



To: House Committee on Ways and Means, Health Subcommittee  
Re: **Hearing on Preserving and Strengthening Medicare, March 16, 2016**  
**Follow-up Questions for the Record**

I appreciate the opportunity to answer these additional questions from the Committee Members.

***From Representative Black of Tennessee:***

1. *Over the next 75 years, it is estimated that Medicare's HI Trust fund will encounter unfunded liabilities totaling some \$3 trillion (The SMI unfunded liability is \$24.8 trillion, for a total unfunded liability of \$27.8 trillion). The Trustees suggest that a decrease in expenditure of 15% would allow this shortfall to be closed. **Question:** What ideas do you have for achieving this 15% reduction? How do you balance the need to make these reductions in Medicare spending while preserving access and quality of care?*

Moving away from fee-for-service Medicare towards programs and payments that reward value – such as Medicare Advantage, premium support, or other risk-bearing entities – is an avenue for slowing the growth of low-value health care spending while ensuring that all beneficiaries continue to have access to innovative, high-value care.

2. *As life expectancy increases, people will receive Medicare benefits for longer amounts of time, causing benefits to be a larger share of lifetime earnings for later populations. The reigning assumption has always been that these later generations would also pay more in payroll taxes, because real earnings generally grow overtime. However, real wages have barely increased over the past 5 years, if not for longer. **Question:** Given the fact that younger generations will not be paying as much as anticipated into the system, while drawing much more out of it, how is the HI Trust Fund impacted, and can we further state that Medicare's solvency can be improved by jump starting wage growth?*

Medicare solvency will always been improved when the taxable wage base is larger relative to aggregate promised benefits. The wage base could be expanded through longer working lives, higher earnings, or higher tax rates. Fiscal balance could also be restored by reducing spending, such as though payment reforms described above.

***From Representative Price of Georgia:***

1. **Question:** *CMS has stated their goal is to “make unprecedented improvements to the program for plans that provide high quality care to the most vulnerable enrollees.” How do significant reductions in payment for the chronically ill improve the Medicare Advantage Program and improve care provided to our sickest and most vulnerable members? Can you*

*speculate as to the clinical rationale of reducing payments to chronically ill? Are you aware of the clinical studies were relied upon by CMS in making this determination?*

I am not familiar with CMS's rationale or the studies upon which they relied. I believe that a well-functioning Medicare program would use carefully risk-adjusted payments to make sure that there is no disincentive to enroll sicker populations, and that adequate funds are available to provide them with the high-quality care that they need.

2. **Question:** *Currently, hospital outpatient departments are allowed to bill patients at a higher rate than freestanding community based physician offices. What are your thoughts on how this payment disparity has affected consolidation in the healthcare marketplace? Last November, Congress passed site neutral Medicare payment policies for any off-campus HOPDs that were acquired or built after Nov 2, 2015 which is estimated to save approximately \$9 billion over 10 years. Do you think expanding this policy to all off-campus outpatient facilities would be beneficial to Medicare's long term solvency? Do you think that Medicare or beneficiaries should be paying more for the same services at facilities that were purchased or built before the November 2, 2015 enactment date? There has been an effort by some to exempt or carve out certain HOPD facilities from the site neutral payment provision included in the Bipartisan Budget Act – what is your response to that?*

I believe that payment schedules that drive patients to higher-cost sites of care or promote otherwise inefficient market consolidation or organization are harmful to the financial sustainability of the Medicare program and to beneficiaries' ongoing access to high-quality, affordable care. The principle of site-neutral payments is that patients (and the Medicare program) should not pay more for equally appropriate and equally high-quality care just because it is delivered in one type of location vs. another. There are certainly challenges to applying this principle across settings (for example, emergency departments may cost more because of necessary stand-by capacity), but I believe that it should be applied more broadly than it is now.

Sincerely,



Katherine Baicker

## Questions for the Record: Hearing on Preserving and Strengthening Medicare

*From Representative Black of Tennessee:*

1. Over the next 75 years, it is estimated that Medicare's HI Trust fund will encounter unfunded liabilities totaling some \$3 trillion (The SMI unfunded liability is \$24.8 trillion, for a total unfunded liability of \$27.8 trillion). The Trustees suggest that a decrease in expenditure of 15% would allow this shortfall to be closed.

**Question:** What ideas do you have for achieving this 15% reduction? How do you balance the need to make these reductions in Medicare spending while preserving access and quality of care? [Invites discussion of Premium Support.]

**Response (Stuart Guterman):** There are essentially three approaches to reducing Medicare spending: one involves reducing Medicare eligibility and/or benefits, another involves shifting the some of the cost of Medicare services to providers and/or beneficiaries, by reducing Medicare provider payments and/or requiring beneficiaries to pay more for their Medicare benefits, and a third involves changing the way health care is organized and delivered, to increase efficiency and effectiveness and improve outcomes. These sets of strategies are not necessarily mutually exclusive, and some combination of them may be necessary to achieve the desired results. However, I would assert that these three approaches differ both in terms of their impact on Medicare's ability to fulfill its mission of providing access to needed health care for its beneficiaries and in terms of their likelihood of success in controlling Medicare costs.

The first approach, reducing Medicare eligibility and/or benefits, is exemplified by proposals to increase the age of Medicare eligibility from 65 to 67. While this would reduce the number of beneficiaries, and therefore temporarily address the rapid increase in enrollment that is seen as a major factor in projected increases in Medicare spending, its effect on program spending is likely to be small, because Medicare beneficiaries between the ages of 65 and 67 account for a disproportionately small amount of program spending, which increases rapidly with age. Moreover, much of this reduction in Medicare spending would have to be made up by increases in spending from other public and private sources, as the effected population would shift to coverage through the health insurance marketplaces or Medicaid or extended employer-sponsored coverage. Nothing in this approach would address the underlying problem that faces both Medicare and other public programs—and private insurance as well: that our health system spends substantially more than other countries without achieving better results.

The second approach, shifting costs to providers and/or beneficiaries, is exemplified by two policies: one, which has been applied without success for decades, is cutting Medicare payments to providers; the other, which has been proposed over the past several years, is premium support, which essentially places responsibility on Medicare beneficiaries to control health care spending, which both public and private payers—with much more market power—have consistently failed to do so.

While it is true that reductions in Medicare payment rate updates have slowed the rate of program spending several times—the most dramatic example being the Balanced Budget Act of 1997—they did not have a sustained effect on program spending because they did not change the underlying structure of health care delivery; moreover, health care cost growth was supported by sharp increases in provider payment rates from private insurers.

The premium support approach, under which beneficiaries would have financial incentives in choosing to obtain their coverage from traditional Medicare or private plans, was first described by Henry Aaron and Robert Reischauer more than 20 years ago, and various versions of that approach have been proposed over the past several years by the House Budget Committee, among others. However, in Aaron and Reischauer's original proposal, they clearly specify several conditions for the success of such an approach, including two important features not included in the more recent proposals:

- Traditional Medicare's benefit package should be more comprehensive, to foster competition on a level playing field; and
- The federal premium support payment should, initially at least, increase at the same rate as per capita spending on health care for the non-elderly).

Without these conditions, Medicare spending might, indeed, be slower, but nothing in this approach would ensure—or even necessarily encourage—the kinds of changes in health care delivery that would be necessary to slow the total costs of health care for Medicare beneficiaries. The result would be higher out-of-pocket payments from a population that tends to be poorer and sicker than younger Americans. Moreover, the recent premium support proposals fail to take into account the quality of plans or their capacity to serve their enrollees, which would mean that the premium support payments might be set based on the bids submitted by poor performing plans or small plans that do not have the capacity to serve an increased number of enrollees. This not only would put at risk beneficiaries who are currently enrolled on traditional Medicare, it also could result in financial penalties for beneficiaries who currently are enrolled in highly-regarded plans like Kaiser Permanente.

The only strategies that hold real promise for controlling Medicare program costs are those that address the underlying causes of cost growth throughout our health system: increasing accountability for high provider costs and improved rewards for improvements in efficiency and effectiveness and greater transparency in health care prices and quality. This Congress has taken bipartisan action to move in that direction in passing the Medicare Access and CHIP Reauthorization Act of 2015, and it should continue to encourage efforts to move from volume-based to value-based health care financing.

I also would like to reiterate here a point that I made in my testimony: that preserving and strengthening Medicare involves not only reducing program spending, but also recognizing the fact that, with a growing elderly population, it is reasonable to expect that a larger proportion of our economy's resources would be devoted to supporting their access to the health care they need. The base Medicare payroll tax rate has not increased in 30 years, despite the substantial

demographic changes that have occurred since then. Although Medicare payroll tax rates have increased for high-income beneficiaries, a broad re-examination of Medicare financing should include not only the spending side of the equation, but the revenue side as well. Asking current workers to help sustain Medicare's fiscal viability should be seen not as a shift from one generation to the other, but as an attempt to make sure that Medicare continues to serve the needs of the younger generation when they inevitably become Medicare beneficiaries themselves.

2. As life expectancy increases, people will receive Medicare benefits for longer amounts of time, causing benefits to be a larger share of lifetime earnings for later populations. The reigning assumption has always been that these later generations would also pay more in payroll taxes, because real earnings generally grow overtime. However, real wages have barely increased over the past 5 years, if not for longer.

**Question:** Given the fact that younger generations will not be paying as much as anticipated into the system, while drawing much more out of it, how is the HI Trust Fund impacted, and can we further state that Medicare's solvency can be improved by jump starting wage growth?

**Response (Stuart Guterman):** As I mention above, Medicare solvency has a revenue side as well as a cost side. Regardless of assumptions about workers' wage growth in the future, policy makers should consider the prospect of changes in how Medicare is financed, including increases in the base Medicare payroll tax rate. However, spurring wage growth certainly would help to generate more revenue for the Medicare Hospital Insurance Trust Fund, and contribute to preserving Medicare in future years.

However, the issue of workers' stagnant wages is extremely important, not only for Medicare's future and its availability for current workers but also, in a much broader sense, for the viability of the American Dream—if workers cannot count on rising wages, their path toward providing their families with a more secure future is made considerably more difficult. And this has a lot to do with the broader issue of what we spend on health care in this country, not only in Medicare but also throughout the health care sector.

For several decades, wage increases for American workers have been eaten away by the increasing cost of health care. Workers are affected by this phenomenon in three ways:

- Sharp increases in workers' premiums for employer-sponsored health insurance have taken a larger chunk out of workers' paychecks;
- Higher health care costs have increased spending on government health care programs, leading to higher tax burdens on both a federal and state and local level; and
- Higher health insurance premiums mean that employers have to devote a higher proportion of their employee costs to their share of premiums, rather than wage increases.

So, one way of spurring wage increases would be to find a way to slow the growth of health care costs. The U.S. currently spends almost 50 percent more on health care—both as a share of our economy and on a per capita basis—than any other country in the world. (At the same time, I would point out that most other high-income countries have older populations than we do, so the problem is not attributable solely to demographics.) Certainly, freeing up some of the \$42.2 trillion the U.S. is projected to spend between 2015 and 2024 would help reduce the burden on workers—as well as on businesses and all levels of government. In fact, if we were able to hold health care cost growth to the rate of growth in our economy as a whole—which would still represent a whopping 67 percent increase in health spending over that time period—we would free up almost \$5 trillion that could instead go toward wage increases, lower health insurance premiums, and reducing government budget deficits.

Thanks again for the opportunity to testify and to respond to these questions. I'm happy to respond to any follow-up or additional questions you may have.

**To: Taylor Trott, Legislative Assistant, Subcommittee on Health, Committee on Ways and Means, United States House of Representatives.**

**From: Robert Emmet Moffit, PhD., Senior Fellow, The Heritage Foundation**

**Re: Response to Questions for the Record, House Subcommittee on Health, Hearing on “Preserving and Protecting Medicare”, March 16, 2016.**

**Date: 4/13/16**

The following are my responses to Members’ Questions for The Record.

**Representative Black of Tennessee.**

**Question:** What ideas do you have for achieving a 15 percent reduction (in Medicare expenditures)? How do you balance the need to make these reductions in Medicare spending while preserving access and quality of care?

**Answer:** As you note, the Medicare program’s long-term (75 year) unfunded obligations amount to \$27.8 trillion. In my testimony, I outlined four major structural changes that would go a long way to securing that objective. In response to your question, I am providing some preliminary estimates of the budgetary impact of these changes developed by the Heritage Foundation’s Center for Data Analysis (CDA). But I hasten to add, as I noted in my testimony, that whether or not these specific changes could achieve the desired fiscal impact over the long-term should be validated by the Congressional Budget Office (CBO)), or perhaps the Office of the Actuary at the Centers for Medicare and Medicaid Services( CMS).

The first three of these changes are directly applicable to the existing traditional ( fee for service) Medicare program: the combination of Parts A and B, along with reform of Medicare’s cost sharing and Medigap coverage; raising the normal age of eligibility to age 68; and expanding the existing “means testing” in the Medicare Part B and D programs by lowering the income thresholds for the payment of higher premiums from \$85,000 to \$55,000 for single individuals, and from \$170,000 to \$110,000 for couples. With respect to “means-testing”, these changes in the initial income thresholds would mean that the total number of upper income Medicare beneficiaries that would be required to pay higher than the standard premium rates would be increased from 6 percent to an estimated 10 percent of the total Medicare population, including an estimated 3 percent who would pay full premium.

The Heritage Foundation’s Center for Data Analysis (CDA) has provided a preliminary set of estimates for budgetary savings over the years 2017 to 2026 of these structural changes. By combining Medicare Parts A and B, plus the proposed cost-sharing and Medigap reforms, CDA estimates the multi-year savings at \$98 billion. Expanding the “means testing”- that is, reducing the taxpayer subsidies for wealthy recipients enrolled in Medicare Parts B and D-

would yield an estimated \$538 billion. Raising the normal age of Medicare eligibility to 68 would yield \$370 billion.

Beyond these structural changes in the traditional Medicare program, I emphasized the long-term cost saving potential of expanding the defined contribution financing that already covers a majority of Medicare recipients in Medicare Parts C and D- Part D especially. The infrastructure of an expanded defined contribution program already exists with the administration of Medicare Parts C and D. Congress should be able to effect a full transition to such a program within three to five years. As is done today in Medicare Part D, for each Medicare beneficiary, the federal government would make a defined contribution - a fixed dollar amount - to a comprehensive, integrated health plan chosen by that Medicare beneficiary. The contribution would be based on a system of competitive bidding for the provision of today's Medicare Part A, B and D benefits. So the existing Medicare *guarantee* would be the very basis- not the antithesis- of a Medicare "premium support" program, meaning that the government's contribution would offset the premium cost of a person's chosen plan. If an enrollee purchased a more expensive plan than provided by the government contribution, the enrollee would pay an additional amount in premium. If the enrollee purchased a less expensive plan than afforded by the government contribution, the enrollee would be able to keep the difference in personal savings. In other words, with such a program, beneficiaries would be able to purchase even more than they do today with their Medicare dollars.

Once again, the size of potential savings would be based on the assumptions and the details of the premium support proposal. Over many years, there have been several variations, as you know, on this common theme, as well as various savings estimates. In 2013, CBO estimated that if the government contribution were to be based on an *average* bid among competing plans (like the formula that governs the FEHBP today), and applied to the current Medicare population, the savings over the period 2014-2023 would be \$69 billion. If the government contribution were based on the "second lowest" cost plan option, CBO estimated the savings over the same period to amount to \$275 billion.<sup>1</sup>

The key is competition. Health plan options, competing on a level playing field, should include traditional Medicare fee-for-service (FFS). A revamped traditional Medicare, based on the integration and rationalization of benefits and cost sharing as I outlined in my testimony, would be armed with new flexibilities to compete directly and effectively with private plans. The competition would include Medicare Advantage (MA) plans, as well as various private and employment-sponsored plans. All plans would be required to offer catastrophic coverage; in other words, be *real* health insurance; and all plans would operate under improved risk adjustment, as well as the insurance marketing and rating rules that today govern MA plans. The

---

<sup>1</sup> Congressional Budget Office, "Options for Reducing The Deficit: 2014 to 2023," (November 2013), p. 204. <https://www.cbo.gov/sites/default/files/cbofiles/attachments/44715-OptionsForReducingDeficit-3.pdf>

competition among these plans would be intense. It would take place on a regional basis for most plans, but possibly even on a national basis for those insurers who wished to offer plans to compete in every part of America. In my view, these competitive plans should operate in a program administered much like private plans are today in the Federal Employees Health Benefits program (FEHBP), that today covers millions of federal workers and retirees.

**Question:** Given the fact that younger generations will not be paying as much as anticipated into the system, while drawing much more out of it, how is the HI Trust Fund impacted, and can we further state that Medicare's insolvency can be improved by jump starting wage growth?

**Answer:** A strong economy and rising wages increase revenues obviously enhance the solvency of the HI Trust Fund. Slow economic growth and a slow wage growth have the opposite effect. The HI Trust Fund, while just one marker of Medicare's overall financial health, is already deteriorating. According to the January 2016 CBO report, the positive balances in the Trust Fund are projected to steadily decline and the Fund will be exhausted in 2026.

In the short run, it appears that economic forces will not be enough to improve the health of the Trust Fund. CBO is now projecting relatively slow economic growth, as measured by GDP, declining from an estimated 2.7 percent this year to 2 percent in 2020, and growing at an average annual rate of just 2 percent over the period 2021 through 2026.<sup>2</sup> CBO reports, "That rate represents significant slowdown from the average growth of potential output that was observed during the 1980s, 1990s, and early 2000s; the slowdown results largely from slower projected growth in the nation's supply of labor."<sup>3</sup> Moreover, CBO projects that "real labor compensation per hour" in the business sector of the economy will grow at an annual average rate of 2 percent between 2021 and 2026.<sup>4</sup>

In short, America is not going to "grow" out of the impending entitlement challenge. We must, therefore, focus on structural changes in the Medicare entitlement. Congresswoman Black, you are right to emphasize the role of the rising beneficiary life expectancy- a positive development. But an increasingly longer life in retirement, while the ratio of workers to retirees continues to shrink, continues to exert additional pressures on the Trust Fund. In 1965, when Medicare was enacted and the age of eligibility was set at 65, the average U.S. life expectancy was 70.2 years of age. Mortality rates, at every age, have fallen dramatically. Today, according to Census Bureau data, average life expectancy is 79.4 years, meaning that beneficiaries will experience 14.4 years on the Medicare program. That rises to 20.6 years in Medicare coverage by 2060, when the average life expectancy is projected to reach 85.6 years of age.

---

<sup>2</sup> Congressional Budget Office, "The Budget and Economic Outlook: 2016 to 2026," (January 2016), pp.6-7. [https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51129-2016Outlook\\_OneCol-2.pdf](https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51129-2016Outlook_OneCol-2.pdf)

<sup>3</sup> Ibid. p. 7.

<sup>4</sup> Ibid. p.52.

Americans can work longer, expanding labor force participation and beefing up payroll tax revenues and delaying entitlement demands. Increasing the normal age of Medicare eligibility would make a positive contribution to the financial health of the HI trust fund. The National Bureau of Economic Research (NBER) recently published some impressive research showing that Americans have significant health capacity to work at older ages, with Americans in the top quartile of education showing the largest potential gains.<sup>5</sup> There is, as I briefly mentioned in my March 16<sup>th</sup> testimony, already some progress in this direction. The NBER research, mainly focused on men, shows that for males aged 65 and older, labor force participation fell from 47 percent in 1948 to just 16 percent in 1993, but that labor force participation rose to 24 percent in 2013.<sup>6</sup> A key implication of the data on work capacity in relation to health, according to their findings, is that the average number of years worked for men between the ages of 55 and 69 could increase “by at least” 2.5 years.<sup>7</sup>

### **Representative Price of Georgia**

**Question:** Should Medicare beneficiaries be allowed the same access to life-saving technologies that is currently being used by the under 65 population?

**Answer:** Yes, of course. In the case of diabetes, the condition you cite, the total cost of diabetes, according to the American Diabetes Association, amounted to \$245 billion in 2012, including direct medical costs and indirect economic costs. Congressman Price, your example of seniors not having Medicare access to continuous glucose monitors (CGMs), a medical technology today covered by 95 percent of private health plans, is therefore particularly apt. But it is only a recent example of the often radical discontinuity of care and coverage that occurs simply because a person turns age 65.

As far back as 2000, the Lewin Group, a nationally prominent econometrics firm modeling health care policy proposals, found that the cumbersome process for determining coverage, coding and payment levels continued to delays in the provision of new medical technologies. The Lewin analysis then found that the addition of new technologies in the program took anywhere from 15 months to five years. More recently, writing in the April 11, 2016 edition of *The Wall Street Journal*, Scott Gottlieb M.D. cites the problem that Medicare beneficiaries today face securing broader access to aortic heart valves - approved by the FDA

---

<sup>5</sup> Courtney Coile, Kevin Milligan and David A Wise, “Health Capacity to Work at Older Ages: Evidence From the U.S.,” National Bureau of Economic Research, *Working Paper* 21940, January 2016, <http://poseidon01.ssrn.com/delivery.php?ID=17409309011510006602406708609210102702007202306509103612600048061048123068047080011049095104064080112099118021049018096007001068088019125115003097029075126030031111028110077103003103100086118073&EXT=pdf>

<sup>6</sup> *Ibid.*, p. 4.

<sup>7</sup> *Ibid.*, p. 24.

back in 2011 and validated by peer review studies in scientific journals- because Medicare's current rules impede their wider use among seniors. It may well serve Congress to have the Government Accountability Office undertake a comparative analysis of access to medical technologies in private health plans, Medicare Advantage an enrollees in traditional Medicare.

With a premium support system of financing, it is more likely that a person would be able to keep their private coverage or employment-based coverage, assuming it meets Medicare's basic insurance requirements. Seniors would secure offsetting Medicare payments for that plan, and thus keep that plan, and its benefits, covered medical procedures, technologies and provider networks. In other words, we should expand the opportunity for seniors to keep the coverage that they have and they like before retirement, and enable them to take it with them into retirement, wherever possible.

With the maturation of the competitive Medicare programs, Medicare Parts C and D, we are getting a much better idea of the performance of programs driven by consumer choice on cost and outcomes. In the case of Medicare Part D, which provides seniors with broad array of drug therapies, greater access to drug therapy has been correlated with reduced hospitalization and nursing home care. Research has also shown that access to prescription drugs, appropriately prescribed, of course, has been associated with a decline in other medical spending, including hospital emergency room spending.<sup>8</sup> Likewise, the Medicare Advantage program has expanded access to medical treatments, therapies and technologies. As stated in my testimony, I believe we need to go a step further, however, and broaden choice and access further by expanding the financing arrangement that today characterizes Medicare Part D.

**Question:** Do you think that these technologies, which involve an initial cost investment, will help to improve the quality of life of beneficiaries, while also working to save Medicare dollars in the long run?

**Answer:** Yes. Modern medicine has been characterized with impressive advances in technologies - including pharmaceutical therapies, diagnostic screenings and improved surgical interventions. Medical technology obviously increases health care costs, particularly at the inception of its use, as is the case with virtually all new technologies in every sector of the economy. As a general rule, medical technologies, with some exceptions, have been worth that initial cost. It is also safe to say that the nation will not save Medicare dollars by denying persons access to advanced medical technologies that will improve their health and their quality of life, and also reduce medical complications, needless suffering, the incidence of preventable medical conditions and hospital readmissions. In either case, whether the initial cost is high or low is a secondary question. The more important question, over time, is this: Are we getting value for our health care dollars?

---

<sup>8</sup> See J.M. McWilliams, "Implementation of Medicare Part D and Nondrug Medical Spending for Elderly Adults with Limited Prior Drug Coverage," *Journal of the American Medical Association*, 306, (2011): 402-409.

In certain cases, the positive results of technological interventions are beyond dispute, because they reduce both direct (additional or long-term medical care) and indirect costs (lost income or productivity). In a 2013 study of the impact of corneal transplants, for example, the Lewin Group, for example, found that an “average person” whose vision has been restored through such a transplant would avoid \$214,000 in indirect costs( such as lost employment or productivity) over the course of a lifetime. Because three out of four patients getting such a transplant are over 65 (mostly Medicare patients), the direct medical benefit to a beneficiary would be \$67,000 in direct cost savings from the avoidance of blindness.<sup>9</sup> Needless to say, a person’s sight is priceless.

On this general topic of medical technology and value for health care dollars, there is impressive professional literature. In 2001, Professor David M. Cutler of Harvard University and Dr. Mark McClellan, former Administrator of CMS, writing in *Health Affairs*, examined the costs and benefits of technology for five medical conditions: heart attacks, low birthweight babies, depression, cataracts, and breast cancer. For the technological changes in breast cancer screening, they found the benefits “roughly equal” to the costs. They also found that the cost of the medical technologies for treating the first four of the conditions was high, but the health benefits of those technologically-driven treatments were even greater. They conclude: “Although we analyze only some conditions, our results have implications for the health care system more broadly. The benefits from lower infant mortality and better treatment of heart attacks have been sufficiently great that they alone are about equal to the entire cost increase of medical care over time. Thus, recognizing that there are other benefits to medical care, we conclude that medical spending as a whole is clearly worth the cost.”<sup>10</sup> In a 2006 study, published in *New England Journal of Medicine*, Professor Cutler and his colleagues wrote: “Our primary conclusion is that although medical spending has increased over time, the return on spending has been high. In considering health policy, the concern about high medical costs needs to be balanced by the benefits of the care received.”<sup>11</sup>

---

<sup>9</sup> The Lewin Group, “Cost Benefit Analysis of Corneal Transplant,” September 9, 2013, <http://www.restore sight.org/wp-content/uploads/2014/03/Lewin-Study-Sept-2013.pdf>

<sup>10</sup> David M. Cutler and Mark McClellan, “Is Technological Change in Medicine Worth It?” *Health Affairs*, Vol. 20, No. 5 ( 2001), pp. 11-25. <http://content.healthaffairs.org/content/20/5/11.full>

<sup>11</sup> David M. Cutler PhD., Allison B. Rosen,M.D., and Sandeep Vijan,M.D, “The Value of Medical Spending in The United States, 1960-2000,” *The New England Journal of Medicine*, 355: :920-927, August 31, 2006, <http://www.nejm.org/doi/full/10.1056/NEJMsa054744>

