explained in our last issue, waste is not the main driver of the projected growth in health-care spending.<sup>1</sup> At the federal level, the CBO calculates that the aging of the population accounts for nearly half of the increase in Medicare and Medicaid expenditures over the next 25 years—which means that nearly half of the increase is needed simply to keep delivering the same level of care to each beneficiary as we do today. And while waste may explain some of the remaining growth, much clearly reflects the reasonable assumption that medical science

will continue to develop new technologies and procedures that have at least some benefit.

It is also wrong because, as we explain in this issue, merely identifying waste doesn't help much in the gritty business of eliminating waste, which inevitably means getting doctors and hospitals to change how they practice medicine and refusing payment for some services patients want. Most health economists don't even talk about eliminating pure waste. Instead, they talk about the need to alter patient and provider behavior by realigning incentives in ways that encourage the whole system to make cost-benefit trade-offs. The new investments in outcomes research, electronic medical records, and prevention do little to realign

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### ISSUE IN FOCUS

by Neil Howe and Richard Jackson

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incentives, which is why the CBO concludes that, in and of themselves, they are unlikely to generate significant savings in either the near term or the long term.

No cost control strategy, moreover, will succeed unless national leaders set a clear goal and acknowledge that reaching it will require sacrifice. Yet neither the President nor Congress has announced a clear goal or called for any sacrifice. Instead, they are telling the public that expanding insurance coverage will reduce costs and make health care more affordable, which is both misleading and sends exactly the wrong message. Yes, some individuals will pay less out of pocket for health care under the current reform bills. But America as a whole will be paying more. The public might mistakenly infer from what leaders are saying that new federal benefits are actually a solution to our long-term cost challenge.

We sympathize with the goal of expanding insurance coverage. It is a worthy objective, and one that we have long supported. We are also pleased that the President has pledged that any bill he signs will be fully paid for and not add "one dime to our deficits."

Whether reform ultimately turns out to be deficit neutral of course remains to be seen. But even assuming that it does, let's not confuse deficit neutrality with

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<sup>1</sup> "CBO Sets the Record Straight on Demographics and Health Care," *Facing Facts Quarterly*, V.1 (August 2009).

fiscal responsibility. It is not enough to promise that reform will not make an already dire budget outlook even worse. The goal of reform must be to improve that outlook by reducing health-care spending beneath current projections. Yet when it comes to this central challenge—bending the health cost curve—what we are getting amounts to little more than a hope and a prayer.

### No Silver Bullet

At first glance, the case that our health system is extraordinarily wasteful seems open and shut. Health policy experts correctly point out that the United States spends far more on health care than any other country—in fact, 50 percent more per capita than the next runners-up, Norway and Switzerland. Yet when we look at basic health indicators such as infant mortality and life expectancy, our performance is among the worst in the developed world. The understandable reaction is: If other countries are spending so much less and getting better results, how difficult could it be to save huge amounts of money?

On closer examination, however, this international comparison turns out to say little or nothing about the efficiency of the U.S. health system. As the eminent demographer Samuel Preston explains in an important new study,<sup>2</sup> we spend more than other countries in part because we have a higher incidence of chronic disease. The dismal U.S. ranking on life expectancy is mainly attributable to lifestyle factors like obesity (where we now lead the developed world) and smoking (where we led the developed world until the mid-1980s), not to the poor performance of doctors and hospitals. In fact, our health system delivers spectacular results. U.S. survival rates for virtually every major killer, from cancer to cardiovascular disease, are the very highest or among the very highest in the world—which should hardly be surprising since we are the leading generator of medical R&D and technology for the world. Another reason we spend more than other countries is that we perform far more elective procedures, from hip replacements to Lasik to cosmetic surgery, that do nothing to increase life expectancy but may have a big impact on quality of life.

The critical importance of lifestyle factors in driving up costs suggests that greater emphasis on prevention could, in principle, yield large long-term savings. The problem is: How do you get people to change their unhealthy behaviors? None of the required changes—whether it's eating a balanced diet, losing weight, exercising regularly, drinking less, or quitting

smoking—are easy or painless. Experts agree that public education and wellness programs rarely work unless they are backed up by financial incentives—for instance, charging people with unhealthy lifestyles higher premiums. The Senate bills would take a step in this direction, but are coming under fire from those who say that penalizing unhealthy lifestyles undermines the purpose of insurance and is really no different than denying coverage based on pre-existing conditions.

As for preventive screening and testing, a large literature concludes that such measures usually fail to generate much net savings and may actually add to total health-care spending. Often, the extra cost of testing millions of people, 99.9 percent of whom (typically) will never get the disease being screened for, exceeds the savings that may result from the early detection of a limited number of cases. Testing may also lead to the treatment of diseases, such as slow-growing prostate cancer, that never would have become a problem if undiagnosed. Then there is the dynamic that is sometimes called “the failure of success.” It is well known to demographers and epidemiologists that curing one illness merely sets up patients to succumb to the next “competing cause of death,” which could be an even more expensive chronic condition such as diabetes or Alzheimer's.

Health policy experts also point to the disparate practice patterns in our health system as evidence that it is afflicted by widespread inefficiency and waste. Thanks to path-breaking research by scholars at Dartmouth College, we now know that the per capita consumption of health care shows a wide regional variation that is uncorrelated with any measurable health outcome. If all providers followed the practice patterns of the most efficient providers, this research concludes that health-care spending could be reduced substantially—perhaps by as much as 30 percent.

Although this finding is important, it does not point to any easy fix for health-care costs. Demonstrating statistically that, on a system-wide basis, certain higher-cost tests and treatments are less effective than certain lower-cost alternatives is not at all the same thing as demonstrating that they are less effective in every individual case. Leave aside the fact that the statistical results are sensitive to what controls are used and how they are specified. Even if the results are unimpeachable, there will always be some patients for whom the higher-cost option will produce a better outcome.

In fact, the only way to know for certain whether a particular medical procedure will be effective or ineffective in a particular case is to perform the procedure and observe the outcome. Much of the ineffective spending identified by health policy researchers re-

<sup>2</sup> Samuel H. Preston and Jessica Y. Ho, “Low Life Expectancy in the United States: Is the Health Care System at Fault?” PSC Working Paper Series (University of Pennsylvania, July 2009).

flects precisely this sort of post-hoc analysis. It is often said, for example, that it is wasteful to spend so much on patients in their last six months of life, something no one could have known until the patients died.

All of this serves to make a rather simple point. Yes, the systematic enforcement of best-practice guidelines could eliminate much wasteful spending. But inevitably, it would also eliminate some beneficial spending—and so will be perceived by patients and providers as onerous, inconvenient, and even life-threatening. In a word, the process will be anything but painless.

### The Painful Prescription

The argument that we can solve our cost problem by eliminating pure waste starts with the undeniably true observation that there is considerable inefficiency in our health system. It then leaps to the conclusion that if we just increase knowledge about what works and what doesn't, we can bend the health cost curve.

This is a reckless leap of logic. It ignores the fact that, in practice, it is often impossible to distinguish between wasteful and beneficial services. And the fact that in today's health system neither patients nor providers are motivated to consider cost-benefit trade-offs. And the fact that, even if we could somehow eliminate all of the waste, the underlying drivers of demography, technology, and rising public expectations about what constitutes "good health" would continue to push up spending as a share of national income.

To be sure, identifying and eliminating waste and inefficiency must be a key part of any long-term cost control strategy. But let's be realistic. Most patients today are shielded from the full cost of their health-care decisions by third-party payment systems, and so have little incentive to care about the quantity or price of the services they consume. Most physicians are paid on a fee-for-service basis, and so have every incentive to increase the quantity and price of the services they provide. Add to this massive open-ended federal subsidies, barriers to interstate competition among insurers, and a malpractice system that encourages defensive medicine, and it's both feet on the health-cost accelerator. Nothing in any of the current reform bills would do anything fundamental to change this.

In the end, bending the health cost curve will require moving in one of two directions, neither of them easy. One direction points to top-down rationing, accomplished through some new federal agency which, like a philosopher king, would unilaterally decide what constitutes best practice and dictate behavior by fiat. Some European countries like the UK that have highly centralized health systems now con-

trol costs in precisely this fashion. In our political culture, however, the public is likely to perceive such an authoritarian approach as intolerably arbitrary. It is one thing for the government to research and publish best practice guidelines. It is another thing entirely for it to dictate in detail what sorts of care providers can and cannot deliver to their patients.

The other direction points to a wholesale restructuring of our health system's cost-plus incentives. This approach has the virtue of leaving decision-making in the hands of patients and providers, and is likely to result in a more efficient allocation of resources. But let there be no doubt: It too will require sacrifice. And it too will require overcoming the resistance of a gigantic health-care industrial complex, buttressed by literally hundreds of organized lobbies and buoyed by the do-everything expectations of the public.

Either way, our aging society will not be able to escape the difficult ethical and moral questions that imposing limits will raise. At the micro level, we will need to consider how much to spend on averting low-risk outcomes and how much to spend on affecting low-probability cures. Brookings scholar Henry Aaron calls this "the painful prescription." At the macro level, we will have to face the biggest trade-off of all—how much do we tax our children to extend our own lives and how much do we leave for those who will live beyond us. We do not claim to have the answers to these questions. But our leaders must stop pretending they can finesse them.

### A Responsible Plan

The discrepancy between the announced purpose of reform and the likely legislative outcome is enormous. We are told that unless we arrest the growth in health-care spending in both the public and private sectors the nation faces fiscal and economic catastrophe. But far from bending the health cost curve, the bills cobbled together by Congress are struggling just to be deficit neutral. Instead of fundamental reform, we are getting a routine entitlement expansion financed by some routine cuts in Medicare reimbursement rates plus a grab bag of tax hikes. Apart from authorizing a few demonstration projects that may never lead to broader reforms, none of the bills do anything to restructure today's rickety fee-for-service paradigm. Even the boldest and most meaningful attempt to change incentives, the Senate Finance Committee's tax on "Cadillac plans," is just a modest first step—and it will have to overcome fierce opposition if it is to survive in the final bill.

A responsible reform plan would look very different. Its explicit goal would be to stabilize federal

health benefit spending—and perhaps total national health-care spending—as a share of GDP. It would acknowledge that, out of fiscal necessity, public beneficiaries and their providers will have to lose some of their accustomed freedom to choose the type, variety, quantity, and institutional setting of the reimbursable services they consume. It would also acknowledge that, out of economic necessity, private patients and their providers will have to lose many of the same freedoms.

On the public side, the plan would establish a global budget with annual targets for federal health benefits. The most efficient way to enforce this budget is to move decisively away from fee-for-service reimbursement and toward capitated prepayment. As a first step in this direction, Congress could encourage or require the widespread adoption of the kinds of service “bundling” and coordinated-care networks tentatively introduced as demonstration projects in some of the current bills. The surest approach, however, would be to shift Medicare and Medicaid toward the premium support model—that is, to replace today’s open-ended payment promises with fixed-dollar subsidies that would be used to purchase insurance from a menu of approved options.

Crucially, there will have to be a “look back” mechanism to guarantee that projected savings are later recouped if spending levels exceed annual targets. As the administration and Senate Finance Committee have suggested, Congress might establish a special commission that would submit cost-saving recommendations for an up or down vote. But to ensure that the savings actually occur, the plan would, as a back-up, also have to provide for across-the-board sequestration.

On the private side, we believe that the plan should steer the health system toward the “managed competition” model, which is designed to maximize efficiency-enhancing competition within a strict regulatory framework that establishes minimum standards. To this end, the plan would lower barriers to interstate competition in order to create a genuine national insurance market. It would overhaul medical malpractice law in order to discourage defensive medicine. And it would phase out or at least make deep cuts in the tax exclusion for employer-paid health insurance, a costly, perverse, and regressive subsidy that drives up health-care costs for all Americans while heaping the biggest benefits on those with the highest incomes and the most generous coverage.

### Getting Our Priorities Straight

The decision to punt on cost control and lead with a coverage expansion may appear like good

politics, but it is bad policy. Yes, we need to overhaul insurance markets in order to make coverage more secure for those who have it. And yes, we need new federal subsidies to help those who can’t afford coverage to buy it. In a responsible plan, however, the goals of expanding coverage and containing costs would be directly linked, with the first depending on the successful achievement of the second.

There may of course be a deeper political calculus here. Some Democrats doubtless hope that the current coverage expansion will help push the United States toward a national health system—and figure that there is no point in trying to control costs now, since once such a system is in place cost control will be easy. But whatever the advantages of the single-payer model, painless cost control is not one. True, it would create one central bureaucracy with the power to tighten the screws on all resources available for health care. But that bureaucracy would be beholden to Congress, which has trouble tightening even the smallest screws to control the cost of our existing health benefit programs when that means taking something away from a significant constituency. In any case, appointing an all-powerful health-care czar will do nothing to change the difficult trade-offs we must ultimately face—and indeed, may make them even more difficult and politically charged.

The Democrats are by no means the only party averse to making these trade-offs. The Republican leadership has failed to step forward with a credible cost-containment plan of its own—and indeed, is cynically drumming up opposition to any cuts in Medicare spending with its “seniors’ health-care bill of rights.” Once again, good politics seems to trump good policy.

The stakes in health-care reform are large. With the oldest Boomers eligible for Medicare benefits in less than two years, we stand on the brink of a cost explosion that threatens to bust the budget, cripple the economy, and rob our children’s future. We had better get our priorities straight before it’s too late.■

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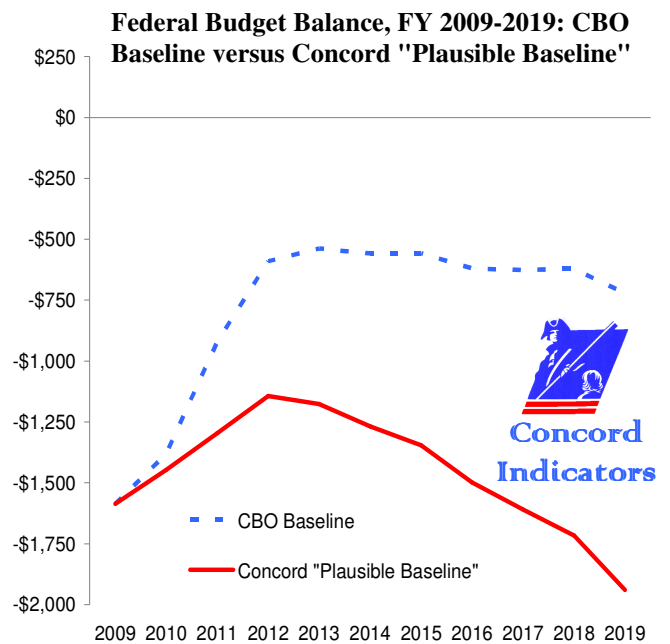
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Federal Budget: Debt & Deficits			Fed. Outlays: FY 2009		
	Bil \$	% GDP		Bil \$	% Budg
Gross Federal Debt: End of September 2009	\$11,910	84.2%	Social Security	\$683	19.4%
Statutory Debt Limit	\$12,104	NA	Medicare	\$430	12.2%
Publicly Held Debt: End of September 2009	\$7,552	53.4%	Medicaid	\$251	7.1%
Debt Held by Foreigners: End of August 2009	\$3,449	45.7%*	Other Entitlements	\$813	23.1%
Budget Balance in FY 2009	-\$1,417	-10.0%	Domestic Discretionary	\$584	16.6%
Budget Balance in FY 2010: CBO Baseline	-\$1,381	-9.6%	Defense	\$663	18.8%
Budget Balance in FY 2010: Concord Baseline†	-\$1,,447	-10.0%	Net Interest	\$191	5.4%
10-yr Budget Balance: CBO Baseline	-\$7,137	NA	Offsetting Receipts	-\$93	-2.6%
10-yr Budget Balance: Concord Baseline†	-\$14,447	NA	TOTAL OUTLAYS	\$3,522	100%
Budget Balance in FY 2019: CBO Baseline	-\$722	-3.4%	TOTAL REVENUES	\$2,105	NA
Budget Balance in FY 2019: Concord Baseline†	-\$1,940	-9.2%	TOTAL DEFICIT	-\$1,417	NA

\*Percent of publicly held debt. †Concord's "plausible baseline" assumes that discretionary spending grows with GDP, that operations in Iraq and Afghanistan are gradually scaled back to about one-third of today's level, and that all expiring tax provisions are extended with AMT relief.

GAO's Long-Term Budget Scenario* (% GDP)					
	1962	1980	2000	2020	2040
Discretionary	12.7%	10.1%	6.3%	8.5%	8.5%
Entitlements*	4.9%	9.6%	9.8%	13.8%	18.9%
Net Interest	1.2%	1.9%	2.3%	4.2%	12.3%
Revenue	17.6%	19.0%	20.9%	18.4%	18.6%
Budget Balance	-1.3%	-2.7%	2.4%	-8.0%	-21.0%
Pub Held Debt	43.7%	26.1%	35.1%	91.2%	266.4%

\*GAO March 2009 update. Assumes discretionary spending grows with GDP and all expiring tax provisions are extended; entitlements are net of offsetting receipts.



NOTE: Concord's "plausible baseline" assumes that discretionary spending grows with GDP, that operations in Iraq and Afghanistan are gradually scaled back to about one-third of today's level, and that all expiring tax provisions are extended with AMT relief.

National Savings (% GDP)	2nd QTR	
	2008	2009
Personal Savings Rate*	2.7%	4.9%
Net Private Savings	4.6%	6.3%
State & Local Savings	-0.3%	-0.2%
Federal Savings	-4.5%	-9.1%
Net National Savings	-0.2%	-3.0%
Current Account Balance	-4.9%	-2.8%
Intl Investment Position	-24.0%	NA

\*Percent of disposable income.

Social Security & Medicare*	Social Security	Medicare HI	Medicare SMI	Social Security & Medicare
	Payroll Cost Rate in 2009	12.4%	3.6%	3.0%†
Payroll Cost Rate in 2040	17.0%	7.6%	7.7%†	32.3%†
75-Year Unfunded Liability (PV \$)**	\$7.7 TRILLION	\$13.8 TRILLION	\$24.4 TRILLION	\$45.9 TRILLION
Infinite-Horizon Unfunded Liability (PV \$)**	\$17.5 TRILLION	\$36.7 TRILLION	\$52.5 TRILLION	\$106.7 TRILLION
Date of First Cash Deficit	2016	2008	NA	NA
Date of Trust-Fund Insolvency	2037	2017	NA	NA
Cash Deficit in Year of Insolvency (2009 \$)	-\$338 BILLION	-\$63 BILLION	NA	NA

\*Data are from 2009 Trustees reports. \*\*Figures are not offset by trust-fund assets. †Figures for Medicare SMI are net of beneficiary premiums. Although SMI is not financed with payroll taxes, net expenditures are shown here as a percent of payroll to facilitate comparison.