The Scouting Report: Reforming the Health Care System

Without reform, rising health care costs are slated to worsen the long-term budget outlook in the U.S. Yet proposals to expand coverage to the uninsured might cost more than no reform at all.

As a major congressional debate on this starts, noted health care expert Henry Aaron joined Politico's Fred Barbash for a live web chat on how to balance the fiscal and societal issues at play in reforming the health care system.

The transcript of this web chat follows.

12:34 Fred Barbash-Moderator: Welcome readers and welcome Henry Aaron, who needs no introduction to those who have followed policy in the fields in which he specializes. A noted health care expert, Henry Aaron focuses on the reform of health care financing; public systems such as Medicare and Medicaid; Social Security; and tax and budget policy. He is one of the nation's most distinguished and prominent scholars on these topics.

Let me begin by asking Henry whether he thinks the heavy focus on the "public option" is indeed the right focus at this stage of the healthcare debate.

12:35 Henry Aaron: I don't think so. First, we don't yet know what the option would look like. Past experience suggests that Congress will not permit a federal program to have a major adverse impact on private competitors; hence, pressure is not likely to be excessive. More importantly, it is a red flag, which I suspect Democrats will give up in order to secure a measure of bi-partisan support. The key issue is going to be how to pay for the cost of extending coverage.

12:36 [Comment From Rolinda] What are the realistic prospects for health care reform as you see them? Many people say that it has to be done before we get into an election year, or it won't happen. Do you agree?

12:36 Henry Aaron: Less than 50/50, but better than ever before. Many people say that it has to be done before we get into an election year, or it won't happen. It won't happen in an election year, but depending on how the debate goes, health could become a major issue in the 2010 mid-term elections, nationalizing what is usually a collection of local campaigns, and that, in turn, could result in another round of reform in 2011.

12:36 [Comment From Erin]

Can we change the culture of health care in this country? Wouldn't an emphasis on wellness and prevention be a better and a more cost-effective strategy than treating illness once it occurs? Or is that just a pipe dream?

12:37 Henry Aaron: No. Wellness and preventive interventions can be very good for our health, but repeated studies have shown that they do not, on balance save money. There are a few exceptions (vaccinations). The central problem is that death comes to us all; preventing early deaths does not avoid eventual and often larger outlays.

12:37 [Comment From Shawn] Why is health care in the US so expensive?

12:38 Henry Aaron: Tons of reasons: complex administration, high physician pay, a huge number of tests (notably, radiology), aggressive end-of-life treatment, and on and on. The large number of reasons means that fixing one problem won't materially bring down the growth of spending. One has to do everything! And that is formidably difficult.

12:39 [Comment From Sally] Why do you think odds of passing health care reform are so low?

12:41 Henry Aaron: We are talking about a $2.5 trillion industry; that means many and extremely well-funded groups sensitive to possible losses of income or autonomy. The added costs for subsidies for those who cannot otherwise afford coverage mean that the government has to find ways to pay for those added outlays--and that means higher taxes or cuts on other spending. Most importantly, the term 'health industry' encompasses a bewildering variety of activities, which makes any far reaching reform enormously complicated.

12:41 [Comment From Christopher Grau] How could you deal with high physician pay without drastically reducing the number of people willing to go through a great deal of expensive schooling?

12:43 Henry Aaron: Right now, U.S. doctors earn more relative to average incomes than do physicians in any other nation. There may be some room here for real economies. But cutting doctors' incomes is not the key to slowing spending growth. As the quip goes, the most costly medical instrument is the doctors pen--his or her capacity to order costly procedures. The advent of better information on what works and what doesn't can help improve the efficiency of those decisions.

12:43 [Comment From Taylor] Do you believe that the private sector will be able to compete with the public?

12:45 Henry Aaron: If there is a public option in the end (which I doubt) the answer will, in my view, be 'yes.' Congress is not going to tolerate a situation in which a new public plan drives private vendors out of business. Whether it should or not is another matter. That means that a public option is likely to be relatively anodyne.

12:45 [Comment From Frank] The polling on this issue is interesting. Everyone thinks their own health care coverage is sub-par, but in the context of reform they don't want to lose it. What is your take on public opinion? And how does that affect what Congress will do?

12:47 Henry Aaron: Actually, I don't think this is what polling does show. Most people think their last visit to a physician or hospitalization went well. They also think the system as a whole needs reform. Interestingly, the evidence is that people do not receive all the care that is recommended

for their particular condition--in fact not much more than half of recommended care. The biggest problem for Congress is that people think they are paying too much out-of-pocket for health care, when, in fact, they are paying only about 15 cents on the dollar. The real problem is total cost, of which few people are aware.

12:48 [Comment From Clif]
Are there any viable models out there to replace the distorted incentives in our current fee-for-service or traditional capitation models?

12:49 Henry Aaron: All reimbursement systems have flaws. But fee-for-service is just not working well in a medical world where treatments for complex conditions require coordination of the services of many providers. There is increasing evidence--and consensus among experts--that the right model is that of a team of providers paid for the package of services that people receive for the conditions from which they suffer. Mayo, Kaiser, Geisinger are all systems that seem to work much better than does ordinary fee for service.

12:50 [Comment From Nick] President Obama has been vague whenever he speaks about Comparative Effectiveness Research. Insurance and Pharmaceutical companies are watching this issue closely as it will effect them the most. What kind of Comparative Effectiveness Research do you believe will be implemented during this reform, if any? What specifically will the criteria be?

12:52 Henry Aaron: I am a huge fan of comparative effectiveness -- and of cost-effectiveness--research. Right now, most of what physicians do has not been subject to tests to determine whether it is better than alternative possible interventions for the same condition. The pay-off will come in several ways--from physicians who want to do the right thing, from insurers who pay more for better care; and from guidelines that give providers and insurers assistance in make health care decisions.

12:52 [Comment From Tom] What do you think of the argument that government can make health care higher quality and more efficient?

12:54 Henry Aaron: Government can sponsor the development of information. Health care is and always will be rendered by independent physicians governed by economic incentives and professional ethics. Improved information can guide both. So can restructured incentives, such as paying for all treatment that diabetics receive as a package rather than for each visit to a physician and each test and each medication separately. And government can help guide the design of such incentives. But in the end, health care is an intimate transaction between a physician and a patient and government will not be involved in that.

12:55 [Comment From Rex] What about cuts in Medicare and Medicaid? Are those feasible? Or desirable?

12:57 Reader Poll: Do you support President Obama's proposal for a public plan?
Yes (63%)
No (37%)

12:58 Henry Aaron: Medicaid is already extremely parsimonious -- in coverage in many states, and in payment levels in most. There is not a lot of room to cut here.

In the case of Medicare, the system is dominated by fee for service provision, which is not the best way to package payment for care. The Medicare benefit package is better than it was (with the advent of drug coverage) but it still has holes (no maximum on patient liability, for example) that should be filled. That said, upper income Medicare enrollees could be required to pay premiums covering a larger part of the cost of their care. On balance, some savings; but the bulk of the projected increases in spending will have to be paid for with higher taxes if we are to honor our commitment to assure the elderly and disabled care similar to what the rest of us receive.

12:58 [Comment From Don] What percent of medical symptoms can be cost effectively dealt with by evidenced-based medicine, otherwise known as cookbook medicine?

\12:59 Henry Aaron: Evidence based medicine is not cookbook medicine. It is information, to be used with judgment by trained providers.

12:59 [Comment From Joe T] What are your thoughts on how the different health care proposals will affect government reimbursement rates for hospitals?

1:01 Henry Aaron: No one knows the answer to this question yet. Medicare already pays hospitals based on patients' diagnoses, but most analysts think that we should move further in the direction of paying for whole episodes of care, which includes payments not just for hospitalization but also for care that is needed upon discharge. The key is to move away from payment for individual services to payment for broader clumps of care, so that providers can allocate funds to what services are most useful, rather than getting paid more to do everything whether or not the service brings significant benefit.

1:02 [Comment From Doc] Is this country prepared to make the choices socialized medicine will force, i.e., sacrificing the quality of care of 1 elderly person to increase the allocation of resources for say 5 younger people? Or using taxpayer dollars to fund the health benefits of drug users, the obese or any other people who freely and willingly choose to abuse their own health?

1:04 Henry Aaron: I don't think anyone is talking about socialized medicine. What is being discussed is increased coverage under conventional insurance (private or public) to pay for privately provided services rendered to patients free to select their provider or provider network. That is the current system. What is being discussed is how to make sure it is available to all, how to help providers render better quality care, and how to slow the growth of spending.

1:04 [Comment From Elana] I'm not sure I understand the debate over the public plan, or the idea for "health care co-ops." Are those issues as important as they seem?

1:06 Henry Aaron: As far as the coops are concerned, I am not sure I understand just what Senator Conrad has in mind either! The details are not out. What worked for electricity in rural areas where private companies refused to operate may not have a direct analogue here.

1:06 [Comment From Laney] Follow-up to Nick's comparative effectiveness question: What parameters will have to be set so that each patient population receives the care they need at a cost they can afford? For example, if a patient has restrictions on the type of medication he or she can take and the agreed most effective drug doesn’t work. What kind of savings will that yield?

1:10 Henry Aaron: That isn't what comparative effectiveness research promises to do. Its purpose is to provide information. Then doctors and insurers will have to decide how to apply it.

Right now if one wants to know, say, whether a CT scan for a patient with a certain form of cancer will or will not affect treatment options and whether the choice of treatment options will influence outcomes, in most cases there is no good information. So, doctors have to take a shot in the dark and insurers have to pay for whatever doctors decided to do. With solid research, doctors would have guidance and insurers could pay more for those interventions with the best change of improving a patient's outcome. Sounds good to me. But decisions on what services to cover raise quite different issues outside the province of comparative effectiveness research.

1:10 [Comment From Eric] Two questions on cost control: 1) when will we see this payoff from the $1.1 billion appropriated for comparative effectiveness research? It strikes me that it may do more for reducing medical errors than reducing costs and 2) what kind of impact do you envision a P4P reimbursement system making in lowering the growth of healthcare costs? Or would you recommend that along with taxing employee benefits?

1:13 Henry Aaron: On 1) the answer is very gradually and over many, many years, as in 'decades.'

On 2) it is very hard to tell. Current P4P is pretty crude and experts are disagreed on whether it will be possible to refine it sufficiently to effect major behavioral change. On balance, I think that a more important avenue for progress is the institution of team-based approaches to care, where a group of physicians, nurses, technicians work together and management norms are used to influence behavior.

1:13 [Comment From Don] DRGs and prospective payments have vastly distorted medicine because they're built on false assumptions that treatments can be packaged. How can you advocate bundled care when there are so many co morbidities?

1:17 Henry Aaron: Don, I can't answer all of the questions that you have been sending (thank you for the attention and involvement), but I think prospective payment was actually a step forward, although seriously flawed for the reasons you indicate. As for packaged payments, let's take diabetics for example. They require a fairly standard range of services in order to slow the advent of complications and co-morbidities that otherwise are all to frequent. The current system does a rather poor job of creating incentives to make sure they get these services. Payment in a lump to a group responsible for maintaining the health of diabetics would come closer to getting the incentives right--not perfect, but closer. Incidentally, a careful study by McKinsey and Company found that care of diabetics was better in the United Kingdom than in either the United States or Germany and speculated that it was the ready access to primary care in the British system that accounted for the advantage.

1:17 [Comment From Evie] What about children born of parents who lack health care? How will they be taken care of?

1:18 Henry Aaron: President Obama ran on a commitment to mandate coverage for children. The extension of the State Child Health Insurance Program earlier this year already made real progress. I would expect more later this year--if something passes!!

1:18 [Comment From BG] Do you think having a public option will drive private vendors out of business? Or will it spur them to be efficient?

1:20 Henry Aaron: We don't know yet. My own guess is that the public plan will not crowd out private insurers or materially cut costs. There is a danger, not much discussed so far, that the public plan could become a dumping ground for high-cost patients that private companies would rather not have on their books.

1:20 [Comment From Ramon (Detroit)] I, like most Americans, agree that everyone should have healthcare. But we don't live in a utopian society and I am concerned that if a plan is passed by Congress and signed by the President, that the quality of my care will deteriorate and I wont be able to keep my doctor. Is this the case? Also, the quality of healthcare is already abysmal, won't the Obama plan only decrease the quality of our healthcare?

1:22 Henry Aaron: A lot of people worried about just this risk back in the early 1990s when the Clinton plan crashed and burned. For that reason, President Obama has been explicit that if you like your current coverage, you will be able to keep it. I think that is key to anything that Congress does. That is not to say, that if a large bill passes, the health insurance industry will not evolve and change over time--it assuredly will. But any changes will be gradual and occur over time and changes will occur through the voluntary acts of individuals.

1:22 [Comment From Alyson Chadwick] What do you say to people who think there is no pt to health care reform without a public option?

1:25 Henry Aaron: I would ask them to consider the situation of the nearly 50 million people now without insurance. I would point to Massachusetts, which has no public plan (other, I might add, than Medicare and Medicaid) where the number of people without health insurance has been reduced by more than two thirds. I would ask whether it is moral to hold hostage those now without health insurance to the insistence on a public plan, which may be the condition necessary to achieve the more-than 60 votes necessary for action in the Senate.

1:25 [Comment From Carla Jenkins] Even though the majority of Americans would like a single payer option, will Congress consider it?

1:27 Henry Aaron: I am not sure that a majority favors a single-payer option--or, to be blunt, even know just what a single-payer option is. But whether that view is or is not correct, Congress is not disposed to vote for it. I am not sure that there are more than a tiny handful of votes in the senate and probably not more than fifty in the House. One reason is that it would increase public budgets by roughly 40 percent.

1:28 Fred Barbash-Moderator: That's it for today. Thanks so much to all who participated. Smart questions. And thanks to Henry Aaron for his smart answers. It was the most valuable discussion on this topic I have seen in quite a while.

We'll be back next week. Same time, same place.