TESTIMONY
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Chairman Neal, Ranking Member Brady, and distinguished members of the Committee. Thank you very much for the opportunity to share my thoughts this morning.

My name is Donald Berwick. I am a pediatrician by training, and the founding CEO and now Senior Fellow at the Institute for Healthcare Improvement – a global non-profit whose mission is to help improve the quality of health care worldwide. I am on the health care policy faculty of Harvard Medical School. Most relevant to this testimony, I served as Administrator of the Centers for Medicare and Medicaid Services from July, 2010, to December, 2011. I was a recess appointee of President Obama's, and had to leave that post due to Constitutional limits on the duration of a recess appointment, since the Senate did not move my nomination to confirmation hearings.

Serving as CMS Administrator was the greatest privilege of my professional career. Every day, I got to show up for work to protect and advance the health and interests of over 100 million Americans, including some of our most vulnerable people, while protecting, as well, the integrity and sustainability of Medicare, Medicaid, and the Children's Health Insurance Program. My duties additionally included helping to implement the coverage expansions, quality improvement, and program integrity provisions of the Affordable Care Act, which was passed three months before my arrival. CMS was charged by statute to implement about 70% of the provisions of the ACA.

In effect, I had the honor to help lead "Medicare for Some," and the successes and potential of that program have given me confidence that a wise choice for this nation would be Medicare for All.

The reason for that is not that Medicare for All is somehow a morally righteous or inherently correct idea. It is, after all, not a goal – it is a mechanism to achieve goals. And, like all mechanisms, its value lies completely in whether or not it supports the improvements that we, all together, want to achieve for our nation.

Any proposal for health care reform in this nation should be interrogated with respect to our goals. I propose that four goals, in particular, should be our guides in that interrogation.

The first three goals I have long summarized as the so-called "Triple Aim," which was first articulated by my colleagues, Dr. John Whittington, of Peoria, Illinois, and the recently deceased Dr. Tom Nolan, a protégée of the famous quality scholar, Dr. W. Edwards Deming.[1] The "Triple Aim" refers to the three primary goals of the health and heath care system: first, to improve the health care of individuals; second, to improve the health of populations; and, third, to continually reduce costs through the reduction of waste and non-value-added activities – that is, to make sure that every dollar spent adds value to the lives of the people we serve. As Administrator of CMS, I centered that Agency's strategies on the Triple Aim, as any employee who was there at the time will tell you.

We have a long way to go to achieve the Triple Aim in American health and care. We know from hundreds, if not thousands, of disciplined research studies, including landmark reports from the National Academies of Sciences, Engineering, and Medicine,[2] [3] that, notwithstanding the miraculous technical progress we have made against many diseases and health burdens, individual health care – Aim Number One – still suffers from pervasive, major problems in patient safety, in failures to use scientifically effective care, in overuse of ineffective or incorrect care, in lack of patient-centeredness, in dropped balls for people with chronic illness, and in unwarranted delays.

With respect to Aim Number Two – better health for populations – we remain seriously underinvested in prevention and in addressing the underlying social determinants of illness, such as poor nutrition, physical inactivity, housing instability, inadequate local transportation, environmental threats, violence, and the continuing effects of structural racism and poverty. The United States ranks 56$^{th}$ in the world in infant mortality and 43$^{rd}$ in life expectancy.[4] Other nations spend on average two dollars on addressing social determinants of illness for every dollar they spend on health care; our nation spends less than half as much, just 90 cents on these actual causes, for every dollar we spend on care. In effect, we generously support a massive, three trillion dollar repair shop for injuries and diseases – our health care system – without addressing at all sufficiently upstream the causes of those injuries and diseases. As a result, we are always playing "catch-up" at higher cost and lower effectiveness than prevention would allow.

Our reactive, fragmented system has perpetuated severe racial, socio-economic, and ethnic disparities that many other nations will not tolerate. Hispanics and Blacks have higher rates of obesity and death due to diabetes than Whites; but they are more likely to forgo necessary care because of cost or barriers to access, and they are less likely to have a regular source of care other than the emergency room.[5] Inadequate coverage and a segregated delivery system impact outcome measures across the population. The infant mortality rate among Black babies is over double that of Whites.[6] In 2014, among individuals with a diagnosis of HIV, the death rate among Black individuals was eight times higher

than that in White individuals.[7] Black and American Indian and Alaska Native women are three times more likely to die from a pregnancy-related cause than are White women.[8]

With regard to Aim Number Three – reducing per capita costs by reducing waste – we lag way, way behind other nations. As you all know well by now, we spend just about twice as much per capita on health care as any other high-income nation, and yet in a recent comparison among 10 high-income countries, not one of which spends per capita as much as 70% of what we spend, the US ranks worst in life expectancy, infant mortality, maternal mortality, and obesity rates.[9] At least three major scientific reports of the last decade have estimated that 30% to 35% of America's entire, three trillion dollar health care bill, represents waste, not effective care.[10] We waste through arcane and complex administrative processes and paperwork; we waste through poor care coordination and errors in care; we waste through overuse of scientifically incorrect care; we waste through indefensible, opaque, non-competitive pricing of drugs, devices, procedures, and tests; and we waste through fraud and abuse by a small, but very damaging, minority of care providers.

That is our troubling scorecard on the Triple Aim – we are often very far from excellence in better care for individuals, better health for populations, and lower per capita costs through reducing waste and focusing on what truly helps. But there is also a fourth, indeed, overarching aim for our health care policy; it is, in fact, a precondition to the Triple Aim. That aim is Universal Coverage – leaving no one out. It is an embarrassing paradox that our nation – the wealthiest on earth, and spending by far the most on health care – has not yet made health care a human right. Even after the immense gains under the Affordable Care Act, we still leave almost 30 million Americans without health insurance. According to the Kaiser Family Foundation, 22% of Native American, 19% of Hispanic, 11% of Black, and 7% of White individuals still lack health insurance.[11]

No other western nation does that. None. We are alone. Indeed, Article 25 of the United Nations Universal Declaration of Human Rights, written over seven decades ago, explicitly lists medical care as a fundamental right.[12]

Yet I have many friends and colleagues who say that declaring health care to be a human right – leaving no one out – is somehow not feasible or somehow unwise for our nation. I simply do not understand that point of view. It seems to me wrong, immoral. It is also economically unwise, because the downstream effects of lack of health insurance coverage are well known, well documented, harmful to people, and costly to communities.

It seems to me that a nation founded on an "inalienable right to life, liberty, and the pursuit of happiness" ought to promise itself the right to those forms of social policy and cohesion, including health care, that make life, liberty, and the pursuit of happiness possible. We promise elementary and secondary education; we

promise clean water and clean air; we promise public safety and first responders; we promise due process in our courts. Why not promise health care?

And so, this is my recommendation for the questions we should ask about any major proposal for American health care reform: Will it advance the causes of better care for individuals, better health for populations, lower per capita costs through reducing waste, and leaving no one out?

And so, through that lens, let me take a moment to describe some of the work of the Administrator of Medicare for Some – examples from my own work as Administrator of CMS. What does the job of leading CMS have to do with progress toward the Triple Aim and Universal Coverage?

One of the four is easy: universality. By its design, Medicare leaves just about no one out who qualifies by age. In this crazy debate about whether or not health care is a human right in our nation, we have already made a choice – way back in 1965 – that it is a right, for some of us. And the result has been an entirely feasible, immensely popular form of governmentally sponsored, guaranteed health insurance for a crucial subpopulation. CMS stands as protector of that right, and my work as Administrator included continual surveillance for violations of access to care to which Medicare beneficiaries are, by law, entitled.

What about better care for individuals? In May, 2011, I received a superb report from the HHS Inspector General, Dan Levinson, documenting widespread overuse of antipsychotic medications in American nursing homes, resulting in over-sedation – essentially chemical restraints – for hundreds of thousands of nursing home patients.[13] This report had special meaning for me, since I had watched my own father, for 50 years a physician in a small Connecticut town, get over-sedated in a nursing home, leading to a severe pressure ulcer and weeks of disorientation. Within days of receiving Dan's report, I invited to my office for a meeting leaders from the nursing home industry, geriatricians, geriatric nurses, and others. They came – after all, Medicaid pays for half of the nursing home care in the nation – and, showing them the IG report, I said, "Please… this is unacceptable. Either you fix it, or we shall take further steps to do so." I recall that within a month of that meeting, the nursing home associations had produced strategic plans for reducing over-sedation. In cooperation with the industry, CMS organized in March of 2012, the National Partnership to Improve Dementia Care in Nursing Homes, including a focus on reducing over-sedation. By 2016, overuse of sedation had fallen by 33% and progress continues to this day.[14] I note that Chairman Neal has recently called attention to the need for further progress, but it is no accident that he directs that call to CMS, because he knows that CMS, and CMS alone among payers, can get that job done. No private insurer could have or would have taken such action.

Here is another example of pursuing better care. Patient safety has been a serious concern among quality scholars for decades, coming to a head with the

publication in 1999 of the Institute of Medicine report, *To Err Is Human*, which estimated that 44,000 to 98,000 Americans died each year in hospitals due to errors in their care. Progress has been steady since, but very slow. In April, 2011, under the aegis of the Center for Medicare and Medicaid Innovation – CMMI – which was created by the Affordable Care Act, we launched the Partnership for Patients, the largest patient safety improvement project in history in any nation to help hospitals reduce a range of avoidable complications and to improve coordination of care for discharged patients and thereby reduce hospital readmissions.[15] This program invested one billion dollars in improving patient safety, and linked progress to rewards and penalties for hospital quality also authorized under the ACA. Over 4000 hospitals participated in the program. As of 2017, the Partnership for Patients was estimated to have saved over 125,000 lives, prevented over three million infections and injuries in hospitals, and reduced costs by over $26 billion – an immense return on a $1 billion investment. That program and that progress continue to this day. No private insurer could have or would have organized such an effort at that scale. In our nation, CMS, and CMS alone among payers, could do that.

In its history, CMS has been perhaps the most important single force for organizing, resourcing, and incentivizing improvements in individual patient care in the nation.

What about better health for populations? As you know, Title 18 and 19 did not primarily establish Medicare and Medicaid for prevention; they began as hospital-focused programs. But, over the years, their effects on preventive practice, and even more recently, on addressing the social determinants of illness, have grown. The ACA authorized first-dollar coverage never before offered for clinical preventive services of proven benefit, and I got to oversee the issuing of regulations that now give tens of millions of elders access to such prevention, including an annual wellness visit. CMS started those innovations; private insurers did not. They followed. CMS, and CMS alone among payers, could change those norms for coverage.

When I was Administrator, the Director of the Centers for Disease Control and Prevention (CDC), Dr. Tom Frieden, and I organized a joint project that we called the “Million Hearts Campaign,” to reduce heart attacks and strokes by advancing a few proven preventive measures throughout the nation. That program continues on now.[16] No private insurer could have or would have organized such a national program.

Think for a moment of the possibilities this would offer to intercept the vicious opioid epidemic sweeping our nation. No commercial insurer can or would take on stopping that epidemic as a central strategic imperative. Medicare for All could.

Note that one reason that commercial insurers do not generally invest significantly in addressing prevention and social determinants of health is their time frame. Churn, as people migrate through their lives from one insurer to another, or even to uninsured status, means than an insurer who invests in preventing heart attacks or strokes may never see any financial return; the beneficiaries will have moved on to other coverage. Medicare does not face that barrier. From the time of a beneficiary's enrollment, CMS and the beneficiary become lifelong partners.

A universal Medicare for All program could help advance health equity, in part by providing targeted support to physicians and hospitals serving vulnerable or impoverished patients. It could offer trainees incentives to enter critical fields of medicine, such as primary care, and to work in underserved areas. Arguably, Medicare for All is the nation's best option for the protection and improvement of our public's health.

The third part of the Triple Aim is reducing per capita costs through reducing waste and non-value-added expenditures. As a price-setter, Medicare can and does address cost directly, through trying to set reasonable payment levels, and, when it is allowed to do so, through competitive bidding.

Here is such an example. In the Medicare Modernization Act of 2003 (MMA), Congress mandated that CMS conduct a competitive bidding experiment for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) following an earlier successful pilot. In 2011, despite heavy opposition from the industry and some members of Congress, CMS implemented DMEPOS competitive bidding in nine metropolitan areas. Based on the bids at the time, the agency estimated that the program would save nearly $26 billion over 10 years, 2013-2022, once fully phased-in across the US. Beneficiaries would save an additional $17 billion in lower copayments and premiums. (Unfortunately, this Administration has permitted this program to sunset. While CMS has announced that new competitively-bid contracts will become effective January 1, 2021, the future of the program remains uncertain. In the meantime, taxpayers and beneficiaries pay more than they should for routine items and supplies.)

That is just one example of how CMS can be a force for reducing costs in ways that help beneficiaries. The potential levers are many. Broadly, I can see at least four ways in which Medicare for All would reduce health care costs, just as the current Medicare program often does.

First, by simplifying the administrative procedures and paperwork that are plaguing our clinicians, hospitals, and patients. I would estimate that CMS administers Medicare with overhead costs of about 2% or 3% of the total. (The actual administrative budget when I served was about 1% of the total, but I am giving allowance for costs in other government agencies, like the IRS and Social Security Administration, plus billing processes in the delivery system.) As you

know well, the ACA seeks to limit commercial insurance overhead to 15% - over five times as much as CMS overhead.

Streamlining payment offers vast cost savings. Under the simplifications of Medicare for All, providers of care would face just one set of billing rules and processes, greatly reducing operating costs. Research demonstrates that in the US, hospitals spend over 25% of total expenditures on administration, compared to 12.5% and 15.5% across hospitals in Canada and England, respectively.[17] A survey from 2009 revealed that the average physician in a practice spent almost $70,000 per year in time interacting with health insurers.[18] This not only inflates prices, but also affects the quality and supply of care and the morale of clinicians; evidence suggests that providers most burdened by administrative work (such as primary care physicians) are more prone to burnout and less likely to continue clinical practice.[19]

Second, by using price-setting authority and negotiation as a large-volume purchaser of supplies, drugs, and services. Medicare's heft today as an administrative price-setter places a burden on its shoulders to exercise that authority prudently, balancing interests always: the sustainability of the Trust Fund, the defense of the public purse, the out-of-pocket costs for beneficiaries, and the financial vitality of the people and organizations that provide care. The same would be true of an expanded Medicare program. In addition, Medicare, more than any other payer, can accelerate progress toward value-based payment and away from volume-driven payment.

I think that it is essential for hospitals to have incomes sufficient for their sustainability, but, in this regard, it must be noted that some hospitals and other providers are engaging today in unconscionable pricing practices in the non-Medicare sector, charging as much as 400% of Medicare rates in some markets.[20] There really is no justification for these rates, and one strong argument for Medicare for All would be its capacity to insist on fairer pricing that will force attention toward greater efficiencies and reforms at the delivery system level. This is not an agenda that the current commercial sector insurers are generally able or willing to undertake.

Third, by energetically pursuing and supporting improvements in the quality of care. A concerted national agenda to reduce patient injuries and complications, to increase use of evidence-based clinical care, to reduce overuse of incorrect care (like excessive antibiotic use and unwarranted testing), to give more control to patients over the care decisions that affect them, and to help people with chronic illnesses to stay where they want to be – at home and in their communities – would all reduce total health care expenditures, while improving outcomes for patients and families.

Fourth, by allowing for investments in reducing upstream causes of illness and disability. A Medicare for All system would at long last help our nation to invest in

community-based resources and social care services that can reduce dependency on high-tech, high-cost care by helping people stay well and at home. It would also allow for a long-overdue national effort to reduce the large racial and socio-economic disparities in health that continue in our nation. Absent a Medicare for All system of payment, I simply do not see the mechanisms or will to rebalance our investments toward health and wellbeing, and to end the tragic health inequities that our nation continues to tolerate. Today's opioid epidemic, rising maternal mortality rates, and what the economists Angus Deaton and Anne Case term "deaths of despair"[21] are all national burdens that call out for national leadership. A Medicare for All system would give our country a mechanism for setting such priorities and acting on them, all together.

If anyone can show me a payment model that beats Medicare for All in achieving the Triple Aim and universal coverage, I am all ears. But I have as yet seen none. And the nation's experience with Medicare for Some – as it exists now, and as endorsed by the overwhelming popularity of Medicare in our nation – suggests that we may, indeed, already have an answer in our hands.

I do not wish to minimize or disregard the many obstacles and objections to Medicare for All as a pathway for our nation. But, whereas some others find the obstacles to be insurmountable, I do not. I believe that we have the wits, experience, wealth, and agility to overcome every one, as we have for Medicare as we know it today. To be specific, here are some of the objections:

- That Medicare for All is unaffordable. I think the opposite may be true; that is, without Medicare for All, health care in our nation may be bound to head, as it is now heading, for true unaffordability. Medicare for All is a positive way out. As I noted above, the level of waste in our health care system is enormous. A publicly accountable, transparent, and mission-oriented payer would offer us as a nation leverage against wasteful health care expenditures that is not achievable in the current, chaotic payment environment.

- That Medicare for All is a governmental takeover of health care. It is not. Not one single bill that I know of proposes under any form of expanded governmental coverage that government should become the provider of health care for all Americans. Medicare for All is about paying for care – consolidating payment in a public program. It is not about providing care. Care provision, through today's array of hospitals, clinicians, nursing homes, and so on, would remain as it is – largely private sector and entrepreneurial.

- That Medicare for All would severely underpay hospitals and clinicians. That would be neither wise nor inevitable. When government becomes the payer for any good or service, and is subject to oversight from

Congress, it is and should be held accountable for responsible practices. That is how Medicare works today; and it is how Medicare for All should and would work in the future.

- That Medicare for All implies a financially unrealistic package of health care services. Any insurer – government or commercial – has to end up implementing a defined benefit package, and the content and comprehensiveness of that coverage will always be subject to debate and negotiation. What Medicare for All does do is to move that dialogue into daylight, as we can consider as a nation what we wish to include in universal coverage and what not. That is exactly what happened, for example, when the ACA extended coverage for clinical prevention services, and when Congress took steps toward assuring mental health care parity. The current commercial insurance system does the same – deciding what is and is not covered – but it does that largely out of sight and without any real form of pubic accountability.

- That Medicare for All would unacceptably disrupt people's current relationships with their health care insurers. Indeed, Medicare for All would give every American not now covered by Medicare a new insurer – a public insurer. Whether this threat to existing bonds between people and commercial insurers in fact troubles Americans I find doubtful. I suspect that what most Americans value is their bond with clinicians, not with insurers.

- That the tax increases implied by Medicare for All are massive. This represents a negative framing of a positive result. Yes, indeed, the fund flows for health care under Medicare for All would become public, as opposed to the private payment now channeled through payroll check deductions and employer contributions to commercial health insurance. These are existing fees – "taxes" really – through private channels. What the American worker cares most about financially is how much he or she takes home at the end of the day. Under Medicare for All, properly designed, that amount – take home pay – goes up, not down.

I end where I began: Medicare for All is not an end in itself. It is a means to achieve what we care about: better care, better health, lower cost, and leaving no one out. I am open to considering any proposal that moves our nation fast and well toward those goals. Compared with Medicare for All, I see none better.

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