Durenberger File

Office of Senator Durenberger
Alternatives to Clinton Premium Caps

Clinton Plan:

The President's plan relies heavily on premium caps to achieve savings in the system. The CBO estimate assumes that the caps would be 100% effective and that they would lead to savings of $56 billion a year.

The Clinton bill would impose a formula to cap premium growth beginnning in 1996. The Board will determine abaseline target for each regional alliance based on adjusted historical spending. These amounts would be capped to allow a rise based on a formula tied to CPI plus general inflation factors (1.5% in 1996 declining to CPI plus 0 in 1999).

The Administration has argued that these caps are necessary to impose budgetary discipline. It also argues that the caps are "back-ups" that will not affect competition in the market.

Flaws in the Clinton Plan:

There are several key flaws in the arguments.

● Timing: The caps will be imposed in 1996, well before many medical markets will be functioning competitively.

● Data: There are serious flaws in the available data, making baseline calculations likely to be inaccurate in many cases. Data will not be developed prior to enforcement. This will lead to unfairness in areas where the cap is complied with. When some areas get caps lifted legislatively, other capped areas will rebel. This will undermine the market, add a political factor that will be contrary to efficiency, and undermine the whole process of health reform.

● Equity: Caps based on formulas tied to current spending will freeze in excessive expenditures in high cost areas and dramatically penalize areas where significant efficiencies have already been achieved. State-by-state limits overlook regional markets. In many states, large numbers of people move across state lines for care.

● Market Distortion: The design of the caps will inhibit not facilitate evolution of competitive markets. Insurers face significant uncertainty as they bid in the new market, which will include large numbers of previously uninsured individuals. Their incentive will be to bid high, both because of uncertainty and because the annual adjustments will prevent any correction. Many bad guesses in year one will lead to bankruptcy in year two.

ALTERNATIVE

Expenditure Targets (or Performance Targets)

Some have argued that we should not have premium caps of any kind. Given the structure of the Clinton cap, it is easy to understand that view.

However, there are several reasons why we should construct some form of budgetary discipline in the reformed system. The first is short-term; that is, to capture some scorable savings for the ultimate bill.

The second is more important. We do need better information on market development and we need some accountability on the part of the providers/insurers to achieve market efficiencies.

Thus, we should develop a performance target provision that will accomplish specific goals:

- Targets that will encourage market evolution and provider accountability. Targets will generate information on health spending and will give providers goals to shoot for.

- Targets that will reward efficient markets and punish inefficient markets. They convert into enforceable limits only after sufficient time has elapsed to allow market development and will only be imposed on markets that have failed. They will be a stick to accelerate market evolution.

Several major issues will need to be resolve.

1. Baseline problems:

First, the design of the Performance Target provision must take into account some of the problems in establishing the baseline.

PPRC recognizes the lack of data in this area and recommends the construction of a transition from historical baselines in the short term to a common limit (adjusted for certain factors). Without some transition, historical baselines lock in various inequities, particularly low spending regions.

The transition formula could accommodate the concerns about "windfall" as the subsidies phase in and previously uninsured (uncompensated care) individuals acquire coverage. There is also an issue on adequate subsidies for public program recipients. IF Medicare and Medicaid payment rises to a level equivalent to private sector, the implicit cost shift from public payer to private payer would decrease or disappear. (Some argue that we will always be underpaying public programs. If the Medicare and Medicaid cuts go into effect, it is unlikely that payment rates

will rise, unless we restructure those programs immediately.)

GAO has found that there are seven variables that are significant predictors of state spending: income, number of physicians, number of hospital beds, number of nursing home beds, a measure of health status, percent of hospital beds in metro areas, and a regulatory variable (rate regulation in the state). In other words, system capacity is an important source of variation. The only factors that should be used for adjustment are ones that states cannot control, ie input costs of labor and nonlabor, demography, geographic distribution, health status and epidemiological factors, and social or environmental conditions affecting special needs for services.

The formula then would develop information on market structure that would correspond with the market evolution models developed in the private sector. APM has broken markets into four stages of development (unstructured, loose framework, flux and consolidation, and managed competition).

The transition formula translates into a "glide path" that sets the market performance targets over time.

Steps must be simultaneously implemented to collect additional data that could allow targets to be set more accurately. A process must be established so that the national board or other entity is given the authority to make corrections in performance targets (in a budget neutral way?).

2. States and Markets

We know that all medical markets are local, and do not respect state lines. We also know that we need some entities to be accountable for the collection of data on all these data points.

PPRC has found that substate data (ie, market by market) would be harder to collect that state-wide data. How can we design a data collection system and an enforcement system that would recognize market areas not state boundaries?

Should states be responsible for gathering data within market regions in order for targets to be set and adjusted?

This process would make the states accountable for collecting data on their medical markets. The performance targets would be visble, readily measurable, thus keeping sellers honest. But, how would we deal with interstate markets?

3. Issues Regarding Enforcement:

Once there was an adequate baseline with appropriate techniques for adjustment, the next issue is when those targets become limits, and how they are enforced?

Performance targets become mandatory limits ONLY in noncompetitive markets that have failed to meet the targets over the four year period. Four years is long enough for adequate data on the baseline to have been collected, and for the baseline to be adjusted accordingly. It is also enough time for markets to begin evolving.

An open issue is how to enforce those limits. If it is state by state, how does one deal with a New York situation, where some markets like Albany and Rochester may be well below the target, and some like Long Island well above? If the target is set at the state level, would states use low spending markets to average out high spending markets to assert compliance, easing the pressure on the high spenders and reducing the likelihood that limits would be enforced? The issue becomes acute in the states with high variations across regions, like New York (Albany versus Long Island) and Massachusetts (Worcester versus Boston) and California (Bay Area versus Los Angeles). It is less of a problem in states like Oregon which is generally low spending across markets, or Florida which is high spending across markets. On the other hand, states could use internal pressure to force market evolution in non conforming markets.

Resolution of this issue requires consideration of the trade offs between state level targets and market level targets (which will be harder to develop accurately according to PPRC.) In either case, there would still be a strong incentive to gather adequate information on the market (to develop the baseline) and to reduce spending through efficient delivery of care.

4. Institutional issues:

Open issue on who should develop the formula. PPRC (or a body similar in structure to PPRC is the right one. ProPAC is also appropriate for hospital analysis. AHCPR does not have this type of expertise specifically, although an expanded AHCPR might develop it. Given that time is of the essence, that PPRC and ProPAC have credibility and capability at date of passage (and could begin development of preliminary models prior to legislative passage?), these organizations are the best bet.

Proposal

1. National Board develops formula for baseline, including mechanisms for adjusters for variations out of state control (eg demographics, labor and non labor cost variations, etc). Baseline adjusts for potential windfall as uncompensated care becomes insured (tie to phase in of subsidies however constructed). Open issue: does Board impose the formulas, or does Congress approve first? Base closing model as possibility?

2. Board begins the process of identification of regional markets (including markets that cross state lines), and directs states to begin to collect data in the market areas (interstate cooperation will be required. New England region has already developed a tristate entity, for example). Data will include prices, costs, and other factors relevant to market structure.

3. Board develops a transition formula that will create equity across regions over time, moving toward a national "glide path." (range within which all markets must fall).

4. Board (or Congress) develops an adjustment factor, based on CPI plus percentage. The base formula, plus the transition adjustment, plus the CPI+ percentage equals the performance target.

5. Process for subsequent baseline adjustment at end of first year after enactment (State petition process?)

6. Congress specifies (or Board develops) a process for enforcement of premium limits at end of year 4 that will apply only to noncompetitive markets (defined as those that have failed to meet targets at that point in time). No limits enforced on competitive markets.

7. Limits convert to targets once market is in compliance (do we want a minimum period of limits-- such as 2 years?)

OPTIONS

1. **Phased Approach** (Breaux-Durenberger w/universal coverage imperative).

- Subsidies effective immediately
- No initial mandate; individual mandate and/or employer mandate are applied if universal coverage is not met by a certain date (e.g. 2000).
- Congress defines default mandate (e.g. individual) but could modify (e.g. add employer mandate) to tailor it to remaining uninsured.

Advantages:
- Allows changes in market to occur before mandate is imposed, potentially avoiding unnecessary mandate.
- Mandate could be tailored to the remaining uninsured.
- No employment effects in early years

Disadvantages:
- More costly than phasing in subsidies
- Leaves people uninsured until deadline.
- Uncertainty for businesses and individuals

2. **Individual mandate.** (Modification to Chafee bill.)

- Subsidies phased-in as savings accrue
- Individual mandate effective when subsidies fully phased in
- If savings aren't realized by date certain (date?), benefits commission would submit to Congress a proposal for fast-track consideration to make up shortfall (could include changes to benefit package; spending cuts; tax cap; premium taxes/caps).
- The proposal could not call for delaying the subsidies, but disapproval by Congress would mean a delay in the subsidies.

pros:
- federal budget not put at risk, greater budgeting flexibility;

cons:
- uncertainty about universal coverage; benefits level; and premium caps/taxes.
- If savings not realized, will not achieve u.c.
- uncertainty for industry re. demand and uncompensated care as well as financing

3. **Modified, phased-in employer mandate** (variation Urban Institute, Pepper Commission).

- Mandate on large (>100) companies to pay at least 50% of premiums.
- Employer contribution not capped as percent of payroll.
- All businesses get subsidies for low wage workers.
- Mandate for small businesses phased in (e.g. after three years for 50 and under; after four years for 25 and under; could phase-in only if certain percent of employees remain uninsured)
- Sliding scale subsidies for low income families.

pros:
- maintains current large employer involvement; since no cap on employer contribution, employers stay engaged in cost control;
- individuals more conscious of true health care costs;
- well targeted subsidies;
- w/employer contribution, lower marginal tax rate for lower income;
- government subsidies help level playing field among small businesses even before mandate is in place.

cons:
- could still have job losses and wage effects;

Options for Getting to Universal Coverage

Assumes:
- Achieving universal coverage
  - will require subsidies for lower-income individuals (e.g. up to 240% of poverty); and
  - will probably require an individual mandate: and,
  - may require an employer mandate.

- Congress should commit to achieving universal coverage by date certain.

Advantages and Disadvantages of Individual Mandate
pros:
- promotes individual responsibility;
- no negative impact on the labor market or firm structure;
- subsidies are easily targeted at low-income families (rather than low-income workers or low-wage firms).

cons:
- incentive for employers to drop coverage for low wage earners
- high marginal tax rate between 100% and 240% of poverty
- harder to enforce
- politically unpopular(?)

Advantages and Disadvantages of Employer Mandate (as in HSA)
pros:
- maintains current employer contributions and role in cost control;
- easier to enforce;
- broad acceptance (but most business opposes).

cons:
- job loss at lower-income levels; wage reductions (since 88% of cost of insurance is passed through to employee, employees are still really paying for health care)
- since employer contribution capped, employers have no incentive to hold down costs;
- hides true cost of health care for individuals
- subsidies not well targeted

Solving the Deficit Problem in Health Reform

Three bills -- the Administration's, Chafee-Thomas, and Cooper-Breaux have three different ways to prevent deficit spending that might occur due to incorrect budget estimation. In simple terms, the Administration's bill caps the entitlement for subsidies, Chafee-Thomas controls the phase-in of subsidies, and Cooper-Breaux controls the cost-shift for government underpayments of subsidies. CBO has rejected the Administraton's cap on entitlements as not legally binding, and has not yet ruled on the other two bills.

The fundamental choice in designing a budgeting mechanism is who or what will be at risk if the government is wrong about its estimates of costs and revenues. Under the Clinton plan, the government would be at risk. In Chafee-Thomas, those receiving Medicaid would be at risk because the subsidies would be delayed. In Cooper-Breaux, all Americans would be at risk because health premiums would increase to make up any shortfall.

Three other budgeting mechanisms are worth mentioning. First, a tax cap could be manipulated by automatically lowering the cap to raise the revenue necessary to make up for a shortfall. Second, the benefits and/or cost-sharing could be put controlled by requiring automatic reductions to reduce costs. Third, the price of plans could be automatically reduced to make up a shortfall. This last approach is different from the Administration's bill because it would use price controls to enforce a limit on government spending, not on all health care spending as in the Administration's bill. The price controls could be targetted at high cost markets.

The following two options use two different starting points: the Chafee-Thomas and Cooper-Breaux bills. Additions are made to strengthen their weaknesses using all of the above options.

Option 1-- Chafee-Thomas with Fast-Track Consideration

A provision would be added to the Chafee-Thomas budgeting mechanism to require the benefits commission to submit to Congress for fast-track consideration a proposal to make up the shortfall. The proposal could not call for delaying the subsidies, but disapproval by Congress would mean a delay in the subsidies. The commission's proposal could call for a reduction in benefits, Medicare cuts, lowering the tax cap, or price controls on high cost markets.

Option 2 -- A Variation on Cooper-Breaux with Fast-Track

A shortfall in funding the subsidies would trigger a premium tax on all health plans including self-insured plans. The amount of the tax would be limited to the amount of the shortfall. A provision would be added for fast-track consideration of a delay in the phase-in of subsidies or any of the other possibilites listed for the commission's proposal in option 1.

BENEFIT PACKAGE APPROACHES

OPTION 1 (CLINTON'S HEALTH SECURITY ACT)

List a comprehensive standard package of specific services to be provided to all Americans. A national board would be responsible for interpreting and updating the benefits package and recommending revisions to the Congress and President.

OPTION 2 (CHAFEE - H.E.A.R.T.)

List of general medical benefits to be included in all benefit plans. Commission or a Board to define co-insurance, deductibles, out-of-pocket limits and to recommend additions or subtractions of general categories to the benefit plans.

OPTION 3 (BREAUX-COOPER)

List of general benefits to be included in all benefit plans. Commission or Board to develop specific uniform benefit on an annual basis for Congressional consideration.

OPTION 4 - VARIATION TO OPTION 2 OR 3

Add to either Breaux or Chafee another control mechanism to the Board or Commission when recommending changes to the benefit package. Require that X percent of the benefit plans offered in an area by purchasing groups, cost no more than Y dollars per year.

OPTION 5:

Limit the number of standard benefit packages which can be offered by insurance plans. The options could be defined in statute or could be defined by a federal board or commission, or the National Association of Insurance Commissioners. Standards could be approved by the Secretary of Health and Human Services or by the Congress. This general approach would be consistent with the original Durenberger small group reform legislation (2 defined benefit packages), or with Medigap standards (10 defined benefit packages).

OPTION 6:

Set the standards for a minimum or catastrophic insurance package which must be offered by all insurers and allow them to develop more generous packages, but require insurers to separately price each alternative.

OPTION 7:

Set an actuarial value and allow insurance plans to develop a benefit package within that limit. The value could be a nationwide standard or could vary by region. Congress could set broad standards which required hospitalization and out-patient services or could remain silent and leave that decision up to individual plans.

DESIGN OF BENEFIT PACKAGE AFFECTS THE FOLLOWING IN HEALTH CARE REFORM

Voucher Amounts
Cost to Federal Government and deficit or tax increases
Who or what body decides benefit changes
Who oversees delivery of benefits
Technology and how its included and encouraged
Co-payments and deductibles
Catastrophic alternative and/or Medical Savings Accounts

Finance Friends Mtg.
Friday 10-1 (4 issues)

3 hearings

1. early retirees
2. mal practice / Anti-trust
3. Mentally ill / Institutionalization

Employer Mandate Trigger

call Bill

5/13/94
VERSION

Dear Dave:

I have just finished reviewing your Medicare Choice Bill, S.1996, and find that we share many of the same objectives for improving the Medicare program.

Like you, I think it is important to expand beneficiary choice to include the full range of delivery system options, from fee-for-service, to PPOs, point of service plans, HMOs, and the variety of combinations that are emerging. Medicare beneficiaries should have the ability to enroll in the type of plan that best meets their own particular needs. Your inclusion of quality and solvency standards, the prohibition against health screening, and the annual open enrollment period provide some of the beneficiary protections that are critical to any expansion of plan choice. Some protections now included in the Medicare HMO program, however, such as appeal rights and state licensure of plans, do not appear to be included in Medicare Choice, and their ommission may cause consumer concern. Similarly, I am concerned anti-discrimination provisions relating to health status do not also extend to race, ethnicity, and gender.

The information requirements in the Bill on plan costs, quality, performance, and other relevant factors are vital to any effort to provide beneficiaries more choices and infuse principles of managed competition into Medicare. I recently initiated a number of projects to improve and expand the information beneficiaries now receive. For example, we are currently engaged in the development of valid quality measures that will be meaningful to beneficiaries. We also devoted a special portion of our recent research solicitation to encourage projects that study and develop better ways of providing and disseminating information to Medicare beneficiaries. Without first-rate techniques to provide and disseminate appropriate information on all plans, managed competition cannot succeed.

I also strongly endor e simplifying program administration. A standardized, paperless, one-stop billing process for Medicare and supplementary insurance claims will help both beneficiaries and providers.

There are, however, some provisions of Medicare Choice that are likely to cause concern among aging advocates. For example, placing fee-for-service beneficiaries partly at risk for higher health care costs in their geographic area or for any excess growth rates in their area seems to convert Medicare from a benefits program to the equivalent of a voucher, which is inconsistent with the history of the program and the principles of social insurance. Similarly, moving toward tying Medicare reimbursement to the cost of the lowest priced plan and penalizing beneficiaries for enrolling in certain types of supplementary insurance could be interpreted as a way of devolving our responsibilities as public officials onto

individual beneficiaries.

There are many elements of Medicare Choice that will enhance the Medicare program. We would very much like to work with you and your staff to refine those elements that may be of potential concern to the aging community. I look forward to working together on this.

Sincerely yours,

Bruce Vladeck

Durenberger

August 27, 1993

TO: Chris Jennings

FROM: Jordana Zubkoff

SUBJECT: Minnesota Events on September 17

I had a long conversation with Susan Foote Tuesday morning when she returned from her vacation and I spoke with her again on Thursday regarding the Mayo Clinic suggestion. We discussed the Minnesota health care folks she was proposing for a meeting with Mrs. Clinton as well as the suggestions from Senator Wellstone's office. Her opinion of Senator Wellstone's suggestion is that the school based clinic would be fine, but that these programs are "high quality fillers" that are just filling in the gaps in the health care system. In addition, these types of programs are not unique to Minnesota.

Per Susan, Senator Durenberger would love to host an event for Mrs. Clinton to meet with representatives of the Minneapolis health care community, particularly the HMO Council, the Business Health Care Action Group and other organized group purchasers. I have attached a memo she faxed outlining possible issues and people for a meeting at the Mayo Clinic. I asked her not to contact any outside individuals until she has spoken to you. Rochester, Minnesota is approximately an hour and a half drive from Minneapolis and is accessible either by car or by plane.

To: Chris Jennings
Office of the First Lady

From: Susan Foote
Senator Durenberger's Office

Re: Visit of Mrs. Clinton to the Mayo Clinic

Date: August 26, 1993

Senator Durenberger would be honored to escort the First Lady to the Mayo Clinic when she visits Minnesota on September 17th. As you know, the Mayo Clinic is a pioneer group practice model, with a unique organizational structure that provides world-class medicine at competitive prices. Among the Mayo innovations include salaried physicians, sophisticated technology assessment, and an attitude that if you do it right the first time, you save money and get the best results.

In addition, Mayo is on the forefront of changes in the medical marketplace that make Minnesota one of the highest quality, lowest cost states in the nation. Among the issues that could be discussed with the First Lady are the following:

1. Network Building in Rural Areas

A significant concern of supporters of the managed competiton approach is its viability in rural areas. The Mayo Clinic has developed a reputation as a referral center. However, it is located in a rural area that extends south into Iowa and east into Wisconsin. Mayo has been building up a regional referral base by affiliating with rural practitioners primarily through purchase of rural practices (Decorah, Iowa/ Eau Claire, Wis).

The rural practitioners get the prestige of the Mayo name, the educational opportunities provided by a teaching facility, and access to the tertiary care facilities of the Rochester hospital. In many areas, Mayo is in competition with other large clinics, leading to a competitive model in rural areas. The participants in the meeting will be well equipped to address the issue of rural network building as it has developed in their region.

Another facet of this network building involves the ability to create efficient networks across state lines. Often, regional markets extend into more than one state. In these cases, there is concern that the networks might be dismantled by a health reform approach that gives states excessive flexibility. This is an issue that Senator Durenberger raised with the First Lady when she met with the Senators last spring.

2. Creative Managed Care/Quality Improvement

Mayo offers a managed care program of its own and has collaborated with other managed care networks as a referral center. The most exciting development is Mayo's participation in a major new health care delivery network. The Business Health Care Action Group (composed of 15 of the largest Twin Cities Employers) put out a bid for an integrated service network to be offered to the employees (about 170,000 lives).

The Coalition has negotiated a comprehensive health plan with Health Partners (a large HMO formerly called Group Health) that includes a working relationship with Park Nicollet and Mayo. An innovative feature of this plan is an Institute committed to development of practice guidelines and quality improvement. It is the first major evaluation system built right into a health services delivery network.

The CEO of Health Partners is George Halvorson, a major player in the health care marketplace in Minnesota. You might want to ask that he be included in the meeting because of his relationship to Mayo and his knowledge of the cost savings generated by a competitive market with high HMO penetration. He has just completed a book on health care markets and is exceptionally knowledgeable. Health Partners is moving its networks into rural areas, so George could also speak about rural competition and access.

3. Medical Education Issues

Mayo is a leader in medical education. They have many concerns about adequate supply of primary care physicians, support for research and training and other issues. Minnesota's medical education institutions (U. of MN and Mayo) produce primary care physicians in substantial numbers compared to other major research institutions. The First Lady may want to talk about physician supply with them.

I hope this gives you some ideas for a Mayo visit. As I said to Jordana on the telephone, the Mayo leadership is terrific, and they are quite familiar with the protocol required for dealing with visiting public officials.

Please let me know if I can be of further assistance.

154 RUSSELL SENATE OFFICE BUILDING
WASHINGTON, DC 20510-2301
(202) 224-3244

1020 PLYMOUTH BUILDING
12 SOUTH SIXTH STREET
MINNEAPOLIS, MN 55402
(612) 370-3382

United States Senate

DAVE DURENBERGER

August 2, 1993

Chris Jennings
Congressional Liason for the First Lady
Health Care Task Force
210 Old Executive Office Building
Washington, D.C. 20500

Dear Chris:

Minnesota has a number of very knowledgeable health care providers, buyers and consumers, and policy analysts. Senator Durenberger would be honored to help the White House identify and organize meetings with key leaders.

In fact, he suggested that the First Lady might want to participate in a health care summit similar to the very successful model of the economic summit the President convened in Arkansas during the transition.

Minnesota is the model of a functioning health care marketplace. I am in the process of completing a major report that documents the achievements of the Minnesota market in terms of costs, quality, and access. I will be sure to send it over to you when it is completed.

Here is a partial list of individuals and organizations, by category. This is not meant to be exhaustive. It is a selected list of people that have impressed me with their knowledge and background in health care:

1. <u>HMOs (called ISNs or integrated service networks under Minnesota law)</u>

HMO Council (representing all HMOs in the state)
Dr. James Ehlen, Chairman (he is also CEO of Medica)
Medica
5601 Smetana Drive
Hopkins, MN 55343
(612) 627-4301

George Halvorson, President
(is one of the most knowledgeable and creative HMO leaders).
HealthPartners
2829 University Avenue SE
Minneapolis, MN 55414-3230
(612) 623-8400

2. Hospitals

Richard Norling, President and CEO
Fairview Hospital
2312 South Sixth Street
Minneapolis, MN 55454
(612) 672-6612

Gordon Sprenger, CEO
HealthSpan
2810 - 57th Avenue North
Minneapolis, MN 55430
(612) 863-4524

3. Organized group purchasers

Steve Wetzell, Manager
Business Health Care Action Group (15 large employers)
3639 Elmo Road
Hopkins, MN 55305
(612) 627-5304

Robert Cooley, Manager
Employee Insurance Division
State of Minnesota
Station 6-2642
200 Centennial Office Building
658 Cedar Street
St. Paul, MN 55155
(612) 296-2642
(Bob runs the state employee health plan on a managed competition model. It is really impressive.)

4. Consumers/Advocates

Luanne Nyberg, President
Childrens Defense Fund of Minnesota
550 Rice Street
Suite 104
St. Paul, MN 55103
(612) 227-6121

5. **General Experts**

Sheila Leatherman, President
Center for Health Care Policy and Evaluation
United HealthCare Corporation
9900 Bren Road East, Route 8092
Hopkins, MN 55343
(data systems, report cards)
(612) 936-7373

Cindy Polich, V.P.
United HealthCare Corporation
9900 Bren Road East, Route 8092
Hopkins, MN 55343
(long term care)
(612) 936-7360

Dale Shaller
Consultant
1819 Fourth Street North
Stillwater, MN 55082-4217
(612) 430-0759

Patricia Drury
Consultant
3401 St. Louis Avenue
Minneapolis, MN 55416
(612) 922-5225

Professor Bryan Dowd (612) 624-5468
Professor Roger Feldman (612) 624-5468
Professor Jon Christianson (612) 624-4610
University of Minnesota
Institute for Health Services Research
P.O. Box 729
420 Delaware Street SE
Minneapolis, MN 55455

Please feel free to call me or Senator Durenberger for additional suggestions.

Sincerely,

Susan Bartlett Foote
Senior Health Policy Advisor

To: Chris Jennings

From: Susan Foote

Re: First Lady/Durenberger Event

Date: Sept. 5, 1993

Time: Late morning One and half hours/ 11:00 -12:30/ Sept. 17

Place: Meeting room close to Northrup Auditorium
Possibly on the Augsburg College Campus -within one mile of Sabo event

Who: 75 invitees from provider community

What: The central theme of the meeting should highlight the group practice tradition in Minnesota and its contribution to competition in the health care marketplace. Minnesota has a high penetration of HMOs and PPOs, and burgeoning networks of integrated service systems in rural areas. This tradition is of central importance to Minnesota's success in keeping costs low and quality high and is a key element in the President's health reform package.

Invited guests (with representative presenters) will be leaders in creative group practice and health care service networks. These would include representatives from the Twin Cities-based HMOs and PPOs, organized medicine and nursing, along with rural group practices that are the underpinnings of future accountable health plans throughout the state. A few key state leaders and U. of M scholars would also be invited.

Proposed Program: How Competition Works in Minnesota

1. Welcome and introduction of First Lady
   Senator Durenberger (2 minutes)

2. Acknowledgement and brief remarks
   First Lady (3-5 minutes)

3. Overview of Minnesota marketplace/Why competition works in Minnesota
   Senator Durenberger (10 minutes)

4. Overview of managed care successes in Minnesota, with a focus on how the HMO and PPO penetration (about 70% in Twin Cities) has kept costs low (administrative efficiencies, competition on the basis of price and quality, etc) (8 minutes)

   Presenter: George Halvorson, CEO HealthPartners

5. Overview of issues of quality and consumer satisfaction in the Minnesota managed care market/ building quality into integrated network health care delivery (8 minutes)

   Presenter: James Reinertsen, MD
   CEO Park Nicollet

6. How hospitals have adapted to the competitive environment (8 minutes)
   Presenter: Rick Norling,
   Fairview Hospital and Health Care Services

7. Building networks to the rural areas (8 minutes)
   Representative from rural clinic (TBA)

8. Opportunity for First Lady and Senator Durenberger to question presenters
   (15 minutes)

   Open the floor to q and a to First Lady, Senator, and or presenters (15 minutes)

Is there time for press availability after the event? (10 minutes-15 minutes) Press would be in attendance at the meeting, with possible taping of the conversation for later broadcast on public television.

I can be reached at home this weekend P6/b(6)
or at the office (202) 224-4055.

PLEASE CALL ME AT EITHER LOCATION ON MONDAY SEPTEMBER 6TH. ONCE WE HAVE FINAL CLEARANCE FROM YOU WE CAN PROCEED TO CONFIRM SPEAKERS, INVITE GUESTS, AND WORK WITH YOUR STAFF REGARDING SECURITY ETC.

THANKS.

CALL SABO Augsburg College

THE WHITE HOUSE
WASHINGTON

9/3/93

Susan Foote 5:50 pm

re: size of event in Minnesota

public event
10 [illegible] for public

50? 200? 5000?

what about security - would like to stay on university campus

202 224 4055 W

P6/b(6) H

inviting providers, clinics, HMO types for the event

Senator - introductory remarks
3 speakers

sending fax

To: Chris Jennings

From: Susan Foote

Re: First Lady/Durenberger Event

Date: Sept. 3, 1993

Senator Durenberger called in to the office immediately following our conversation, so this proposal conveys his personal views about how to set up the meeting.

Time: Late morning One and half hours/ 11:00 -12:30

Senator Durenberger felt that the meeting should be a public event. He says that all the other meetings are public, and that it is inappropriate to have this meeting "behind closed doors."

The central theme of the meeting should highlight the group practice and group culture in the Minnesota medical community. This tradition is of central importance to Minnesota's success in keeping costs low and quality high and is a key element in the President's health reform package.

Invited guests (with representative presenters) should be drawn from the many creative group practice and health care service network models that exist across the state. These would include representatives from the Twin Cities based HMOs and PPOs, along with rural group practices that are the underpinnings of future accountable health plans throughout the state. Examples include the Willmar Clinic, Duluth Clinic, Fargo Clinic, Olmsted Clinic, Dakota Clinic, Grand Forks among others.

Proposed Program:

1. Opening remarks and welcome by Senator Durenberger/ Why competition works in Minnesota - An overview (15 minutes)

2. Overview of managed care successes in Minnesota, with a focus on how the HMO and PPO penetration (about 70% in Twin Cities) has kept costs low (administrative efficiencies, competition on the basis of price and quality, etc) (10 minutes)

   Presenter: George Halvorson, CEO HealthPartners

3. Overview of issues of quality and consumer satisfaction in the Minnesota managed care market/ building quality into integrated network health care delivery (10 minutes)

   Presenter: James Reinertsen, MD
   CEO Park Nicollet

4. How hospitals have adapted to the competitive environment (10 minutes)
   Presenter: Rick Norling,
   Fairview Hospital and Health Care Services

5. Building networks to the rural areas (20 minutes)

   Panel discussion presenters:
   Steve Orr - Lutheran Hospital Systems
   Scott Wordelman- Chisago City Health Systems
   Lynn Freeman, Clinic Administrator Willmar Clinic
   Bob Waller, Mayo Clinic

6. Opportunity for First Lady and Senator Durenberger to respond, ask questions, etc.
   (10 minutes)

LOGISTICAL ISSUES TO RESOLVE:

Audience size - Demand among providers will be high. Senator wants to include rural providers as well. We do not want to compete with concurrent events hosted by Sabo. But, we want to be responsive to the Senator's desire for a public event and the numbers of providers who will want to attend.

I suggest 150-300 invited guests. Please advise.

Location - There are likely to be available spaces on the University campus (Medical School, Law School). Also possible is auditorium on the Augsburg College campus. What are security needs, restrictions, etc.?

Press - We suggest that public television may want to tape the discussion for later broadcast. Other press will surely want to cover it. Is there time for press availability after the event? (10 minutes-15 minutes)

I can be reached at home this weekend (202) 588-0299 or at the office (202) 224-4055. We need the logistical decisions BEFORE Tuesday so planning can begin. THANKS

(fyi - attached news clip of DD's response to President's NGA address.)

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work as well, holding a prayer service in an effort to maintain calm. The story of Vidor spread throughout the country.

Into this came Simpson, 7-feet tall and 300 pounds with a noticeable limp from a construction accident. Simpson was not the first black to move to Vidor after the desegregation order. That title was held by John DeQuir Sr., 59, who moved into Vidor Villas in February. Simpson had come a month later.

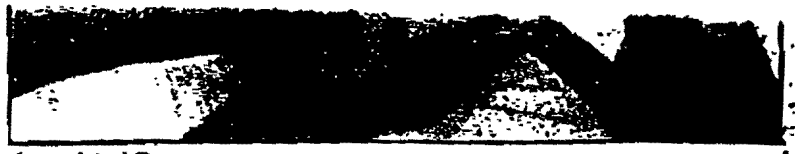
At first, things seemed to be going well. Simpson attended Central Baptist Church of Vidor and would regularly make his way to the soup kitch-

becoming a target. Finally, he decided it was time to move on.

A few hours later, Simpson was fatally shot on a street in Beaumont, 8 miles from Vidor.

Police said Thursday that Simpson was walking with a friend, Lydia Washington, when several black men drove up in a car and tried to rob the pair. One man shot Simpson several times with a 9-millimeter pistol when he tried to run away; he died in a Beaumont hospital. Washington was shot in the leg and was hospitalized in stable condition.

"It's just a loss. There's no other way



Associated Press

Bill Simpson, shown in a photo taken last Friday, was shot to death Wednesday night near his new home in Beaumont, Texas.

to put it," said businesswoman Lin-Marie Garsee, who befriended Simpson and rented him a house. "Everybody is shocked. I mean, total shock."

Yesterday morning Beaumont police arrested Michael Wayne Zeno, 19, whom they identified as the gunman and described as a member of a local gang called the Hoover Crips. Capital-murder charges were pending. Three accomplices also are being sought.

...er: Health care reform on track

...esotans told controls necessary before expansion

...dy cannot afford to offer ..., inefficient care. It will ... bank, and we will all be

...ger, one of a dozen GOP ...s the administration is ...n health care, laid out his ...even as White House offi... noted "the vast majority of ...s" would be covered by ...er the administration's re...

...o Durenberger said there are still too many questions about the reported phase-in period — all states would be required to cover all residents by Dec. 31, 1997 — to draw conclusions about its impact.

But the aide said Durenberger is relieved at reports that the administration will not seek to cover all 37 million uninsured Americans immediately upon passage of reforms next year and that Clinton no longer is considering proposing short-term price controls on the health industry.

Clinton intends to unveil his health-care plan in a speech to Congress the week of Sept. 20, and he probably will issue a detailed description of it at that time. But it may take weeks for the administration to submit draft legislation to Congress, officials said.

After this summer's bruising budget battle, in which Republicans unanimously voted against the president, Durenberger sounded a conciliatory note. In a letter to his Senate colleagues, he wrote: "The president wants health reform to be bipartisan. I wholeheartedly agree."

To the letter, he attached the report to his constituents in which he praised Clinton and Hillary Rodham Clinton, his principal adviser on health-care reform, for shunning a government-run, single-payer system like Canada's and supporting a private sector plan.

But Durenberger, who supports a more pure market-driven system, expressed concerns that:

Health care continued on page 10A

National news

Workers installing the baggage system at Denver International Airport were on strike as negotiators sought to end a dispute that may delay the airport's Dec. 19 opening. At issue is whether millwrights will maintain the baggage system once it's built. More than 300 workers walked out. Negotiators for Local 2834 of the Millwright & Machinery Erectors met with officials from BAE Automated Systems, which is building the computerized baggage-handling system.

A 13-year-old boy was indicted on a second-degree murder charge in Bath, N.Y., for the beating death of a 4-year-old boy. Eric Smith was charged with killing Derrick Robie Aug. 2, as the younger boy walked alone in the village of Savona. Police said

After the hurricane, time for repairs

day, the last black to stay on in what is known as one of the meanest towns in the South, where the common wisdom for a black man is to be gone by sundown.

He went to nearby Beaumont. And there, as he was standing on the street late Wednesday night, he was gunned down in an apparent act of random violence. Authorities blame suspected black gang members.

All that fear in Vidor, only to have his life end when he thought those long nights of danger were over.

Simpson was a homeless manual laborer who became a minor celebrity in these parts because of his willing-

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When word

Durenberg

By Greg Gordon
Washington Bureau Correspondent

Minn

Washington, D.C.
Sen. Dave Durenberger, whose vote is considered key to passing health care reforms, said Thursday that President Clinton is "heading in the right direction" but that he should not try to cover uninsured Americans until medical costs are under control.

"For many reasons," Durenberger, R-Minn., said in a report to his constituents, "I believe that we should get costs under control FIRST, by reforming the delivery of health care, and THEN phase in coverage for all.

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Gov. Ed Schafer, also
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oved a $5.7 billion aid
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damage is estimated at
0 billion. And officials
n states expect to ask
more money later and
tax increases and bud-
p pay for repairs.

latest tally of losses:
41 million; Wisconsin,
Missouri, $292 million;
million; Illinois, $210

Health care/ Durenberger says plan would be unfair to Minnesota

Continued from page 7A

■ Under Clinton's plan, small businesses might be forced to contribute to workers' health insurance premiums while costs remain out of control. Declaring, "We must never sacrifice jobs for health insurance," Durenberger contended that many firms will buy coverage when it becomes affordable.

■ By leaving flexibility to each state, the Clinton plan might encourage "51 different health care systems." He called for national rules and direction that give states flexibility in deciding when reform is possible.

■ Clinton has shown no recognition that Minnesota and several other states have developed highly efficient health care systems, yet are being asked to subsidize wasteful systems elsewhere.

For example, Durenberger said, Minnesota enrolls two Medicare patients for less than half the money that it costs to cover one in Philadelphia, but residents in the two states pay the same Medicare taxes.

The basic benefits package, in its current form, will include hospital and doctors' services, family planning services, "pregnancy-related services," hospice care, home health care, nursing home care (up to 100 days after a hospital stay), routine eye and ear examinations and preventive dental services for children.

It will not cover cosmetic orthodontia or other cosmetic surgery, hearing aids, eyeglasses for adults, in vitro fertilization services, sex-change surgery or private hospital rooms.

The basic package reflects a minimum that all health insurance plans would have to cover. Employers could provide more but they would lose their federal tax deduction for such extra expenses after three years, or at the end of existing labor contracts that expire after Jan. 1, 1997.

Meanwhile, after months of considering a new per-pack cigarette tax ranging from 50 cents to $2, Clinton told his staff Tuesday night he was leaning toward the low end of the scale, and wanted to consider taxing liquor so tobacco would not have to shoulder the entire burden of paying for the health care plan.

The development, said some administration officials and members of Congress from tobacco-producing states, is easy to explain: Clinton has needed those congressional votes again.

The White House publicly dismissed talk of deal-making yesterday, but some members of Congress have unabashedly claimed a quid pro quo. Others said the development reflects an understanding on the part of the White House that a hefty tobacco tax would make it impossible for them to support health reform.

The administration believes it needs to raise $16 billion from sin taxes to help pay the costs of health care reform, White House health care spokesman Kevin Anderson said. A $1-a-pack tax, in addition to the current federal 24-cent tax, would raise the entire amount, he added. The Coalition on Smoking OR Health says an additional $1 tax would raise $13.5 billion.

Lawmakers from the tobacco-producing states say 44,000 people would be put out of work by a $1 tax because of the decrease in smoking that would follow.

Antismoking proponents were highly critical of a tax in the range of 50 to 75 cents.

To impose that level of tax "would be a great mistake," said former surgeon general C. Everett Koop, who said the job loss figure was "an exaggeration."

"If you rise the tax high enough, you will cut down on consumption and if you cut down on consumption, you save lives."

The Coalition on Smoking OR Health, an antismoking umbrella group for the American Heart Association, the American Lung Association and the American Cancer Society, estimates that 1.1 million lives would be saved by a new $1 tax.

This report includes information from the Washington Post and the New York Times.

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n page 7A

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ter systems shut down, entire public water sys- toines for 12 days. Mos- tial carriers of encepha- l in stagnant water.

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fore and he is going to need them

Dear Mr. H, My neighborhood looks like it has the plaguel Scores of houses, mine included, are afflicted by some strange, irregular discoloration that gives the hardboard siding a blotchy appearance. And worse yet, it doesn't go away. Two years ago my neighbor next door repainted. The house looked nice for a while but now "it" is back blotchy as before.

154 RUSSELL SENATE OFFICE BUILDING
WASHINGTON, DC 20510-2301
(202) 224-3244

1020 PLYMOUTH BUILDING
12 SOUTH SIXTH STREET
MINNEAPOLIS, MN 55402
(612) 370-3382

United States Senate

DAVE DURENBERGER

July 13, 1993

Christopher C. Jennings
Congressional Liaison for the First Lady
Health Care Task Force
Old Executive Office Building
Room 212
Washington, D.C. 20500

Dear Chris:

I enjoyed speaking with you this morning. Enclosed are the materials that we discussed. This package includes:

1) "Medical Technology Meets Managed Competition," the Senator's views on aspects of medical technology;

2) "The Bi-Partisan Path to Health Reform" which includes the Senator's sense of the points of agreement and disagreement between the Administration and moderate Republicans;

3) Materials relating to his Responsible Federalism proposal that would allows states to "swap" responsibility for Medicaid in return for assuming community and public health functions.

Please call our scheduler, Julie Hasler, at 224-9468 to set up the meeting with Ira Magaziner and Senator Durenberger that we discussed.

Sincerely,

Susan Bartlett Foote
Legislative Assistant
for Health

Senator Dave Durenberger
U.S. Senator for Minnesota

THE PATH TO BIPARTISAN HEALTH REFORM

Key Differences between the Administration and Republicans

by Senator Dave Durenberger (R-MN)
May 17, 1993

Congress and the President agree that our national goal in health care is universal access to high quality care through universal coverage of financial risk.

WE AGREE that reducing the cost growth in medical services is key to our success. We agree that only an American solution to the cost of health care can reduce that growth from the current and projected 20% of GNP by the end of President Clinton's first term (what he calls the cost of doing nothing) to 10% of GNP by the end of his second (or Bob Dole's first). And that should be our goal.

We agree that true consumer choice and producer competition is the American solution and that something called "managed competition" can make medical markets work.

So at meetings the last two weeks we've aired our differences on two crucial issues. They are:

"Who manages competition?"

"How do we pay for universal coverage?"

WHO MANAGES COMPETITION?

Not all congressional Republicans and Democrats believe that managing competition is the solution to cost containment.

Some Democrats believe that universal coverage is more important than fixing the market. Indeed, some don't trust markets at all. They favor state or federal government regulation of prices for services. Sometimes they use the term managed competition to describe this regulated system, but with so much government, there is little competition to manage.

MORE

On the contrary, some Republicans stress the competition over the management. They believe that individuals, completely unassisted, should "manage" competition. They argue that if every American were required to pay for the first, say $3,000, of medical services and government guaranteed access to catastrophic insurance protection of greater risks, individuals could select the best physicians and services and competition would flourish.

They are both mistaken. Let's look closely at what markets require to work well. The current market in medical services does not work because we consumers do not have the information we need to judge what is of value to us, nor the incentive to acquire that information. Indemnity insurance has combined with fee-for-service medicine to rob us and the providers of the incentives we need to do what is right. We need to change how we buy and how we sell health care services.

President Clinton and a large number of Democrats and Republicans seem to favor a system that changes how services are delivered by changing the way consumers buy coverage. Large employers and cooperative -- consumer managed -- groups of individuals and small employer purchasers will demand information about cost and quality of health plans.

These plans compete for our business by providing us each year with better health and medical services, more information about what "works" and by increasing our satisfaction level with one plan compared to others.

The most competitive plans will link the financing and administration of services with the medical caregivers. Paid by an annual premium (not on fee-for-service), they will have the incentive to deliver high-quality, cost-effective care. Physicians make most of the diagnostic and treatment decisions. So, rewarding good physician behavior should be the key to higher quality and lower cost.

We know this works because we have evidence in several key markets. The Mayo Clinic and a growing number of multi-specialty clinics in the United States have achieved the size and scale to do excellent medicine at low prices. Mayo's cost increases the last 10 years are 4.8% a year against a national average of 11%.

If every insurance plan in America covered first class airfare to Rochester, Minnesota, our national prices for health care would be less than 10% of the GNP today! In Los Angeles and Miami today, you pay insurance premiums that are 78% above the national average while in Rochester, Minnesota, they are 23% below the average. In Minneapolis-St. Paul, Minnesota, they've dropped from 10% above to 15% below the average in ten years of competition "managed" mainly by employers choosing among several strong "accountable health plans".

MORE

Decisions about appropriate use of specialists, technology, hospitals and other care settings are made by the medical providers. Decisions about satisfaction and value (appropriate price) are made by consumers.

In order to help consumers make good choices, we need to provide better and more useful information for them. Minnesota's health care market, despite its successes, lacks the necessary information for truly effective consumer choice.

A growing number of state governments, pressured by rising costs of Medicaid and politics, are pressing enactment of laws to prescribe the power of purchasing groups, to dictate doctor-hospital-technology relationships and to authorize purchasing groups to set prices paid to providers.

This is antithetical to markets which reward the choices of good providers with more business and which then pass the dollar savings on to the purchasers of accountable health plans (us).

HOW DO WE PAY FOR UNIVERSAL COVERAGE?

This is where the differences between the Democrats and the Republicans present the President with his greatest difficulty. And, may also present him with his most significant opportunity.

Today there are three differences between the Republican approach, on which more than 40 Republicans in the Senate agree, and President Clinton and the Democrats.

1st: Timing of Universal Coverage

The President and the Democrats want universal coverage legislated this year and in place by 1996. The President and the Democrats seem willing to raise taxes by $100 billion a year to accomplish it.

Republicans oppose universal coverage now for several reasons:

> Very substantial price disparities for the same services exist in different parts of the country. A majority of the states are below the national average and about a dozen states are above the national average. Universal coverage now means that states in which the medical practice has been conservative or in which efforts at reform have been increasingly successful would be sending large amounts of tax money to reward inefficient care givers and communities.

Adding millions quickly to coverage paid by third-party payers in these and other states will run up the costs and utilization beyond all expectations.

In addition, the reason Republicans reject universal coverage now is that the imposition of universal coverage on the current marketplace will impede and probably defeat efforts to bring costs down through market reform.

The Republican position is that we must provide the national policy framework to restore sound markets a community at a time and then move to universal coverage by redesign of public policies which subsidize the price of health plans for all Americans.

Republicans believe that the process of redesigning public policy can begin now with the passage of insurance underwriting reforms--including guaranteed issue and portability from job to job--which were included in S.1872, the Bentsen Durenberger bill that passed the Senate in August of 1992. We also believe that we should encourage buyer coalitions to bring about reform of the delivery system.

We believe Medicare should be restructured to provide more comprehensive benefits through the purchase of an accountable health plan. This would replace the confusing and uncertain Part A/Part B/Medigap patchwork in the present system. We agree that long term care should be built into Medicare, and that the promise of retiree health benefits by private firms should be supplemental to the Medicare program.

Republicans believe that the current $100 billion annual payroll and income tax subsidy should be restructured. The current system favors well-paid employees and punishes the self-employed. We need a more equitable tax subsidy keyed to the price of the low-cost comprehensive plan in each community.

Republicans believe that Medicaid should be scrapped and a premium supplement paid to guarantee access to health plans for all low-income persons on a sliding income scale.

Republicans believe in individual and community responsibility for public health and for psychosocial and education-related services.

MORE

2nd: Employer Mandates

Democrats and Republicans agree that ultimately every American should own a health plan. And, we agree on all underwriting insurance reforms. BUT, the President and many Democrats want to ensure universal coverage NOW with mandates on all employers to provide coverage or pay a 7% payroll tax to purchasing groups to buy health plans for employees.

Republicans support a mandate on individuals to own a health plan, but believe it should only come into effect when market reform is underway. Republicans believe that employers should be required to offer health plans, and some of us also think there should be a choice of plans presented. But, with so much inequality among employers and with so much price variation, we don't believe employers should be forced to "play or pay."

Republicans believe that unless the cost shifting onto the private marketplace can be eliminated and inequalities reduced, ERISA should remain intact.

3rd: Price Controls and Global Budgets

The President and the Democrats still talk about annual limits on state health spending through fixed budgets on providers and voluntary or involuntary price controls on services.

Republicans reject this arbitrary approach. We believe that the federal government can and should design performance targets on a market-by-market basis to measure changes in the percentage of annual cost growth. Some Republicans do believe that without enforceable annual expenditure limits, the market cannot be made to fulfill expectations of cost containment.

Republicans do not want to penalize the low-cost, high-quality states who have made good progress toward reform, nor to discourage efficient providers or high-value plans from getting more business. If market incentives are properly designed, we will see reductions in cost. Top-down budgets will just invite gamesmanship, rationing, and quality reduction -- not real reform.

Republicans and Democrats have many points of agreement. But important differences remain. We are searching for a common ground, for only with bipartisan effort can true health reform succeed.

-- # # # --

6B

Medical Technology Meets Managed Competition

Medical technology is an integral part of health care, not an expensive add-on or afterthought. Therefore, technology policy must be consistent with the approach to health care reform. Our present market has failed to generate adequate information on new technologies and perverse economic incentives have led to overutilization. In managed competition, health plans, not government, are best suited to make most technology decisions. The federal government can provide a safety valve for specific coverage decisions and can facilitate the acquisition, evaluation, and dissemination of information on new technologies.

by Senator Dave Durenberger and Susan Bartlett Foote

In the veritable blizzard of studies, reports, articles, and speeches devoted to reforming the health care system, medical technology issues (defined to include drugs, devices, and procedures) are rarely addressed. Given the critical role of medical technology in the cost and the quality of medical services, this oversight is significant.

Why this short shrift? The root cause stems from an erroneous premise about the role of technology in health care. The false assumption is that technology is an independent "cost-driver," an add-on, an afterthought, a problem one turns to after the "important" work of health reform has been done.

In reality, technology is inseparable from health care services. In a modern medical setting, technology *is* health care. Rational technology policy is essential to the overall success of health reform.

Air travel provides a good analogy. Airline service involves skilled professionals (pilots, engineers, air traffic controllers) using complex technical equipment. One cannot separate the skills of these individuals from the technology they operate (aircraft design, computers, and safety equipment). In modern medicine, technology is integral to the service.

We do not imply that technology is an unmitigated good in either case. On the contrary, there may be an oversupply of equipment, inaccessible facilities, costly innovations, inappropriate government subsidies, and so on. But, the answer is not to return to the days of the propeller or to the black bag. The answer is to manage the technology in socially desirable ways.

There is widespread agreement that the health care marketplace is dysfunctional and that reform is necessary. The fundamental debate is whether the market can be fixed or whether to replace the market with a government-dominated system.

Marketplace Mistrust

Advocates of a government model assume that a governing body should control most of the decisions about health care services. Among these decisions is when and how a technology becomes available and the price that can be charged. (American Health Security Act of 1993). These regulators simply do not trust the market generally, and their mistrust spills over to decisions about new technology.

Even some supporters of a market-based system of services assume, often without much analysis, that a federal regulatory board should control technology. But such regulation is actually inconsistent with the principles of managed competition. Because of the integral relationship of technology to services, it is hard to see how competition could thrive if government regulates all the tools of the trade.

Managed competition rests on a careful mix of provider competition

Dave Durenberger is the senior Republican U.S. Senator from Minnesota. He serves on the Senate Finance and Senate Human Resources committees. Susan Bartlett Foote, JD, is the senior health policy analyst on Durenberger's staff.

and consumer choice. The challenge for policymakers is to design a management system — the rules of the game — in which private entities, both buyers and sellers, compete.

Technology management must not be based on knee-jerk ideological responses — that government is *always* better than the market, or that the market must be *totally* unfettered. In some places, the market works well, and where it does not, we offer ways for government to improve the functioning of the market or to supplement it if necessary.

Market Failures

Our present health care system has two key failures in terms of medical technology.

First, there is an absence of adequate information on the costs and benefits of new technologies. Without good information, providers and consumers cannot make decisions about the value of alternative decisions. The information deficit is inextricably linked to the second problem—perverse economic incentives.

These incentives lead to overutilization of existing technology regardless of cost. In a fee-for-service system, the more services a provider performs, the more she earns. High-tech services are often more lucrative than non-technical alternatives like counseling, or watchful waiting. For insured patients, there are few, if any, financial restraints if a technology or procedure is recommended. And, providers' medical liability concerns, both real and perceived, add fuel to the flames by encouraging unnecessary tests to protect the medical record.

In turn, this cost-insensitive market has not created demand for information about the comparative risks, benefits, and costs of alternative technologies. If buyers do not need to balance costs and benefits, there is little incentive to pay to produce credible information about them.

Government Management

We can get some insight into how government manages technology by looking at Medicare. Medicare is a $129 billion program serving 31 million beneficiaries. Its track record offers little encouragement about the wisdom of more government in technology decisions.

Medicare includes Part A hospital insurance coverage and Part B, a supplementary program covering physician services, outpatient services, and some limited ambulatory care. For its first 16 years, Medicare was a retrospective, cost-based, fee-for-service model — in other words, a federal bill-paying service.

In 1983, Congress changed the Part A hospital payment system, moving to a prospective fixed-price system based on diagnostic-related groups (DRGs). More recently, Congress enacted a new method for paying physicians under Part B. The shortcoming of the resource-based relative value scale (RBRVS) is that it is premised on fee-for-service, but it provides greater rewards to the primary care and cognitive-based services at the expense of high-tech interventions.

Medicare's Technology Policy

The Medicare law governing technology establishes a set of benefits and explicitly excludes certain services from coverage. The law provides only vague authority to consider coverage for new technologies and procedures.

In addition, the decisionmaking process for coverage is highly decentralized. In most cases, carriers that have contracted with the U.S. Health Care Financing Administration (HCFA) to process claims make independent decisions on technology coverage. In recent years, patient groups and insurers have put greater pressure on HCFA to offer greater uniformity on coverage decisions.

Under the current system, HCFA can decide to issue a national coverage decision under certain circumstances. It can ask for an evaluation of a particular type of medical technology from the Office of Health Technology Assessment (OHTA), which is part of the Agency for Health Care Policy and Research (AHCPR).

Federal technology policy under Medicare suffers from a range of problems:

• **The government has underfunded evaluation of technology.** The Medicare program spends only a fraction of its budget on evaluation or assessment of technology. The total budget for AHCPR, of which OHTA is a part, runs about $120 million a year. Compare this to $129 billion spent on Medicare services (HCFA, 1992) and to government spending on basic research at the National Institutes of Health — more than $8 billion. The pressure to pay for services has overwhelmed government's willingness to pay for evaluation.

• **Government cannot do cost-effectiveness assessments.** Although cost data is essential to evaluation of a technology's contribution, government regulators are ill-equipped to evaluate costs. As currently structured, there is no clinical base for their analysis. They do not use technology, they do not purchase equipment, they pay no bills. All the relevant data reside in the private sector where the services are performed.

• **Government assessments are political.** Politics pervades HCFA decisionmaking. In compliance with a consent decree, HCFA issued a proposed rule in 1989 to revamp its technology policy but has never promulgated a final rule (Federal Register, January 30, 1989). In fact, the proposed rule was withdrawn in the fall of 1992 on the grounds that further study was necessary — after three years of study. The reluctance of the Department of Health and Human Services to promulgate a highly controversial rule illustrates how politically charged government decisions about technology policy are.

• **Public payers are still payers.** HCFA doesn't have explicit authority to consider costs when making a decision about coverage. However, there is widespread suspicion that HCFA does so implicitly, primarily by delaying decisions on coverage if the technology could raises costs. It is unrealistic to think that HCFA, which pays more than $100 billion for Medicare, would be unconcerned about costs.

While some may argue that technology policy should be made by government, there is no reason to believe that government would be any more generous than a private plan. Any payer — public or private — must be concerned about the bottom line.

• **Government cannot make timely decisions.** Finally, government decisionmaking is bureaucratic, slow, rigid, and rule-oriented. Innovation is rapid and dynamic. A bureaucratic approach to technology policy that would affect all Americans, not just the Medicare population, raises serious concerns. OHTA performed only about 10 assessments in 1991 and eight in 1992. Some assessments have been buried in the bowels of OHTA for over three years.

It appears that the Clinton Administration's health reform proposal will be based on some form of managed competition, which rests on a fundamental belief in competition. Competition for health care services will best serve the consumer of health care. Government assists the competitive process by ensuring four basic institutional changes:

(1) Comprehensive service organizations, often called accountable health plans, or AHPs, deliver care to people who enroll in the plans. These organizations accept an annual payment in return for providing a uniform package of benefits.

(2) Purchasing pools made up of large employers or groups of employees of small businesses and the self-employed, act as buying agents and managers. Often called health insurance purchasing cooperatives or HIPCs, these pools allow all individuals to participate in the market equally. It is through these pools that individuals select their preferred health plans.

(3) A national board, composed of expert advisers, would define the uniform effective benefit package that all plans would have to offer.

(4) Other reforms include tax code revisions, malpractice reform, and antitrust reforms to support the functioning of the marketplace.

Technology and Competition

We must rethink of our concept of a benefit package. Under managed competition, a national board will set a general benefit package that all plans must offer. We must move away from the laundry list approach, where procedures are enumerated and the individual feels entitled to receive them. It is time to end the artificial distortions for treatment that a laundry-list benefit package creates.

The new package represents a commitment by plans to provide high-quality health care to their enrollees. It is an exchange of promises, not an entitlement to a specific set of identified interventions.

Thus the health plans determine which specific procedures are appropriate for the conditions of individual beneficiaries. If a treatment is not specifically included in the federal benefit package — and few would be — plans are free to decide whether and under what circumstances to provide it.

However, if a plan does not offer a particular intervention, it must be able to articulate defensible, scientific principles for the decision. There would be an appeals process that would be linked to other available grievance procedures.

Some will object to such an approach, claiming that plans will be driven by economic motives and will deprive beneficiaries of newer and more expensive interventions. Or they may argue that plans will cave in to excessive consumer demands for high-tech products, allowing our present arms race to fuel the cost-escalation spiral.

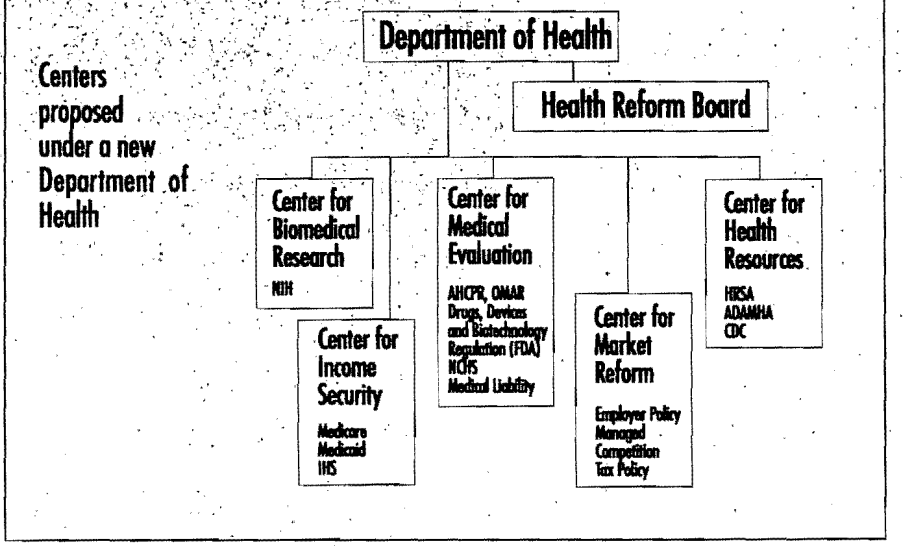
Yet we believe assigning technology decisions to plans will have the following advantages:

• **It will put consumers in the driver's seat.** Under managed competition, consumers select among competing plans. The consumer can weigh the price of the plan against the data on outcomes (a quality measure) and consumer satisfaction. In many instances, we believe that the highest quality plans will also be the most cost-effective. However, consumers are in a position to weigh differences in making their choice.

If a national board in Washington made decisions on what procedures to cover, the process would be much

Figure 1

Designing an Infrastructure For Health Reform



less accessible to consumers. Centralization at the federal level would politicize medical judgments, which would then be imposed on everyone through the uniform benefit package. It would also eliminate the ability of plans to reflect local preferences.

• **It will generate data on cost-effectiveness.** Producers of technology will have to market their products to cost-sensitive plans, and plans will invest in cost-reducing, quality-enhancing approaches. Data to justify the claims will be carefully scrutinized. Information on costs, risks, and benefits will be demanded and produced, relieving some of the gaps in our present knowledge.

• **It will temper demand with information.** There are many assumptions made about insatiable consumer demand. It is true that, without reliable information, Americans often want the latest treatment. However, the research of John Wennberg, MD, of Dartmouth demonstrates that patients may prefer less intervention than doctors do.

In the case of prostate surgery, he has found that when patients are given detailed information about side effects, they are much less likely to want surgery than physicians are to prescribe it. The popularity of living wills and advance directives are evidence that people facing decisions about sustaining life may be more likely to say "enough is enough" than physicians have been.

• **It will allow plans to be responsive to consumer values.** At some level, tension between cost and quality is inevitable in any system. The issue is whether the plans are the appropriate place to balance these goals. We contend that for most decisions they are. Plans can respond to local and regional values, and plans are subject to much less political pressure than a federal agency might be. Consumers, the most important actors in this system, can vote with their feet during open enrollment.

No system will make these decisions easy because tradeoffs will inevitably have to be made. However, to use Uwe Reinhardt's terminology, "ad hoc decisions in the trenches" are preferable to arbitrary, highly politicized, federal uniformity (Eckholm, 1993).

Government's Role

The federal government has two extremely important roles to play in a technology policy under managed competition.

First, the federal government should assume a modest role in centralized coverage policy. While most decisions will be made at the plan level, there are several points at which uniform national policy is in the best interests of the health care system and all its participants.

Second, it must retain and expand its function in acquiring and processing information about technologies. It is inefficient and wasteful for duplicative, overlapping studies on technologies to be performed by plans.

While many decisions about coverage will reside in the hands of the plans, there are three key points at which the federal government should assert a role:

(1) Clinical trials. Participation in federally approved clinical trials or other outcomes research projects should be covered in the uniform benefit package. Mandating coverage for trials will help generate good information and will alleviate some of the pressure on plans when they refuse to provide access to new procedures before sufficient data has been made available.

(2) High cost/high benefit innovations. When a new technology may produce enormous social benefit at exceptionally high cost, plans will be under significant pressure to provide the benefit. For example, a cure for AIDS that costs $2 million

per patient could jeopardize the plan's ability to provide the full range of health care to other members. In these rare situations, the federal board can provide a safety valve for society. An explicit coverage decision must include consideration of the global cost consequences of the innovation. If the system included controls or caps on plan premiums, adjustments on these restraints might be required.

(3) Highly contentious technologies. Some decisions are so contentious in the medical community that national policy may be warranted. The board can serve as a safety valve once again to help resolve disputes, and provide necessary national consistency. An example is coverage prostate cancer screening, when the test is costly and of questionable reliability, but appealing to the public. Plans may want a national decision on minimum requirements (which they could exceed but not fall below) to minimize dissent among the public.

Plans and consumers would have the power to petition the board for a coverage policy determination under these carefully designed limits. The board would have the discretion to determine when explicit, uniform decisions are necessary and appropriate.

Finally, the board can step in if plans flagrantly disregard consumer values. The board will be able to alter the benefit package, or even recommend a different approach to Congress, if the allocation of decisionmaking responsibility is unsatisfactory. While we don't expect this reserve authority to be used, it provides the ultimate safety valve to the system.

Information is essential to the success of managed competition. But information is often costly to gather and analyze, and the market may not generate all the information necessary to good decisionmaking. Therefore, the federal government will play a major role in acquiring and evaluating information on technology. Information is required at three levels: research, including randomized clinical trials; assessment; and guidelines based on demonstrated outcomes of alternative procedures.

At all three levels, there is a federal role in the gathering and processing of information. Admittedly, the federal track record in evaluation is mixed (Foote, 1987), and the public policy environment for many technologies can be characterized as uncertain, conflicting, and inconsistent (Foote, 1992).

However, we believe that government can fulfill this task if government activities are brought together in a center for medical evaluation (Durenberger, 1992) (See Figure 1).

This center would elevate evaluative sciences within the federal bureaucracy. There are many excellent programs now ongoing in a variety of agencies. NIH has great capacity to do clinical trials, and AHCPR has designed excellent programs for cooperation (Patient Outcome Research Teams), guideline development, and some technology assessment.

This center would have the authority to encourage coordination and cooperation among government agencies currently engaged in evaluation. It could also help private sector plans cooperate, facilitate public-private partnerships, and bring the clinical expertise of professionals to the table, including the best centers of excellence in the country.

The center can ensure that information not available in the marketplace is being developed and disseminated. Through public-private partnerships and other cooperative efforts, the center can also ensure that information flows to and from the plans.

Continual Information

The goal is to learn what works and what doesn't. We need to move away from binary decisions of coverage (yes/no) and arbitrary technology classifications (experimental/unnecessary) to a constant flow of scientific and clinical information about new methods and new ideas.

This commitment to encouraging information and evaluation, to dissemination and data collection, to measurement of outcomes, will take time to mature. But, if government brings the best researchers together, it can facilitate quality innovation, not paralyze it. Government should not, however, force plans to accept mandated guidelines or protocols.

We must have a strong commitment to evaluation because information is the linchpin of managed competition. Resources are essential to this effort. Funding could come from general revenues, or from a small tax on premiums. Recall that an enrollee's medical costs in federally-approved clinical trials will be borne by the plans. Funding information is our federal investment in better health care decisions.

We do not believe the prediction of Robert Reischauer of the Congressional Budget Office that effective cost controls "would almost certainly involve giving up some aspects of our current system that many people find desirable, such as rapid access to new technologies . . . and extensive research and development." (Reischauer, 1993).

We believe it is imperative to give this approach a chance before we place the blame for high health care costs on technology. Our government has never understood technol-

ogy, never devoted adequate resources to its evaluation, and has failed to assess it wisely and well. Instead of assessing technology through rationing, which would negatively affect the quality of care, let us do everything possible to improve its use through information. Before we give up on technological innovation, we must try to do technology assessment right.

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