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Before

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Hearing on
**Health Reform in the 21st Century:
Reforming the Health Care Delivery System**

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Mr. Chairman, Members of the Committee:

I very much appreciate the opportunity to provide testimony to the Committee as it undertakes an important inquiry into the crucial topic of reforming the health delivery system as part of health reform. It is a subject that I have been deeply involved with through most of my professional career. I practiced general internal medicine for over twenty years, twelve of which were in a small group practice located a few blocks from here. I have been medical director of a D.C.-area preferred provider organization and helped organize and oversee two physician-run independent practice associations (IPAs).

In the latter part of the Clinton administration, I had operational responsibility for provider payment systems at the Centers for Medicare and Medicaid Services (CMS) and was in charge of contracting with Medicare Advantage plans. In recent years, as a Institute fellow at the Urban Institute, I have been studying the effects of the Medicare physician fee schedule, as well as important innovations, including the Patient-centered Medical Home, that offer promise to improve how care is provided to Medicare beneficiaries and individuals covered under other insurance plans.

My CMS experience demonstrated to me the central role of the Medicare program in how health delivery is organized and provided. With Rick Mayes, an assistant professor of public policy at the University of Richmond, I co-wrote *Medicare Prospective Payment and the Shaping of U.S. Health Care*, a book that reviewed the crucial, positive role Medicare has played. Although health care spending remains a challenge for all payers, Medicare's track record, especially in recent years, has been better than that experienced by self-funded employers and commercial insurers, while offering near universal provider participation.

At this moment when we have an opportunity to finally achieve near-universal health insurance coverage, Medicare should take the initiative—preferably in collaboration with other public and private payers—to produce additional delivery system changes in response to new challenges. The most obvious one is the pressure of health care costs. Combined public and private spending on health care services in the United States totaled nearly \$2.1 trillion in 2006, or 16 percent of the economy (Catlin et al. 2008); more worrisome is that since the end of World War II, health care spending has exceeded per capita growth in the nation's economy by more than 2 percentage points, with no signs of abating (2004 Technical Review Panel).

However, for all of the dire estimates that health care costs will consume the entire gross domestic product and Medicare and Medicaid or the entire federal budget, in fact, we only need to reduce spending by about 1.5 percent per year to maintain the share of the nation's economy and the federal budget devoted to health care. We need to take action now as part of health reform to complement the initiatives undertaken in health information technology and comparative effectiveness, which were addressed in the American Recovery and Reinvestment Act of 2009. By doing so, Congress can avoid being forced in the future to enact arbitrary cuts in benefits and raising payroll or income

taxes to address funding shortfalls. As various detailed analyses have shown—including those by the Commonwealth Fund and the Congressional Budget Office—there are plenty of opportunities to bend the cost curve by the needed amount to avoid doomsday scenarios.

From Acute Care to Chronic Care Management

The opportunity to find relatively painless savings in the health care system requires a clear recognition that public and private insurance programs continue to follow an acute care model of health care, that is, that patients are basically healthy until they experience an unexpected, acute event, which are then expertly diagnosed and treated. Such an orientation ignores the growing impact of long-established, chronic illnesses on patient well-being and on health care costs.

Policymakers are just beginning to realize the implications for Medicare of beneficiaries living longer with chronic illness, particularly multiple chronic diseases. The twenty percent of beneficiaries with five or more chronic conditions account for two-thirds of Medicare spending, see about 14 different physicians in a year, and have 40 office visits (Partnership for Solutions 2002). The chances of an otherwise unnecessary hospitalization—for conditions that can and should be managed effectively on an ambulatory basis—increase from about 1 percent for a beneficiary with just one condition to about 13 percent for a beneficiary with five conditions and about 27 percent for a person with eight chronic conditions (Wolff, Starfield and Anderson 2002). Further, the number of chronic conditions has more influence than age on health care spending in the Medicare population (Berenson and Horvath 2002).

Just 5 percent of Medicare beneficiaries are responsible for 43 percent of program spending (Riley 2007). Although multiple chronic conditions is a particular issue in the Medicare program, the concentration of spending associated with a small percentage of covered enrollees and beneficiaries, many with chronic conditions, is even greater in self-funded and commercial insurance programs and in Medicaid programs.

The dominant role of chronic conditions as predictors of patient well-being and health spending suggests why we need to invest much more in programs that educate the public about prevention and wellness approaches so that Americans can avoid developing some chronic conditions in the first place. Over many decades, laborious and often contentious efforts to decrease cigarette smoking have borne fruit—now, a relatively small percentage of adults smoke. The current major public health challenge—not only in the United States but internationally—is overweight and obesity, which lead directly to a number of chronic conditions, including type-2 diabetes, hypertension, heart failure, degenerative arthritis, and chronic, recurrent back pain. These kinds of conditions interact to compound adverse health effects. For example, people with disabling degenerative arthritis of the knees or back can't easily exercise, which in turn makes sustainable weight loss almost impossible.

There is surely a role for the health delivery system in supporting primary and secondary prevention efforts to prevent or minimize the development of chronic conditions. Ideas for moving away from fee-for-service reimbursement for discrete services to paying provider organizations for caring for populations and accountable for the health outcomes of the patients under their care would move the whole health system in the right direction to refocus it on maintaining health rather than treating illnesses. At the same time, there is a danger of “medicalizing” activities best carried out elsewhere in society, such as in schools and the workplace, through broad-based nutrition education, and even by using tax policy to disfavor certain products, an approach that was used successfully in reducing cigarette purchases. Although health reform should attempt to better align the roles of public health and personal health provided in the health delivery system, currently, the immediate opportunity for health delivery is better management of established chronic conditions—both to reduce preventable complications and to help patients and families assume a much larger role in managing their chronic conditions.

Need to Alter the Professional Workforce

It must be recognized that patients with multiple chronic conditions experience more acute events—strokes, heart attacks, etc.—than average and that hospitals and expert specialists are needed to provide often life-saving care to these patients in their moments of real need. However, Medicare and other insurers’ program designs for the most part ignore the importance of established chronic illnesses in generating reasonable demands on the health care system and escalating health care costs.

For example, for the needs of an aging population with chronic conditions, we have a clear need for a different health professions workforce—in general, a much greater supply of primary care physicians, primary care nurse practitioners, and physician assistants, and, specifically, a much greater supply of geriatricians to care for the frail elderly. Yet, current physician payment policies in Medicare ignore these workforce needs and instead disproportionately reward the provision of niche specialty services, such as imaging and performance of minor procedures. Those who provide these services certainly have a role in a rational delivery system, but their role has been rewarded to the detriment of forging delivery approaches appropriate to the challenge of chronic care.

Health care reform should correct the current distortions in public and private fee schedule prices that produce the wrong mix of services for patients. Despite the promise of the resource-based relative value scale, first implemented in 1992, to better reward so-called evaluation and management services compared to procedures and tests, the Medicare fee schedule, which is also a guide for health plan schedules, continues to pay more generously for tests and procedures than for basic evaluation and management services, provided not just by primary care physicians but by other important specialties. For example, a recent *Wall Street Journal* article described how current fee schedules have contributed to shortages of neuro-ophthalmologists, who do not perform profitable tests or procedures to cross-subsidize the lengthy, expert evaluations that lie at the heart of their valuable professional activities (Fuhrmans 2008).

The result is that public and private fee schedules reward procedurally-oriented specialists disproportionately well, at the expense of physicians who provide evaluation and management services or core surgical services. Thus, distorted fee schedule prices not only contribute to shortages of primary care physicians, including family physicians and general internists, but to a shortage of general surgeons as well. One result of the payment disparities in most public and private fee schedules is that medical students are advised to “follow the *road* to success,” that is, enter the specialties of radiology, orthopedics, anesthesiology, and dermatology, which in addition to being highly remunerative also support gentler lifestyles, usually without emergencies outside of regular work hours.¹

Whatever the blueprint for delivery system reform, it is likely to fail unless immediate steps are taken to address the likely collapse of the primary care physician workforce infrastructure in many parts of the country. Primary care physicians have not been responsible for the volume increases in Medicare physician services yet have experienced the same payment freezes as those who are responsible. Baby boomer family physicians and general internists are approaching retirement, along with many of their patients, while younger primary care physicians, who will find themselves in greater demand because of primary care shortages, will feel little personal commitment to serving Medicare patients, especially if Congress continues to flat-line their payments. Virtually no geriatricians are going into practice despite the manifest need for their expertise.

The trends to decreased family practice and general internal medicine residencies are stark, and many programs survive only by the entry of foreign-born graduates of overseas medical schools. So we are robbing developing countries of vital and needed professional workforce while ignoring the opportunity to develop an indigenous workforce more attuned to issues of health disparities and cultural competence.

A substantial body of evidence documents that countries and parts of the United States which rely more on primary care produce higher quality results at lower costs than those with more reliance on care provided by specialists (Starfield, Shi, and Macinko 2005). No matter what other specific delivery system reform initiatives this Committee chooses to promote, there will be need for a stable primary care workforce willing and able to take on the challenge of providing care to the growing share of the population with serious chronic conditions. Because of the long pipeline required to train physicians, Congress needs to address this issue immediately.

The Tyranny of the Urgent

The delivery system needs to be re-oriented also in the nature of the interaction between practices and patients with chronic conditions. In his seminal article laying out the rationale for a team approach to chronic care management, Ed Wagner described the problem of well-intentioned physicians routinely subjected to the “tyranny of the urgent”:

¹ In some versions of this advice, the “O” stands for ophthalmology.

Amidst the press of acutely ill patients, it is difficult for even the most motivated and elegantly trained providers to assure that patients receive the systematic assessments, preventive interventions, education, psychosocial support, and follow-up that they need. (Wagner, Austin and Von Korff et al. 1996, 511)

Again, this insight describes a health delivery system primarily oriented to the understandable demands of patients with acute, if not always serious, problems to the detriment of time and attention to patients with chronic conditions and to the frail elderly. These patients often are, in effect, ignored, that is, until they suffer an acute event and hospitalized for what could have been avoided—if the delivery system had been organized and financially supported to be vigilant in the care of these patients rather than reactive.

In this regard, Medicare demonstrations—and common sense—suggest that programs to provide chronic care management and coordination assistance to patients will not succeed if the patients' regular physicians are not involved. The results of the Medicare Health Support Pilot demonstrate that disease management approaches that bypass the physician-patient relationship are unlikely to be successful. But as this and other completed and ongoing Medicare demonstrations also show, we need to develop approaches to supporting patients with chronic conditions with much more precision, with full recognition of the nuanced differences across different conditions, population groups, practice sizes, and organizational make-ups.

In this regard, I think the Patient-centered Medical Home demonstration, which this Committee was instrumental in legislating, is a very important one. It directly brings the physician practice into the line of responsibility for the well-being of patients with chronic conditions. However, there are many challenges to this concept that the current demonstration design is not designed to answer (Berenson et al. 2008). The design needs to be reviewed and expanded to test models of the medical home more appropriate for solo and small-group practices. Specifically, given the persistence of the small practice in many communities—practices that will continue to face the tyranny of the urgent—we need to test whether supplemental chronic care management and coordination activities should be provided directly in the practices or by other professionals collaborating with physicians as part of “virtual” teams, with the chronic care support activities residing in the community, perhaps in the public health center or the community hospital, as in the North Carolina Medicaid Community Care Network model. One of the Medicare Physician Group Practice (PGP) Demonstration sites—the one in Middletown, Connecticut—uses this approach; it may be more practical for those parts of the country which are unlikely to form multispecialty or large single-specialty groups.

We also need to review how the important proposals for improving care provided to frail elderly with geriatric syndromes, including the Independence At Home approach that emphasizes home visits for poorly mobile seniors and the Geriatric Assessment and Chronic Care Coordination approach that targets the frail elderly with dementia, can be part of an overall strategy to improve the spectrum of approaches of better caring for at-

risk patients; current medical home designs do not acknowledge the very different levels of disability that beneficiaries with multiple chronic conditions experience.

Finally, to reemphasize the point that we need to bring much more nuance to discussions of chronic conditions, we need a much more forthright discussion of the relative responsibilities of primary care physicians and specialists in caring for patients with chronic conditions. Earlier, I emphasized the need to build up the primary care workforce, and I surely envision that primary care generalists would be the core physician component of a team caring for patients with the most common and costly medical conditions, including congestive heart failure, diabetes, chronic obstructive pulmonary disease, and depression. However, for other important diseases, it might well be that specific specialists are the more appropriate core physician. For example, neurologists would likely play a primary role as principal physician for many patients with progressive Parkinson's disease and multiple sclerosis; oncologists for some cancers; nephrologists for some patients with end-stage renal disease. Perhaps the proof of the medical home concept should begin with primary care and with patients with the most prevalent high-cost chronic conditions. But in the end, we need a delivery system that is sophisticated enough to tailor delivery to particular circumstances of individual patients rather than assuming that one model of a medical home would work well across the board.

In short, there are many challenges to figuring out how to better care for patients with chronic conditions and geriatric syndromes. But this is precisely where there is the biggest potential bang for the buck—in terms of beneficiary well-being and bending the health spending curve.

I would further emphasize the need to focus policy attention on the range of potential approaches to caring for the multiple chronic condition population, rather than on geographic variations in spending. Colleagues at the Urban Institute are studying this geographic variations issue using an alternative methodology from that used by the Dartmouth group, which has done important work in this area. Our preliminary findings cast doubt on both the magnitude of the geographic spending variations and the source of the variations that the Dartmouth researchers found. Analysis of spending for individual patients who live in different geographic areas suggests that variations in individual characteristics, especially patient's underlying health status and a range of socio-economic factors, including income and the presence of supplemental insurance, account for almost all of the explainable variation. In our analysis, local provider supply—the number of hospital beds and physicians per capita—did not explain the Medicare or total health cost of individual patients. While there still remains unexplained variation, it does not appear to be due to variations in provider supply (Hadley et al. 2006).

Thus, in my view, there remains too much uncertainty about the Dartmouth findings to ground public policy on them, such as limits on provider supply or caps on Medicare spending in high-cost areas. We will need to reconcile these different results. At the same time, policy recommendations suggested by Elliot Fisher and other members of the Dartmouth team, particularly those fostering development of “accountable care

organizations,” have merit and do not rely on the geographic variations findings for their support. I would also point out that Medicare payment systems already adjust payments for geographic differences in the costs of inputs, such as wage rates, in determining prices to pay across the country. We need to better understand the differences in practice patterns before we can target specific policy interventions based on geography.

Integrated Care Systems

The preferred approach to sorting out how best to serve the diverse and complex needs of patients with an array of chronic and acute care needs would be to develop and implement an improved payment model to support integrated delivery systems, which would have the size, scope, and resources to sort out themselves how best to serve the patients they care for, rather than having payers, such as Medicare, doing it from far away. For the more than 30 years that I have been in and around discussions of health care system reform, the idea of organizing physicians, hospitals, and other professionals and providers into integrated and accountable organizations better able to manage the complexity of patient needs has usually assumed the policy high ground.

The original concept of health maintenance organizations, developed by Paul Elwood and colleagues, assumed the development of integrated physician groups; and Alain Enthoven’s vision of managed competition assumed replacement of unaccountable and independent physicians and hospitals with organizations that were better able to improve quality and manage costs. Over the years, these organizations have been variously labeled “multispecialty group practices,” “integrated delivery networks,” “physician-hospital organizations,” “accountable health organizations,” “organized delivery systems,” or other terms to reflect changing fashion and nuanced differences in their configurations.

Proponents of this form of health care delivery have pointed to real-world examples of organizations that exemplify the best of breed and the potential of new organizational forms to improve care. Indeed, for most of my career, the same organizations have been cited: the Permanente Medical Group, the Mayo Clinic, Intermountain Healthcare, and the Geisinger Clinic, now the Geisinger Health System. Recently, there has been one interesting addition to the list of cutting-edge organizations that are reengineering how health care is being delivered to improve value—the Veterans Health Administration—which demonstrates that government programs also can get it right.

As others on the panel are able to discuss, integrated delivery systems can promote collaborative team-based care to better serve patients’ complex care needs, especially in the area of chronic care management; promote adoption and enhancement of electronic health records, including patient access to a personalized health record via customized Web portals, and mount and sustain systematic quality improvement and patient safety efforts.

And at a time when health care costs are rising at a pace that robs workers of well-earned wage increases because their employers must first pay the price of double-digit premium increases and is beginning to threaten the fiscal sustainability of the Medicare and Medicaid programs, integrated delivery systems offer the potential of reducing costs, while maintaining or even improving quality. A major problem is that, because they are dependent on current payment approaches, these organizations are often penalized financially for undertaking activities that reduce costs. The result is that the potential of these organizations is not being realized.

It is striking that the same exemplary organizations that have been prominently identified over a number of decades as leaders are the same ones at the cutting edge of care improvement today. I have pondered why there has been relatively little uptake nationally into this form of health care delivery.

With colleagues at the Center for Studying Health System Change (HSC), I have conducted research documenting that in recent years physicians have been much more active in forming single-specialty groups than in organizing and joining multispecialty groups. Single-specialty consolidation provides them more negotiating leverage with health insurers and permits the requisite organizational size and scope to be able to own and self-refer lucrative ancillary services, such as MRI and PET scans (Berenson, Bodenheimer, and Pham 2006). Similarly, HSC has found that collaboration between hospitals and particular physician specialties, often in joint ventures based around the construction of new facilities, has focused on developing and promoting profitable service lines and not on meeting the challenges of caring for an aging population or of patients with multiple chronic illnesses.

Thus, an important argument for correcting distortions in relative payments to physicians, hospitals, and other providers under standard fee-for-service and prospective payment approaches is to establish the conditions under which different providers would be willing to come together to form new organizations—organizations oriented more to providing greater value for populations they are responsible for than to take advantage of the “winners” in fee-for-service reimbursement. As long as providers can prosper on their own they will not be interested in joining in multispecialty or multiprovider collaborative efforts to form such organizations supported under new payment approaches.

The Need to Internalize Savings to Provider Organizations

Altered incentives can be a key to enhancing provider willingness to become more vigilant, not only to improve care transitions but also to reduce inappropriate provision of many services, reduce errors, and implement chronic care management programs to better support patients with complex health care needs. Diagnosis related group (DRG)-based case rates for hospitals and 60-day, episode-based case rates for home health agencies provide models for payment approaches that internalize to the organization the rewards for increasing efficiency.

A number of case studies have documented examples of organizations that have initiated programs improving quality and decreasing costs for patients and payers only to find that they could not sustain the direct costs of running the program and the decreased revenues that resulted from their success. Payment approaches need to reward rather than penalize cost-reducing behavior. In this regard, the approach used in the Medicare PGP demonstration—the “shared savings” approach that permits the group and Medicare to share in financial savings when the group successfully reduces total Part A and B spending—seems most practical for adoption initially for integrated care systems.

Accordingly, it is time to move away from a “one size fits all” payment system relying on a Medicare fee schedule for physicians and prospective payment based on diagnosis-related groups for hospitals. Over time, approaches that derive from the PGP shared savings approach might include forms of direct capitation to large provider organizations, but without having to rely on private health plans as intermediaries. These alternatives need to be adopted and emphasized by traditional Medicare as a way to encourage accountable care system development, while initially maintaining a parallel system for providers who have not chosen to integrate. If anything, these new payment constructs might be tilted gently to encourage the new integrated models, for example, by maintaining some form of expenditure cap on physicians receiving fee-for-service payments, while exempting physicians in integrated systems whose performance would then be subject to the discipline of the shared savings or capitation incentives. The main point is that integrated delivery networks should be supported with payment systems developed specifically to take advantage of the added value they provide.

One final point on integrated care organizations. I share the objective of making this model available not just to the relatively few true multispecialty medical groups, which are most common on the West Coast, but also to the small, single-specialty practice. We want all physicians to be able to become eligible for a population-based payment that does not rely on the standard fee for service. However, I would point to established organizational models that continue to function well in some parts of the country but seems to be largely hidden from the policy view. Those would be the independent practice associations (IPAs), which typically contract with particular health plans for commercial, Medicare Advantage, and, sometimes, Medicaid programs in what has been called the “delegated-capitation model.”

IPAs in California and some other parts of the country, including Phoenix, Denver, and Rochester, New York, perform well as integrated-care organizations even though the physicians have not formally come together into a single group. In addition to performing standard credentialing and management functions closer to the practices than distant health plan “regulators,” IPAs are increasingly engaging their constituent practices in quality improvement activities and even purchasing electronic health records for them while ensuring interoperability across practice sites. The IPAs often house the chronic-care management professionals, who can interact with physicians in virtual teams to support patients with chronic conditions and the frail elderly at home.

True multispecialty group practices and physician-hospital organizations (PHOs) are the other organizations that could be relied upon to reorient health delivery if supported by a new payment approach—first in Medicare and then presumably across all payers. I would be hesitant to permit looser affiliations of physicians, such as those on hospital medical staffs, to qualify as accountable care organizations, eligible for a different payment approach.

Although there are significant management and leadership challenges in forming risk-bearing or -sharing medical groups and IPAs, the accumulated 20-year experience with these organizations suggests that traditional Medicare could contract directly with these organizations without relying on a Medicare Advantage (MA) plan intermediary, thereby immediately saving the 8 to 10 percent additional administrative costs and profits that MA plans require to provide the Medicare benefit package. With improved risk-adjustment techniques and new availability of performance measures, including measures of patient experience with care as well as more standard primary and secondary prevention measures, some flaws that plagued the use of capitation payments (widely used in the 1980s and 1990s) should not repeat. In particular, we need to assure the public that these organizations will not accomplish cost savings by the systematic underprovision of needed services; the public perception that capitation payment incentives lead to underservice contributed to the managed care backlash. With new protections and an enhanced ability to identify underservice, providers should be encouraged to leave behind the “legacy” fee-for-service payment system to be part of integrated systems supported by new payment approaches.

The Public Plan in Health Reform

In closing, I would like to emphasize the importance of providing a range of health plan options in health reform. It is important to permit individuals satisfied with their private insurance plan to stay with it. It is also important to have a public plan—patterned on Medicare but separate from it—as an option for those seeking care under newly established purchasing exchanges. As emphasized by Urban Institute colleagues in a recent policy brief, “the intent of the competing public plan is to use the administrative efficiencies of government-run health insurance plans, as well as the purchasing power of government, to control costs” (Holahan and Blumberg 2008). This power is necessary to counter the ability that hospitals and some physician groups have developed to demand high prices from insurers, that is, to develop market power, a phenomenon that characterizes increasing numbers of communities (Nichols et al. 2004).

While endorsing the need to provide competition between public and private plans in health reform, some would restrict the ability of the public plan to control costs by altering prices in payment schedules. Instead, they suggest that the public plan should be allowed only to use a combination of public information, new payment approaches, and other non-price, value-based purchasing approaches to try to rein in spending (Nichols and Bertko, 2009). However, differentiating “price controls” from all the other tools a value-based purchaser—public or private—would use is both arbitrary and

unworkable because, in practice, pricing services is inextricably linked to the other approaches recommended.

For example, one of the more successful cost-containing initiatives Medicare has used in recent years was the 2005 Deficit Reduction Act limitation that imaging services not exceed the prices used for reimbursement to outpatient hospitals. In the first year under the new pricing structure, overall costs were reduced by 13 percent (U.S. Government Accountability Office 2008). But, importantly, the decreased costs resulted not only from the price reductions themselves but from moderation in the volume of imaging services paid for; per-beneficiary utilization of imaging services, which has been rising about 6 percent per year from 2000 to 2006 continued to rise in 2007 but at about half the rate; imaging services subject to the cap continued to grow much faster than other imaging services. In short, the pricing reductions were also effective at altering provider imaging ordering behavior, although not necessarily in straight-forward ways. To limit arbitrarily the public payer from using pricing to influence such behavior and having payers rely only on more intrusive approaches, such as prior authorization of the imaging request, does not make good policy sense.

Private insurers do raise a legitimate concern about whether the public plan will effectively overuse its potential market position to drive down prices to win the competition. But this concern ignores the reality that the public plan in competition with private plans has built-in restraints that limit action to push down prices too low. The Medicare experience is instructive in this regard. As in Medicare, the public plan would have to balance spending-growth restraint with the duty to preserve access to needed care and the quality of that care. If the public plan would aggressively move too strongly on the cost containment side, individuals would be able to select from among the private plan options. Further, the public plan, as with Medicare, as a strong buyer, would become responsible for the health and stability of the delivery system. If it would limit payments too strictly, it would face the risk of causing hospital closures, slowing down the introduction of desirable new treatments, and, for some specialties, reducing the availability of physician services (Holahan and Blumberg 2008).

Ultimately, having a public plan competing with private plans would promote useful competition. Private plans that offer better services and greater access to providers, even at somewhat higher costs, would likely survive in this competition. Indeed, free-market advocates often suggest that public payers using “Soviet-style price controls” inevitably produce an inferior product. As it happens, in the U.S. system, private payers typically use the same kind of price controls as Medicare does—only they pay more. Health plans that truly innovate or choose to compete by offering what used to be called “alternative delivery systems,” such as group and staff model HMOs, should be able to carve out successful competitive niches in many markets. With enhanced transparency to promote informed choice by those seeking care through a purchasing exchange, it is not at all clear what the outcome of level playing-field competition would be. I would urge the Committee to spend time setting up mechanisms to ensure fair competition; we should not prejudge the results of the competition before it even begins. Without a public plan option as a predictable approach to limiting health care spending, the promise of

universal coverage is likely to be unrealized under the continuing pressure of rising health care spending.

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