
# Statement before the United States Senate Committee on Health, Education, Labor, & Pensions
# Hearing on Healthcare Reform

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*The views expressed in this testimony are those of the author alone and do not necessarily represent those of the American Enterprise Institute.*

Mr. Chairman, Mr. Ranking Member, thank you for the opportunity to share my testimony with the Committee. The American healthcare system is capable of delivering unparalleled care. Our medical products sector is the world's source of innovation. But for too many people, these opportunities are inaccessible. The same system capable of delivering innovative, intensive services sometimes fails to provide for the most routine care. High technology medical products that extend lives and reduce suffering are leaving some families bankrupt.

There is no single cause for these shortcomings, and no straightforward solutions. When I worked at the Centers for Medicare and Medicaid Services (CMS), I spent my weeks at the agency here in Washington, and my weekends back home, practicing in the acute setting of a busy, urban hospital. I can tell you first hand, our perception of problems from inside the Humphrey Building often didn't comport with what was really taking place on the wards. As you'd expect, neither did our policy prescriptions for "fixing" what was wrong.

For example, look at data on all of the variation that exists in the way doctors in different geographies approach similar problems and it's easy to conclude that supply must be creating its own demand. More cardiologists mean more catheterizations. The solution then seems obvious. We need to more closely regulate pay to shift money between providers. We need to limit the number of specialists we train. We need to restrict certain services according to demographics, or based on "comparative" data and clinical guidelines we develop in a new federal agency.

I'd suggest data also show that we can identify the variation, but we don't understand its causes nearly as well as we think we do. There are complex factors that go into local medical conventions. There are misaligned incentives driving medical behavior that have corroded over many years of shortsighted payments rules. These problems exist precisely because of fixed rules and pay schemes hatched here in Washington, not in spite of them. As the largest purchaser of healthcare, Medicare shapes the entire market. It's not the medical decision making that's flawed. It's the incentives driving those judgments, incentives detached from the outcomes we want to achieve.

Moreover, every hospital can't be a Mayo Clinic or Geisinger Health System. There are plenty of poorly performing hospitals, for example, which hobble along with the crutch of their not-for-profit status. Paying for episodes of care rather than procedures – as many private insurers are increasingly doing – would better align incentives. But here again, politics has been the enemy of optimal solutions. Congress is unwilling to turn over care to private plans better able to implement payment reforms, as well as manage local delivery of care. Another idea for fixing Medicare is risk-adjusted or capitated payments that adjust with quality, so people or Medicare pay more for better overall quality. Right now, you can be certain that setting more payment and practice rules here in Congress, or at a new Federal Health Board, will shift the volumes but won't change the outcomes.

Or take, for example, the refrain around the need for more comparative data. There is no question many important clinical questions remain unanswered. But the reasons are often complex. A lot of

uncertainty about the relative benefits of two treatments remains because answering these questions is very hard. It takes long and large trials to discern small differences between two active treatments. Yet we are proposing to do shorter, cheaper studies based on backward looking databases rather than forward-looking trials to probe these questions.

The knowledge we glean from looking back through databases of patient information adds context to these clinical questions. But it won't definitively answer them. If it were so easy to resolve these issues, simply by sifting through existing information, you'd think insurers or academic researchers or competing drug and device firms would gather the $5 million it takes to do a really good database study. In many cases, definitive answers won't even come from a single study.

We should pay for these rigorous studies out of public funds. But we shouldn't mislead ourselves to believe that simple and cheap studies can resolve questions that persist despite close attention. Proponents of comparative research almost all point to the treatment of back pain or early prostate cancer as two areas in need of more research. On PubMed there are literally thousands of studies addressing these topics. Questions persist because none of the studies are large enough and long enough to provide definitive answers that address all the variation in patients' conditions.

Simply placing the government's imprint on a finding won't close off scientific debate either. The underlying evidence needs to be rigorous. If we're going to set binding rules in Washington based on the results, we need to do these things with precision. This means we need to also invest in a better clinical trial infrastructure for doing more rigorous research, modeled perhaps after the success of the National Cancer Institute's (NCI) cancer cooperative groups. We need to make it less expensive, and easier to do these more rigorous investigations. But getting real answers that endure scrutiny isn't going to be nearly as easy as our policy proposals envision.

Finally, take the catchphrases around "access to affordable insurance." If you read the Washington Post, you'd think that insurance is synonymous with good healthcare. That is hardly true. But insurance has become the end in itself, paying no heed along the way to serious problems with our current programs. Medicaid recipients technically have insurance. But in some parts of this country, they might as well be uninsured when it comes to their ability to access specialized services or expensive procedures. Some of the most vulnerable Americans are confined to an insurance product that is healthcare in name only.

Payment rates are so low, and regulations so burdensome, many doctors opt out of Medicaid entirely. More are also declining Medicare. As we supplant federal for state regulation of health insurance, or create a new "public" plan modeled off Medicare, the best doctors may leave the system entirely, especially in urban markets that will support cash-only practice. Our efforts to fashion a more egalitarian system are creating more tiers of care based on income.

In Medicaid, as in all these challenges, it seems our solutions always involve more rules. We call for more regulation of medical practice and more payment changes. When I was at Medicare, we compared this policy behavior to the carnival game "whack-a-mole." As soon as we spotted a problem, we passed a rule to fix it, only to find that our solution wasn't the repair we expected. We had only caused a new problem to pop up somewhere else.

Managing disease isn't a commodity service amenable to designs and workforce rules hatched here in Washington. This isn't like building cars. We shouldn't mislead ourselves to thinking we can understand all the reasons treatments often deviate from guidelines or to set treatment plans here in Washington to smooth out these variations. Agencies like Medicare and Medicaid can't even keep up with existing guidelines as technology and science changes, let alone write new ones. By the time CMS issues a coverage or coding change, the standard of care has already changed.

The current proposals for "fixing" healthcare rely on a lot of the usual patches. They increase political, rather than individual, control of the medicine, through a collection of new commissions, boards, and agencies. The plan before this committee shifts to the government, and probably Medicare, more of the clinical decisions properly left to people and their doctors.

That means my colleagues at CMS, and all 20 of the agency's doctors, are going to be calling more of the shots on what patients can get access to. That's the rub. More political control, through federal regulation or a public plan that displaces individual decision-making, doesn't mean better decisions. Medicare made 165 decisions about covering, and not covering, certain cancer products since 2000 without a single oncologist on its staff. We shouldn't let that kind of a process displace individual control over medical decisions by patients acting through private insurance plans.

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