

RESPONSE TO ALICE RIVLIN'S PAPER

(Please note: This paper was written quickly on a laptop in Jackson Hole on a short deadline. It has not been revised for formal publication, but for use only on the Fresh Thinking Web Site.)

I would like to begin by thanking Alice Rivlin for offering a very insightful paper on health reform this year. It gives us a better understanding of the main thinking about the political feasibility of different policy reform ideas in Washington. I feel sure the paper will stimulate lively discussion. Few, if any people, can match Alice Rivlin for depth of knowledge and understanding about the Washington politics of health reform. I don't pretend to be one of them.

I. Objectives.

I agree with Alice's three main objectives of health reform: it should set the country on a clear path to universal coverage; it should move the system to more efficient and more cost-effective care; and it should, eventually, slow the current projected growth in total healthcare spending.

While I think they are "self evident truths", they are not obvious to many people. For example, Governor Romney's plan for Massachusetts, and Governor Schwarzenegger's failed proposal for California are weak or silent on moving the system to more efficient cost-effective care and slowing the current projected growth in total healthcare spending. They, and I fear President-elect Obama's campaign statements,

seem to indicate a belief that we can leave untouched the present inflationary, uncoordinated fee-for-service small practice system, and then patch around it to cover those not covered. Universal coverage will not be sustainable if we do not get healthcare spending under control.

Rivlin's third objective—*eventually* slow the current projected growth in spending—doesn't convey the urgency with which the issue of expenditures must be addressed. In 2008, health expenditures drained the Federal Budget of more than one trillion dollars, that is counting not only Medicare and Federal Medicaid, but also other programs, civilian employees' health care, and the tax revenues lost from the exclusion of employer contributions to employee health care. People get an impression that understates the impact of health spending on the budget by looking only at Medicare and Medicaid. Too many CBO reports do just this. On the present trends, the total is heading for a doubling in the next ten years. Bending that growth curve is an urgent necessity.

I also agree that 2009 is a good time to start if for no other reason than that to persuade potential purchasers of U.S. Government securities that Congress is capable of getting us back on a track that will eventually balance the budget.

The long run goal should be a system in which government pays everyone's way into an efficient delivery system serving their area of residence or work, and in which Accountable Care Systems (see below) compete to provide value for money to informed cost conscious consumers, and in which there is guaranteed issue, community rating, risk equalization, standard benefits, and exchanges to facilitate consumer shopping and choice.

II. Building on Strengths

I also agree with Alice Rivlin that reform should build on our strengths, but I have some divergent views as to what are the strengths of healthcare in the USA.

Employer-Based Health Insurance

First, the employment-basis of health insurance is not a strength. On the contrary, employer-based health insurance is at the root of many of our problems, as rising unemployment and uninsurance in 2009 will bring home to us. Employers use health

insurance as a tool in the labor market to attract employees. At least in the case of publicly-held companies, managements focus on short term quarterly profits. They do not see their health insurance purchasing as a tool to reform the healthcare delivery system. Rather, they purchase what they can in the existing uncoordinated fee for service small practice system. Reform of the whole health care system is too broad and remote a goal for them to pursue, especially when they do not understand it. Conventional economic thinking would have it that if employers each seek the best deal, the invisible hand will force the health care delivery system to reorganize for quality and efficiency, just like in the market for cars. But the invisible hand is not working in employer-based health insurance. The desire to minimize the costs of administration leads most employers to choose to offer a single insurance carrier. In addition, insurance companies want to be the single carrier for each employer and they offer employers a better deal if they can insure their whole group. For the most part, employer thinking does not include alternative organized delivery systems; they think mainly in terms of traditional “free choice” fee-for-service, in which case offering more carriers would add to administrative costs with no benefit. Thus, most employers have locked their employees into fee for service. They have not created a market in which quality cost-effective alternative delivery systems can compete for market share.

To continue, for the most part, with but few exceptions, employers do not understand health insurance or health care. They make many serious errors. For example, in the 1990s, many assigned their employees to HMOs, without choice and without apparent savings to the employee. That meant that many employees lost access to the doctors they knew and trusted. That brought on the anti-managed care backlash. They should have done what we do at Stanford, i.e. the University decided we can or should only afford the price of the lowest priced plan meeting standards of good quality and coverage. The University contributes that amount and offers employees a range of choices. Thus, nobody is in managed care against his will, our employees are satisfied, and we experience no backlash.

Employers lock in fee for service costs. In the comparatively few cases in which they do offer employees a choice of alternative delivery systems, they often pay 80-100% of the premium of the plan of the employee’s choice. For example, GIC in

Massachusetts offers public employees choices, but, by law, the State pays 80% of the premium. That means that an employee choosing a plan that costs \$100 per month less than another only gets to keep \$20 in savings, pre-tax, and about \$12 net after tax. That is a weak incentive to choose a less costly plan, and for the plan to offer a lower price. Most health plans figure there are other better ways to use the money to attract customers.

Employer payments inevitably come out of wages. When health insurance was cheap, that wasn't a major issue. But now health insurance costs are high relative to wages. Rising health insurance costs are depressing real wages. This system denies low-income people access to the less costly systems they would prefer. It forces them to participate in buying the most costly form of coverage.

People now change jobs frequently. We now rarely have lifetime employment with one employer. The job-based system forces people to change insurance, and possibly providers when they change jobs. This adds to cost. It also reduces the incentives for health plans and providers to invest in the future health of employees.

Today's health insurance system does not include Risk Equalization of premiums. (Risk Equalization compensates carriers for enrolling predictably sicker people. The Dutch do this now on a national scale.) This means that it is very important for insurers and at-risk providers to avoid enrollment of predictably sick people. We have the absurd situation in which insurers have a powerful incentive to avoid covering the sick, which is after all, the purpose of health insurance.

The Dutch use a system of Risk Equalization in which insurers enrolling predictably sick people are compensated for doing so. It works there and it could work here. It is easy to see how this could be done at the level of regional exchanges, which I will discuss later, but hard to imagine millions of employers individually doing Risk Equalization which would be costly on a small scale, but cheap on a large scale. Politicians like to criticize insurance companies for trying to avoid enrolling sick people. I say it is we, the American People, who deserve to be criticized for maintaining a situation in which such an incentive can exist when it could be corrected,

The employer-based system is praised for its familiarity and, therefore conceptual simplicity. I believe it will become incredibly complex to patch around employer-programs with public programs as people fall into and out of employment, especially if

we want to protect the right of people to keep the health plan and delivery system of their choice.

It is now fashionable for politicians to say to voters “under my plan, you will be able to keep what you have if you like it.” I think that was an over-reaction to the political failure of the Clinton health plan. But I think it will be impossible to keep that promise in the context of an equitable and efficient health system. For example, if one has 100% employer-paid, tax free, “free choice” fee for service insurance, as some employees have now, it will not be possible to reconcile that with efficient use of health care resources.

Organized Delivery Systems

Large multi specialty group practices and other integrated delivery systems are an important strength of American Healthcare. It was a large disappointment for me that the Rivlin paper does not even mention them, as if they were non-existent or insignificant. I fear that reflects the dominant thinking in Washington policy circles.

Large multi specialty group practices and other integrated delivery systems care for roughly 40 million Americans. They are equipped to provide nearly all of the health services that patients require, aside from relatively infrequent tertiary or quaternary care which they can refer to Academic Health Centers. They keep comprehensive longitudinal medical records for their patients and they are now leading the way to converting these to electronic form on their own initiative without government help. Providers in the systems share these records, so that each doctor is fully and conveniently informed about the complete picture of the patient. This can save large amounts of money as costly errors and unnecessary duplication of diagnostic tests are avoided. These groups are rolling out information systems with many quality and service enhancing functions. These groups have cultures of team work. The sharing of records creates ongoing peer review. The doctors in these systems are usually paid salaries, possibly with bonuses for quality and patient satisfaction. They emphasize disease prevention and chronic disease management. *In short, they are doing as a matter of course all the things that politicians are now saying should be done in all of American health care.*

Senator Obama’s campaign proposed to save the Average American family some \$2500 per family per year, mostly through information technology and disease

prevention/management. *These are the institutions already doing those good things.* It would seem reasonable to think that the way to spread these good practices is to create markets in which these institutions can grow. On the other hand, as Rivlin correctly notes, there are likely to be no savings from just buying computers for doctors. The gain is in the doctors' commitment to develop and use the technology to improve quality and economy. It is not in the computers themselves.

The institutions I am referring to exist in every region of America and in rural as well as urban settings. The rural examples include the Marshfield Clinic in WI, the Geisinger Health System in PA, Scott and White in Temple, TX, the Billings Clinic in MT and more. I have been told in Washington that they can exist only in the Western United States. But such institutions include the Fallon and Leahy Clinics, as well as Harvard Vanguard in MA. Nationally better known are the Mayo Clinic in 3 states including FL, and Kaiser Permanente in 9 including VA, MD, DC and also GA.

In America, we suffer grievously from fragmented uncoordinated care. We wouldn't know the alternative, coordinated integrated care, without these organizations.

We suffer from lack of disease management in the uncoordinated fee for service sector. Insurance companies hire specialized disease management companies to make up for the deficiency in the traditional sector. We wouldn't even know about what disease management can do for patients without these organized systems of care.

These organized systems of care can deliver comprehensive care for much lower cost than in the traditional sector. The Dartmouth team found that if everyone delivered care at the same standard as the Mayo Clinic, Medicare would cost 30% less. The RAND health insurance experiment found that Group Health Cooperative of Puget Sound provided comprehensive services for 28% less than the traditional sector in Seattle for virtually the same outcomes. I say "can deliver" because such savings are not guaranteed independently of market conditions. Mayo and Group Health Cooperative produced these savings in the absence of economic competition from similar groups, or in fact, any economic competition. It is not difficult to believe that over the long term, the savings could be greater if there were sustained economic competition to serve cost conscious consumers with choices.

The list of what these systems do to cut costs while improving care is long. I have written about it elsewhere and will not repeat it here.¹ In a recent communication, George Halvorson reported that last year, a new program to prevent hip fractures among Kaiser Southern California members, targeted at 620,000 members reduced the incidence of hip fractures by over 37%.

Some of these systems have international reputations. In 2002, *The British Medical Journal* published an article called “More for their Dollar: A Comparison of the English National Service with Kaiser Permanente in California” by Sir Richard Feachem and associates. They found that after adjusting for all appropriate adjusters, Kaiser in California cost a small amount more, per capita, but for that Kaiser members enjoyed much better access to services and technology. When the dust settled after the inevitable debate, their conclusion emerged intact.. For example, NHS elders spent 3.5 times as many days in hospital as similar Kaiser members in California. Several English teams came over to study how Kaiser did it. Their conclusion was superior integration of services, especially around stronger better resourced primary care.

When I suggest that a foundation of our health policy must be the superior performance of these organized systems, I am often told that policy makers believe these systems are too few in number and they must focus on the larger traditional sector. But Shortell has identified 468 physician organizations with 100 or more MDs many of which, in the right market conditions could grow into integrated delivery systems. In a recent article in JAMA (July 2, 2008) Stephen Shortell and Lawrence Casalino defined “An Accountable Care System” as “an entity that can implement organized processes for improving quality and controlling costs of care and be held accountable for the results.” They listed several existing types of organization that would be candidates for that role, including multi specialty group practices, hospital-medical staff organizations, physician hospital organizations, interdependent practice organizations, and Health-plan provider organizations. In my view, if public policy made it clear that traditional providers would have to compete with the existing organized systems on the basis of quality and cost,

¹ Please see “The US Experience with Managed Care and Managed Competition,” in *Wanting it All: The Challenge of Reforming the US Health Care System*, Jane S. Little, ed. Federal Reserve Bank of Boston, 2007. Also *Quality, Affordable Health Care or All: Moving Beyond the Employer-Based Health Insurance System*, Committee for Economic Development, www.ced.org.

many of these entities would move quickly to form new Accountable Care Systems. In the existing successful organized systems, they would see many good examples of best practices they could emulate.

If public policy were sufficiently determined, the Congress might offer substantial grants to existing non-profit delivery systems to create clones in areas that needed them. A precedent for this would be the HMO Act of 1973.

Another question I hear is this: “If these organized systems of care are such a good idea, why haven’t they spread to take over America?” I would divide the answer into ancient history and modern history. As to the ancient history, recall that the organized medical profession in this country clung fiercely to the value of autonomy, and to the principles of “Medical Ethics”: “free choice of provider at all times” (no HMOs or even preferred provider insurance); “free choice of treatment” (no utilization management); “fee for service payment”; “direct doctor-patient negotiation of fees” and solo or small single specialty group practice. These principles were enforced by systematic coercive actions such as ostracism, boycotts, denial of referrals, denial of hospital privileges, slander, political action such as “any willing provider laws” outlawing selective provider contracts or “corporate practice of medicine” and the like. Paul Starr has documented this history. When the great medical pioneer Dr. Russell V. Lee founded the Palo Alto Clinic, he was expelled from the Santa Clara County Medical Society. I have personally witnessed some of the slanderous attacks. All of this inhibited the founding and growth of multi-specialty group practice and especially prepaid group practice. Remnants of all this remain in our culture today. As to modern history, as I mentioned earlier that employers in great majority offer their employees a single insurance carrier. This has made it very difficult for insurance plans affiliated with a single medical group to be offered, therefore for medical groups to market their superior cost-effectiveness in the form of lower premiums. Most employer plans offer virtual free choice of provider, which means that the worker cannot capture for himself the benefits of less costly practice by limiting his choice to one medical group. On the other hand, such a plan is not a good candidate for the role of sole source of insurance plan for an

employment group. Most of the time, some workers, understandably, want to remain with their accustomed provider,

So, if we want efficient organized systems to prosper and to threaten traditional providers with loss of patients unless they form Accountable Care Systems and get cost and quality under control, we must open all health insurance markets to consumer choice and it must be cost conscious choice so that the efficient systems can market their superior cost-effectiveness. This points to the second important strength of America's health care system today.

Large Scale Examples of Cost Conscious Consumer Choice of Plan

While most American employers do not offer cost-conscious choices of insurance carrier, some do and this has given us important experience on which to base the design of a model of consumer choice of health plan. The list of employment groups that have cost conscious multiple choice include the Federal Employees' Health Benefits Program (FEHBP) covering roughly 9 million people and in successful operation since 1960. In California, 58% of Federal employees have chosen HMOs. (Recall that many live in areas not now served by HMOs.) Others are the State of Wisconsin Employee Trust Funds (ETF) covering all State Employees, the State of California Public Employees' Retirement System (CalPERS) which covers State Employees and also the employees of many local government agencies. The State employees receive defined contributions, while, unfortunately many of the local public agencies have "employer pays all" arrangements which make those employees cost-unconscious. To their regret today, many local government agencies acceded to these unwise union demands. More than two-thirds of all CalPERS covered workers have chosen HMOs. Over 90% of Wisconsin State Employees have chosen HMOs. The University of California, with several hundred thousand covered lives offers a range of choices and contributes a fixed dollar amount set at the price of the low-priced plan. Stanford University has a similar model. In both universities, 81% of employees have chosen HMOs, either Kaiser Permanente or one of several network models that market the services of about 200 multi-specialty group practices and a few IPAs. The insurance carriers pay the groups for professional services on a per capita basis rather than fee for service.

None of these programs perform managed competition perfectly. But they work tolerably well in spite of their flaws. The FEHBP needs a standard benefits package, regional pricing to reflect differences in regional costs, a true fixed dollar contribution set at the price of the low priced plan in each region or some other design to be sure that a qualified plan can always gain customers by offering a lower price, and Risk Equalization. Risk equalization can be performed using technologies developed for Medicare Advantage, and in some use in the private sector. The Dutch base their universal health insurance based on regulated competition in the private sector on Risk Equalization. Critics emphasize deficiencies in risk equalization as an argument against consumer choice models. But I find it implausible that, considering the growth of electronic data bases, information technology, and predictive modeling techniques, that very serviceable models cannot be developed. Of course, this will be a matter continuing refinements both by the exchanges using Risk Equalization and health plans hoping to profit from deficiencies. Considering that some 75-83% of health care spending is on people having one or more chronic conditions, and these conditions can usually be identified by use of pharmaceuticals, it must be possible to fashion good enough predictors.

These experiences show that the concept of multiple cost-conscious choice of plan is feasible and practical. Even without state-of-the-art risk equalization, the FEHBP and CalPERS have endured and worked for nearly 50 years. Each has had some problems of instability related to adverse risk selection. But people have learned that biased risk selection can be managed by plan design. It has always seemed puzzling to me that so many Washington-based people choose to ignore choice of plan arrangements when that is how they get their health insurance

The other important thing they show is that *when offered cost conscious multiple choice of plan, very high percentages of people choose the cost-effective organized systems, that is, they migrate to value for money.* After the managed care backlash of the 1990s, the conventional wisdom in political circles became that the American people do not like managed care. As the experiences I have just cited show, this is not true. What they do not like is being assigned to managed care without a choice. On the other hand, when offered a cost conscious choice, very high percentages of people choose it if they

have convenient access to a good managed care organization. The conventional wisdom became that the wider the network, the better. But this isn't true either. In California in the 1990s, the most satisfied patients were those who belonged to the most restrictive network, i.e. Kaiser Permanente, doubtless because they were there by choice.

III. Moving Forward to Transform the Whole System to Efficient Integrated Delivery Systems Using Competition and Cost Conscious Consumer Choice.

The first step is for the Federal Government to create a new institution modeled on the Federal Reserve with its expertise and independence, to create and run exchanges in all regions of this country. (An exchange is an institution where buyers and sellers of health insurance execute transactions according to rules.) Exchanges are market-organizers that are intended to make it easy for consumers to shop and compare, aided by good independent unbiased information on costs and quality. Exchanges should follow the principles of Managed Competition: free entry to those entities that qualify, including standards of quality and financial stability, wide choice for consumers, guaranteed issue and renewal, community rating, Risk Equalization, and a standard benefits package. (Standardization makes it easier to compare plans on cost and quality, safer to switch plans, and it reduces the transactions costs that arise from providers having to deal with large numbers of different plan designs.)

Why should the "Health Fed" have political independence? The reason is to prevent the further transformation of the health system into a big pork barrel of earmarks and particularized benefits for constituents and campaign contributors. I do not consider such independence to be undemocratic. The Health Fed would be accountable to the legislature for performance of broad goals such as efficient and high quality coverage, in a manner similar to the accountability of the Federal Reserve. I think pork barrel, which means deceit, is undemocratic. It means resources that the American people were told would be used to pursue broad public policy goals efficiently are instead used by politicians to get themselves reelected, or to secure the endowment of institutions named for them.

The Health Fed would also create an Institute for Medical Outcomes and Technology Assessment to do comparative cost-effectiveness studies and produce unbiased information for use by providers and health insurers. It is especially important that this institution have strong insulation from political retaliation from politicians whose constituents make and sell medical technologies that are found wanting in studies by the Institute.

Exchanges should be rolled out sequentially, though I think legislation should set a clear path as a clear signal to providers that in the future they will have to create or participate in well-performing Accountable Care Systems. In a manner reminiscent of the Cooper, Andrews, and Stenholm's Managed Competition Acts of 1992 and 1993, all employment groups of up to 100 employees should be required to purchase their health insurance through an exchange, under penalty of losing the tax exclusion for employer contributions. In other words, just as the tax exclusion now provides powerful incentives shaping employer-based health insurance, it would be re-shaped to motivate employers to enter an arrangement in which their employees would have wide choices.

When we developed this proposal in the CED study group, strong preferences were expressed for making participation in exchanges voluntary. But experience has shown that voluntary exchanges are too vulnerable to adverse selection, as those who are having the most difficulty obtaining insurance on their own—typically the most costly--join first. That drives up premiums and makes the exchange unattractive to lower risk groups. This is a problem in the way the Obama campaign proposed the exchange.

At the same time, the tax exclusion should be capped at the price of the lowest priced qualified plan participating in an exchange in each market area. The important purposes of this would be, first, to save the Federal and state budgets a great deal of money that can be used to subsidize health insurance purchases of people with low incomes, the unemployed, and others, or to help balance the budget. And second, it would be a major contribution to reforming incentives. In fact, tax-favored employer health plans should be required to make the contributions they want to make in the form of fixed dollar defined contributions.

Of course, as is well known, the existing tax exclusion is very inefficient and very inequitable.

When this step is completed, we would have roughly a third of all employees in the market for employer-sponsored health insurance participating in a competitive market for efficient delivery systems, opening a large market for such systems.

One should recognize that such a change in health insurance arrangements would be highly beneficial to small employment groups, regardless of eventual total system reform. It would lead to large savings in the administrative cost of insurance, both on the part of employers and insurers.. Tens or hundreds of thousands of people would get their coverage through large scale standard contracts. Costly inefficient smaller bureaucracies would be replaced by an efficient bureaucracy with economies of scale. (I use the successful experience of CalPERS as a good example.) The exchanges would spread risk for groups now far too small to bear risk. For example, we now have conditions such as Gaucher's Disease which costs \$300,000 per person per year to treat. Buying through the exchanges gives employers and employees stable rates that small employers usually do not enjoy now. And employees have choices, including that they are much more likely to be able to remain with the delivery system of their choice as they change jobs.

When this is in place and working, it is likely that larger employers will see the benefits and want to be included. The tax cap will make employees desire access to cost-effective organized systems of care. Then the threshold should be raised from employers of up to 100 to 200, 500, etc, until eventually virtually all employees are included.

A parallel reform of Medicare is needed to complete this program. It should be along the lines of the recommendations of the Bipartisan Commission on Medicare, chaired by Senator John Breaux and Congressman Bill Thomas. Their approach is based on multiple choice of plan and fixed dollar premium support payments. One way to do this would be to say that newly eligible beneficiaries would enter a new system based on defined contributions and multiple choices through the exchanges. More and more, this would mean that people reaching retirement age would receive eligibility and premium support payments through reformed Medicare. In my view, this approach would roll out much too slowly to head off the fiscal train wreck toward which we are heading. But it would be a serious start. Because of taking advantage of the efficiencies of competing

delivery systems, these premium support payments would be able to grow at a lower rate than the growth of fee-for-service Medicare. In 10 years, the per person health expenditures could reasonably be expected to be some 30% less than they would otherwise be. (This is based on the Dartmouth/Wennberg findings that Medicare would cost 30% less if everyone practiced at the standard of the Mayo Clinic, or the RAND finding regarding Group Health Cooperative.) Over the longer run, as the competing care systems meet in the marketplace for cost conscious consumers, the per person costs could be half what they otherwise could be.

IV. Conclusion

In conclusion, I believe that America should make a maximum effort to take advantage of incentives and the performance of known, proven models of organization of care, to improve quality, equity and economy of care, before raising the specter of rationing and global budgets, both of which are politically impossible to enforce in the United States.

This is a centrist, often bi-partisan idea, to build on the successful experiences of the FEHBP, CalPERS, and Wisconsin State Employee Trust Funds. It builds on the strengths of America's health care system. It has enjoyed bi partisan support from such luminaries as Gephardt and Stockman, the Managed Competition Acts of 1992 and 1993 introduced by the Conservative Democratic Forum and joined by Republicans, including the version introduced in the Senate by Breaux and Durenberger, and these days the Healthy Americans Act (S.334) co sponsored by Senators Wyden and Bennett and 15 other Senators of both parties, as well as bi partisan support in the House of Representatives. In short, only a bi partisan solution is likely to be durable and not undone at the next change of party control, and only a solution along these lines is likely to attract both Democrats and Republicans.