

## Comments by Jon Kingsdale on

### Alice Rivlin's "Transition to Comprehensive Health Care Reform"

Dr. Rivlin makes so many good points that to list them would fill my allotted pages. I do want to emphasize and build upon several that relate to the politics of cost control. I will also identify a few pitfalls to be avoided and suggest two alternate (future) scenarios which she might consider.

Content aside, Dr. Rivlin offers the extremely helpful perspective that comprehensive reform is an evolutionary process, rather than a single act of Congress. As a student of history and a perpetrator of health insurance,\* I have witnessed or, worse yet, implemented enough (disappointing) cost solutions and (under-whelming) innovations in coverage to appreciate the evolutionary approach: while a comprehensive politico-economic strategy is imperative to winning the game of affordable-universal-coverage, enactment (hopefully) in 2009 is only the first inning.

The first of Dr. Rivlin's points that I would emphasize and build upon is that "excess growth in health spending...is unsustainable." While indisputable in theory, it is worth recalling that many policy-makers said much the same in the 1970's, when health care costs *soared* to 8% of GDP, and HEW Secretary Califano warned that automakers were spending more on health insurance than steel. "Unsustainable" trends do eventually end, but we must articulate a more compelling, immediate need to control medical costs if we hope to mobilize public support for this difficult challenge.

I would argue that raising our standard of living, moderating class antagonisms, and improving the nation's health status all depend upon it. With over half of U.S. health care now publicly financed, and with employment-funded premiums absorbing most of the compensation "gains" that wage-laborers have realized since 1987, the opportunity costs of untamed medical spending arguably harm the nation's health and civility. In light of falling bridges, failing schools, inadequate policing, child malnutrition, inadequate public health and environmental measures—all of which are being squeezed from government budgets by the ballooning costs of Medicare, Medicaid and public employees' benefits--run-away medical spending may actually reduce the nation's quality-life years.

Politically, however, controlling medical costs is far more difficult than expanding coverage. As Uwe Reinhardt often observes, everyone's health care costs are someone's revenue. Many of these revenue-takers enjoy exceptional political power, by virtue of being in the business of saving people's lives or, alternatively, being able to scare them

---

\* Despite my professorial credential in history, I have spent all but one of the past 34 years outside academia, in such disreputable trades as health insurance executive, lobbyist, and government bureaucrat.

nearly to death (ala “Harry & Louise”). As important as curbing medical spending is to sustaining universal coverage, the successful experience of Massachusetts in first tackling coverage expansion suggests the political wisdom of sequencing reforms. Or, to borrow from the experience of our greatest national success in expanding coverage, had Lyndon Johnson insisted on prospective payment, certificates of need, and prepaid group practice to control the costs of covering the old and the poor, Senator Kennedy might still be fighting for the enactment of Medicare and Medicaid.

Staging reform is crucial, and the first, big step toward moderating trend is to cover everyone. For decades now, as premiums have risen, the most price-sensitive buyers have exited the market. Literally, as premiums rise, penny-strapped employers cut back or do not offer group health benefits, while increasing percentages of employees decline their offers. The resulting free care and bad debt further add to everyone else’s medical costs. Only when we get everyone in, under the tent, will we *have to* confront the cost of covering them all.

In the context of a federal stimulus package, we could begin by raising income eligibility and the federal match for public programs (principally Medicaid, SCHIP, and a new coverage program to cover the unemployed). We should do this as soon as possible. Demonstrating real progress quickly is a political salve for the wounds that ideological opponents will likely seek to carve into reform, starting the day after it passes. Next we should expand private insurance, but only *after* this deep recession should we saddle employers and consumers with yet more insurance costs.

Moreover, it takes a year or more to craft good regulations; and it will take even more time to build health insurance exchange(s) and adjust – or adjust to -- the underwriting regulations and market conditions of 50 different states. This is necessary work, if we expect participants in existing insurance markets to adapt to the new rules and improve the functioning of these markets. And we must provide a glide path for those institutions, such as the safety-net providers, who depend on direct public financing and may actually be hurt by a significant reduction in the number of uninsured.

All of this should be accompanied by massive amounts of communication, education, and outreach, if we are to avoid confusion and backlash. In Massachusetts, with 2% of the U.S. population, \$7.5 million was spent on outreach and education in the first year of implementation, plus huge volumes of “earned media” and volunteerism. We mobilized dozens of community, business and religious associations, and partnered with the Red Sox, CVS, Bank America and many other firms to communicate with the public and reach the uninsured. The Connector alone held 338 outreach meetings across the Commonwealth during the first two years of reform. So, we should stage the expansion of employer and individual insurance.

Finally, the new Congress should build *only* the foundation for eventually addressing costs. Otherwise, opposition to cost containment may well overwhelm the votes for coverage expansion.

The challenge of reining in costs is so great that effective initiatives must be preceded by a strategy to build political constituencies for them. Most revenue-takers are technically expert, highly motivated, well organized and funded, and publicly admired—they save lives! Potential constituencies for cost control, such as employers and tax-payers, are dispersed, inexpert on the issue, and easily portrayed by revenue-takers as simply motivated by selfishness. (In this regard, health insurers are *sui generis*: revenue-takers who may want to control medical costs down the supply chain, but whose ability to do so is compromised by the perceived venality of their motives.)

This is where mandates come in. In addition to their other advantages, fair and flexible mandates on employers to contribute, and on individuals to purchase, a minimum level of health coverage would begin to create a constituency for cost control. The most price-sensitive buyers now simply exit the market, but keeping them in puts a political megaphone to their price sensitivity

Creating a political constituency for controlling costs means *not* making the potential constituents so angry at reform that they block it. Reforming any sector that represents 16% of GDP (and climbing) requires sustained, organized political support. Dr. Rivlin is right about “extreme solutions” being politically naive, but holding out for single-payer or high-deductible health plans are just the most obvious examples of a political insensitivity that, unchecked, might once again snatch defeat from the jaws of victory.

Another lesson of Massachusetts’ successful effort in boosting coverage to 97.4% of residents is that if you need a big majority for passage, you need even broader public and constituency support to implement. After all, we would re-finance (and re-organize) our largest economic sector: at \$2.4 trillion and growing—while everything else shrinks--healthcare will soon be 50% larger than American manufacturing, and is already four times the size of the transportation or construction industries and 16 times as large as agriculture. This is a big deal.

But it *can* be done! Support of healthcare reform among Massachusetts voters ranges (in three recent surveys) from 69% to 75%, and a majority of employers in Massachusetts—who overturned Governor Dukakis’ 1988 universal coverage law—also support the reform. It does require strategic sequencing of reform, so that reformers are not fighting on all fronts simultaneously. For example, when pharmaceutical and device manufacturers promise to focus their considerable political clout to fight either for or against NHI, depending on whether the legislation includes an institute for cost-effectiveness studies-- one might prudently settle (for the time being) for efficacy studies or delegate the question to a “Health Fed.”

Similarly, I would argue that there is no need to wage a bloody battle with what should be the natural constituencies for cost control—employers and consumers--over defining a standard benefit package for all. This would be a battle of intense ideological and financial consequence fought in front of an electorate that doubts whether the federal government should even resuscitate our imploding credit system, let alone dictate health care coverage. Employers of a certain size should make at least a “Fair & Reasonable

Contribution” (i.e. modest) toward coverage for their employees; and individuals should have at least “Minimum Credible Coverage”—not ideal, but *minimum*, analogous to a minimum wage.

The political challenge of passing even a modest employer mandate and a very flexible individual mandate—such as Massachusetts has done—is huge. But the pay-off is huge, too. First, we cannot get close to universal coverage without either (1) fully tax-funded coverage, or (2) individual and employer mandates. Just as importantly, we cannot moderate trend without building the kind of constituency for cost control that mandates create. With employers, tax-payers and even insured, middle- and working-class consumers committed to paying for coverage, every escalation in medical costs will amplify their demands to stop it.

At some point, as the pain increases, the unsustainable premium trend will meet sufficient political resistance to bend. This is when the economists and policy-makers should roll out their elegant models of cost containment. This is when a “Health Fed” will be able to move from studies of efficacy to cost-effectiveness and cost-benefit comparisons; and employers will demand that the major cost advantage of public programs—their ability to constrain provider fees—somehow be shared with the private sector.

Until that point, Dr. Rivlin’s skepticism about IT investments is more than justified. Not until the reimbursement spigot from all payers begins to dry up will providers deploy their (new, federally capitalized) connectivity to control costs. At this point, most doctors will have to join scalable firms and large medical enterprises will re-orient their IT -- away from ever-more aggressive FFS billing, comprehensive screenings, test-ordering, and sophisticated interventional gadgetry, and toward preventing adverse drug interactions and hospital re-admissions, coordinating emergency with continuing care, and facilitating (non-billable) electronic communications. In sum, at this point, hospitals and large group practices may begin to use modern IT to manage like most other large processing enterprises do: to reduce errors and defects, drive down supply chain costs, and substitute replicable, automated processes for skilled labor--thus freeing up their most expensive professionals to solve problems.

As to where healthcare reform might eventually lead, first I suggest that we not underestimate the political inertia of such a gargantuan enterprise as American health care. Before joining Dr. Rivlin in dismissing a federal framework and funding for state-based initiatives, we should recall the heady optimism over national reform in 1993 and its denouement in 1994. If only as a BATNA to what she considers true national reform, I would suggest that someone flesh out and hold in reserve a federal plan to replicate Massachusetts in five or ten more states. If that’s all we can do this time at bat, remember this is only one inning; a few more state initiatives might even set us up well for the rest of the game. Many national reforms--child labor laws, minimum wage, medical aid to mothers and infants, even welfare reform in the 1990s--started with a few progressive states showing the way.

Speaking of alternative scenarios, while I like vouchers and agree with Dr. Rivlin that they could be the end-game, we cannot count on a single path of evolution. Another path, which I consider likely, is that we retain employer financing. Were we to cap the deductibility of employer-financed health insurance, this would have some of the same benefits as vouchers, in terms of equity and downward pressure on premiums. While politically challenging, capping the deduction is far less daunting than eliminating it altogether, and, again, it helps build the political constituency for cost control.

Clearly, we will eventually need to moderate increases in health care spending. Politically, we will be in better shape to do so after committing to cover everyone. Clearly, we will need all the political pressure that can be generated to bend the trend of medical spending.