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What's Next?

Jim Cooper
Congressman

"WHAT'S NEXT?"

KEY NOTE SPEAKER: CONGRESSMAN JIM COOPER[1]
[edited for reading]

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Jim Cooper: Thank-you Grace Ann. I am honored to be back at Belmont. It's a great place.

I'm going to try to be of maximum use to you so I hope that you will be coming up with questions. I will do my best to try to answer them. As the Chinese curse goes, "May you live in interesting times." We are certainly doing that.

Let me start off with a few slides, and hopefully that will provoke some questions. This is the way I see the progression of recent American history. Unfortunately, the South was always a bastion of fee-for-service care; it still largely is. Managed care has largely failed us because it was largely managing costs, not care, in the '80s and '90s. Providers talk about value-based care, and "better" **is** better, but "better" is very hard to define. This field is very trendy right now. I'm a big advocate for pay-for-performance, but you have to be able to measure performance.

So, what's next? The bottom line is that "better" is still way too expensive. Health costs are a crushing burden on both families and our nation. You can cite the usual statistic that half of bankruptcies are caused by healthcare expenses. You will discover that the median bankrupting health care expense is about $3,000, so healthcare has become something that we view as a quasi-free good. No one wants to pay the full price, or even a fair price.

With our employer-sponsored benefit system, we are used to seeing only one quarter of the health care price tags on our pay stubs. We ignore the employer portion, which is largely taken out of our foregone cash wage increases, and we wonder why wages have been

[1] Congressman Jim Cooper was born and raised in Tennessee. He and Martha, his wife of thirty years, live in Nashville and have three children. A New York Times columnist called him "the House's conscience, a lonely voice for civility in this ugly era" and a "tart-tongued moderate" who "seeks bipartisanship on fiscal matters and other issues in a polarized political climate." USA Today named him one of the "Brave 38" of a "tiny band of heroes" in Congress for his work on a bipartisan budget plan. In Congress, he's known for his work on the federal budget, health care and government reform. He's also a businessman, attorney and part-time Vanderbilt professor when Congress is not in session.

sagging in America for forty years. The healthcare sector is taking our cash wage increases from us, and that is an astonishing insight. It could be the greatest robbery of all time. Because to take everybody's forgone cash pay raise in America for forty years, and put it in the health sector, and get away with it, that's amazing.

I teach this at Vanderbilt's business school. In fact, I was just there this morning for several hours. So, if I'm glossing over some of these things quickly, especially economics for lawyers, stop me, and I'll try to be clearer. We are in a massive health care bubble right now, and this bubble is particularly threatening for Nashville, because, as I have explained in many other talks, we don't even use real accounting in Washington for Medicare and Medicaid. We are only seeing a tiny fraction of their cost in congressional budgeting.

The Trump administration gives every sign of making this problem worse because he has promised not to touch Medicare. He has also presented a budget that adds $10 trillion in extra debt over the next ten years. Sadly, the Democrats are copying that, almost completely. They wanted to make Obamacare the issue, not debt reduction. Paul Krugman wrote in this morning's *New York Times*, "Where are the deficit scolds when we need them?"[2] Well, I am a deficit scold, and I'm still scolding. Deficits are a problem that we, as individuals and as a nation, don't want to acknowledge.

Political parties play the game of obstructionism. Democrats hated Republican obstructionism when they could obstruct. Now Republicans are hating our obstructionism when we can obstruct. I believe in fair play, and we shouldn't be hypocritical about things. Now, it's very tempting to be hypocritical. Many of our senators, in particular, have had to reverse all of their previous speeches. They are, somehow, overcoming their embarrassment. Wouldn't it be nice if we didn't have to have these wide pendulum swings.

The Flashpoints: the things in health care debates that really get people upset. If you're a Democrat, you talk about the number of uninsured, and that's terrible. And the repeal of Obamacare is about to throw at least 20 million people out in the cold without insurance. And that is a genuinely bad problem. The uninsured are largely powerless. We should be embarrassed here in Tennessee because, a few years ago [during early TennCare reforms], we almost had the lowest percentage of uninsured in America. We were second only to Hawaii, and we didn't care enough about that accomplishment to keep it. That was a landmark, signal accomplishment that put us ahead of the rest of the nation. This was largely in the Gov. McWherter era, but then, for fiscal and other reasons, we largely gave our accomplishment up. A low number of uninsured is a strong indicator of health system equity.

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[2] Paul Krugman, *Making the Rust Belt Rustier*, N.Y. TIMES (Jan. 27, 2017).

Right now, we're hearing a lot about health **insurance premium increases**, as if we hadn't experienced forty years of premium hikes. We should all know that healthcare expenses have gone up 2.5% higher than the rate of inflation for forty years. Now, the last five years were a period of relative moderation, but the forty-year trend is staggering. And we're shocked that premiums are still going up? So many people in America have no sense of history. I'm not justifying the latest premium increases, but that's been a Republican flashpoint. It's like gas prices at the pump. People don't get angry about the prices of snacks at convenience stores, which is actually how most retail gas establishments make their money. But when it comes to the price at the pump, one or two pennies shifts markets.

Deductible increases. The phrase now is that we have such high deductibles that healthcare is too expensive to use. That's when your deductibles are $5,000 to $10,000. That's really self-pay until you've met your deductible. You have no insurance until you get a catastrophic problem, and then the converse problem happens, and healthcare's problem is it's too cheap, because you're not really paying the bill anymore. It's 90% to 100% free.

Gaps in coverage. That's what's currently in vogue. Obamacare is too expensive. Let's return your freedom of choice so you can get that policy you used to have or the policy that was affordable. Beware: many of those policies had lifetime limits, exclusions, all sorts of things that nobody in their right mind would want to have. The good old days were not as great as some people remember.

What I've only talked about so far are financing issues, and that's great for business school, but what really matters to people is delivery of care. And these are often unspoken issues, at least in the political realm. Medical care itself is the third leading cause of death in America![3] That's from the *British Medical Journal*; some American medical journals say it's the fifth or sixth leading cause of death. Whoa! This is what we are doing to ourselves, folks. This is astonishing. The Institute of Medicine Report "To Err Is Human"[4] came out sixteen years ago claiming one hundred thousand unnecessary deaths in America every year due to preventable medical error. That's like jumbo jets falling out of the sky every week, and we aren't upset about that? In medicine, of course, these are individual, not group, tragedies. (Now, you tend to hear about

[3] Martin A. Makary and Michael Daniel, *Medical Error – The Third Leading Cause of Death in the US*, THE BMJ (May 3, 3016), http://www.bmj.com/content/353/bmj.i2139.
[4] *To Err Is Human: Building A Safer Health System*, INSTITUTE OF MEDICINE (Nov. 2000), https://www.nap.edu/resource/9728/To-Err-is-Human-1999--report-brief.pdf.

VA medical malpractice, because the VA is a public entity. In contrast, private hospitals settle their bad cases.)

Drug price increases. There has been publicity about these, particularly with companies like EpiPen after they raised the price from $100 to $600 of potentially life-saving anaphylactic shock treatment, and moved their corporate headquarters from America to Holland (where by law they cannot sell their product for over $100). And the president of the company is the daughter of a US Senator, Joe Manchin of West Virginia. This is very embarrassing for price-gouging drug companies.

Life expectancy in many rural parts of the country is decreasing for women. Now, part of that decrease is due to behavioral issues, but this isn't progress; this is regress. You have a problem here, too, with the opioid epidemic that is largely the result of prescription drugs. For evidence of this, one of the popular commercials on TV now is for "opioid-induced constipation," because so many of us get constipated due to overdosing on opioids. This is a problem caused by a problem. An additional problem is that antibiotics are failing us due to over-prescription and patient abuse. Finally, doctors don't have time to listen to patients anymore. To me, these health care delivery issues should be much more engaging than finance issues, but you rarely hear about these as much.

Financing really influences delivery. You know that value is defined as price times efficacy. Somehow access to care has become more important in the public mind than the care itself. But the quality of care is super, super important. That's where the value comes from.

Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)[5] is probably the biggest new federal law having to do with value. The Reg just came out this year, and it contains a forest of acronyms.[6]

First, understand why MACRA passed. Congress finally, after ten or fifteen years of fruitless debate, decided to bargain to solve the "doc fix" problem, which is the sustainable growth rate (SGR) problem.[7] The deal was, we had to pass the "doc fix" to keep the docs happy. The price of that was asking the docs to behave. The trouble is that Congress doesn't know how to get doctors to behave.

The Reg is massive, dense. The Reg tries to give doctors 2 to 4 percent more money if they improve their results, if they behave

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[5] Medicare Access and Chip Reauthorization Act of 2015, PL 114-10, 129 Stat 87 (2015).
[6] 81 FED. REG. 77008-01 (Nov. 4, 2016) (codified at 42 C.F.R. § 414 and 42 C.F.R. §495).
[7] Conor Ryan, *Explaining The Medicare Sustainable Growth Rate,* AM. ACTION FORUM (Mar. 26, 2015), https://www.americanactionforum.org/insight/explaining-the-medicare-sustainable-growth-rate/.

in better ways. Now providers want that little bit of extra money, but what people miss in MACRA (and the reason I voted against it), was because this will cost us hundreds of billions, even trillions of dollars. One price tag on this is $4 trillion dollars. All this new federal money goes to one profession, physicians. Why are we doing this? Because Congress years ago established a price/unit equation that, when the volume of procedures increased unreasonably, we would lower the unit price so that doctors' income could remain stable. The intent was not to punish physicians but to not be reward them for huge volume increases. Now, we are rewarding them for the volume increases, and we are paying them extra.

This is not how MACRA was portrayed to the public. It was portrayed that every year we are going to cut doctors reimbursement for Medicare by 24%, or by 23%, or by 28%, and nobody wanted that to happen. Nobody was looking at volume part of the equation, only the unit price. Then, last year when it artificially looked cheaper to do the "doc fix," we fixed the doctors.[8]

This is another massive transfer of wealth in this country that most people are not aware of. In return for as much as $4 trillion we get physicians to practice better, to have better outcomes, to have more teamwork in medicine. We can only enforce that improvement through this MACRA Reg, this bureaucratic rule, which is a lawyer's field day but a nightmare for practitioners.

Financing really owns delivery of care. It's almost taboo to say this because, in Washington, Congress is afraid of doctors. We are afraid of hospitals. We are afraid of anybody who is actually involved in the nitty gritty of care. We will pay them some more money if they promise to behave better, but that's about the extent of our involvement. So what will doctors really have to do to earn their bail out?

My perspective of this is shockingly bipartisan for somebody in Washington because I'm a Blue Dog Democrat, which means I only vote with my party about 80% of the time. That makes me a dangerous radical because almost everybody else in Washington votes for their party about 99% of the time, certainly anybody who is on TV a lot or anybody who advances in party rank. If you aren't loyal, if you aren't reliable, they don't want you around. I try to look at what I'm voting on to decide whether it's good for Tennessee or not, good for America. That approach is considered hopelessly old fashioned.

Essentially, we have lost our Congress today. What we have is parliament. In parliament, people vote for their party. In Congress, you're supposed to vote your conscience and your district. A parliament without a prime minister is a recipe for chaos. Even if we

[8] Louise Radnofsky, *What is the 'Doc Fix'?*, WALL ST. J. BLOG (Mar. 26, 2015) https://blogs.wsj.com/washwire/2015/03/26/what-is-the-doc-fix/.

without the current president, we would have gridlock due to the partisanship in our parliament.

I've offered rival bills to Clintoncare and Obamacare before those presidential proposals were voted on by Congress. I relied on the Jackson Hole Group for these market-based bipartisan approaches. The first one, in the early 1990s, was called Cooper-Breaux.[9] The next one, I was smart enough not to have my name on while I was its marketing director in the House of Representatives. It was called Wyden-Bennett, [10] and it was also completely bipartisan.

You start off with an equal number of Democrats and Republicans on the bill, which is the way every major bill should be in Congress because health care, in particular, shouldn't be a partisan slugfest. The last thing you want to think about when you are sick or injured is politics.

But, during the Obamacare debates, my colleagues on the Democratic side tried belatedly to be bipartisan. They offered some very tempting bait for Republicans. They offered to give them credit for an entire malpractice package. We could have had relief for physicians and other providers if there had been one Republican who was willing to say, "put my name on the bill."

See, the parliamentary aspect, the party-loyalty aspect of Congress, is so severe that Republicans didn't want to give a Democratic president credit for any major victory. One of my favorite phrases is, "Any jackass can kick a barn down. It takes a carpenter to build one." Nobody in Congress wants to be in the carpentry business anymore.

Proof of this was the bipartisan, conservative alternative to Obamacare called Wyden-Bennett. Few business groups in America supported it because it was too difficult for Realtors, the Retail Federation, the National Restaurant Association, etc. to marshal their members behind that plan, or any plan. It was much easier to criticize, and that's another reason why we end up with partisan bills.

Right now, during the "Obamacare repeal and replace" crisis we trying to move to value in health care. Obamacare will be repealed at least in name, but there will be no replacement. Senator Lamar Alexander (R-TN) has said it would take three years to come up with a replacement. Diane Black has said, more optimistically, it

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[9]Also known as the "Managed Competition Plan." *See* Cox News Service, *Rival to Clinton Health Plan Faulted for Insuring Too Fee*, CHICAGO TRIBUNE (May 5, 1994), http://articles.chicagotribune.com/1994-05-05/news/9405050150_1_rep-jim-cooper-health-insurance-clinton-s-plan.

[10] Also known as the "Healthy Americans Act." *See* Edwin Park, *An Examination of the Wyden-Bennett Health Reform Plan*, CTR. ON BUDGET AND POLICY PRIORITIES (Sep. 24, 2008), https://www.cbpp.org/research/an-examination-of-the-wyden-bennett-health-reform-plan.

would take two years. And that is just to come up with plans that Republicans could support, not bipartisan plans.

The shocking thing is, Republicans are already seven years late. Because, if folks like me could produce an alternative for Obamacare, where were they? All the conservative think tanks agree on this. Check out the American Enterprise Institute, a very notable conservative think tank. They published a journal article last year saying it's long overdue for Republicans to have a replacement plan, so where is one?[11]

The Republican Obamacare replacement plan is a list of Band-Aids because that's the only thing they could come up with. Some of these Band-Aids could help. A well-placed Band-Aid could be good: stop bleeding, stop infection.

But Band-Aids are not a comprehensive plan. If you repeal Obamacare, by April of this year insurance companies have to come up with their rates for next year, and they will have no idea what they are going to do without a replacement already passed by Congress. This is amazing. Why is America, the greatest country in the world, in this time crunch? Because when Republicans try to beat something with nothing, which is what they are trying to do by taking down Obamacare with no replacement except a few Band-Aids, that's the dilemma we face.

What are the Band-Aids?

Interstate Insurance. Sounds great, but you know that it's a little more complicated than you think. First off, it's already allowed by Obamacare, but there are few takers. Georgia tried it a little bit. Why are there no takers? Because how would Blue Cross of Tennessee suddenly start selling insurance in Alabama? First of all, Blue Cross of Alabama already owns that market. It's as close to a monopoly as you can find in this country, and you have to develop local networks of providers, doctors and hospitals, who are willing to sign up with Blue Cross of Tennessee. How many of them are going to do that in Alabama and risk the anger of Blue Cross of Alabama? It's like zero.

Interstate sale of insurance might work with car insurance or something like that, and don't forget regulatory capture. I've been in the room a time or two when the insurance industry in Tennessee picked the insurance commissioner. Do you think they picked a real watch-dog with sharp teeth? That's not the way it works. So this is a very poor Band-Aid.

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[11] James C. Capretta, *The GOP Should Provide Health Insurance for All Americans*, AM. ENTER. INST. (Dec. 23, 2016), http://www.aei.org/publication/the-gop-should-provide-health-insurance-for-all-americans/.

State High-Risk Pools. A traditional, conservative solution. That's the way it used to be in most states. Let's go back to the good old days. I hope you read the *Wall Street Journal* on state high-risk pools.[12] They have a graph of what states were doing when state high-risk pools were in full strength before Obamacare had eroded some of them. This slide shows Tennessee, our wonderful state. We had 3,265 enrollees statewide, and we weren't paying for all of that program. Is that a solution? That's like one of the smallest Band-Aids you can find. That basically allows politicians to take some of the worst complainers and say, "Hey get a high-risk policy. By the way, we will subsidize it a little bit."

This last week or two, I have talked to hospital companies, and they've said we could go back to high-risk pools but, to make this program work, we would need thirty-seven billion dollars. No one in Congress is thinking of spending more than a billion or two. That's a big gap between one to two billion and thirty-seven billion dollars. How do you bridge that gap?

Friday, a week ago, we passed the budget for the United States of America for 2017,[13] and that money was not in there. How much money is thirty-seven billion dollars? That is three Mexican walls. Three. So where are we going to find the money? Our own Diane Black is the Chairman of the House Budget Committee. Grover Norquist is not keen on people raising taxes, and other groups don't want to be cut by thirty-seven billion dollars. So, the chances of hospital groups getting a fully funded Band-Aid for high-risk pools approaches zero because the votes have already been cast for the budget for 2017. Now this May, we will vote on the budget for 2018. Maybe there is greater hope for that budget.

Block-Granting Medicaid. Another common trope. It's going to be the answer to all our problems. States love the idea of more state discretion. They can run the program, but remember where most of the money comes from for Medicaid: from the Feds. We have an automatic problem any time the administrator of a program is not paying for it. This is almost a complete disconnect, and it got worse in the later stages of Obamacare when Medicaid expansion was 90% paid-for by the federal government.

Republicans tend to hate Medicaid because it's not benefitting their supporters. It's welfare. Doctors hate it because of low reimbursement, although reimbursement is higher here in Tennessee. There are many instances in which TennCare pays our providers well, way better than in some other states.

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[12] Drew Altman, *High-Risk Pools as Fallback for High-Cost Patients Require New Rules*, WALL ST. J. (Jan 23, 2017).
[13] Office of Mgmt. and Budget, *2017 United States Budget Estimate*, INSIDE GOV (2017), http://federal-budget.insidegov.com/l/120/2017-Estimate.

What will block granting do? Republican governors are getting smarter, like Governor Scott of Florida, like John Kasich of Ohio, like Governor Hutchinson from Arkansas, realizing that, in return for short-term discretion, they are going to have real fiscal problems going forward because Congress is not going to adjust Medicaid spending with healthcare inflation, which is inflation plus 2.5%. They're going to be squeezed. More and more governors are saying, "Hey, that's not a good deal for us."

What we need to do is fundamentally restructure Medicaid so there's not this gamesmanship with the FMAP. States are pretending to pay for programing but really coming up with state dollars, only recycling federal dollars. During the questioning of Tom Price for his confirmation hearing, a new U.S. senator named Kennedy from Louisiana raised a related question. The senator stated that it's not in the interest of states to prosecute Medicaid fraud because they wouldn't be saving their own money. They would mainly be helping the federal government save its money, so why do it? That was an amazing question. Even fraud prosecution is hurt when you have state-level gamesmanship.

Gaps in Insurance Coverage. That's what a lot of people are talking about now. Let's go ahead and let people buy defective insurance policies. Is that a good idea? Well, it's true that Obamacare benefits are expensive. Why are they expensive? Because, in most states, they tried to rely on the private sector to determine policy benefit levels. Now, you could reduce the number of state-level mandates because many providers groups have gotten legislatures to require acupuncture or free wigs or whatever, and it probably shouldn't have been done. There are thousands of such mandates spread out across states. So we could curb those, but I don't think anybody wants to return to lifetime limits on policies or get rid of preexisting conditions or coverage of adult children.

This **community rating** issue is a little trickier. Obamacare allows 64 year-olds to be charged as much as three times more than 21 year-old, a three-to-one ratio.[14] Many Republicans want to move that ratio to increase to five-to-one. Will that really help? I really hope we have more intergenerational equity in this country so that we realize that Grandma is still part of our family, and the young people are not immortal (as sometimes they believe). Having fairer pricing on health insurance is very important.

We probably need to keep the **individual mandate** to make any of this work, and that sounds like preserving a Democratic idea, but where did Obamacare get the idea? It is a conservative idea from Romneycare, and from the Heritage Foundation and the American Enterprise Institute. It's all about individual responsibility. How are

[14] Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 (2010).

Republicans able to do a 180-U-turn on this topic, to abandon their own principles? A headline in the *New York Times* today is "Republicans abandoning their prior philosophy to accommodate the new administration."[15] You want to be flexible in life but you don't want to be unprincipled.

I hear folks champion **health savings accounts**, and they are great, especially for high-income people, but that is a tax break; that is not insurance. That is really self-pay, and we probably need more of that because someone has to ration care, and it's not popular to mention the "R" word. The only question is whether you are self-rationing or somebody else does it. We hate other people doing it, so we prefer that we do it ourselves. What happens with health savings accounts and high deductibles? People skimp on necessary care and then they overconsume, once the deductible has been met. Can't we be smarter than that? There's got to be a better way. The deductible is not only poorly understood by regular people, it's such a primitive rationing device.

This is something I came up with years ago. It explains our conundrum of cost, quality, access. You can have two but not three, and it's a perpetual problem. Well, why is this a trilemma? Because the main players in this debate refuse to understand each other. The main players are the physicians, patients, and businesses.

Physicians are motivated by the Hippocratic Oath, and the bottom line for them is, they will try anything that is not harming the patient. Treatments cannot be too extravagant if the patient benefits, because they aren't worried about who's paying the bill. Most doctors have no idea. My wife was prescribed a very simple cholesterol control medicine the other day. One little bottle of pills was $700. The doctor never told us that. The generic was $10. That's a big difference.

Patients, we have a natural survival instinct, but we really only pay attention to that copay or deductible because that's the only part that we see when we are paying the bills.

Only the business tries to do the economic or rational thing, which is optimize marginal cost and marginal benefit, because they look at the whole premium. But we don't listen to business in many health care debates. Therefore, it's like three ships passing in the night. How can we help our physician friends and our patient friends and our business friends to all get on the same page here because we are all talking about the same thing? It's like the blind men and an elephant. One touches a wall, one a snake, one a tree. They are all touching an elephant. We've got to realize we are all touching the elephant here.

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[15] Jennifer Steinhauer, *Republicans Now Marching With Trump on Ideas They Had Opposed*, NEW YORK TIMES (Jan. 26, 2017).

To me, this is the way things are working. The fee-for-service world still largely dominates the South. I was talking to a Vanderbilt Founder's Medalist, a brain surgeon, brilliant person, who chose to practice in a small Georgia town. I asked him why. He said well, he wanted to be the last place in America affected by managed care. Congratulations. You can't hide from economics. You can't hide from the future. And you shouldn't bury your talents in a town where they can't be fully utilized. When we move from the fee-for-service world, we have two basic choices: more personal responsibility or more provider responsibility.

Personal responsibility means either consumer-driven health plans with high deductibles. Provider responsibility involves getting providers to bear more risk? It's one thing they are so reluctant to do. Providers are the natural bearers of risk. They are the ones trying to sell a service, and if you're selling something that's too expensive, usually you offer vendor financing. But our providers haven't been organized enough to offer vendor financing, so insurance companies came in and became middle-men.

Authors like David Goldhill—a reformer from the right, not from the left—wants to put health insurance companies out of business. Instead of helping the market, he thinks they perpetuate healthcare inflation. They are not shoppers in patients' best interests. Now, it's considered unpatriotic to criticize something from the private sector, but how are these even private-sector firms when they benefit from the third largest health program in America at a cost to you of $250 billion a year in tax breaks? These are heavily subsidized private health insurance companies, if they are even still private. Blue Cross, in addition, gets its own explicit subsidy in the tax code, and yet they are private? Give me a break. They are more like public utilities than private entities.

The goal is to get somehow through consumer-driven health plans to some other risk bearing entity to wellness, because that's what we all want. I think what we really want is not just value-based care because, see, that is not completely consumer-oriented. What we want is patient satisfaction. What you want in any industry is a happy customer. With Wal-Mart, it is "everyday low prices" on stuff that you want to buy, not what Wal-Mart wants you to buy. It's not complicated. Where are the "everyday low prices" in medicine?

So often, we conflate higher prices with higher value because we don't have an easy metric. This is sometimes called perfume pricing. How do you sell more perfume? You raise the price. It might not smell good, but at least it smells expensive. You don't want cheap stuff. This is sometimes how silly people are when it comes to making individual choices.

These are just a few thoughts. Hopefully, it provoked some of your thinking. I will be happy to try to answer any questions you have. Thank-you for letting me be here today.