xc: CHR

TO: Hillary Clinton

FROM: Carol H. Rasco

SUBJ: Jim Mongen

DATE: February 1, 1993

I had a delightful one plus hour visit with Jim. It was a promising visit; I will look forward to reading the material referenced in the following paragraph. He was fine not meeting with you, he had not been led to believe that would definitely happen.

He did say that before he makes the final personal and financial decisions needed to take this job it would heighten his comfort level if you, Ira and I would read over the attached three items he has written in recent months; he said the title of the one to Kaiser might put us all off immediately but that he wants to make sure we feel comfortable with his positions to date. He stated further that he is not "set" in the positions stated but again, needed for us to give him some initial feedback. He will be in DC through Thursday. He did meet with Ira before coming to see me today. I will talk with Ira tomorrow morning (Tuesday) after I have a chance to read these tonight, and we will then get back to you.

Thank you.

Thank you.

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JAMES J. MONGAN, M.D.
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Kansas City, Missouri 64113

CURRENT POSITION: Executive Director, Truman Medical Center and Dean, University of Missouri-Kansas City School of Medicine

EXPERIENCE:

1987 - Present Dean, University of Missouri at Kansas City School of Medicine and Executive Director, Truman Medical Center. Added responsibilities as Medical School Dean to existant Hospital Responsibilities.

1981 - 1987 Executive Director, Truman Medical Center, Kansas City, MO, the multi-institutional public hospital system for Kansas City, MO and Jackson County, MO, and the teaching hospitals for the University of Missouri-Kansas City School of Medicine.

1979 - 1981 The White House - Assistant Surgeon General and Associate Director for Health and Human Resources, Domestic Policy Staff. Responsible for White House management of the development of Administration policy in the Health and Human Services area. This involved both translating the President's decisions into a legislative, regulatory and budgetary program and working with the Congress and interest groups in achieving passage of these programs.

1977 - 1979 Department of HEW - Deputy Assistant Secretary for Health Policy and Special Assistant to the Secretary for National Health Insurance. Responsibilities involved developing policy for the six Public Health Services Agencies and developing the Administration's National Health Plan.

1970 - 1977 U.S. Senate Finance Committee - Professional Staff Member - Responsibilities involved Medicare, Medicaid, and National Health Insurance proposals. Work involved extensive contact and cooperation with other Congressional committees, the Administration, State Health and Welfare Departments and Washington offices of most health and welfare related organizations.

1968 - 1970 Department of HEW, Denver Regional Office, Medical Officer, U.S. Public Health Service - Responsibilities involved working with physicians and institutions on professional aspects of Medicare and Medicaid, and working with migrant labor groups on establishment of migrant health centers.

1967 - 1968	Rotating Internship, Kaiser Foundation Hospital, San Francisco, CA

COMMITTEE/BOARD APPOINTMENTS:

Member, Board of Trustees, American Hospital Association 1988-1991

Board Member, Council of Teaching Hospitals, American Association of Medical Colleges 1984 - 1990

Board Member, Midwest Research Institute, Kansas City, MO

Member, Commission on the Future Structure of Veterans Health Care - Department of Veterans Affairs 1990--1991

Member, Prospective Payment Assessment Commission, U.S. Congress 1983 - 1989

Member, Health Advisory Committee, U.S. General Accounting Office

Member, Pew Health Professions Commission

Member, Kaiser Commission on the Future of Medicaid

Pembroke Hill School Board of Trustees, Kansas City, MO

ACADEMIC APPOINTMENTS: Professor of Medicine, University of Missouri-Kansas City School of Medicine

Professor in Health Care Administration, University of Missouri-Kansas City School of Business and Public Administration

OTHER APPOINTMENTS: Faculty, House Ways & Means Committee Retreat Issues Seminar - West Point, 1991

Fellow, King's Fund International

EDUCATION: 1959 - 1962 University of California at Berkeley
1963 - 1967 Stanford Medical School

DEGREES: 1966 A.B. - Stanford University
1967 M.D. - Stanford University

DRAFT

HEALTH CARE REFORM & NEW DECISIONS FOR BUSINESS

Presented by FORBES Magazine
A Harvard School of Public Health Conference

THE PLAZA HOTEL
New York, New York
October 1, 1992

James J. Mongan, M.D.
Executive Director, Truman Medical Center
Dean, University of Missouri-Kansas City School of Medicine
Kansas City, Missouri

I've been asked to talk this morning about employer mandates, an idea that is not very popular to some in this audience. But I would encourage all of you to listen closely for the next half hour, because if anything happens in the health insurance debate over the next few years, it will involve employer mandates and I'm going to tell you why.

This concept will be central to the debate because it is a concept that lies squarely in the middle of the policy debate, bracketed on the right by the Bush administration's weak broth of small market insurance reforms, state pools and tax credits, which almost all agree would leave millions of uninsured; and bracketed on the left by tax financed, governmentally dominated, national health insurance proposals, with very large public costs, which appear to go against the grain of this nation's anti big government ethos.

Before focusing in detail on the concept of employer mandates, let me begin with a brief word on two issues:

- First, a minute or two to define the problem of the uninsured and how we got where we are today.
- and then a very brief over view of the politics of the health insurance debate.

The problem, stated most simply and starkly is that we have 37 million people, or about 15% of the population, who have no health insurance coverage under either public or private programs. But almost more important than the number itself is the fact that the number grew over the past decade, rising from about 26 million uninsured in 1980. Most of that growth came during the recession in the early 80s, but the numbers did not decline during the relatively prosperous mid 80s. That should be a warning sign to people concerned about this issue.

Why did the number of uninsured fail to decline during the supposed "boom" years of the mid 80s? Well, there is no single clear answer, but a number of factors appear to play a part. First is the shift from jobs in the relatively well insured manufacturing sector to jobs in the more poorly insured service sector. Second is the fact that a good deal of new job formation has been in small businesses — jobs which are traditionally not well

insured. And finally, the increasing cost of health insurance is driving more small businesses and individuals out of the health insurance market.

Now just one more number to keep in mind about the uninsured — a large majority of these people, over two-thirds of them, are employed, working Americans, or their dependents.

Well, what about current programs to deal with this problem. You have undoubtedly heard of the Medicaid program, a massive federal/state program covering over 30 million poor people and costing over 120 billion dollars. But Medicaid was never designed to cover all of the poor. In fact, it was specifically designed to cover only those in the various welfare categories. It specifically does not cover the working poor — those millions of Americans who toil at what are often the hardest jobs, for what is often the least reward. As a result, Medicaid covers well under half of the poor people in the nation today.

Now a word on politics before I move to a focus on the employer mandate approach. As I indicated previously, there are three generic approaches to solving our health insurance problems — a set of incremental changes involving small market insurance reform and tax credits, the employer mandate approach, and the approach of a publically financed governmental program.

As far as the position the business community should take with regard to these three proposals — if you believe you have the political muscle to halt the momentum toward providing universal coverage, it may appear to be in at least your short term self interest to support the incremental approach and avoid either mandated employer coverage or a governmental payroll tax-financed program.

But, if you do not have the muscle to stop the momentum toward universal coverage, or if you have the foresight to recognize the importance of universal coverage, then you are left with two options:

- building on the present system through an employer mandate, or
- moving to a governmental payroll tax financed system.

The political calculus is as simple as that.

(SLIDE ONE)

Against that background, let me turn to a discussion of employer mandates. I'll begin with an introduction of the concept. I'll then turn to the question of why we might consider employer mandates as an approach to the health insurance issue. Next, I'll talk about how employer mandates work. Then I'll turn to a set of issues which must be addressed

with employer mandate proposals. Next, I'll look at the cost impact of employer mandates on government and employers, and finally, I'll focus on some problems with employer mandates before concluding with some summary remarks.

(MOVE TO SLIDE TWO)

First, the concept of employer mandates as a solution to the health insurance problem our nation faces. The concept is quite straight forward, and it is that we could substantially improve health insurance coverage by requiring employers to provide coverage to their employees. Two approaches to this basic concept have been developed over the past decade of debate. The first approach would be a direct requirement or mandate that employers provide health insurance coverage. The second approach would be to not <u>directly</u> mandate coverage, but to in a sense <u>indirectly</u> mandate coverage by placing a tax in lieu of providing coverage, on those employers who choose not to provide health insurance coverage. This has been labeled the "pay or play" approach.

I believe it is important to note that the concept of employer mandates did not just drop into the health insurance debate some years back by accident. The concept grows out

of a number of related policy precedents in this country, ranging from programs such as Social Security through Workmen's Compensation and the minimum wage. In each of these programs, our country decided to achieve a social goal through the mechanism of laws which would require certain actions from employers.

Not only is there precedent in our nation's general social policy, but there is substantial precedent in the health insurance debate over the past two decades. In fact, I think it is of great interest that this approach is the approach that had been chosen by both the Nixon/Ford administrations and the Carter administration, the last two administrations to seriously grapple with comprehensive proposals for health insurance reform.

It is also of interest that a number of important groups involved in the health insurance debate have moved in this direction over recent years, even though they had not favored this type of approach in the past. Among those are the two major provider groups, the American Hospital Association and the American Medical Association, organized labor, and some large employer groups. In addition, the Pepper Commission, chaired by Senator Rockefeller, the Commission which has most recently looked extensively at this issue, concluded its work with a report which recommended a "pay or play" proposal.

(SLIDE THREE)

You might ask the question, Why consider employer mandates as an answer to our health insurance problem? I believe there are three important reasons for giving consideration to this approach.

First off, it would solve a good part of the coverage problem. That statement is based on the following compelling, underlying logic. Most American workers are currently insured through the work place. About 75% of American workers are provided health insurance by their employers. But equally importantly, most of the uninsured are workers or dependents of workers. Again, about 75% of those 37 million people without health insurance in the United States are workers or dependents of employed people. Now, of course, based on the numbers I have just given you, employer mandates by themselves would not solve our health insurance coverage problems. They would need to be coupled with expansions of a public program to cover the 25% of the uninsured who are not linked to the labor market in order to achieve universal coverage.

There are two major political advantages to building a health insurance proposal around the concept of employer mandates. First, it keeps most of the cost of a proposal off budget

and consequently reduces the need for direct tax increases — a powerful political attribute during a period of $300 billion deficits.

As importantly, the employer mandate approach would build on the present public, private system and is consequently potentially the least disruptive approach for insurors, providers, payors and consumers. Building on the present system is more than a political cliche when you consider the impact some of the alternative proposals might have on this very large and critical sector of the American economy.

(SLIDE FOUR)

Let me turn now to a brief discussion of how employer mandates work. There are two approaches which have been developed during the policy debate over recent years. The first, which I have labeled the Direct Mandate, is the "thou shalt" approach, under which, by federal statute, employers would be told that "thou shalt" provide coverage for their employees. This mandate would be enforced, either through the tax code or through civil penalties.

The second approach which developed in recent years is the indirect mandate, or the "pay or play" approach. Under this approach, an employer can either provide coverage or pay a tax which would support coverage through a public program for its employees. This latter approach, I believe, grew out of a political concern that in spite of a good deal of precedent for mandating various actions by American employers, the concept of mandating still carries a somewhat harsh conotation which perhaps might be softened by the implication of some choice which is offered under the pay or play approach.

Leaving aside this political distinction, the substantive trade off between the two approaches appears to, in a sense, trade the interests of insurors vs those of small, low wage employers. Insurors potentially gain business under a direct mandate, whereas they potentially lose business with the existence of a residual public program. Of course, the critical factor in this equation would be the level of premium or payroll tax set in order for an employer to access the public program.

On the other hand, small and low wage employers would potentially benefit from paying a payroll based tax as opposed to a premium, which would often be significantly higher for small or low wage employers.

(SLIDE FIVE)

Those who have structured, or might in the future structure, employer mandate proposals have a number of issues which must be addressed in putting together such a proposal. I would list merely a few of the key issues.

- A definition of employers, employees and dependents must be developed.
- A definition of a benefit package and a definition of a cost sharing package - the level of premiums, deductibles and co-payments must be developed.
- A definition of administrative roles for the federal and state governments, employers and insurors must be developed.
- And finally, and most importantly, there must be a definition of what quality and cost control elements should be added to the proposal.

Technically employer mandate proposals could be coupled with anything from quite loose to very tight cost control provisions. In other words, cost control provisions could range anywhere from incorporating the current cost containment provisions of the various public and private payors, all the way to requiring a single set of rules for all payors — the so called "all payor global budgeting systems".

I think it is fair to say that most proponents of employer mandate proposals believe that if our nation were to mandate that employers provide coverage, there would be some obligation to couple that proposal with provisions and requirements that would put some reasonable limitations on the cost of that coverage.

(SLIDE SIX)

Let me turn at this point to a brief discussion on the cost impact of employer mandate proposals. The cost impact would of course, vary enormously depending on decisions made about the issues I have just listed. Obviously, a package which has broader benefits, lesser cost sharing and a broad definition of employers and employees would be considerably more expensive than a package with a more limited benefit package, higher cost sharing responsibilities and a more restricted definition of employers and employees.

For illustrative purposes I will describe the numbers set forth by the Pepper Commission with respect to their pay or play recommendations. In summary, their pay or play proposal, which would include their proposals to cover all those who are not connected to the labor force through a residual federal program, would result in increased federal spending of $24 billion. This would be coupled with reduced state and local spending of $7.4 billion.

Employer spending would rise by $14.7 billion in the aggregate. However, that number comes about as a result of decreased expenditures by employers who now insure of $12.8 billion because of the elimination of current cost shifting to these employers; and an increase in spending of $27.5 billion by those employers who do not now offer insurance coverage. Under the Pepper Commission proposal, current household expenditures would decrease by $19.3 billion leading to net new health spending of $12 billion.

There has been much discussion among economists — which has been as useful as most discussions among economists — on the issue of who would ultimately bear the the burden of employer mandates.

Some assert it would be low-wage workers themselves, other assert it would be employers who do not now insure, still others say it would be consumers who would pay higher prices for the goods and services these employers produce, and some say it will be the government as more insurance is purchased with pre-tax dollars.

Employer mandate proposals cannot be criticized for all of these impacts simultaneously. As Dr. Stephen Long of the Rand Corporation has said, "Certainly it can't be the case that workers bear 100% of the burden, that 100% goes into higher prices, and that 100% over burdens the owners of small businesses, all at the same time."

My sense is that the ultimate impact is spread, probably appropriately, among all of the parties mentioned.

One more point on the economic impact of mandates. Those who might be critical of this approach on the grounds of its impact on low-wage workers themselves, should keep in mind that almost all workers who have health insurance offered at the workplace willingly accept such coverage.

(CHART SEVEN)

Those of us who have worked on various health insurance proposals over the past few decades have learned that there are indeed no easy answers. It is true that <u>there is no free lunch.</u>

So, before concluding these remarks, I think it is important to spend a moment focusing on some of the problems with employer mandate proposals.

There are a number of key problems. The first of these is a set of structural problems. These structural problems grow out of the fact that our society is not composed entirely of "Ozzie and Harriet" type families with a working father, spouse at home, and two children. Indeed, these proposals must deal with difficult problems presented by, how you cover parttime employees, employees with multiple employers, cases where both spouses are employed and issues of divorced spouses to name a few.

There is also, of course, the issue of the impact on small employers of these proposals. Small employers have vigorously opposed employer mandates on the grounds that the burden of mandates could put them out of business. I think that there is general agreement that the impact on some small employers would have to be offset, to some extent, by phasing in requirements, adding tax credits, and insurance pooling requirements to ease the situation of small employers newly facing a mandate.

Of course the general economic impact of any health insurance proposals must be studied, as all of them have a potential impact on unemployment and inflation. I should point out that the Pepper Commission's estimate was that the impact with respect to unemployment would be less than 50,000 jobs potentially displaced — a number small enough to be offset by job creation through the normal workings of the economy.

Their estimate with regard to inflation was that the reduced inflation in health care costs due to cost containment provisions would offset any general inflationary impact.

And finally, there are some philosophic concerns regarding employer mandate proposals. Some simply don't see mandating various actions by employers as a government role, in spite of past precedents; and there are others who have concerns about the accountability for public expenditures when such expenditures occur in an off budget fashion.

Before leaving this list, I have a final word for those who may be nodding vigorous assent to all of these problems, and that is simply this; as I said a moment ago, there are no easy answers, there are no free lunches. And so I would suggest that each of you be equally rigorous about developing a similar problem list for the other alternative solutions which have been advanced to our health insurance problem.

(CHART EIGHT)

Let me now summarize the employer mandate concept, and say a word about the down side and up side of this approach. The concept involves either directly or indirectly mandating that employers provide health insurance to their employees. The approach is either "thou shalt" provide or "pay or play".

The down sides to these approaches involve primarily a set of technical and small employer concerns which must be dealt with, and a set of broader, general economic and philosophic concerns.

On the other side of the coin, the up side of these approaches is that together with Medicaid expansions, they can solve the coverage problem, something which cannot be said for a number of alternative solutions. They are pragmatically based on quite compelling logic, they would be predominately off budget with a reduced need for tax increases, a matter of significant importance in an era of $300 billion federal deficits. And, finally, they would build on our present public-private health insurance system. Because of these attributes, these proposals have drawn growing support from many parties involved on all sides of the health insurance debate over recent years.

(SLIDES OFF - LIGHTS UP)

For the last half hour, I have talked to you in the dry and technical language of a policy analyst. For the next few minutes I'd like to talk to you as a Physician who runs an inner city Public Hospital for the poor in our nation's heartland — in Kansas City.

These 37 million uninsured are not just an abstract statistic. I see them every day in the Emergency room waiting area near my office.

- They often work in low paid jobs in food service or retail — they may have served you breakfast or helped you at the convenience store last night.
- Many are irregularly or seasonally employed in construction or agriculture — they may have helped to build your house or put food on your table.
- and many have chronic illnesses and are essentially uninsurable if they are self employed or work for a small employer.

These people I have just described are the embodiment of the national problem of 37 million people without insurance — they are people in your community and in your daily life. Public hospitals such as ours in Kansas City serve as our nation's partial response to this problem. I say partial, because there are many we do not serve — many who do not live where there is a public hospital, many who receive some care at other hospitals, and many who defer needed medical care.

Reflect for a moment on that point. Some say they don't understand this problem. The uninsured, they say, receive medical care when they need to. Unfortunately, this is not

correct. It is generally true in our society that for a visible, dramatic, acute episode of illness everybody receives care. Few babies are born in the street, few with a fractured hip are left lying in the street, but many with hypertension, diabetes, pulmonary disease and heart disease go without medical care until their condition deteriorates. This is not just an insurance problem — it is a health problem for millions of Americans.

I hope that as our policy makers, including some of you in this room, wrestle with these economic and administrative complexities, you won't forget these people. I hope you'll remember that the ultimate test as we work through this debate is the extent to which we provide adequate coverage to all Americans.

Let me re-emphasize that point. You'll hear many plans discussed here over the next few days. As you listen, keep in mind — there is a threshold issue. Almost every other advanced western nation has met a standard — every citizen is covered. We must keep and hold a focus on that singular point. Yes, economic effects are important, the impact on the insurance industry is important, but the acid test of any proposal ought first to be is everybody covered. We, as the richest, most powerful nation on earth, should be ashamed to fail the test so many other nations have met <u>without</u> crippling their economies.

Surely one of the most enduring measures of a nation's values is its willingness to provide such coverage for all of its citizens.

I hope that by the end of this decade our nation will no longer fail to measure up to this test of national values.

EMPLOYER MANDATES

OVERVIEW

- Introduction
- Why Consider Employer Mandates
- How Employer Mandates Work
- Issues to Address With Employer Mandates
- Cost Impact of Employer Mandates
- Problems With Employer Mandates
- Summary

Prepared By: Dr. James J. Mongan – Executive Director, Truman Medical Center
– Dean, University of Missouri-Kansas City, School of Medicine

EMPLOYER MANDATES

INTRODUCTION

- **CONCEPT** – Improve health insurance coverage by requiring employers to provide coverage to employees
- **TWO APPROACHES** – Direct requirement (or mandate) or tax in lieu of providing coverage (Play or Pay)
- **RELATED POLICY PRECEDENTS** – Social Security, Workmen's Compensation, Minimum Wage
- **PRECEDENTS IN HEALTH INSURANCE DEBATE** – Approach chosen by both the Nixon/Ford Administrations and the Carter Administration
- **CURRENT SUPPORT** – Number of groups moving in this direction - AHA, AMA, Labor, Some Large Employers, Pepper Commission

EMPLOYER MANDATES

WHY CONSIDER EMPLOYER MANDATE

- **SOLVES A LARGE PART OF COVERAGE PROBLEM**
- **UNDERLYING LOGIC**
  - Most American workers insured through workplace (about 75%)
  - Most uninsured are workers or dependents of workers (again, about 75%)
  - Would need to be coupled with Medicaid expansion to achieve universal coverage
- **TWO MAJOR POLITICAL ADVANTAGES**
  - Keeps most costs off budget and reduces need for tax increases
  - Builds on present public/private system – Potentially least disruptive to insurers, providers, payers, consumers

EMPLOYER MANDATES

HOW EMPLOYER MANDATES WORK

- **DIRECT MANDATE:** "Thou Shalt" approach
  - Enforcement through either tax code or civil penalties
- **INDIRECT MANDATE:** "Play or Pay" approach
  - Employer can either provide coverage or pay a tax which would support coverage through a public program
- **TRADE-OFF:** Appears to be insurers vs small/low-wage employers
  - Insurers potentially gain business under direct mandate, potentially lose business with residual public program
  - Small/low-wage employers potentially benefit from payroll based tax as opposed to premium

EMPLOYER MANDATES

ISSUES TO ADDRESS WITH EMPLOYER MANDATES

- DEFINITION OF EMPLOYERS
- DEFINITION OF EMPLOYEES
- DEFINITION OF DEPENDENTS
- DEFINITION OF COST-SHARING
  – Premiums, Deductibles, Co-payments
- DEFINITION OF ADMINISTRATIVE ROLES
  – Federal and state governments, insurers, employers
- DEFINITION OF QUALITY AND COST CONTROLS

EMPLOYER MANDATES

ILLUSTRATIVE COSTS DATA ON EMPLOYER MANDATE AS PROPOSED BY PEPPER COMMISSION

(In Billions, 1990)

Federal spending		**$24.0**
State and Local spending		**(7.4)**
Employer spending (after taxes)		**14.7**
Employers who now insure	**(12.8)**	
Employers who do not now insure	**27.5**	
Household expenditures		**(19.3)**
Net new spending		**$12.0**

EMPLOYER MANDATES

PROBLEMS WITH EMPLOYER MANDATES

- **STRUCTURAL PROBLEMS**
  - Part-time employees, employees with multiple employers, both spouses employed, children of divorced spouses
- **IMPACT ON SMALL EMPLOYERS**
  - Impact on some small employers could be offset to a greater or lesser extent by phasing, tax credits, and pooling requirements
- **GENERAL ECONOMIC IMPACT**
  - Potential impact on unemployment and inflation
- **PHILOSOPHICAL**
  - Some don't see as government role
  - Concerns over accountability for public expenditures

EMPLOYER MANDATES

SUMMARY

- **CONCEPT**
  - Direct or indirect employer mandate
  - "Thou Shalt" vs "Play or Pay"
- **DOWNSIDES**
  - Technical and small employer concerns
  - General economic and philosophical concerns
- **UPSIDES**
  - Together with Medicaid expansion can solve coverage problem
  - Pragmatically based on quite compelling logic
  - Predominantly off-budget with reduced need for tax increases
  - Builds on present system with growing support from many parties involved in debate

REMARKS PREPARED FOR THE
KING'S FUND INTERNATIONAL SEMINAR
ADELAIDE, SOUTH AUSTRALIA
November 15-20, 1992

JAMES J. MONGAN, M.D.
EXECUTIVE DIRECTOR, TRUMAN MEDICAL CENTER
DEAN, UNIVERSITY OF MISSOURI-KANSAS CITY SCHOOL OF MEDICINE

I am very pleased to have this opportunity to meet new friends and colleagues from other English speaking countries, and to address the challenging issue set forth as the theme for the conference.

In preparing this presentation on whether or not there was a right way to make Hard Choices for allocating resources in our health systems — I started down a path towards a certain conclusion. I thought I might find, and be able to defend, a "right way". I was going to argue for "rationality".

Upon further study and analysis, I found that path, in my judgement, to be a blind alley. So, I retraced my steps and started down a different path towards what I now believe to be a more likely conclusion.

At the risk of being somewhat unfaithful to my original outline, I thought the logic behind my mis-started journey might be of some interest to you.

I started from the premise that in all of our countries health care expenditures either are currently, or will in the future be, capped. It is the capping of expenditures which inevitabily leads to the conference theme — Hard Choices for Health Systems.

In examining this first premise, I was struck by the fact that although many in our country feel a cap on health expenditures is inevitable, few have focused on a key issue — What occurs underneath a cap?

It has been noted that there are at least four potential impacts or consequences of a cap on health expenditures:

- Such caps might lead to increased productivity within institutions forced to exist within constrained resources
- Such caps might lead to reduced profits or earnings among health care institutions and practitioners
- Such caps might lead to a forced focus on the clinical efficacy of specific health services and a testing of society's philosophic views about the value of those services particularly at the very beginning and the very end of the life span

- And finally, such caps might lead to direct or indirect rationing of services - direct rationing by devising lists of covered services as proposed in our state of Oregon, or indirect rationing by limiting resources to the point of queuing.

It seemed to me that the Hard Choices we had to make were choices among these consequences — particularly the latter two — a focus on rational choices based on clinical efficacy; or rationing, either in its direct or indirect manifestation.

Parenthetically, I might say that I have skipped over the first two consequences of a cap as I enumerated them — enhanced productivity and reduced profits and earnings — because I assume they will both occur to some extent, but that a point is, or will be reached where no further savings are yielded.

Certainly in our country I am convinced that there are further efficiency savings to be had, but the are probably not sufficient to keep us from needing to limit services. Similarly, I believe that by cross-national comparisons, we could squeeze a bit in profits and earnings, in portions of the health sector, but again, probably, not to the extent that you would yield significant savings.

This logic path led me to framing the Hard Choice as an issue between rational choices based on clinical efficacy of services on the one hand; and the rationing of services -directly or indirectly — on the other.

The first steps down this path were easy for me. It seemed to me that before we began to ration services we had an obligation as health professionals to make certain that we were only paying for clinically efficacious services.

I was, and remain, clear in my opposition to the direct rationing of service as proposed in our state of Oregon.

I am strongly opposed to it, because of both philosophic and practical considerations. Philosophically, I don't like the idea of financing benefits for one group of poor people by taking them from another group of poor people. I also have little respect for Oregonians trumpeting the need for limits when their State's spending on Medicaid as a proportion of its budget is well below the national average.

But, in addition to these political or philosophical concerns, I also believe that this kind of explicit rationing, by devising a list of uncovered services, will not work for two reasons. First, it will prove nearly impossible to produce a sustainable consensus on those services which should be un-covered. Its fairly easy to agree that we should not cover cosmetic surgery, or perhaps even experimental procedures. But when you get much beyond this, it gets much more difficult and the savings from those items we can comfortably agree to exclude, are minimal.

The second problem is that even if a list were developed it would be quite ineffective. A case in point. The proposed Oregon list of excluded services would not cover care for cancer patients who had less than a 10% chance of survival over five years. Now that prognosis itself can be evaded; and more importantly, the treatment of symptoms such as seizures or internal bleeding would be covered, eroding much of the savings.

So, I believe that direct regulation of demand as exemplified by the Oregon rationing proposal will not have a significant future as a means of regulating health costs.

Well, if we do not make the Hard Choice of direct rationing by lists of services, what about the Hard Choice of indirect rationing?

Indirect rationing, by health expenditure caps leading to reduced availability of facilities, practitioners and services seemed to be the most common consequence of expenditure caps in countries where they exist. And, in our country, indirect rationing occurs in public hospitals which serve the indigent, such as my own in Kansas City, because we are given only so much money to work with by our local governments.

Although I live each day within a system of indrect rationing, my bias had been that society should be able to do better than this — through making the Hard Choice of allocating resources by making rational expenditure decisions based on clinical efficacy.

So the next step down my logic path was to propose that there is a "right way" to make difficult allocational decisions — basing such decisions on clinical efficacy. After all, numerous commentators in our country have spoken sweepingly of vast savings, some even estimating that thirty to fifty percent of the nation's health bill might be said to consist of expenditures that produce little or no demonstrable health benefits.

But here is where the trouble on my logical journey began, ultimately forcing me to turn back and re-trace my steps to a different conclusion. In retrospect, I should perhaps have known that the path, or option, you know least about often appears attractive on the surface. My work in the past had not brought me directly into contact with much of the health research and policy literature on clinical efficacy. After a reasonable review of portions of that literature, I found surprisingly little which I felt to be of use in the real world of limiting health care costs — the world of Hard Choices.

I found four general difficulties with the writings I reviewed. First, it was easier to find generalizations than data. Many articles cite substantial savings from focusing on the clinical efficacy of services, or structuring clinical practice parameters; but articles with specifics are harder to find.

Second, where you do find specifics, they are murky at best. One example. The surgical procedure known as Carotid Endarterectomy, a procedure aimed at clearing the carotid artery in order to either prevent stroke or improve outcome in stroke patients has been the subject of substantial comment. It would be nice to find clearly that the procedure either is or is not useful, either in all patients or some readily identifiable subset of patients.

Its unfortunately not that easy. In one exhaustive analysis, Brook and his colleagues at the Rand Corporation identified 280 actual indications for this procedure out of 1,300 procedures reviewed. This large list grew out of the fact that there were sixteen different clinical presentations including such things as a history of a single stroke, history of multiple strokes, transient strokelike condition, etc. These clinical patterns in turn occured in patients of different ages, with different risk factors, and with different x-ray findings.

Further, there was not much clustering of the indications for this procedure. It took 100 separate sets of indications to cover 80% of the 1,300 procedures reviewed in the sample. In other words, there were many different sets of circumstances which led to the procedure being performed, and there was far from substantial agreement on the appropriateness of the procedure in each set of circumstances. Not nearly as simple as two identifiable groups of people, one of which would benefit from intervention and one of which would not.

And there are additional problems with the data. Another study by Brook and his colleagues showed that after looking closely at different geographic areas which had high use and

low use of the procedure, there were no discernable differences in the percentage of inappropriate care in either site. So much for attempting to put limits on the procedure in high use areas.

A similar study by the same authors on coronary angiography, an invasive X-ray procedure involving injecting dye directly into the coronary circulation yielded results which appeared similarly complex. In this case, there were 119 clinical indications for the 1,600 patients studied — an intimidating number of sub-sets for which to establish useful review criteria. And, again, in this study there were no significant differences in the percentage of inappropriate procedures from high use to low use areas.

The third problem in the literature on clinical efficacy is one I have alluded to while describing the murkiness of the data. Not only is the data murky, but it also does not yield many clues which might lead to effective control strategies. If you cannot <u>easily</u> identify groups of people who would unequivocally fail to benefit from a procedure, or if you cannot target geographic areas of over-use, a health service administrator has little to work with on implementing a resource allocation strategy based on clinical efficacy. Practice parameters would be more useful written in black and white than in shades of grey.

The fourth problem which grows out of the writings I reviewed is that a focus on clinical efficacy and clinical practice parameters might indeed lead to increased expenditures. Some economists, including Eli Ginsberg, have stated a belief that the cost of expanding desirable services that are found to be under utilized are likely to exceed the savings from the elimination of unnecessary procedures.

So that was my analysis of a brief but substantial review of portions of the literature on clinical efficacy. It left me much less supportive of "rationality" as a way to make Hard Choices. So, as I said, I retraced my path.

But before turning away completely from the clinical efficacy discussion, let me touch on what I view as a somewhat related issue — that is the philosophic or moral challenge raised by some that we spend far too much on services that may not be useful at both ends of the life spectrum. Specifically, they point to such things as the fact that 28% of all Medicare expenditures go toward people in their last year of life, and the fact that 7% of all babies born are low birth weight infants and they account for 57% of costs incurred for all newborns.

I don't argue with these facts, but again they fail to lead anywhere. With respect to expenditures in the last year of life, they are difficult to control when one does not know in advance when the last year begins! An insurmountable dilemma. In addition, there is data that our system already devotes less resources to those over 80 than it does to those between 65 and 80.

With respect to low birth weight infants, it is hard to believe that a society such as ours which is tied in knots over the abortion issue, would have any interest in restricting expenditures for low birth weights infants.

Again, I find no magic in a focus on the two ends of the life spectrum as a way to make Hard Choices in allocating resources.

Well, as I indicated, having surveyed the literature with respect to clinical efficacy and rationality as a way to make Hard Choices I began to back up and retrace my path.

Which paths remain? I have already stated my belief that direct rationing as discussed in Oregon will not work and now my belief that rationality is equally problematic.

In observing health systems with expenditure lids and in contemplating my own institution which operates under an expenditure lid, I have reached the conclusion that, for better or worse, the future holds more of the "same old, same old". The current reality, where expenditure lids exist, is an indirect rationing of services by limiting resources.

Most of you know how that works. Let me say a word about what it means at my institution. I have a budget I must live within. We are forced to make regular decisions restricting expenditures for commodities, equipment and personnel. Those decisions are often difficult — they are never enjoyable. They always have the risk of impacting the quality of care we deliver. I must say in all candor, that at least at the resource level we have dealt with in the past decade, these restrictions appear <u>not</u> to have impacted directly on the quality of care we provide. Their main impact has appeared to be on our ability to recruit and retain key professional staff, which, of course, at some point, has the potential to impact on quality, unless we are in a situation where all institutions face the same constraints.

My biggest fear for the future is that I am not at all sure we have the ability to measure and track quality well enough to give society a meaningful early warning when it is beginning to squeeze too hard.

My conclusion is that the current reality of indirect rationing is unlikely to change -that there is no good answer to making Hard Choices; and that we all will have to slog through the daily realities in our own countries and institutions of doing our best to make do with limited resources. We will have to live with the fact that there will be no magic list of covered services, no matter how much we might yearn for one; nor will there be a conclusive list of useful and non useful services. We will, in the end, fall back on nothing more than our best human judgement as we manage within scarce resources. No magic — only hard work and error, but in the end that's what society looks to us to do.

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January 8, 1993

MEMORANDUM

TO: Members, Kaiser Family Foundation Medicaid Commission Working Group on Health Reform

From: Jim Mongan

RE: Concerns regarding developing Clinton Administration Approach to Health Care Reform

The developing Clinton Administration approach to Health Reform appears to be on the right track in at least two key respects:

- A commitment to Universal Coverage through a phased-in employer mandate for the uninsured who are employed, and an expansion of public financing for those not employed, and
- a commitment to strong cost control provisons with immediate impact in order to enable expansion of health coverage, and to allow a return to a healthy national economy.

The developing proposal, however, appears to be heading badly off-track in one key respect:

- an over-reliance on the largely un-tested, theoretical concept of managed competition as the basic framework for coverage expansion and cost containment; as opposed to managed competition being encouraged and facilitated as one among a number of building blocks used for coverage and cost control.

The remainder of this memorandum will consist of three sections:

- a summary of the concern regarding an over-emphasis on managed competition.
- a further elaboration of those concerns, and
- some ideas to address the concerns.

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SUMMARY OF CONCERN

Advocates of the theoretical concept of managed competion contend that it will control health care costs, protect the health sector from government regulation (which is why it receives support from most providers and insurers) and facilitate improved coverage and access for the uninsured. There is precious little evidence that it will accomplish any of these objectives, and real grounds for concern that standing alone as the basic framework for health care reform it could hinder the attainment of these objectives.

Progress in the United States is all about trying new ideas — it is not about taking blind leaps of faith which risk the health of the American people and their economy. The key thesis of this memorandum is that managed competition as the basic framework for health reform will not work. This does not mean that new concepts such as managed competition should not be an important element in reform; but that it would be irresponsible to depend on managed competiton as the basic framework for reform.

FURTHER ELABORATION OF CONCERNS

As indicated above, advocates of managed competition assert that it will control health care costs, protect the health sector from government regulation, and facilitate improved coverage and access for the uninsured. Each of these assertions should be examined in turn.

Cost Control - There is simply no substantial body of evidence, from the experience of the past few decades, that managed competition is effective in controlling health care costs. Advocates of managed competition attempt to avoid this reality by asserting that there has been no perfect laboratory for managed competition, where each of an ever growing list of fundamental fiscal, tax, and procedural incentives and regulations are in place. That may be all right for advocates, but it would be irresponsible for those officially responsible for developing our Nation's health reform strategy to base that strategy upon a leap of faith — not a proven concept.

Surely it must be cause for concern that an examination of health care costs in the San Francisco Bay area and Minneapolis, where substantial price competition has been in place among competing Health Maintenance Organizations, and fee for service plans for three decades and one decade respectively, shows no evidence that the rate of increase in health care costs has changed.

Similarly, it must be of concern that a 1992 Congressional Budget Office report showed mixed results regarding managed competition; with no significant savings attributed to practice models based on fee for service medicine and only modest savings attributable to the much less prevalent, and more difficult to build staff model HMOs, which hire their own physicians and run their own facilities.

And it must be of concern that there is thus far no evidence that there is a difference in the rate of increase of health care costs, over time, between staff model HMOs and traditional health insurance.

In addition to the above concerns about the underlying effectiveness of managed competition in controlling health care costs, there remains the extremely significant issue of timing of savings. Even the most ardent advocates of managed competition must concede that it would take at least two years, after passage of legislation, to set out the various regulations and tax incentives and to set up the infra-structure of Health Insurance Purchasing Cooperatives in each area of the nation, which would be needed to implement the concept.

Additional years would be necessary to stimulate and build the wide availabililty of delivery models with potential for savings, such as staff model HMOs. In brief, even if one were to believe managed competition might lead to savings, those savings would be five years down the road.

These concerns about the inability of managed competition to demonstrate a record of controlling cost, and the inability to yield immediate cost control, do not mean that there should be no role for managed competition in health reform. It means that managed competition should be an element within a broader basic framework for reform, under which the principles of managed competition could be allowed to attempt to prove their effectiveness and grow into a broader role over time.

Protecting Health Sector from Regulation - Managed Competition has been an enormously attractive concept to politicians of both parties, and scattered editorialists, because it purports to achieve the objectives of cost control and universal access through the operation of market forces, as opposed to federal regulation. This has also been the basis for support for managed competition from many groups of providers and insurers and a large portion of the business community.

However, as those charged with drafting specific health reform legislation will soon realize, this promise of a low level of federal regulation will quickly disappear. It simply takes a massive amount of regulation to attempt to set up the incentives and infra-structure for managed competition. Among the myriad of needed regulations are the following:

- Regulations to implement tax code changes
- Very detailed regulation of risk adjusters to premium rates
- Regulations on enrollment and marketing
- Regulations to detail the structure of Health Insurance Purchasing Cooperatives and
- Regulations to assure the quality and fiscal soundness of provider networks

These represent merely a sample of areas which would need to be addressed.

Improved Coverage and Access for the Uninsured - Managed competition advocates assert that this approach can facilitate improved access for the uninsured through Health Insurance Purchasing Cooperatives (HIPCs) managing the enrollment of newly covered individuals among competing Provider Networks. Here again there are a number of significant, realworld difficulties with this theoretical construct which would predictably limit provider networks from actively competing to cover the poor, even when a funding source exists. A few of these difficulties are as follows:

- Many of the poor are sicker, and consequently more expensive to cover; and we are years away from being able to actually risk-adjust premiums. The best we have been able to do under the Medicare HMO option is to adjust for age and sex, which account for only a portion of the risk differential.

- Even if we were able to adjust for risk, there are extra costs and management difficulties involved in operating in the inner city, such as security and social service costs, and recruiting and staffing difficulties.

- Provider networks serving a significant number of minorities and the poor can quickly find themselves at a marketing disadvantage. Unfortunately, advertising that you are especially strong in Watts does not help sales in Beverly Hills.

An additional major concern regarding access for the poor involves those situations where provider networks market to and enroll substantial numbers of poor people and then fail to provide adequate, readily available personnel and facilities, due to the cost and management problems of running inner city health care programs. The consequences of systematic underservice could be tragic, particularly if current inner city providers such as Neighborhood Health Centers, Public Hospitals and Teaching Hospitals were to be underbid and closed, leaving no alternative delivery system.

Again, these concerns do not mean that there should be no role for managed competition in Health Reform. These concerns mean instead that much work should be done on issues ranging from risk-adjustment through the development of guarantees for inner city coverage before managed competition is adopted as the basic framework for reform.

Additional Concern - There is at least one other major concern which should be set out regarding managed competition. That is the striking vagueness or lack of specificity, at this relatively mature stage of policy discussion about managed competition, concerning the structure of the major administrative vehicle for implementing managed competition — the Health Insurance Purchasing Cooperative or HIPC. An extraordinary set of questions remain unanswered at this time concerning what, specifically and concretely, a HIPC is or is not. An illustrative list of these questions is as follows:

- What is their range of responsibilities — do they only negotiate with provider networks, or do they also audit networks for compliance with quality and fiscal standards, manage open enrollment, enroll those new to an area, deal with consumer complaints, assure reasonable geographic access to services within plans, make income determination, etc., etc.?
- What is their governance structure — are they public, quasi public, or private bodies? Who holds HIPCs accountable, and how?
- Do HIPCs cross state lines and what criteria are appropriate for designating their geographic areas?
- Is the location and accessibility of their offices an issue — do they serve individuals with waiting rooms and 800 numbers, for those with complaints about out of area services provided by their networks?
- What kind and level of staffing is envisioned for HIPCs — do they have only employee benefits managers or do they also have actuaries, auditors, inspectors, customer relations representatives, etc., etc.?

In short, if managed competition, based on HIPCs is to be the basic framework for health reform, it puts an enormous burden on answering these and a myriad of other questions. If, on the other hand, managed competition were to be an element within a broader basic framework for reform, a number of these issues could be dealt with, area by area, over time.

IDEAS TO ADDRESS CONCERNS

As stated previously, the major thesis of this memorandum is that managed competition should not be the basic framework for Health Reform, but rather should be an element within a broader basic framework.

The basic framework of the Health Reform Proposal ought to consist of the two pillars upon which it is based:

- Strong cost control provisions which can become quickly effective, and
- Universal coverage, through a phased in employer mandate for the employed uninsured, and an expansion of public financing for those not employed.

Cost control cannot be quickly implemented through either managed competition or the imposition of a national global budget, which would demand an infra-structure of agencies in each geographic area to allocate budgets among types of providers, and between specific providers of each type.

Immediate impact, if it is judged necessary, can only be obtained through an extension of Medicare payment rates to all payors, or broader reimbursement controls, or a combination of these two.

These immediate steps could, if needed, serve as a first step towards a global budget, and they could be consistant with managed competition, for a portion of the population which could grow over time.

Universal coverage can be attained through a phased in employer mandate, most likely by employer size, and an expansion of public financing, most likely by income level.

Managed competition could also be implemented on a phased basis, area by area, over-time, with the pace of progress fitting local conditions. HIPCs could begin as purchasing cooperatives for small-employers and could grow as market conditions dictate. Overtime, they could demonstrate their ability to be of help to large employers and to the publically funded programs for the aged and the poor. A tax-cap, long sought by advocates of managed competition, might perhaps prove useful, both as a stimulant of competition, and as an important revenue source for expanded coverage. Such a cap would have to be set at a level consistent with a comprehensive benefit package and perhaps consideration should be given to a phase in period.

In conclusion, reform should be built around a basic framework of Universal Coverage and Cost Control, with that framework facilitating and allowing — but not totally dependent upon — the growth of managed competition as an important element of reform over time.