

quality of health care services so that patients can become informed consumers.

Although the impact of this approach is unknown, we believe that cost savings are likely to be limited by the medical needs of the 10% of people who account for 70% of costs. These patients tend to exceed their financial liabilities associated with these products quickly, and their ability and willingness to behave like shoppers who can make trade-offs in cost and quality are uncertain at best. In addition, these insurance products have thus far proved unpopular with employees despite their lower effect on their paychecks, and enrollment to date has been low.

On the political left, advocates of the single-payer approach argue that elimination of the employer-based commercial insurance system would dramatically reduce administrative costs. Despite the large savings that would result, political support for this approach is currently limited. The strongest resistance to the single-payer approach comes from the commercial insurance industry, but providers worry that this approach would extend the lower reimbursement structure of Medicare and Medicaid to all patients, and these payments would not increase fast enough to cover increasing provider costs. Thus, for the time being at least, the development of a broad coalition around a single-payer system is unlikely. There is, however, widespread interest in reducing administrative costs by pursuing standardization of the claims-payment systems of U.S. private insurers (e.g., through adoption of a universal billing form).

#### LOWEST POTENTIAL FOR COST SAVINGS

Two familiar targets for cost reduction are malpractice and drug-pricing reform, but the potential savings from these approaches are probably small. Although the current malpractice system is an inefficient way to protect patients from negligent care, the direct costs of malpractice premiums and estimated costs of "defensive medicine" are not major factors in overall health care spending. In any case, political support for malpractice reform is partisan and weak because of the resistance to major changes on the part of plaintiffs' lawyers.

Costs can be reduced through more restrictive drug formularies and tougher price negotiations, but the savings are modest because pharmaceuticals account for just 10 to 15% of health care spending. The political appetite for tight government control of drug pricing is also limited by concerns about its effect on the development of new drugs.

Enhanced primary prevention efforts (e.g., programs to reduce smoking, alcohol abuse, or obesity) have strong bipartisan support, and they would lead to important general health benefits. This approach makes particular sense for employers, who can enhance the health of their workforce, and also delay the onset of serious illness among their employees by many years, at which point most costs would be absorbed by Medicare.

However, candidates would be ill-advised to believe they can fund broader access to health care through savings derived from primary prevention. Prevention is more likely to delay than to eliminate long-term societal costs, because longer life spans mean more years of health care adding to overall costs. Controversy persists regarding whether improved care can lead to significant savings through a "compression of morbidity"—that is, longer and healthier lives with a relatively quick, low-cost period of illness just before death. Regardless of what the right answer is, savings from increased primary prevention will not be substantial in the near term.

#### RATIONING OPTIONS

Should other options fail to provide sufficient cost reductions, policymakers may be forced to consider various forms of rationing, including two types that have been proposed from different ends of the political spectrum. From the left comes the proposal for fixed, all-payer budget ceilings for health expenditures, such as those that are used in Canada and some European countries with multiple payers. The U.S. experiment with this approach is the Medicare funding policy that requires decreases in payments to physicians when overall spending increases.

Although there would certainly be considerable savings from this approach, inflation in health care spending in countries that use it does not lag far behind ours because of the constant political pressure to increase spending for essential services. Administration of these budgets would require a large government role, and such a strong government regulatory role is not likely to gain consensus in the U.S. culture.

From the right come proposals for indirect rationing by limiting Medicare and Medicaid payment for new or "discretionary" services. This approach would have Medicare evolve to provide a defined contribution toward the health care costs of the U.S. elderly instead of defined benefits. Under this framework, patients who are able to pay for the services that are not covered would do so with their own money, and patients who are unable to pay would go without. We think such a dramatic and visible increase in the two-class nature of our health system is too obviously inconsistent with our core values to be politically viable.

#### DISCUSSION

We see three paths toward controlling health care costs. First, we could allow the current situation to persist. Consequences would almost certainly include increased taxation and financial burdens on individual patients and businesses, greater competition for scarce governmental resources, and a continued increase in the number of uninsured Americans. The alternative extreme would move our country toward one of the indirect rationing methods described above. This path would be practical only as a last resort. The third path would be to assemble the most reasonable package, short of rationing, using a combination of the other ideas mentioned above, and to try to bend the trend line in increasing health care costs.

While recognizing that the many stakeholders in health care will have different preferences, we suggest the following. First, modify reimbursement with the explicit goal of rewarding the practice of evidence-based medicine, reductions in variance among physicians in the use of services, and improvement in the care of patients with chronic conditions. We recommend consideration of blended arrangements including pay-for-performance programs, case rates, and even adequately funded and appropriately risk-adjusted capitation.

Second, invest in new effectiveness-review bodies. These groups would inform decisions regarding the coverage for and use of health care tests and treatments in the future.

Third, maximize support for electronic medical records with computerized decision support, recognizing that this will involve considerable national investment and cultural change. Such support can come in the form of higher reimbursement for physicians who have adopted electronic records or grants from hospitals, payers, or government to provide support for their implementation.

Fourth, enhance the standardization of health care transactions in order to drive down administrative costs. Fifth, provide

support for regional efforts to improve the quality of care at the end of life. Finally, provide support for prevention programs, not because they save money, but because they lead to a better quality of life and a more productive workforce.

We recognize that many ideas for cost containment are not addressed here and that there are many potential cost-containment packages besides our approach. Our intent has been to set out a framework for considering various proposals. To deal successfully with this important issue, we must move away from clichés that fit our own political beliefs and grapple seriously with the true effectiveness and the political reality of each of these ideas. We need a real and honest dialogue on this issue—particularly in a presidential election year.

#### NATIONAL ALCOHOL AWARENESS MONTH

Mr. JOHNSON. Madam President, today I rise to recognize April as National Alcohol Awareness Month. We must all remain aware that alcohol is a drug that can pose serious health and well-being risks if used improperly. From underage drinking to drunk driving to alcohol addiction, this substance can have catastrophic and long-reaching effects on the lives of Americans.

I wish to take the opportunity in a month dedicated to alcohol awareness to promote awareness of a devastating alcohol-related condition. Fetal alcohol spectrum disorders, FASD, is an umbrella term describing the varied range of alcohol-related birth defects that may result from the use of alcohol during pregnancy. The effects of this disorder may be mental, behavioral, and/or involve learning disabilities. FASD is the leading known cause of preventable cognitive impairment in America. It is estimated FASD affects 1 in 100 live births each year.

We must move past the stigma of this devastating disease to truly help those and their families who are affected by FASD get the health, education, counseling and support services they need and deserve. We must also address the tragedy of FASD at the source, by increasing awareness that any amount of alcohol during pregnancy can have heartbreaking, lifelong effects, and by ensuring this is understood by all women of child-bearing age and by providing treatment and counseling services for these women.

Earlier this year, several of my colleagues and I reintroduced legislation to address FASD issues within families, at schools, in health care centers, in our legal system, and at its source. In addition to supporting those living with FASD and their families, this bill works to educate our health practitioners, educators and members of our judicial system to recognize the special needs of these individuals. While we increase awareness of the effects alcohol can have on individuals and their families, increasing FASD awareness must also be included to advance the fight against these damaging disorders.