

Oral Testimony
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Committee on Energy & Commerce
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Thank you Congressman Pallone and members of the committee for this opportunity.

We are in the midst of the seventh major attempt of national health reform beginning with the Wilson Administration. Since that first attempt, there has been President Roosevelt's second attempt in 1936, President Truman's third attempt in 1948, President Johnson's fourth attempt – leading to a compromise with the creation of Medicare & Medicaid, President Nixon's limited fifth attempt, and President Clinton's sixth attempt. With President Obama's call for reform, will seven be the lucky number?

My name is Steve Parente. I'm a health economist from the University of Minnesota and a principal in a health care consultancy, HSI Network LLC. My areas of expertise are health insurance, health information technology and medical technology evaluation. At the University, I'm the Director of an MBA

specialization in the medical industry and a professor in the finance department with an adjunct appointment at the Johns Hopkins School of Public Health.

Most recently, I and my colleague Lisa Tomai from HSI have scored health reform proposals as they have emerged in the last four weeks. We are using ARCOLA, a micro-simulation methodology initially funded by the Department of Health and Human Services and published in the Journal Health Affairs.

There are two things people most want to know from these proposals. One, how many uninsured will be covered? Two, what will it cost the nation in one year and in ten years?

HSI estimates, like CBO's recent results, find there is no free lunch to expand health insurance coverage. Our early assessment of the Senate Finance committee proposal shows a 74% reduction in the uninsured with a 10 year cost of 2.7 trillion using public option plan modeled after the Massachusetts Connector. We also modeled an FEHBP version of the public plan and got a cost of over 1.3 trillion, but with a 30% reduction in the uninsured.

CBO scored the Kennedy Bill last week at approximately a 30% reduction for 1 trillion over ten years. Using the ARCOLA model, we found nearly everyone would be covered if all elements of the Kennedy bill were enacted at a ten year

cost of 4 trillion. That 4 trillion estimate over 10 years assumes a public option plan with Bronze, Silver and Gold levels in the proposed insurance exchange with a subsidy for premium support that is income-adjusted and calibrated for assistance at the Silver level. The Silver level is equivalent of PPO plan with medium levels of generosity, something with 15% coinsurance rate, manageable copays and average level of access to physicians and hospitals. We accounted for the public plan being reimbursed at 10% above Medicare reimbursement, which is also 10% below commercial insurance premiums.

In the individual market, we assumed the public option plans would be community rated and the rest of the individual market would be as it is today. For those offered insurance, we assumed a public plan would be community rated as well and available for a very modest subsidy equivalent to their income-adjusted consumer premium contribution. Because the public plan can compete with the individual and group market private sector offering, we saw a crowd out resulting from the public plan of 79 million covered lives with the majority people leaving their employer sponsored medium PPOs and HMOs.

At this time, we are the only group yet to score the full Kennedy proposal. We released it publically last Sunday, June 14, on our hsinetwork.com home page

– two days before CBO’s preliminary estimate. The work was completed as a public service without a funder from industry or a political sponsor.

Some proposals we examined have specific ‘pays fors’ already scored by CBO that can substantially reduce their cost such Coburn / Ryan with a 72% reduction and 10 year cost of \$200 billion with ‘pay fors’ and 1.7 trillion without.

One conclusion emerges every time we score a plan. None are revenue neutral. Even with Medicare & Medicaid ‘pay fors’, the savings in those programs need to deal with cost pressures of those programs. In all likelihood these proposals, if enacted with escalate the rate of growth of our national debt, particularly the Kennedy plan. As a nation, we are on the verge of making multi-trillion dollar gamble that more per capita health care deficit spending will make us better off as a society. We are wagering with starting bids in the trillions that excessive spending into the healthcare system accelerates breakthrough medical technologies that can eliminate whole diseases, like diabetes or Alzheimer’s, in ways similar to the innovations introduced over half a century which reduced tuberculosis from being one the leading causes of death.

It is not an unreasonable wager, since federal funding for heart disease and cancer either directly through research or indirectly through Medicare has yielded state of art medical care. But it is a wager nonetheless, and we may find our

reckoning is not only with the future debt of our children, but their security where the economic crisis has brought international scrutiny upon the US from the principal purchasers of our treasuries. Furthermore, saving businesses from paying health care costs or a state government with federal intervention is simply an accounting cost shift that only saps our long term economic strength.

President Obama spoke recently in Wisconsin of need to expand health coverage to 'bend the cost curve down'. I watched him say it three times. May I respectfully suggest that bending the cost curve down starts with active management of Medicare. For five months we have been without a CMS Administrator while over \$400 billion in medical claims have already been spent. I would take the President more seriously if there was someone at the helm.

As some of you may know, I was a McCain health policy advisor and discussed taking the CMS post. If I was chosen to serve, my one goal was to work with carriers and intermediaries through existing contracts to rapidly reduce fraud at the point of service and get as much of the 80% of rudimentary clinical data for health IT from labs, imaging and primary care physicians. This would be done by simply offering to pay 90% of physician and outpatient care in 4 days or less using proven technologies in the retail sector as a model. This initiative could have reduced the eventual \$70 billion dollar price tag for health IT investment to \$0.

How? Giving the physicians and hospitals additional financial incentive to submit existing clinical data in exchange for eliminating - in effect - unpaid loans to the federal government for 50 day claim turn around. While the US Treasury may use this antiquated accounts receivable system to make 'money on the float' it also simultaneously invites fraud and fuels an active black market for deceased physician IDs to create fraud for imaginary patient and services at the scale of billions. If these innovations were championed by a CMS Administrator, we could save as much as \$100 billion per year in Medicare & Medicaid for phantom services, patients and physicians.

In summary, there is greater consensus today that health care reform must be undertaken. It will not be free. It will be, as it always was, a political decision more so than economic. So much could be done now without a giant expansion where most if not all players in this \$2.5 trillion health economy, including patients, will benefit. Thus, proposals for deficit financed expansion must be carefully weighed. Many have asked what I, a health reform economic modeler, thinks would do the best. I don't have a silver bullet, but I do offer two observations that are the roots of the conundrum. First, we as a wealthy society have a collective appetite for high option PPO for all and the collective financial resources for high deductible health plan, with preventive services for all. Second, this industry is excellent at medical innovation through carefully, deliberately and

strategically placed monopoly rights over 100 years of regulation and patent law.

Threats to monopoly rights will erode incentives for innovation and

entrepreneurship. The government's likely gain in monopoly market share through

a public plan and subsidized health insurance will not address the conundrum.

Thank you again for this opportunity.