Symposium Keynote Speeches: Opening Remarks

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Opening Remarks

Ezekiel Emanuel

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I want to thank Dean Post and Abbe Gluck for the invitation. Today, I will present a talk in four parts.

The first part is to go back and think about the puzzle of why we have Medicare and Medicaid in the crazy way we do. It defies logic, and as my grandmother would have said, “what is this meshuga‘as (craziness)”? You have Medicare Part A, which is a trust fund based upon payroll tax, and if you are over 65, then you are in. Part B is an insurance model, where the beneficiary pays some premium and it is therefore voluntary. Both are administered and financed exclusively by the federal government with uniform eligibility, requirements and benefits. Then you have Medicaid, this joint federal-state monstrosity, a categorical program with federal minimal requirements for both eligibility and benefits, and there is great variation by the states. The consequences—human, medical, and economic—of these different structures and these different ways of organization are not trivial. Millions of people have been adversely affected by being excluded, especially the poor by being excluded from insurance by the design of Medicaid the way it is. We have very different levels of efficiency in the program, very different levels of coverage, and very different levels of benefit design. As you have heard from other speakers, the data are very different. We actually have data, albeit claims data, from Medicare and very little research on Medicaid because the data is just not very worthwhile. No rational health policy person would have designed it this way. So what accounts for these variable structures? Pure and simple—politics.

I want to recount the history a little bit because I think it is important that every time you explore a health system and the government’s role, and Medicaid in particular, you understand where it came from.

We got, by accident, an employer based health insurance system that was then resisted mightily by the medical profession all the way through. Once it got started, a number of decisions, without as much conscious effort, turbo-charged the system, especially the 1954 tax exclusion that made health insurance really valuable—more valuable than income. That corresponded to a time when the government was financing hospital expansion, and medicine was becoming more

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1. Vice Provost for Global Initiatives and chair of the Department of Medical Ethics and Health Policy at the University of Pennsylvania.
effective through more drugs and interventions, financed largely by the federal government. At that time, if you had an employer-based system, there were two groups excluded, those who are unemployed or unemployable, and the elderly. All through the 1950s, pressure grew because hospital care was becoming expensive and it was actually effective—and that combination of it being effective and therefore desirable and increasingly expensive made it combustible, especially around the elderly. Hospitals become increasingly financially bothered by the fact that they were providing more and more charity care.

Medicare was initially proposed in 1957 by Rhode Island Democratic Congressman Aime Forand. He proposed the social security framework, which had been proposed for health insurance before, and he focused in on healthcare for the elderly, eligibility at 65, covering only hospital care. That was the initial bill. It is quite clear what it owes to social security, which in turn is quite clear what it owes to Otto von Bismarck. He proposed it in 1957, a lot of debate ensued, and in June of 1958 the House actually held hearings on the bill, even though it never held hearings on a health bill before. Interestingly and predictably, the American Medical Association (AMA), the Chamber of Commerce, pharmaceutical companies and the health insurance companies of America were against it. The American Hospital Association (AHA) was equivocally supportive—equivocal in the sense that they were not so confident in the government financing it, but they knew that something had to be done because they were hemorrhaging money. This stayed on the agenda through 1958 and 1959 and really exploded in the election year in 1960. This is a case in which election years really mattered in getting something done. In March of 1964, the House voted, and the bill got defeated 17 to 8. In the 1960 presidential election, healthcare was actually a very large focus. The American Federation of Labor and Congress of Industrial Organizations (AFL-CIO) campaigned, forced all the Democratic candidates to endorse the social security based approach and interestingly, two Texans, Sam Rayburn, who was Speaker of the House, and the majority leader, Lyndon Johnson, also supported this social security based approach to health insurance.

Because it was an election year and because this support for healthcare for the elderly was popular even then, Richard Nixon and the Republicans needed their alternative. For all of their eight years, the Eisenhower administration studiously avoided health insurance for reasons related to Truman, but the avoidance strategy was not going to be tenable in the 1960 election. Arthur Flemming, an interesting guy, noted as a Republican that government action on healthcare for the poor and the elderly would be necessary, that an exclusively private solution would not be possible, and that voluntary insurance probably would not solve the issue. Nonetheless, he ended up with a program that was a re-tread of the Republican approach to health insurance over the decades, something that ironically Richard Nixon and others in the party had been advocating for going back to the late 1940s: that the Federal government provide income league subsidies to the elderly individuals so that they could go into the market and purchase private health
insurance. The program would be voluntary so that individuals could decide whether or not to participate and it would be financed by general revenues. Does that sound familiar to anyone? Literally Richard Nixon had proposed this as early as 1948.

So that is where it was. The Democrats wanted the social security structure and Richard Nixon, Fleming, and Republicans wanted this voluntary insurance with government subsidies. Political pressure was building. Wilbur Mills, who some of you may know from the Fanny Fox affair, was a conservative Democrat from Arkansas, highly respected, Chairman of the House Ways and Means Committee, and political pressure had built such that he could not avoid dealing with the issue. After the defeat of Forand’s social security bill in his committee, he nonetheless thought something had to be done and he began working with the AMA to develop a bill for state-run public assistance programs to provide payments to physicians and hospitals on behalf of poor elderly people. His view was that it was voluntary on the states to adopt, and again this is a case of funding coming from general revenues. It was an interesting combination of a Democratic bill with AMA support, and an extremely powerful member of the house supporting it. The insurance debate was extremely intense throughout 1960.

After the conventions that nominated Kennedy and Nixon, Congress came back into session—this was a highly unusual event—to vote on health care in the Senate. They had the three alternative bills before them. They had the Democratic bill, they had the Republican bill, and they had Wilbur Mills’ bill. Kennedy, Johnson, and Nixon were all there during this unique August session. The Republican bill was brought up first and it went down to a strict party line vote, 67-28. The Democratic social security inspired bill was defeated 51-44 with a bunch of conservative Democrats going over to the Republican side. As a consolation, the Mills bill, giving money to the states so that they could then pay doctors and hospitals on behalf of the elderly (it was called the Kerr-Mills bill, because Senator Kerr from Oklahoma, a conservative Democrat, had supported it in the Senate) passed 91-2. That did not satisfy the election. Health insurance turned out to be a key issue in the Nixon-Kennedy debate on September 26th. That presidential debate was mainly focused on healthcare, and Nixon, Lodge, Kennedy and Johnson all said that the Kerr-Mills bill was completely inadequate and that they would do something more on healthcare. Just as predictably, with the election nothing happened. Democrats introduced their bill, Republicans had their bill, and not much happened. Part of it was we got to see what happens with the Kerr-Mills bill.

In 1961, the AMA, true to form, organized AMPAC, their first political action committee, to lobby and campaign against Medicare. They surreptitiously funded a guy called Ronald Reagan to make a record, a ten-minute speech and diatribe against the federal government providing health coverage, denouncing it as socialized medicine, and never revealing the fact that it was funded by the AMA. But pressure continued to build. The Kerr-Mills bill was a pretty big failure—it
was even called by some government Senate reports “a big failure.” By 1964, hospitals days had increased by 33% between 1960 and 1964. It went from 29 dollars a day to 40 dollars a day, just an amazing increase. Half the elderly had insurance and most of that insurance was not worthwhile because it could not even cover a hospital day. There was a growing consensus in the government that only the government could solve this problem. The landslide victory of Lyndon Johnson, the largest plurality, 61.2%, 486 electoral votes or something in that range, changed everything. Wilbur Mills heard the message loud and clear. In January 1965, the first bill introduced into the House and the first bill introduced into the Senate were health care, the health care Democrat reform bill; Mills took over control of writing the legislation. Within two months, on March 23, 1964, (for those of you who want to know, March 23 is a very important day in the history of medicine and health care legislation), he had the House Ways and Means Committee pass the bill. And he organized the bill. The Democrat’s Social Security-based bill is Part A. The Republican private insurance subsidized by the government with premiums is Part B. Medicaid is the old Kerr-Mills bill. And there you have the monstrosity that we have that we have had to live with, with all its positives and defects.

So this three prong, very different kind of structure, really traces back to Mills taking the path of least resistance, merging the three bills to reduce political opposition, giving something to everyone. It then took, from that period on, seventeen years to get all the states to adopt Medicaid because the states were not required to introduce Medicaid. In 1982, the good state of Arizona, not Texas, was the last state to expand Medicaid. This time, I believe Texas will be the last state to adopt the Medicaid expansion.

Whatever else you think about Medicare, it has been a huge success on the main dimension it was meant to address. I want to remind people that the main motivation was not to provide the elderly health care. It was financial risk protection. And that really is the fundamental basis on which it was passed: to relieve the elderly of the fiscal burden of paying for health care. One way I like to point out its success is that in 1964, just about 30% of the elderly were living in poverty in this country, even with Social Security. Now, today, with the combination of Medicare and the increases in Social Security, the indexing of Social Security, which is largely, though not exclusively by any means, determined by health care costs, 9% of the elderly are in poverty. It is the lowest demographic in the United States in poverty. Conversely, in 1964, 19% of the general population, non-elderly population was in poverty. And today it is 15%. Among children, it was 23% in 1964 and today it is an embarrassingly shameful 20%. So at least regarding financial risk protection, Medicare has had a huge impact as witnessed by the relative, much better financial position of the elderly in this country.

Let me say one other thing, not about the passage of Medicare and Medicaid, but about their initial implementation. As all of you know, the AMA was
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steadfastly against Medicare and Medicaid, was not willing to compromise, and Lyndon Johnson, to his credit, was able to get Medicare and Medicaid passed.

Hospitals were more ambiguous; they wanted the money but did not want the government involved. There were lots of threats that they would not take the Medicare payment when it opened for enrollment in 1966. To counter this, the politicians decide the best approach to the medical profession was bribery. On the one hand, the government would not pay directly—this is how we got the intermediaries such as Blue Cross Blue Shield paying doctors as carriers to ameliorate the opposition. The doctors were taking money from the insurance companies and not from the government. But may I remind you that the doctors opposed these insurance companies in the beginning as well. More importantly, in my opinion, was the decision that the government would pay hospitals cost plus, cost plus with depreciation on their capital investments. Think about what type of incentive this creates for a hospital! Not only did the Hill Burton Act from 1946 create this huge incentive to build hospitals, especially in poorer states, but this idea that cost plus capital expenditures would be paid for just hugely incentivizes adding new wings to the hospitals, and doing whatever you can to build capital to your hospitals. As my good friend, the late Rashi Fein, used to tell me is that in the 1960s, a lot of hospitals had expansion ideas and their dreams and the plans were in the desk drawer of the president and they might go out and fundraise. But after Medicare they did not need to go out and fundraise! They had a funder! The federal government would reimburse them!

The impact was significant on the structure of Medicare and Medicaid. We had this fragmented system paying doctors separately from hospitals. We paid proceduralists more than primary care doctors. We paid in this mechanism of cost plus depreciation that hugely incentivized expansion and the resulting healthcare inflation. There was no control mechanism built into the system. None. This is the end of part one, the history of how we got to the crazy puzzle.

In part two of this talk, I want to present the problem of the bureaucracy that was created. I will start in an unusual place for someone who swings from the left. Today, Medicare and Medicaid are a combined 850 billion dollars in federal outlays. When I was growing up, I remember people complaining: “do not build that aircraft carrier, build hospitals instead for the same price!” Today, that is not true. Today, it is: “do not build that hospital, instead we can solve the military budget problems for that price!” It dwarfs what we spend on Social Security and on the military budget! It is an enormous amount of money.

The fact is that the Centers for Medicare and Medicaid Services (CMS) oversee 850 billion dollars with 6,000 employees. That is an administrative budget of 4 billion dollars. More money is spent paying carriers than others. That is 140 million dollars spent per employee administering the program. Now, someone might look at that and say wow, what an efficient program! But no organization can run that lean; by any standard, that is absurd! There is under-employment and under-administration of the system. Just to give you metrics, United Healthcare
has 123 billion dollars in revenue and 156,000 employees. Sigma has 32 billion dollars in revenue and 36,000 employees; they are running at about 1 million dollars per employee. Think about the most efficient companies out there, tech companies. Facebook has 8 billion dollars in revenue per year with 2,000 employees—that is 4 million dollars per employee. Google has 60 billion in revenue, about 48,000 employees. That is 1 million dollars per employee. You just cannot administer a program like that! As a consequence there are real problems at Medicare!

I will give you some examples. Until a few weeks ago, there was not a single oncologist employed by Medicare. I am an oncologist. Between 10-15% of the Medicare budget goes to cancer, and they did not have a single oncologist thinking about that! They just hired one, and it turns out he is a pediatric oncologist. He might be a genius but he has never seen ovarian, prostate, breast or colon cancer. It is very hard to run a program where regarding 15% of your budget, you do not have someone with expertise there. No company would run like that. There are many other consequences to limited manpower: limited updates on payment, and reliance on the rack for payment updates. Updates on the Relative Value Units (RVU) for physician practice overhead are done very slowly, and are not done very well. The revisions on the RVU are largely outsourced to the AMA and the rack with a huge conflict of interest. Giving data back—they are running these large experiments on ACOs, but can they give the data back in a timely fashion? No. Anyone who is working at Medicare will tell you how ridiculously outdated their data systems are.

Part three, I will discuss the politicization of their decisions at all levels. We legalize overpayments to part C plans. It is legalized! In the Affordable Care Act (ACA), we had to bring it down to merely overpay from 114% on average to 101%. A great achievement, but this is still overpaying! Again, I see everything through the lens of cancer. Consider the coverage of Avastin for breast cancer—this is a drug for which the Food and Drug Administration pulled its indication for breast cancer because the data suggests it does not work, yet the CMS is still willing to pay for it. There are many other areas where treatment—such as proton beam for prostate cancer—have never been shown to work better—and still we're paying out the wazzoo for it. A comparison between the US Preventative Services Task Force indication for screening tests and what is covered by Medicare shows that there is no alignment. The Task Force says PSA not for any man, yet Medicare pays a fortune for it. Colon cancer screening for people over age 75 is not indicated, but it is covered. Pap smear for all women over 65 is not recommended and certainly not for women with a hysterectomy, but it is still paid for. Recent data commented on in JAMA Internal Medicine showed that between 34 and 56 percent of women aged 65 and over had a pap smear, still paid for. So, I think Harlan (Krumholz) was right, Medicare was instrumental in improving cardiology, and that is a very important achievement. But in my view, the glass is half full. There
are so many things we can do to improve the quality of care and to reduce costs that are not done.

Let me give you another example here pursuant to fraud and abuse. We have no idea how much fraud and abuse there is in Medicare, but it is not trivial. The return on investment for doing fraud and abuse in Medicare is seventeen dollars for every single dollar spent. What venture capitalist would not like that return on investment? And that is just overt fraud, not subtle fraud. How much do we spend each year on combating fraud in the Medicare system? 388 million dollars. Why do we spend so little on combating fraud and abuse? I am not 100% sure but I will give you my hypothesis. Medicare pays 1 billion claims a year. Let us say it has the best fraud recognition program, that would be 99.99% accurate. So in only 1 out of 10,000 charges that a claim is a fraud, is a mistake made. Out of 1 billion claims, it still makes 100,000 errors, even at that great accuracy. That is 100,000 honest claims flagged as fraud or potential fraud with a fantastic performance record. What happens? What do these 100,000 honest hospitals or doctors do? All you need is one or two of these honest doctors or hospitals calling their congressman saying “do you know what!” That is why we do not do more, I think: because of the fear of attack. There is also a pervasive fear of failure created by the Washington environment. In Washington, any failure will be attacked. A 90% success rate is not good enough.

The last thing I want to say is that the bureaucracy is really subject to Newton’s first law of motion: the law of inertia. The object in motion will stay in motion unless acted on by an outside force. The bureaucracy is that in spades, very resistant to shaking off fee-for-service (FFS). I think that has been a big problem. In the 1990s, CMS ran a bundles program plan and it turned out to be hugely successful; on average, it saved 10% and quality was as good if not better. But what happened? Nothing! The experiment never got expanded. When I was in the administration, we were thinking about how to structure the payment perform section. I was 100% behind bundles because I thought it was the easier way for doctors and hospitals to change off of FFS onto another option that would not incentivize overuse. The bureaucracy was very resistant to doing that. Why? Because they did not have the structure. They had three main excuses: (1) hospitals and doctors are not ready, (2) we can not pay that way because we do not have computers we have to pay by hand, and (3) they were very unclear that it would save money. However, we would never known unless we ran the experiment!

The best I got out of multiple arguments and debates was up to ten experiments with bundled payments. They have done a bundle payment called the Acute Care Episode (ACE) demonstration with orthopedic procedures, and the results are in: moderate savings and better quality. But still they cannot get it generalized. The actuary will not certify that it will save money, only five systems participated, lots of other worries. It is very hard to get change done. In addition, there is a large suspicion of the private sector. All through Medicare, we put into the Bill the importance of releasing Medicare data so people could use it. We have regulations
that have substantially restricted who could get the data because there is a fear in Medicare that if the private sector uses the data and makes a profit on it, that is a bad thing. So I am a little worried.

I also think you have an incentive structure that does not encourage what we want to do. Yes we have the Center for Medicare and Medicaid Innovation (CMMI), and I fought very hard for it, but no one in the bureaucracy is rewarded or promoted to control total cost of Medicare or to improve the quality of healthcare delivered via Medicare. It is hard to know what the chief objective is; the number one goal of most people was not to limit options of Medicare beneficiaries. It has influenced the design of the Accountable Care Organization (ACO) experiment so that there is not prospective assignment, only retrospective assignment, which makes it very hard to make money. So I think there are serious problems with the bureaucracy.

What do we need from Medicare going forward? Payment change, payment change, payment change! Nothing else matters as much as payment change! Medicare has to collaborate with the private sector.

Here is my list of what we need going forward.

1. We need a timeline. Providers out there—doctors and hospitals—need to know what our timeline for shifting off FFS is. They need to plan now. It is very hard to motivate your physician if you do not set a deadline if they can still make a hefty margin on FFS. You have to say by x date, half your payments will be off FFS.

2. Second, I do not think this voluntary demonstration project is going to go well enough. The requirement of mandatory demonstrations was put in the ACA bill. In combination with articulating a timeline, we need a mandatory demonstration, which needs to be on something that is high margin to the medical system—orthopedic procedures, cardiac procedures, cancer. That will get everyone’s attention and communicate the timeline and show that it is real. It will also give us data on which to make an evaluation. I think it will completely change the expectations. The expectation for change in payment, you have to fulfill it so that people will believe you.

3. Third, we need to push on Part C. Alan Weil said we know that Medicare Part C is managed care mainly paying the providers care FFS. We need to change the Part C to really do two things. One is to competitively bid the prices instead of paying them in the complicated way we do them. Let them set the prices, let us have a competitive marketplace. Second, have them shift their own payments off FFS so we use their leverage.

4. Fourth, we need more competitive bidding for all the other services. We have seen successful bidding around durable medical equipment, bringing
prices down 40%. We can do better than that. And the Part C parts needs Congressional approval.

5. The last thing is the accountable-care states: states should run programs like those in Maryland, Oregon, and Arkansas, where they share a portion of the savings if they can keep down their GDP. Those are worth hundreds of millions of dollars to states and can be very motivational. We have outlined how that system can work.

Let me conclude with two observations to bring home these points.

One is the importance of never underestimating path dependence. The way structures get put in place has a very important effect way into the future because it can become virtually impossible to change those structures. We have seen that in the creation of Medicare and Medicaid, we use a Social Security apparatus with Part A. We use public assistance for Medicaid. Once you have that structure you are stuck with it, and I do not think that within our policy making process we think hard enough about the consequence of that and it can really create perverse incentives over time.

The last thing I would like to conclude with is somewhat more controversial. I did not want to disappoint anyone, it is not something that anyone predicted I would say. I think the closer you look at Medicare, the more you have to be hesitant about the notion of the single payer built on the Medicare model, meaning Part E, Medicare for everyone. As I said, the system is chronically, habitually, and structurally under-administered, it is subject to a lot of politicization, it is resistant to reform, and it obeys Newton's first law. If you have one system for 310 million people, it will become even harder to change and more controversial with every change because of the interest groups that exist. Are there downsides to the proliferation and problems we have with too many insurance companies and different payment models? Absolutely. Fragmentation has made it very difficult to get enough scale and enough influence from any one payer to change the provider side. On the other hand, it does have slightly more flexibility and slightly more experiments and I think that over the next decade that will be more important as we try to move off and to change the whole healthcare system.