Remarks from G. William Hoagland

Senior Vice President | Bipartisan Policy Center

Panel: The Scoring of Major Health Reform Hutchins Center at Brookings

May 27, 2015 1:00-2:30 p.m.

- It is fair to put my biases on the table at the outset – as one of the first group of employees at CBO 40 years ago making estimates for various income security programs – I may sound like a sycophant for CBO.

- My bottom line – when you look at an industry that makes up nearly 18% of the economy, with an equal mix of private and public funding, employs nearly 16 million people, is impacted by rapidly changing biological/scientific/innovations and advancements, produces and delivers a product (health care) that is so basic to each and every one and is loaded with all the emotional luggage of the human spirit, an industry experiencing consolidation and restructuring, and finally not to mention the time constraints and data limitations CBO analysts have to operate under in making estimates of policies that can easily be modified by an administrative regulation or judicial ruling -- I think CBO's scoring of health care related legislation over the last many years is admirable.

- No question that the CBO product is an estimate and estimates can always be improved, but those same limitations of CBO cost estimates apply to CMS, academics, trade associations, and the private sector. We can only hope that at least we get the plus or minus sign correct.

- There were five questions David and I were asked to address – I will touch on all five but focus on the first particularly.

- **First Question: Does CBO systematically underestimate savings from health reform legislation?**

- CBOers and alumni will know that we had a motto at CBO we even embellished it on our softball t-shirts – On the one hand on the other hand.

- That is my quick answer to this first question – maybe/maybe not.

- Reading again the paper that Louise and Brendan prepared for this discussion, I think they correctly conclude that at least for the five health reform packages they reviewed, it is pretty difficult to say that CBO systematically underestimates savings.

- The five: the 1983 Prospective Payment System, the 1988 Medicare Catastrophic Coverage Act, the Balanced Budget Act of 1997, the Medicare Modernization Act of 2002 and finally the 2010 ACA Medicare savings (not the entire legislation).

- While out of these five cases, the authors conclude that in 4 out of 5 health spending was "significantly" lower than CBO had projected at the time of the laws' enactment, but they could not say whether this was due to "health care reform legislation" or due to the underlying baseline projections upon which the reform estimates were made.

- From my perspective, there may be a "chicken and egg" issue here. Policy or even the threat of policy changes in the health care arena, can impact the baseline. Sorting out what is due to policy and what is due simply to a changing health care baseline is almost impossible.

- As it relates particularly to the ACA's Medicare savings discussed in the background paper – the focus is on CBO's downward revision in CBO's Medicare baseline spending -- a 12% reduction baseline estimates over the period 2011 to 2022 from what had been earlier projected in the period of 2010-2014.

- Two comments.

- First I do not see this revision in the baseline as necessarily an indication of a bias in the underlying estimates of the provisions in the ACA that impacted the Medicare program. At the time of the passage of the ACA – the two major changes to Medicare estimated by CBO were the reduction of annual updates to FFS Medicare and adjustments to the Medicare Advantage rates – for a total of $332 billion over the period 2010-2019. The savings from the legislation for the period 2010-2014 was $58 billion.

- I do not see how we can conclude any systematic underestimate of savings based on a projection of a baseline where the provisions of the law have only been in effect realistically for 4 years on a baseline revision that covers double that time period -- 8 years.

- I agree, however, with those who might argue that CBO's estimates do not and did not incorporate savings from among other things number of the quality improvement provisions, preventive services in Medicare, and payments for biosimialar biological products.

- **But that then brings me to the second question – "Should CBO Score policy proposals for which there is no hard evidence?"**

- I think the simple answer is NO. Unless there is clear, solid evidence that a policy change will produce budgetary consequences – CBO should not score savings. I assume that on a number of the provisions in the ACA this was and still is the case today.

- My estimate is that of then over 268 unique sections in the ACA, CBO was unable or found no savings to be scored in nearly half (125 sections). Not a criticism but an indication that as good as the CBO staff is there is a limit to their time and available evidence to score the myriad provisions of any mayor health care legislation.

- And there is the issue of significant legislation being funded through annual appropriations (within an overall spending cap) without the ability to score savings on the mandatory side of the ledger – e.g. Health Care Fraud Enforcement (section 10606 ACA) supported housing for an aging population, reducing long-term, assisted living funded through Medicaid.

- While I am one who believes that health expenditures are a function of many factors – environmental, nutrition, physical activity, emotional state of mind, the community – and while one may find anecdotal examples of individual programs or experiments that translate into savings, CBO should remain conservative and base estimates on hard, peer reviewed academic research.

- Having said that, Peggy Noonan did in an article back in the winter that quoted a long-time senior analyst, who said that the heartbreak of his life has been witnessing the daily corruption of information even including the scientific papers that manipulate data to advance a political agenda.

- There is this term I was unfamiliar with called the "White Hat" bias that Linda Bilheimer at CBO brought to my attention. Apparently this is a particular issue in the area of obesity research where editors of journals may reject research papers publications if they do not support the editors underlying view point.

- If CBO bases its estimates only on peer-reviewed studies, and if the White Hat bias is real, then there is an argument in support of Cutler's critique that CBO might want to cast a wider net than traditional evidence studies.

- And while I am on this subject, for those of us who may depend on foundation support for our research and investigations, let's not be naïve that those funding sources don't have their own political biases also whether that be on the left The Commonwealth Fund or the Kaiser Family Foundation or on the right the Peterson Foundation.

- **The third related question – is there a way CBO can convey to policy makers that some policies regardless of hard, analytical savings estimates should be considered?**

- That seems to me to be a function of the democratic process writ large. CBO plays a role as does other legislative agencies in providing information to policy makers, as does the committee hearing investigation process.

- And CBO does have a distinguished Panel of Health Advisers from which to draw upon – I am not familiar with its operations entirely but do assume it at least informs CBO and thereby decision makers on policies that might be pursued regardless of clear evidence of budgetary consequences.

- The fourth question– **should CBO assume going from pilot programs to national implementation will raise or lower estimates?**

- Not dodging the question, but I don't think CBO has any say here at least under a number of the pilot programs in the ACA. If the Secretary determines a pilot will produce savings going to scale, she has the authority to do so without CBO scoring or further legislative action.

- Should she be correct then her administrative action would be reflected in actual numbers that then would be incorporated by CBO in any baseline updates.

- And the fifth and final question – **Do scoring conventions affect CBO's ability to capture potential effects? And does this fact mean that these policies don't get enacted?**

- CBO is restricted in law by specific requirements on the baseline or starting point for developing estimates.

- As an example, they had to assume that under current law last April 1, physician reimbursements will be reduced by 21 percent, even though the law had been adjusted over 14 times since its enactment in 1997.

- Should they not assume current law – no! I may not agree with the way current law handles certain expiring provisions, such as trust funded accounts, but the fact that this convention exists prevents analysts from having to make judgement calls on their own.

- While not always satisfactory in my mind, at least the convention does force elected officials to make hard decisions, such as was the case with the recent SGR fix to include more fundamental changes to the fee-for-service payment mechanism.

White hat bias is a phrase coined by public health researchers David Allison and Mark Cope to describe "bias leading to the distortion of information in the service of what may be perceived to be righteous ends".[1]

This initial paper contrasted the treatment of research on the effects of nutritively-sweetened beverages and breastfeeding on obesity. They contrasted evidence which implicated these behaviors as risk and protective factors (respectively), comparing the treatment given to evidence for each conclusion. Their analyses confirmed that papers reporting null effects of soft drinks or breast-feeding on obesity were cited significantly less often than expected, and, when cited, were

interpreted in ways that mislead readers about the underlying finding. Positive papers were cited more frequently than expected. For instance, of 207 citations of two papers finding no effects of sugared soft drink consumption on obesity, the majority of citations (84 and 66%) were misleadingly positive. Allison and Cope explained this bias in terms of "righteous zeal, indignation toward certain aspects of industry", and other factors.

A meta-analysis had been reported showing that industry-funded studies reported smaller effects than did non-industry-funded studies,[2] the implication being that industry funding lead researchers to bias their results in favor of the funder's presumed commercial interest. Allison and Cope's reanalysis of these data indicated that it was poor studies that found larger effects, and that the industry-funded studies were larger and better run: a finding consistent with a white hat bias, and suggesting that the true effect of sugar-sweetened beverages is smaller than most studies report. Paradoxically, having shown that industry studies were well run but that publication and citation bias existed against negative findings, and as predicted from a WHB effect, Allison became the subject of a media report by ABC condemning the influence of industry on diet science.[3]

Allison and Cope suggest that science might be protected better from these effects by authors and journals practicing higher standards of probity and humility in citing the literature. Young, Ioannidis and Al-Ubaydli[4] discuss related concepts, framing scientific information and journals in the context of an economic good, with the goal being to transfer knowledge from scientists to its consumers, suggesting that acknowledging the full spectrum of effects on publication and treating addressing the effects as a moral imperative may aid this goal.