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An Interview

with David Cutler and Grace-Marie Turner

by Doug Norris and Ksenia Draaghtel

David Cutler

As part of the SOA '10 Health Meeting, a lively debate was held between two leading voices in health care reform. Grace-Marie Turner founded the Galen Institute in 1995, as an advocacy group against the increasing role of the federal government in the American health sector. David Cutler is the Otto Eckstein Professor of Applied Economics at Harvard University, and was senior health care advisor to Barack Obama. Cutler and Turner kicked off the SOA '10 Health Meeting with a bang, debating the principles behind the Patient Protection and Affordable Care Act (PPACA) for more than an hour. We were fortunate to be able to spend more time with Turner and Cutler after the main session ended, and share highlights of that discussion here.

Grace-Marie Turner

What do you see as the role of actuaries in the implementation of PPACA, and where can we be of best use?

David: I think that actuaries are going to play a hugely important role. The system is changing, or it's going to change, and the actuaries are going to be incredibly important. Let me just give one example from accountable care organizations. Lots of provider groups are now integrating because they want to be able to coordinate care. They think that that is where the money is going; they think that is what will deliver higher value, and they don't have much experience with how they are going to handle all of the patients. How they should price it out, how they should do the internal transfers, and things like that, and they really need actuaries to help them with that. They really need the actuaries to say, "Look, here's how we should do the risk for it, here's how we should think about the costing, here's how we can do some of these transfers." Anytime there is change, we need all hands on deck. We need the doctors there, the clinical folks, the financial folks, and you really have to have the actuaries there as well.

Grace-Marie: I'd look at it also from the perspective of implementation. I think actuaries really need to continue to have an active voice in responding to the regulations that come out, and making recommendations for legislation to fix problems with this bill that may move us in what they know will be the wrong direction. This is not settled policy; there is still a lot that needs to be fixed, and for it to work so that the American people accept it. And I think that actuaries bring a real-world perspective: "will this work or won't that work?" and rather than going down that road and finding out if it did or didn't work, actuaries need to be engaged up front and say, "we can anticipate that this is what's going to happen, and you need to make changes now to get to a better result or to avoid a bad result."

If you had carte blanche to design health care reform from scratch, what would your top three requirements be?

Grace-Marie: I really think that we have to do entitlement reform. You can't have a program that is 38 trillion dollars in deficit, as Medicare is, and not address that. You can't take the money out of Medicare, and put it into creating new entitlement programs which are themselves unsustainable, and create more problems, and not solve the initial problem. I think dealing fundamentally with entitlement reform in a way that moves us towards a 21st-century system of medical care delivery, so that consumers have more choices, more options. A defined contribution model, and refundable tax credits, and giving people control of the resources

to make better decisions about protecting themselves, both against how they're going to arrange payment for routine care, as well as protecting themselves against larger financial risks for medical care. We've got to address the financing of this and entitlement reform and getting that right. We need to provide real incentives for the marketplace to respond to consumers with more affordable options, and that means moving power and control over payment decisions and spending decisions to consumers. That can be allowing them to decide the kind of health insurance they want to purchase, and to balance that with their other spending or other family priorities. And giving them the resources to be able to make those decisions. Thirdly, to give the states more authority to create that safety net, because states are so different, and their needs and their resources are so different. I just think that a "one size fits all" federal solution is not going to work. We need to empower the states to be much more engaged, to have much better information in order to be much bigger and better players in the safety net equation.

David: Our current policy for cost containment in health care is that every year three million lose private coverage, one million go on public plans, and 1.5-2 million go uninsured. That just doesn't strike me as a very good system. So that's the first thing, is providing coverage. The second thing, is to put in place a process for the delivery of medical care so that it is higher quality and lower cost. I think that the impact of this reform is going to be far greater than what the estimates are, because we are changing the incentives a lot, and those are not factored into any of the current estimates at all. So I think the impact on the delivery of care and on the cost and on the quality is just going to be immense. The third thing to do is to tackle some of the hard issues in society, which is going to help us in lots of margins. The fact that we've been able to do something for people is going to enable us to maybe raise the age of eligibility for Medicare, or go back and do new trade agreements, or do something, but the fact that we've actually done something for the lower class, for the lower- or middle-income people, I think it's going to have huge spillover benefits.

What do you see as the unintended consequences of the affordable care act?

Grace-Marie: We already see that now a third of employers are considering dropping health insurance. If you would have talked about that as a likely result of this legislation before it passed, I think people would have said "that's not what we want." We see health care costs likely going up faster than they otherwise would have. In all this, 500 billion dollars in new taxes on the medical devices industry, health insurers, pharmacy, [these cost increases] can only be pushed through to patients and employers in the form of higher premiums. I think that one of the unintended consequences is that it is going to destabilize the market for employer-provided health insurance. It's going to turn health insurers into basically regulated utilities. It's going to increase costs, and it's going to increase the federal deficit. And people are going to be very demoralized, because it's not going to achieve a lot of the goals that were promised. "If you like your doctor, you'll be able to keep your doctor." Not true. "If you like your health insurance, you'll be able to keep your health insurance." Not true. Employers were thinking that they would be grandfathered and protected from the provisions of this legislation, and we know from the administration's own analysis that 51 percent of employers are likely not to be able to be grandfathered. 80 percent of small employers—small employers facing the brunt of the high costs, the higher costs, and they were the ones who most wanted to see lower costs. So I see a whole cascade of unintended consequences, and at some point, Congress is going to have to put a firewall up and say we need to stop this and go back and rethink, "Did we try to do too much, too fast, all at once?"

David: The experience in Massachusetts is the opposite—the experience in Massachusetts is that it has stabilized the market. Remember that this was built without much in the way of cost savings to Massachusetts, just to cover people. The experience in Massachusetts is that more people have coverage,

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and more people have employer-based coverage, and by three-to-one, people are happy with it. So maybe the national reform will work differently than Massachusetts, but that is the evidence that we have to go on. I don't know if it's unintended consequences, but when you talk about costs, the Congressional Budget Office, when they did their costs, and the Medicare actuaries, when they did their costs, they didn't really know how to deal with any of the payment reform changes. They didn't really know how to deal with anything about accountable care organizations, or any kind of payment performed in Medicare, so as a result they assumed that those wouldn't save anything. According to their analysis, those provisions cost more money than they saved. Now, it may be that those are correct, and that all the payment reform that everyone agrees upon will actually wind up costing more money than it saves, or it may be that these things will actually work in the way that the vast bulk of the medical profession thinks they will work. And the vast bulk of the analyst community thinks that they will work, and that they'll wind up leading to enormous cost savings and value enhancements. Again, we don't know for sure, because we've never tried it on a big-scale basis, but I would put at least a fair amount of weight on what the people who work in the industry say, and how they describe the way that their life works and the likely impact of these sorts of changes.

Grace-Marie: As David says, the penalty to employers for non-compliance is not very high, but we're a law-abiding country. People don't want to break the law, especially employers. They want to comply, so if you say that you have to provide health insurance, they'll do it. And with those who signed up for insurance, especially through Commonwealth Care, it was heavily subsidized. The great majority of people who signed up for that were signing up for free, or nearly-free, coverage, so of course you're going to expand coverage among them. The fact that they didn't talk about costs, they just wanted to talk about coverage, now they're saying "oh my goodness, this is going to fail if we don't address the cost equation." Well, the cost equation has to be built into the structure of this so that you move toward a system that is affordable. But don't say, "OK, now we're going to come and deal with the cost issue," so what does government do? They say, "Well, we're going to do price controls," as they propose. What the governor is saying is that we are just going to cap premiums for health insurance—well, you can't do that, because that's illegal. So what are they going to do now? Price controls are their tool. If they don't fundamentally change the market forces, and they didn't do it in Massachusetts, I'm worried that they aren't going to do it in this legislation as well.

The British health care system was based upon the premise that all citizens should have access to care independent of their ability to pay. It has been said that the U.S. health care system does not have any founding basis like that. What do you think it should be, or it is already?

Grace-Marie: We don't have a system. The British National Health System is a system, a government organized entity, and is now more than sixty years old. We have a fundamentally different philosophy in this country about what our country is about. Theirs is solidarity and making sure that everybody is in it together, and we're all going to make sacrifices for each other. That's not the American ethic. The American ethic is freedom and independence, and yes, we are a compassionate people. We spent 300 billion dollars last year in charitable contributions. People want to help others. The whole question between equality and liberty is really fundamentally at issue here. In this legislation, we want to find a balance. We want to make sure that we take care of everybody, but that we to do it in a way that allows people to have freedom and liberty in their choices. And I worry that we have lost the liberty and we haven't really gotten to equality. I think we're still going to wind up very likely with a two tiered system in this country, because people with means and resources are always going to figure a way to buy their way out, and get what they need, and people in the system are going to have a harder time.

David: The very interesting thing is that everyone agreed that we need to save money. And as we're

talking about the recession, there weren't a ton of different ideas at that table on how to save money that weren't already floating around. Where there was a difference of opinion was the Democrats said that it's a social responsibility to make sure everybody is covered, and the Republicans said that we would like to see everyone covered, but we don't think we can afford it. That was basically the consensus.

Grace-Marie: I don't think that's right. I would disagree with that.

David: And I come down on the side that we as a country are rich enough that we ought to be able to afford to cover people. And I think it ought to be a right as an American to get health insurance coverage. I don't think that's the only philosophy, but I think that's a place where we are coming to, and I feel comfortable that the vast bulk of Americans are there.

Grace-Marie: You know, I talked to Republicans, and they, too, want us to get to a system where everybody has access to affordable care and affordable coverage. But we want to do it in a way that allows people many more choices in a much more competitive market that empowers individuals to decide the kind of care arrangements that work best for them. Not to have government tell them what they must do, or what they must have, or how much of their income they must pay for health insurance. It's just fundamentally opposed to what happens in every other sector of the economy.

Any final comments?

David: I'm actually encouraged when I go talk to all sorts of groups that oppose reform, or that were on the fence about reform, or that didn't know what they thought. All sorts of groups are starting to say, "OK, maybe I liked it, maybe I didn't like it, maybe I liked parts of it, maybe I didn't like parts of it, but now the job is to make it work." And that gives me some hope, because what I'm not seeing is "Damn it! I didn't like this part; I'm going to fight it." I was on a panel with the head of the hospital association, who said "Well, there were parts that we liked of course, and parts we didn't like, but our job now is to make it work." When you talk to physician groups, "our job now is to make it work." When you talk to health insurance, "our job is to make it work." And I'm cautiously optimistic that what we will do is make it work, and we'll find things that go right and we'll strengthen them, and we'll find things that go wrong and we'll fix them, and we'll find things that are unintended in a good way and we'll be happy, and things that are unintended in a bad way and we'll adjust to them. But that's really what our mission is for the next five, 10, 15 years—to take this and find a way to make it work for people. And as I say, I'm fairly optimistic with how it's starting out.

Grace-Marie: The American people didn't support this. You know you had 30 percent approval for passage of this legislation, so you've passed a major overhaul of the health care system with the majority of the American people opposed. I think that makes it so much more difficult for this to work and for people to accept it, and we are a law-abiding country. People aren't going to break the law. This is what we are going to deal with. President Obama is here at least until 2013, and maybe until 2017, and so they're not going to be able to override it. People want health reform, just not so much all at once with so many problems, with unintended consequences, that really works against the way that rest of the economy works. Power and control is devolving to Washington and to bureaucracies, rather than to individuals. ■