

Transcript

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The Massachusetts Health Care Reform: A Blueprint for the Future

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Massachusetts is the first state to require that individuals purchase health insurance, and the first to propose a “Connector,” or state-mandated health insurance market for consumers and small businesses. As part of the well-regarded Colby Hewitt Health Care Series, Pioneer held “A Blueprint for the Future” featuring an in-depth presentation by Health and Human Services Secretary Tim Murphy, as well as presentations by two nationally recognized health policy leaders: Professor Regina Herzlinger of Harvard Business School and John Goodman, President of the National Center for Policy Analysis. Biographies of the presenters and the moderator, Susan Connelly of Mercer Consulting, can be found on the last page of this transcript.

As part of the Colby Hewitt Health Care Series, Pioneer Institute will monitor the impact of the new legislation, drawing lessons and recommending improvements to the state's health care system.

Pioneer Institute, founded in 1988, is an independent, non-profit public policy research institute based in Boston. Pioneer generates and markets new and practical public policy ideas and peer-reviewed scholarship. Pioneer Institute research explores the application of market principles to state and local policy to advance the core values of an open society—individual freedom and responsibility, economic opportunity, social mobility, and limited government.

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JIM STERGIOS: Health care was the topic of Pioneer’s first paper—the 1988 study on the universal health plan advanced by the Dukakis administration. Across the years, our body of work went on to include a book and various conferences and policy briefs on the social services; work by Jack Needleman on conversions of non-profit to profit hospitals; Charlie Baker, Jr.’s proposal to consolidate the health and human service agencies (implemented in 2003 and 2004); Jerry Grossman’s overview of how we ended up with the health system that we have; and, most recently, Nancy Kane’s important work comparing teaching hospitals and community hospitals on the basis of patient outcomes and cost data.

The purpose of today’s event is to explore the implications of the Commonwealth’s health care reform, and to identify important regulatory issues to businesses and to individuals, the impact of the plans, the meaning of “affordability” underlying this reform, and the impact this legislation may have on the overall health care market.

SUSAN CONNOLLY: Massachusetts’ health reform holds promise for all stakeholders. For providers, it provides new reimbursements and higher reimbursements for those who meet certain quality standards. It offers our health plans a source of new membership. It sets a level playing field for all employers relative to providing health care to their employees. And for those employers who currently provide health care, it helps avoid the increase in costs that results from cost-shifting from the uninsured. It brings federal monies to the state to help us stretch our health care investment. And most importantly, it is expected to make health care benefits possible for all residents, and particularly the more than 500,000 uninsured residents in this state. But, boy, there’s a lot of work to be done to get those results, and we know it.

It’s going to require creative policy-making. It’s going to require a keen awareness of health care benefit financing and administration. We’re going to need the help of experts like we have on our distinguished panel today. You know, access and affordability are often competing objectives, and

we need to learn from these experts what other states have done, and other policy experiments that could apply to our situation, so that we can establish a model that everyone will want to emulate.

In the end, the market will determine the success of this endeavor. It is the consumers and the employer purchasers who will drive the answers to the questions that many of us are asking. Questions like: What will the affordable plans look like? How will the employers react to the new administrative responsibilities placed on them by this legislation? How many non-subsidized individuals will actually be able to afford these new plans? And, finally, how will this mandate change how consumers view and use health care?

I’d like to turn the podium over to our panelists, each of whom will give some remarks, and then we’ll open it up for discussion. Thank you. Our first speaker will be Tim Murphy.

TIM MURPHY: I want to thank Jim Stergios for the invitation today. It’s nice to look around the room and see so many friends, and so many people who have actually helped the administration to develop this health care reform bill.

This morning I’ll talk about the health care reform law that passed on April 12th of 2006. The legislation took a systematic approach, not a product approach. Not, “Why don’t we just increase Medicaid a little bit?” or, “Why don’t we just reform our small-group or our non-group market?” Rather everyone took a step back and said, “What are all the things that ail our system? What can the state and the private sector do to make this better?”

So, why did we do health care reform in Massachusetts? Some of the reasons are not particular to Massachusetts, for example, the double-digit increases in insurance premiums every year. Health care eats up 16 percent of GDP and it is growing at twice or three times the rate of GDP. Because of the price of insurance, we have 500,000 Massachusetts citizens without insurance. This is a low number compared to many states, but it’s still 500,000 individuals who, when they feel sick, don’t

have a physician or a medical home, and often end up in the emergency room. As we all know, that has a disproportionate effect on financing and health quality outcomes.

Another issue that concerned us was the trend by small businesses in the non-group market to drop insurance coverage for their employees. Recent Kaiser Family Foundation research reports suggest that a number of businesses now are starting to drop coverage or employer sponsored insurance for their employees, especially those in the small-group market. While we're fortunate in Massachusetts in that we have about 850,000 people in our small-group market, we are at an inflection point. If we continue to have double-digit increases, the market will fray, and from the governor's perspective, we will then have a real problem in Massachusetts.

A third issue was transparency. Professor Herzlinger will speak about this, but one of the things that we have to recognize within this market is that, as Charlie Baker likes to say, "It's opaque." You don't know what the costs are: costs do not reflect quality.

So, these are the some of the systemic issues in health care. However, there are also other factors that help explain the passage of this health care reform bill.

One is that we had an 11-15 waiver, which was our Medicaid program that we operate with the federal government. Because we don't offer a standard Medicaid program, we have a waiver that allows us to do things a little differently than Title 19 suggests. That waiver expired on June 30th, 2005. The federal government looked at it and said, "You know, you have this demonstration project embedded in your waiver, and we have no interest in continuing that."

The demonstration project had risen to about \$385 million in annual federal funding by the time fiscal 2005 ended. So, we found ourselves in a situation where, over the next three years, we could have lost over a billion dollars from the Massachusetts health care system. The governor and Senator Kennedy realized that we could not afford to lose that

money, and the idea arose that we could direct that money to individuals to help them buy insurance and lower the number of uninsured.

Another source of pressure was the two ballot initiatives that are coming up in 2006. One requires a fundamental change to how we provide health care, mandating a strong kind of pay-for-play payroll tax mechanism. The other one amends the state constitution to say that healthcare is a right. Because we were hesitant to alter a large and complicated process by initiative or referendum, we knew we had to come up with something first.

We began with a broad consensus, which was that we should start with markets, and how we regulate those markets. We proposed some fundamental reforms in our small-group and our non-group sector. Then we moved on to the failings of the private health care market. For example, there are many obstacles to ease of offer and ease of purchase. It is very challenging for small business owners to buy health insurance. While there are some private organizations that do a fantastic job, like the Mass Business Association and the Small Business Service, they are small, capital-poor companies that are not able to reach out to everyone. As a result, there are too many businesses that don't offer insurance. Therefore, their employees don't get to take advantage of the tax breaks for health insurance when bought through an employer.

We also took a hard look at how we are currently paying for the uninsured. For the last two decades we have been doing this through what is called an uncompensated care pool program, which basically says, "If you're a hospital and you provide free-care services, we'll determine what your payer mix is and how financially healthy you are, and then we'll take this money and we'll tax providers and insurance companies, and gather that money in a pool and reallocate it." Obviously, this sort of bulk payment system is opaque. We replaced it by identifying who is uninsured, and then using the billion dollars we get from the federal government to provide a direct premium assistance payment to them so that they can afford private health insurance.

Finally, we remedied some cost-shifting that was occurring between public health care payers and providers. As we went through the most recent economic downturn, our Medicaid rates did not keep up with health care inflation, and the bill addresses that. However, we added the proviso that we are going to start to measure the quality of the hospital services provided to our Medicaid members.

We've re-invented the system to provide a robust safety net, premium assistance for those who are falling through the cracks, and, then, for everybody else, a reformed small group and non-group market so that there are more affordable products. We also wanted to make the individual and the family part of the conversation on health care reform. The health care conversation has traditionally been about the responsibilities of the government and the employers. This bill marks the first time in this country that individual responsibility has entered the conversation. Finally, we've committed to implementing cost-containment strategies and better efficiency measures. If we don't tackle those issues, we'll be back here in five years, right where we started.

So, there are the building blocks of this bill. I give great credit to not only the Governor, but also the Speaker and the Senate President and their leadership team. This is hard stuff, and I think that they made the necessary decisions and tradeoffs to get us to this point.

Let me move quickly through the rest of the presentation.

We have 500,000 people in this state who lack health insurance. Not all of them, though, are in the same situation. For example, contrary to what many believe, not all of them just miss qualifying for Medicare. Expanding the Medicaid program a little will not make them all eligible. 20 percent of

the uninsured in our survey actually already qualify for Medicaid, but have not found their way into the system.

We have made great progress with those 20 percent through administrative measures. Over the last twelve months, we have added 80,000 people to the Mass Health program. One measure was taking advantage of our Internet portal. When Governor Romney came into office, he said, "We need to replace these paper applications and make an eligibility determination on the Web." By taking advantage of that and combining applications, we've been able to make great progress.

Another 40 percent of the uninsured are people who don't qualify for the Medicaid program today and earn less than 300 percent of the federal poverty level. There was a consensus that even if you reform

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the insurance markets, even if you could make more affordable insurance products available to those individuals, if you built up their monthly household budget, it would still be out of their grasp to purchase it on their own. So, we needed to come up with policy solutions for these individuals.

Finally, a full 40 percent of the people who don't have insurance today in Massachusetts earn more than 300 percent of the federal poverty level. That is an individual earning more than \$29,000 a year. Again, the collective judgment was that if we reform our insurance market, make more affordable products available to this group, then it's fair to ask these individuals to purchase health insurance. No subsidy by any government. This is one of your responsibilities.

So, how did we do? I think on the insurance reforms, I would label it as a good start. I don't think we did everything possible to make the market more affordable and more dynamic, but we did a number of things to shift the state from paternalism towards respect for markets.

We've had a dysfunctional individual market. Today in Massachusetts, there are about 50,000 people who buy in our non-group market. Their average age is 53 and their average price point is about \$600 or \$700 a month, because the state has decided that you can only choose between two premium products. And, ultimately, who ends up buying in a guaranteed-issued state? People who either are sick or fear that they could become sick.

It's no great surprise to me that that market has a high price point and the young and healthy will not buy into it. Our fix was to merge those 50,000 lives with 850,000 other lives and make one market. There are a couple of reasons you do that. One is that, in today's small-group market, if you're a sole proprietor, a group of one, you already can buy in. So it did not seem fair to distinguish between those who could incorporate themselves as a sole proprietor and those who just happened to work for a company that didn't offer insurance.

We also wanted those individuals to have more than two choices, something more like the choice available in the small-group market. Now, when you offer more choices and merge the market, those in the non-group market will see a 25 to 40 percent decrease in the cost of their insurance. They'll see that because it's a larger risk pool and there's cost-sharing across subgroups.

Now, of course, the decrease in costs for the 50,000 is subsidized by the 850,000, who end up paying two to three percent more. We addressed that increased cost by modernizing our laws to allow health savings accounts (HSAs) along with HMO products, and by providing "the Connector" to allow products to be developed that offer better quality at lower cost.

The bill also recognizes the insurance products offered were a poor value for younger adults. So, the bill encourages the market to develop insurance products for those 19 to 26 who do not have insurance through their employers.

We also soften the hard cutoffs for dependents. When children graduate high school or college,

they lose their insurance coverage because they are no longer considered eligible for their parents' group plan. This bill allows children to stay on their parents' group insurance plan until two years after the loss of dependency or when they turn 25, whichever is earlier.

And then, finally, the biggest change in the insurance market is that we're moving to a mandatory market in which the risk pools get larger. Today, because we're a community-rated, guaranteed-issued state, we have smaller optional risk pools. The existing system is rife with elements of adverse selection, particularly for that non-group market. By moving to a mandatory market in which the risk pools get larger, hopefully, adverse selection will come down.

So, in our new market, we're still offering primary care and hospitalization and mental health and prescription drugs, but what we're looking to change is the character of the hospital networks. We need to move away from open access to something more value-driven, and away from first dollar coverage to deductibles. A \$1,000 deductible could reduce the monthly premium by 22 percent. People would start to consume differently. The same with co-payments.

There are some issues that are still unresolved. I don't think we went far enough on mandatory benefits. I think that we should have been much more flexible. We have over three dozen mandatory benefits in this state, and it does cost a lot of money. It particularly impacts small businesses and mid-sized businesses, because if you're a company that's fully insured, you have to comply with our mandatory benefits; if you're a self-insured company under ERISA, you don't have to. So, this is a real tax on mid-sized and small businesses. We didn't get as far as I'd like, but we did get a two-year moratorium on any additional benefits.

So even though we didn't get the mandatory benefit relief that we were looking for, it is now possible to take a standard small-group product for an individual at about \$350 and reduce the price by maybe 50 percent, maybe 20 percent. This

is where the consumer will have choice and they'll make decisions.

How do we make it easier to offer and easier to purchase? As I mentioned, this is where you have to recognize that there's been some market failures. And because of the market failure, we came up with an idea, and this idea was called "the Connector." This had its roots with some work that I was doing with the Heritage Foundation about how to make a more efficient market for small businesses and for individuals to buy good, affordable health insurance products.

So, what does the Connector do? Why is it such a breakthrough? Well, the Connector will popularize Section 125 plans. Section 125 plans have been around for many years. But in Massachusetts today, only about 30 to 40 percent of our smaller businesses take advantage of it.

This is a very powerful, very flexible part of the tax code which allows businesses to offer a cafeteria-style plan to their employees to buy health insurance on a pre-tax basis, before income and payroll taxes, which adds up to a 20 to 40 percent savings depending upon someone's tax bracket. In addition to that, deductibles are paid pre-tax when you do a 125 plan. The Connector will provide technical assistance and popularize Section 125 plans on behalf of employers.

Section 125 plans do not require an employer contribution to take advantage of the pre-tax payment. So, what we're saying to employers is, "At least sign up for a 125 plan. At least activate that 20 to 40 percent savings that your employees can get by buying health insurance."

The Connector will also provide better choice for small businesses and their employees. If you're a small business today, you typically offer one insurance product, because you're just dealing with one

company. And your employees are stuck with that product. What we want to do is move to a market in which individuals pick the right product for themselves.

If I own a small business in Boston, I might think Blue Cross is great for me. But maybe half of my employees are from the Worcester area. They might want to buy the Fallon product. The Connector gives them that choice.

What we're ultimately doing with the Connector is shifting the paradigm. Because the Connector will make a variety of products and benefit levels available, and offer different network constructions, the employer is no longer figuring those things out for their employees.

The only choice employers will have to make is how much they want to contribute to their employees. The model moves away from

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something like defined benefits to something closer to a defined contributions model. The employees know that the Connector provides good value because it's independently structured.

The Connector offers two other powerful benefits. First, it is an innovative way of reaching non-traditional

employees. There are people who are working 40 to 50 hours a week, making \$40,000 a year, between Stop 'n' Shop and Home Depot. But because they don't work enough hours at either, they cannot get health insurance. So they have had to enter the non-group market, where they had the choice of two products and paid \$600 a month after taxes.

With the Connector, you can have an account. Your two companies, Stop 'n Shop and Home Depot, can set up Section 125 plans for part-timers. They can make a pro-rated contribution if they choose. The Connector can be an aggregator. You are now buying insurance on a pre-tax basis and you have multiple products to choose from.

And then, finally, the Connector facilitates portability. If today I work for Company A, and Company A is part of the Connector, and then I decide I'm going to take a job with Company B, and Company B is part of the Connector, I don't have to change my insurance. I don't have to recreate my physician relationship; I don't have to recreate pediatrician relationships. The only thing that might change is the employer contribution.

With another new program, Commonwealth Care, we go directly to the individual to provide them premium assistance to help them buy private health insurance instead of giving block payments to hospitals for free care. The program says that if you're not eligible for Medicaid or Medicare and you earn up to 300 percent of the federal poverty level, there will be a means-tested premium assistance payment made on your behalf to buy private health insurance. If you earn less than 100 percent of the federal poverty level (FPL), there will be a special product for you without monthly payments. Once you pass 100 percent, and as you ascend to 300 percent of the FPL, the more you pay and the less the state pays.

One of the biggest issues with the Medicaid program today is the cliff effect. At certain thresholds, if I earn an extra dollar, I might lose my health insurance. So I won't earn the extra dollar. We want to eliminate these cliffs, as we did with welfare reform in the 1990s. We replace the cliffs with a smooth incline.

To make the transition simpler, only companies that are offering Medicaid-managed care plans within the state will be able to offer this product. And the Connector will serve as the administrator. This isn't a Medicaid product; this isn't coming over to EOHHS (Executive Office of Health and Human Services), which I administer. This is about private health insurance and about premium assistance.

The bill also expands our Essential program and our insurance partnership program (both Medicaid programs), and you should think about those as different arrows in the quiver to get people

insurance on a sliding scale basis.

As for financial sustainability, we believe that we've built a robust financial model that is sustainable over the long-term. We estimate about 200,000 people will be eligible for this particular assistance, that the state would pick up about 80 to 85 percent of the cost, and that we have about \$1 billion at our discretion to make those payments.

So, how does that look in Year 1? Even if we were crazily successful, if we get the full 200,000 people in, the cost to the state would be about \$605 million, based upon a \$300 per member per month (PMPM) cost. We have the money for that.

The model is success-based. If we're successful, if we have affordable products, if people recognize the value of insurance, they will no longer go without health insurance, and they will no longer need to avail themselves of free care services. We can then take the money that is in free care today and redeploy it more effectively.

And why is that important? Well, if you take a look at Boston Medical Center, they see about 100,000 uninsured lives a year, and they have a terrific demonstration program that demonstrates the value of health insurance. I won't get into that right now, but suffice it to say, we believe this is a social good, providing better health outcomes and more cost-efficiency.

When you offer a program with premium assistance for low-wage workers, what you have to be concerned about is the fraying of the employer-based system. Will employers do the rational thing and say, "If you're a low-wage worker, just go and get the state subsidy and I'm not going to offer it to you anymore?" We cannot afford that; we cannot handle massive private market dumping into this program.

So, the bill beefs up some of our state non-discrimination laws and adds two new requirements for employers. One is called the free rider surcharge: if you're an employer with 11 or more FTEs and do not sign up for at least a Section 125 plan, you could be subject to a surcharge if your employees persistently use the free care pool.

The second charge is called a fair share or uncompensated care pool assessment: If you're an employer with 11 or more FTEs and you don't offer a fair and reasonable contribution to your employees, you could be subject to a \$295 per employee yearly surcharge.

What is fair and reasonable has been left to the Division of Health Care Finance and Policy. They're actually having informational hearings next week, so if you're an employer and you're interested, we're having hearings in Springfield, Boston, and on the Cape.

So we have Medicaid, we have this Commonwealth Care premium assistance program, and we believe we have the beginnings of affordable products for people who make over 300 percent of the federal poverty level. Government is playing its role, employers have been playing their role, and so what is the responsibility of individuals?

The collective judgment was that individuals and families need to be held accountable within the system. And so, beginning on July 1st, 2007, the Commonwealth will require its citizens to have health insurance. If you don't have health insurance for those last six months of 2007, you will lose your personal exemption on your state tax form. In 2008, the fines increase. They become 50 percent of the cost of an affordable product on a monthly basis.

I don't know if these fines are tough enough. I don't know if people will do the math and decide it is cheaper to pay the fine. But I think it's a good start. If it is not strong enough, we will make it stronger.

We need also to focus on cost and quality within our system, because none of this is sustainable if we keep seeing double-digit increases in health care costs. The bill takes steps to address this. There's a cost and quality council that has the authority to collect information on cost and quality, from the hospital level all the way down to the physician level. We already have a website that provides information to consumers and purchasers. More will happen over time. We need to engage people in a very different way when it comes to health care.

Electronic medical records hold great promise. Blue Cross/Blue Shield was very generous with \$50 million for pilot programs across the state. I think we'll see great benefits from that. And as I mentioned earlier, pay-for-performance in the Medicaid program is part of Year 2 and Year 3 of the rate increases, and we will be working with the providers and the payers to make sure that we have robust pay-for-performance standards within the state.

Why does it matter? I'll give you an example. Fifty percent of the in-patient discharges in the Massachusetts Mass Health program are maternity. Consider the costs that get submitted to the state by the hospitals in the Boston area. Beth Israel charges the state \$2,100. NEMC charges \$3,900. We have all of these different costs within the system, and so we need to find more efficient ways to make our purchases, and not only in the Mass Health program.

It is still a mystery to me why large employers allow a fragmented supply chain to persist and dictate price in the health care system. They don't do it with any other good or service or raw material. So a big part of the debate as we move forward will be about how we get more efficiency, how we get greater rationalization, how we get this type of information out to the public and to purchasers.

I'm going to close with what Susan said at the beginning: implementation, implementation, implementation. We've created a great blueprint, and a lot of hard work and smart thinking went into it. But if we don't implement it well, it's just words on a piece of paper.

The big implementation issues are whether we can create affordable and quality health insurance products. Will the Connector fulfill what we think is a market need and will it do it effectively? Is the premium assistance program sustainable? Can you get true transparency that will engage people? Will large purchasers actually step up to the plate and say that there are better procedures? And finally, will the public accept that they have personal responsibility?

Those are the things that we're focused on. We submitted our first implementation report yesterday, so that'll be on our web site. You can take a look at all the actions that we've taken over the first 60 days of the bill. I'm quite excited about it. It holds a lot of promise, it has been a lot of hard work, and I am impressed that during the last six months of the administration everybody on my team is fully engaged and not looking for their next job.

I really appreciate your attention this morning. Thanks.

REGINA HERZLINGER: It's a pleasure to be here. I am going to compare the health care reform proposal in Massachusetts to the system in Switzerland, because they have similar features and goals, and because the Swiss system has been in place for almost a century and has been very successful. Both aim, for example, to both control costs and improve quality.

The key to the Romney plan is that it's consumer-driven. In other words, consumers will do the purchasing. That is not trivial, for while most American industries are consumer-driven, health care is not. Somebody other than us does the buying. So, in my case, it's my employer, Larry Summers, who takes \$14,000 to \$16,000 out of my salary and purchases health insurance on my behalf. However, there is no way that Larry, despite his incredible brilliance, has any idea what I want.

So, what happens in consumer-driven markets? One of the things that's happened with automobiles is that they have become cheaper as a percentage of income over time. A second thing is that they have become more stylish, environmentally friendly, fuel-efficient, and reliable. You can drive a car for over 100,000 miles without any problem.

Now, why do I focus on automobiles? When I graduated from MIT, I understood how a car worked—compression, explosion, motion, etc.

However, now, because a car is made up of hundreds of thousands of microcircuits, I no longer understand how it works. And although the average consumer is likely as befuddled as I am, cars have become better and cheaper—because there is terrific information in consumer-driven markets. We reward those who give us excellent information. For example, when I look in Consumer Reports, I receive excellent data about safety and reliability. In fact, I know what my dealer paid for the car after no more than ten minutes effort. That is a consumer-driven market.

What about the information in health care? Well, if I needed a mastectomy or one of you gentlemen needed a prostatectomy, you would know virtually nothing about the quality of the physician or the hospital in which that surgery is going to be performed. There'd be a lot of puffery like "We're the

best because we're Harvard, we're Tufts, we're blah, blah, God's anointed children," but very little data.

What doesn't get measured doesn't get managed, and what does not get managed spirals in cost. And that explains how the richest country in the world has 46

million people who are uninsured.

Now, the cost of health care is so high that a significant proportion of those people who earn more than \$50,000 a year are uninsured. The median family income in the United States is \$44,000, so those people are above the average. In fact, one of the fastest growing groups of uninsured earns more than \$75,000 a year. \$75,000 puts them in the top 20 percent of earners in the United States. They're rich, but not rich enough to buy health care.

Now, the reason I let Larry buy my health care for me is that he can do it with pre-tax money. But if I didn't have that option, if I were self-employed, I would need \$12,000 or \$15,000 worth of income to buy a health insurance policy. If I make \$75,000 and take home \$37,500, there's not a chance in hell

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— Regina Herzlinger

I'm going to spend \$10,000 to \$15,000 on health insurance.

Switzerland has a consumer-driven system that maintains universal coverage. Every Swiss has health insurance. If you can't afford it, the state or canton will give you the money, so you're not shoved into a program like Medicaid. They also do risk adjustment. In other words, they compensate for the fragmenting of the risk pool.

The Swiss can choose from a wide variety of health insurance products, which is what you would expect in a consumer-driven market. Here we have 240 models of automobile and we have two models of health insurance. In a consumer-driven market, you'd have a lot more choice.

In an article I wrote for JAMA, I compared Switzerland to the most Swiss state in the United States, a rich, urbanized, white, highly educated state. Not Massachusetts, though it was close, but to Connecticut. The Swiss beat them hands down. Switzerland has excellent resources, tremendous capacity, and you don't have to get on a waiting list to see a doctor. People come from all over the world to go to Switzerland for health care. The market speaks for itself. They achieve excellent outcomes in fighting diseases, and their costs are 11 percent of GDP versus 16 percent for us. In other words, the Swiss get a first-rate health care system at a 33 percent lower cost than in the United States. That's what happens in a consumer-driven system.

How do consumer-driven industries accomplish all this? There are three kinds of entrepreneurs who make any consumer-driven industry work. What we have to do in health care is let these entrepreneurs make their magic.

One kind of entrepreneur knows how to make things better and cheaper. In health care, they're physicians and scientists and related managerial people. In the automobile industry, they are engineers.

The automobile industry really took off with Henry Ford, who was an engineer out of the Midwest. When he entered the market, a car cost

more than a house. Only the rich could afford to own and maintain an automobile. Ford thought he could make it better and cheaper, and drove the price of the Model T down 50 percent in eight years, while leaving enough for himself to become a very wealthy man.

As the price went down, car ownership went up enormously. When you make it better and cheaper, a lot of people can buy it, and the percentage of income that was needed to buy a car went down. So one kind of entrepreneur in a consumer-driven health care system is the biotech industry, the hospital industry, and the physicians. If you give them the freedom, you will get the results.

But they're just one part of the equation. Standing off to the sidelines, as Ford was making Model T's better and cheaper, was another kind of entrepreneur: Alfred Sloan. Now, although Sloan went to MIT, he was no engineer. They called him an industrial engineer, but he was the quintessential business person. He saw Ford's genius, but he also could see that that genius had bred hubris, Ford's special weakness. "I'm smart, you're not. I know how to make it better and cheaper, you don't. You're going to have it my way. I know what's best for you, and don't worry your pretty little head about it."

So, Ford made one model of automobile, and he is alleged to have said, "You can have it in any color as long as it's black." I called the Ford Museum to check this out, and they said, "No, he didn't say that." If he didn't say it, he meant it, because there was only one model. And while Sloan was no engineer, he realized that he could beat Ford by introducing choice in the automobile market.

So, he cobbled together General Motors and offered choice ranging from the then very proletarian Chevrolet to the then top of the market Cadillac. And he cleaned Ford's clock.

A lot of people in health care will say, "Choice is bad. Can't have choice. Give us a lot of big players and then we'll squeeze all the inefficiency out of them." Well, Sloan showed that choice creates competition and competition creates productivity.

The third kind of entrepreneur was J.D. Power. Now, J.D. Power is one of mine, he's an accountant, and he understood that people in the automobile market wanted to know how good their cars were. And he told me he went to Ford or somebody - he worked for Ford - and said, "I want to independently measure how consumers feel about your cars." And they said, "Our cars are marvelous. We don't need this kind of measurement."

So, Power went out and started a business, which he recently sold for a considerable sum, so he did good and he did well. There are other entrepreneurs doing similar work. I rely on *Consumer Reports*, which is an entrepreneurial non-profit. Recently, an automobile writer won a Pulitzer Prize. That's how pervasive intelligent and competent writing is about automobiles.

Where are we with health care, compared to the auto industry? Well, if you're a Henry Ford right now in health care, if you want to change the model in some way, you're actually going to get punished. You're not going to get rewarded. For example, you all know the 80/20 rule. The Italian economist Pareto said that 80 percent of anything could be explained by 20 percent of the possible causes. For example, 80 percent of the beer in the United States is drunk by 16 percent of the beer-drinkers. And as a teacher in a graduate school of business, I know them all personally. [Laughter] So, when business people talk about low-hanging fruit, they're talking about going after the 20 percent who account for 80 percent of the market.

The 20/80 in health care is that 20 percent of the users, the very sick, account for 80 percent of the costs. So Ralph Snyderman, Chancellor for Health Affairs at Duke University, wanted to focus on part of this 20 percent, those with congestive heart failure. These are people who have big balloons around their ankles, because their hearts are flaccid and they get congested.

He said, "I'm going to create -" — he's a Henry Ford—"I'm going to create a whole new model for treating congestive heart failure. And it's not going to be top-down disease management or involve

paying some insurer to tell you how to deliver health care. I'm going to create it myself." So, he and his colleagues created a new program. In one year, they reduced the costs by 40 percent. Implemented nationally, the program would save \$20 billion. And they did it by making people healthier. And when they were healthier, they didn't need to go into the hospital to be decongested, to have all this fluid removed from their system. And Duke lost the entire 40 percent that it saved. Society saved, but at the cost of hospital revenues. If you think like Henry Ford, if you do things more cheaply and better, you are going to lose money in this health care system, and that is why we need a consumer-driven system.

If you're an Alfred Sloan, and you see a trillion-dollar health insurance market dominated by one insurance policy, the PPO, (whatever that stands for,) you will try to identify what people want that the market is ignoring. I, for example, don't have long-term care insurance, and, at my age, I'm tremendously interested in that. The reason I'm very interested is that the average American woman who goes into a nursing home spends most of her own money. Then she goes bankrupt and ends up on Medicaid, which is the only insurance for long-term care.

I don't want to be in that situation. If I were given my \$14,000 to \$16,000, I'd buy a different insurance policy, one with long-term care. Now, the reason I talk about women in nursing homes is not to be sexist, but because they live longer than men. That differential has narrowed about a year as women have been taking the same jobs as men. Soon we may die at the same age as the guys. But, right now, if you're a man in a nursing home, prostate condition or not, Alzheimer's or not, you're a real hottie. My point is that once health care gets more consumer driven, women will be buying much more long-term care. My insurance right now tops out at \$1 million, but the cost of wonder drugs can easily swallow that up. I want to get \$50 million. I, like most people, don't want to go bankrupt. I want catastrophic coverage.

The Swiss consumer-driven system offers many

more choices. For example, Switzerland has a five-year insurance policy. Health insurers lose about 20 percent of their customers every year, so during a period of four years, they lose virtually all of their customers. Not exactly, since the churn is at the margin, but close. So, what incentive does an insurer have to invest in making you healthier right now, for example, helping you lose 200 pounds or stopping some addictive behavior, if four years from now, when that change in behavior itself results in better health care, you're no longer with that insurer?

The Swiss measure your health at the beginning of the five years - forget about civil liberties - and then they predict how healthy you will be in five years. If you're that healthy, or healthier, you get up to 50 percent of your money back. In other words, you're paid up to \$25,000 for staying healthy. Now, that's a hell of an incentive to stay healthy, but you've got to have a long-term insurance policy. In a consumer-driven market, you would begin to see innovations like that.

What are the Henry Fords going to do if you let them loose on the market? They're going to head for the 80/20.

They're going to head for people with chronic diseases, with disabilities, and underserved populations like African-Americans, and they're going to design integrated, accessible systems of care for these people.

And the J.D. Powers, what are they going to do? Well, I get a lot of information that is incredibly irrelevant. I know how many women get mammograms. I don't care. I'm going to get a mammogram, no matter what the data say. What I want to know is, how good is my physician in my hospital if I need to go there for the procedures people like me tend to need? The J.D. Powers are consumer oriented, and will provide that kind of information.

Existing high-deductible insurance policies are incorrectly known as consumer-driven. A real consumer-driven market has more than two

choices. The high-deductibles are merely the first early innovation in insurance. Once we let this market work, we're going to have a lot more. What do we know about high-deductible policies? Well, we have some data from CIGNA. We know that they control costs. Medications went down, in-patient and out-patient admissions went down, but the number of in-patient days went up. I think we can infer from this that sick people used the health care system, while people who were not sick did not. High-deductible plans help control costs without harming health. There is more than high-deductible plans to a consumer-driven market. In Switzerland, they account for only 40 percent of the market. But they are a start.

Costs go down because people use less health care. And quality, surprisingly, goes up. We have some data from Definity, an early provider of high-deductible health insurance. They found that

Existing high-deductible insurance policies are incorrectly known as consumer-driven. A real consumer-driven market has more than two choices.

— Regina Herzlinger

people with asthma do better with consumer-driven health care. These were very careful studies. People with diabetes also do better. One reason is that they take their meds and comply with their disease regimens more

carefully. A McKinsey study found that people take better care of themselves when they pay out of pocket because they will save money if they catch an issue early.

In other words, a consumer-driven system changes the fundamental psychology of the consumer and their behavior. What is the Henry Ford going to do? Well, I told you about the 80/20. And we've heard a lot about integrated health care delivery systems. And we have them, in theory, in Massachusetts. Great word. What does it mean?

Well, every major disease is bigger than a major American industry. For example, cardiovascular disease is bigger than the food, beverage, and tobacco manufacturing industry. Diabetes is bigger than the computer industry. HIV/AIDS is bigger than metal mining. Do you think that there is one company that could manage all the food, all the

beverages, all the tobacco, all the computers, all the metal mining? It's much too difficult.

A consumer-driven system will be about health care the way you need it, for your bad backs, your bad feet, your asthma, your cardiovascular disease, your diabetes.

WebMD, a J. D. Power, has positioned itself as a health care portal, and had a hugely successful IPO in the fall of 2005, because people in the market understand that consumer-driven health care cannot work without health care information, and WebMD was the early arrival.

We're going to have a vast choice of insurance policies. We're going to have terrific information. For example, my former student, Rick Siegrist, CPA, MBA, started a company called Healthshare Technology. If you want to know the risk-adjusted morbidity and mortality, infection rates, clots, and readmission rates for a procedure at a particular hospital, his company can tell you. WebMD knows it, too, because they just bought his company. Do good, do well.

Everyone who has worked on this legislation has done good, and I hope they also do well. It is not perfect, but it is damn close to it.

If you've liked what I've said, thank the Harvard Business School. They've long supported me in this effort. If you don't, blame me. To your good health.

JOHN GOODMAN:

Whenever you have a law that both the left and right votes for, you have to wonder if somebody has seriously miscalculated. I'm not sure any of us knows exactly who did the miscalculation. And that's because I think we have a plan that is just at the beginning stages, and it could very easily evolve into the kind of consumer-driven health care model that Regina just talked about. Alternatively, it could evolve into something that none of us would like.

Let me talk about two choices that are very important to this kind of health plan. The first choice is to be insured or uninsured. What it means to be

uninsured is to have some possibility of having a medical incidence that leads to medical bills that we can't pay for, in which case we have to rely on the charity of others. So, each of us has a choice between private insurance and relying on some sort of social safety net.

Now, what is society doing to encourage you to choose one rather than the other? If you choose to be uninsured and rely on the social safety net, I calculate that, across the country, we're spending about \$1,500 every year per uninsured person, or \$6,000 for a family of four. Whether that number is a little high or low, the point is that we're spending an enormous amount of money providing free care.

What does society do for you if you choose to get private insurance? It depends on how you get it. If you get private insurance through an employer, it can be paid for with pre-tax dollars. That means no federal income tax, no FICA tax, and no state or local income tax. If you're in the 25 percent income tax bracket and you've got a 15 percent FICA tax and a 5 percent state and local tax, we're talking about a tax subsidy that approaches 50 percent. The self-employed avoid the income but not the payroll taxes. However, most of the uninsured in the United States would receive no tax subsidy if they were to buy insurance.

What is the difference between buying insurance with pre-tax dollars and after-tax dollars? If you are middle income and thus in a tax bracket that approaches 50 percent, assuming that a health insurance policy costs \$6,000 a year, you will need to produce \$6,000 worth of goods and services to motivate your employer to purchase it for you. But if you have to buy this insurance with after-tax dollars, then you have to earn \$12,000 in order to buy the insurance after you pay your taxes.

It then is not a surprise there are 46 million people who are uninsured. The surprise is that there is not two or three times that many. Clearly, government is not being neutral, but encouraging people to go without insurance. Neutrality would mean giving just as much encouragement to people to be

insured as to be uninsured.

So, if we're spending \$1,500 per year on free care for those who are uninsured, we ought to be able to spend the same amount on those who buy insurance. In other words, we ought to take the same number of dollars and make them available as a tax credit. To do that, though, we need to coordinate what we're doing on the spending side and what we're doing on the tax side. And this, it seems to me, is the core idea that Governor Romney started with in developing his health plan.

Now, a fact that's not generally appreciated is that when you offer people a tax subsidy to get private health insurance, and they turn down the subsidy, they are, in that very act, going to pay a tax penalty. The tax penalty is the mirror image of the tax subsidy. So, if we offer you \$1,500 of tax relief to buy private insurance and you turn down the offer, then you will pay \$1,500 more in taxes each year. If we do this right, that \$1,500 ought to be dedicated to funding a safety net.

Today, across America, the uninsured pay more in taxes than those who get insurance through an employer. They pay more because they're not getting the tax break the rest of us get. The problem with the current system is those extra taxes are going to Washington and the free care is delivered locally.

The idea behind the Massachusetts health care reform is to use the extra taxes paid by the uninsured to fund the safety net. To use an extreme example, if everybody in Boston decided to be uninsured, the penalty taxes they pay would then support the safety net. On the other hand, if everybody in Boston who now is getting free care decided to get private insurance, you would not need all that free care money, and you could use it instead to subsidize private insurance.

I have argued for some time that we don't need any new money in the health care system. There's enough already, if we coordinate what we're doing on the tax side and on the spending side. And as a matter of fact, when Governor Romney first made his proposal, I believe he said there's enough money in the system to fund what he wanted to do. And the legislature added more money, but, even with that, the new plan depends mainly on money that's already in the system.

I have yet to use the word "mandate." Once you start talking about mandating insurance for individuals, someone else is going to suggest mandating employer participation and we go down the road of more regulation and government control.

All that is necessary is a system under which people who decide to be uninsured have to pay a price and that price should equal the probable cost that they impose on the system. We don't need a mandate—we need only to coordinate what we're doing on the spending side with what we're doing on the tax side.

— John Goodman

There is a second choice that is important. It is a choice not really addressed in the Massachusetts health care reform. It is the choice between private insurance and public insurance. What I mean by public insurance is mainly Medicaid, which is Mass Health, and the SCHIP (State Children's Health Insurance Program). Here, again, the principle is the same: If we're going to spend \$1,500 per person in the Medicaid program, we ought to be willing to spend that same amount of money if people acquire private insurance instead. The same principle would hold for the SCHIP program for children.

If we don't do that, we will encourage people to swap their private coverage for the public program. That is, the expansion of the public program will

crowd out private insurance. According to one study, in the 1990s, every additional dollar spent on Medicaid led to a 50 to 75 cent contraction in private insurance. Thus, taxpayers paid more without reducing the number of uninsured.

In the SCHIP program in the latter part of the 1990s, we signed up a large number of children for the public program. Parents responded by dropping their private insurance coverage. Over the years, the percent who are uninsured hasn't changed at all, but you've caused a big increase in taxpayer burden.

If the Romney reform does not work, it will fail because of three problems. One is that we have to keep the insurance benefits of this program consistent with the cost. In other words, the insurance needs to match the available amount of money, not the other way around. If it is the other way around, then spending will just begin to soar. And what does it mean to keep the insurance consistent with the amount of money budgeted? It means that if you have to, you cut back on benefits.

Now, my preference would be to cut back on mandated benefits. The alternative is to cap the coverage and put overall financial limits on how much the insurance will cover. I used to be opposed to that kind of insurance, but a recent RAND study showed that the key in the health care system is to get to a doctor. Insurance that gets people to a doctor, and gets people into the system, results ultimately in the same amount of care almost regardless of the kind of insurance. There is almost no difference between being uninsured or being on Medicaid or being on Blue Cross, provided you're seeing a doctor. Once you get into the system, it looks like we all get about the same amount of care.

The second problem is crowding out. The program could encourage people to drop their unsubsidized insurance in order to take advantage of the subsidy. Tim Murphy was confident that they have the procedures in place to discourage this, but we will have to see how it plays out.

The final potential problem is adverse selection. By

that I mean that insurance in the exchange is not sold in a market in which risk is being accurately priced. And since it's not being accurately priced, it means that people who are healthy can do better outside the system. For example, almost all employers of some size can self-insure. When they self-insure, they're totally out from under regulation by the state of Massachusetts, and they're under federal law. I would guess that over half the market is already self-insured in this state. As people find that insurance is cheaper outside than inside the exchange, that number could leap.

I am not saying that these problems will cause the plan to fail, but I am saying there are dangers. Unless these situations are monitored closely, the program may not be as successful as we wish.

In dealing with these three problems, and this is the final and concluding point, it's important to note that the federal government, not the state of Massachusetts, controls the key parameters. The federal government funds the vast majority of free-care dollars spent in this state. The most important tax subsidies are federal tax subsidies.

The way you get out of the state insurance market and self-insure is determined by the federal government. So, the federal government controls the three most important parameters. Now, it has ceded one to the state - control over all of the free care dollars. But it will retain the other two, and that leaves the state less room to act or innovate.

Thank you very much.

QUESTION: *Competition among insurance companies means that hospitals and doctors have to spend a fortune filling out reimbursement forms, each company with different forms. That is why administrative costs in the US are ten times what they are in Canada, which has a single system.*

HERZLINGER: It is a very poor idea to focus on one cost element and to say, "We can lower that element if we only had one buyer." There is a lot of competition in the car market, so it costs a lot to buy cars. Why not have the federal government

buy our cars? We'd lower the administrative costs. Why not have them buy our food, buy our housing—we'd lower the administrative costs.

The answer to that is certainly: competition creates more administrative costs. It also lowers total cost, because if you have only one buyer, their idea of what you need for your money is going to dominate, and if you don't like it, bad luck to you.

GOODMAN: The fundamental problem with insurance payments in the United States is not that we are not like Canada. It is the reverse: we are too much like Canada.

In Canada, when you go to see a doctor, you pay nothing. Health care is free. In the United States, when we see a doctor, we pay 10 cents on the dollar, so it's almost free. In both countries, you have a third-party bureaucracy setting doctors' fees and paying by the task. So, in both countries, unlike all the other professions—lawyers, engineers, architects—where 100 years ago they learned that the telephone is a really good way to communicate with their clients, doctors still haven't learned that.

By the end of the 20th century, all the other professions were emailing their clients. How many of you know your doctor's email address? You probably cannot find a lawyer in the United States that doesn't have his clients' records on computer, but 70 to 80 percent of primary care physicians do not. All this is a most unusual situation - totally created by an artificial payment system. We don't need to become more like Canada; we need to become less like Canada.

MURPHY: I agree with both panelists. When you have competition within a system, people necessarily get more efficient on these matters. I come from a financial services background. Take a look back to the early '70s, and the creation of the Depository Trust Corporation. Millions of people worked for competing brokerage firms, but they decided that they needed to come together to have a better clearinghouse. The market figured itself out. It wasn't the government telling them what they needed to do. Lack of competition and

government's pervasiveness within the health care system stops a lot of these things from occurring.

QUESTION: *Will this health care reform deal with people on Medicare? They could pay \$500 or \$600 a month just for supplemental coverage.*

MURPHY: The plan doesn't address people who are on Medicare. A separate program—the Prescription Advantage program—has provided financial assistance to a number of individuals and now, with Medicare Part D in place, that program is being retooled to fill the gaps for individuals. Also, for people who take advantage of Mass Health and Medicare, our SCO plan is pretty interesting.

CONNOLLY: It's also fair to say that product innovation involving high-performing and limited networks might also expand into the Medicare eligible market through the health plans.

QUESTION: *Has there been an assessment of undocumented aliens receiving health care to determine what impact it has on health costs?*

MURPHY: We haven't done a direct assessment of that particular issue. The estimated number of undocumented individuals who use health care services ranges from 50,000 to 100,000. If you consider our Mass Health limited program, which is an emergency-based program available to individuals who can't document citizenship or residency within the state, we've added 20,000 people to those rolls this year. That's related to having gotten tighter on our uncompensated care pool. The federal government, on July 1st, is requiring the Medicaid program to be much more stringent when it comes to documentation of individuals.

Clearly, there are costs, but most undocumented people don't use the system. They're typically working and making a living like the rest of us. It's an issue, however, that we do watch.

QUESTION: *How replicable is this model is for other states?*

HERZLINGER: I think it's going to be a national political event. In the next presidential campaign, there will be a candidate who will propose a consumer-driven kind of system. What the Romney administration has done is admirable and a very good model. But the best way to make it work would be on a federal level, and I think we'll see serious debate about that. As John said, the feds really hold a lot of the cards for making this work.

MURPHY: In the idea stage, we looked at the Healthy New York program. We learned a lot from that with regards to private market crowd-out issues and issues of reinsurance. That program has been in existence since 2000, with probably over 100,000 folks enrolled. That sounds like a lot, but in New York the scale is different. We drew lessons about the product and type of benefits available; we also learned that uptake gets stronger over time, so there is a market for it. We took what was good about Healthy New York and applied it to Massachusetts.

QUESTION: *The market-driven approach has a lot of advantages, but it means changing the relationships between providers, employees and employers. Those relationships are cast in the relative concrete of organized labor agreements and law. How critical is addressing those to moving towards a market-driven system?*

GOODMAN: While members of those labor unions and labor leaders may not be enamored with markets and competition, they are finding the current system isn't working for them. Companies can't afford post-retirement health care and can't afford the health care for their own workers without severe cuts in wages.

More than any other idea, the idea of portability is going to fundamentally change what's happening in the work place. With portability, employers can pay a lot of the cost, but the insurance can travel with the employee as he goes from job to job.

QUESTION: *A larger risk pool means you spread out risk. But given that we're talking about a large uninsured and probably historically uninsured population, it seems that those who are going to benefit most from this plan are those who need it the most, the ones who can pay higher out of pocket expenses and therefore need the system more, and that you'll be drawing in folks with chronic care and long-term care issues. I'm wondering how you will draw in the people who have traditionally said, "Well, I'm healthy, I don't want to pay for health care"?*

MURPHY: Your explanation and question is the reason that, at the end of the day, we got comfortable with the individual requirement to have health insurance. As I mentioned earlier, Massachusetts with the small-group and the non-group market is what's called a modified community rate-setting state, which means that you can get rated on things not related to your health experience, age, occupation, region of the state you live in. We're a guaranteed-issue state, and we do have wait periods and pre-existing condition, but that's only for a period of time.

Your concern is that today the market attracts adverse selection. Individuals claiming to be too healthy for insurance go and avail themselves of the system in Massachusetts and think that "as long as I can pick up my cost for six months, et cetera, I'll get a full benefit." When we looked at this together with our goal of getting people insured, we realized that in order to have balance and the right type of risk pool, we needed not only those folks that are currently using our uncompensated care pool excessively, but also the healthy lives. That's why we decided collectively that an individual mandate was the best way to address the issue that you're raising.

CONNOLLY: The individual mandate is positioned as a mandate for those for whom affordable coverage is available—"affordable" yet to be defined. Are there examples in other states or do you have thoughts regarding how the Commonwealth will or should define affordability—as a percentage of income, relative to

other products in the market? What are the thoughts on how we define whether a plan is affordable?

MURPHY: This is a pretty experimental element of the plan, so there's not much to compare to in other states. However, we define affordability in a lot of different ways on means-tested programs in government. Programs in other states might do this by asking, "Well, how much should someone pay based on income?"

It's also instructive to look at various welfare programs. We often say, "Well, you get so much cash assistance to a certain point, and then at that point you cliff over and should be self-sustaining."

So we need to take a look at Massachusetts-specific costs. When we developed our financial model, we looked at various social and health care assistance programs, and then we triangulated by asking, "How much money do we have available to us within the free care pool? These are dollars that we're spending today. How much do we think that the price point will be for the product?" Obviously, the big input is the products and how we define the benefits and types of services associated with that, and the type of networks. Then we have to find out how much all of that costs.

That's all for financial modeling purposes. We know it's sustainable. The legislation allows other entities to make those final determinations, but I'm sanguine we'll be able to address the issue of affordability.

QUESTION: *When looking at affordability, are we considering both the premium cost and the out-of-pocket cost?*

MURPHY: Yes. I would also say that the Blue Cross/Blue Shield Foundation did a real service to the Commonwealth by having a *Road Map to Coverage* program over the past year. The Urban Institute did some financial modeling on costs and affordability.

HERZLINGER: In Switzerland, the state looks at benefits options and mandated benefits. After

figuring out the cost of mandated benefits, they give people who cannot afford coverage the money to buy the mandated benefits. The problem of course is the Swiss government is designing your car, so if you want a different kind of car—or an insurance policy with different kinds of benefits—those options are completely blocked out of the market.

An alternative approach, which I haven't seen anywhere in the world, would be to define insurance not by benefits, but by providing insurance policy that protects you against bankruptcy, covering all health care services no matter how they're provided.

GOODMAN: Mandated health insurance benefits, requiring coverage for acupuncturists and chiropractors and so forth, adds to the cost of health insurance. This new legislation does not call for mandated benefits to be repealed or put aside. But experience in other states suggests that mandated benefits usually apply to private insurance. State legislatures seldom impose mandated benefits on their own employees, the Medicaid population, or other individuals for whom the state provides the funding. The Massachusetts legislature will now have an economic interest in the cost of these plans, so they may be reluctant to impose additional mandates and may repeal a few.

QUESTION: *The incentives for everyone to buy insurance seems punitive—you lose tax credits or similar. Have you considered positive motivation such as medical savings accounts along with the penalties associated with the individual mandate?*

MURPHY: The goal of the reform is to give everyone an opportunity to buy insurance on a pre-tax basis. Today, if you're uninsured or not buying through an employer, you're paying in post-tax dollars for every service that you offer. It's a huge benefit to set up a structure that allows the product to be offered at 25 to 40 percent less.

The Connector was seeded with about \$25 million of start-up funding that could in part be used to

provide technical assistance to help small businesses sign up and start “125” plans, which allow employees to buy insurance on a pre-tax basis. For example, bonus payments could be made to those businesses that have those types of plans.

There are also health outcome and psychological benefits for people in that they will know that they have insurance, a doctor, and a medical home. This piece of legislation has many carrots. Finally, if you don’t fall within 300 percent of the federal poverty level and therefore don’t qualify for Medicaid, never before has government delivered a subsidy directly to you to buy health insurance. You were uninsured, nervous and often you got your health care in an emergency room.

CONNOLLY: I’d like to build on your comment about the Connector and the services it will offer. In the past, a number of employers felt that, although they pay a reasonable and fair share for health care, they still have a large part of their work force that may not be eligible for employer-sponsored coverage. Now, under the legislation, they’re being asked to set up “125” plans, to collect premiums, to remit it - maybe to the connector, maybe to outside plans - to track status changes, to figure out what happens when a part-time employee doesn’t have enough salary to payroll-deduct the premium, and to understand who is responsible for that delinquent premium. What kinds of services will the Connector make available to employers to help them with that administrative responsibility?

MURPHY: Those are all excellent points. Today we have exactly one employee at the Connector. We were fortunate to get a great candidate, and those are things that he’s going to have to figure out. [LAUGHTER]

In all seriousness, when we designed this and put it together, we were concerned about the issues that you raised. We didn’t want to set up another layer of government bureaucracy that made it even more challenging for businesses to compete within the state. My earlier comment still holds: We have to be very cautious, because we have a tendency to

overdo it here. All that being said, the social good and the opportunity through the federal tax code to get people to buy insurance on a pre-tax basis makes it worth the effort.

We know that our employer base is changing. There are more people working multiple jobs, more part-timers. There are fewer traditional jobs. We needed a mechanism that could get everybody insured. We’re going to have to listen and understand the concerns of employers and work to set this up in the most efficient way. Wrong decisions will cause problems, and we knew that going in. But this is one of those situations where you need to set the goal and then work together to achieve it.

GOODMAN: There’s a problem with the language in the legislation. There’s no such thing as a fair share payment by an employer. As long as we keep talking about how the employer has some moral obligation to do something, we miss the nature of what’s going on in the labor market.

Health insurance provided by employers is labor compensation. It’s an alternative to wages; it does not really come out of the pocket of the employer, but out of the pocket of workers. As employers compete for labor, they provide health insurance for middle-income employees in high tax brackets, because they know that you can take advantage of a generous tax break that people can’t get on their own.

The reason why employers do not provide insurance to low-income workers is that there is Medicaid and free care, so the workers themselves would rather have the compensation in the form of wages because they know they have alternatives.

QUESTION: *With the free market, wouldn’t the insurance come in part with a guarantee that you do not sue the physician?*

HERZLINGER: I could imagine an insurance policy that costs X dollars that says, “If the following events occur, you’re flat-lined or you cannot sue the doctor.” And that would compete against an insurance policy that allows you to sue

the pants or skirt off the doctor and it costs Y.

Y is clearly going to be more than X, so you'll have a market solution that recognizes that although the right to sue and the legal system are a very important component of the checks and balances in our wonderful country, beyond a reasonable limit, you're going to have to pay for it.

QUESTION: *The fundamental model that the plan adopts is one where insurance companies compete for enrollees and have to squeeze providers in the middle. That is distinct from a consumer-directed plan where enrollees or consumers choose providers and providers compete for those consumers. We're moving in the right direction, so I want to commend you for that. But it strikes me that the challenge in implementation is how to find ways to accent and build on consumer-driven competition and that relationship with the provider? Why will it be worth my while to choose Beth Israel if my daughter has a delivery rather than Mass General, which according to your price chart is more expensive? With an insurer in the middle, what sort of financial incentive will help move that along?*

MURPHY: Great question. Insurance companies are intermediaries that from an efficiency perspective give access to an array of providers. You're already starting to see a number of products that differentiate between so-called Tier 1 and Tier 2 hospitals. You pay a higher co-pay if you go to a Tier 2 versus a Tier 1, and that's based upon efficiency and quality rankings of that particular health plan of those providers.

I could imagine an insurance product that basically says this: For a knee replacement, the insurance company has determined, as they've looked across all of the various providers within the state, that this is the price point. This is what they'll pay. Now, here are all the providers you could go to. They're all quality providers. If you choose to go to X hospital, where the price point is higher, you pay the up-charge. That's your choice. So, you have a defined amount of dollars you can walk around with, and then you can make your decision.

The point is that when you start to have that type of conversation, all of a sudden people start to understand that they are being benchmarked and they become more transparent about costs.

There are multiple ways in which insurance products can drive consumer-directed insurance. The reason why it hasn't happened to date is that, though health insurance has grown over time, health insurance was for most CFOs and CEOs was just part of the compensation package. It was less of a cost concern. And they really didn't want to get in a big fight with the hospitals. After all, they served on the hospital boards and viewed them as community assets. The fact is that hospitals are businesses. We've reached the tipping point where companies now have to treat them like any other supplier.

GOODMAN: To get to the world that Reggie Herzlinger talked about and the focused factories for diabetics that she has written about, we have to change the way the suppliers and producers get compensated. We need very flexible accounts that allow consumers to control the whole package of money. And then we'll get the supply-side innovation. Fundamentally, we need a change in the tax law. Right now, even with health savings accounts, the tax law encourages all of us to run our payments through third party payers. And the third party payment system isn't going to allow the Duke University Hospital heart program and the diabetic-focused factories to flourish.

HERZLINGER: Remember also that health services are being globalized. India, for example, spends \$14 billion on health care. One billion people in India, and only \$14 billion on health care. But there are four big hospital chains with serious money and capitalization, and fabulous physicians. They look at this market in the United States and are thinking, "We can clean their clocks!" They can out-compete the American health service system not only because of the difference in purchasing power, but because they've created more efficient ways to deliver health care. Some people say that is ridiculous, but those are the people who also thought that competition with Japan, Korea and Germany was ridiculous.

CONNOLLY: I'd like to close by noting that this legislation is a framework and that the regulations will define many important details. It's the responsibility of all of us to attend hearings and to be forthcoming with our opinions. The input this morning from our experts in research and policy-making will help us make the right decisions.

STERGIOS: Thank you to all of the panelists and to Susan. Today's event, is the second health care event we've held this spring in honor of Colby

Hewitt, our late chairman. Colby's work and focus on health care ensured that Pioneer has been active in health care research over the past eight years. We will continue this effort in his memory as part of the Colby Hewitt Health Care Series. The aim of this event is right in line with his thinking—to provide a greater understanding regarding the issues and explore market opportunities and policies in health care. We look forward to seeing you at upcoming events.

Susan Connolly is a World Wide Partner and National Leader of the Specialty Practices of Mercer's Health & Benefits Boston office. Susan has 20 years of consulting experience, bringing to her consulting a deep knowledge of health and benefit issues, including benefit strategy, plan design, financing and health and productivity management. Susan served on the Finance Working Group of the Massachusetts Governor's Health Care Task Force and received a BA in classical languages from Smith College.

John Goodman founded the National Center for Policy Analysis in 1983, and has served as President since its inception. Dr. Goodman has been called "the father of Health Savings Accounts" by the *Wall Street Journal* and has contributed texts, research studies, editorials and congressional testimony to the national health care policy debate. Dr. Goodman received a Ph.D. in economics from Columbia University. He has taught and done research at several colleges and universities including Columbia University, Stanford University, Dartmouth University, Southern Methodist University and the University of Dallas.

Regina Herzlinger is the Nancy R. McPherson Professor of Business Administration Chair at the Harvard Business School. She is widely recognized for her innovative research in health care. Professor Herzlinger's newest book, *Consumer-Driven Health Care: Implications for Providers, Payers, and Policymakers* is the latest in a series of influential books, studies, and articles in academic, professional, and general interest journals. Mrs. Herzlinger has served on the Scientific Advisory Group to the U.S. Secretary of the Air Force and as an active participant in the HBS Healthcare Initiative. Regina Herzlinger received her Bachelor's Degree from MIT and her Doctorate from the Harvard Business School.

Tim Murphy is the Secretary of the Executive Office of Health and Human Services. Secretary Murphy previously served the Romney Administration as Director of Policy in the Governor's Office and Director of Capital in the Executive Office for Administration and Finance. Before joining the Romney Administration, Murphy was a Vice President in the Investment Banking Division of J.P. Morgan in New York City. He advised and raised capital for both for-profit and not-for-profit clients, including hospitals. Secretary Murphy has a bachelor's degree from Merrimack College and a Master's in Public Policy from Harvard University.

Jim Stergios is Executive Director at Pioneer Institute. Having previously served as Research Director, he rejoined Pioneer in September 2005, after three years in the Commonwealth's Executive Office of Environmental Affairs, where he served as the Chief of Staff and Undersecretary for Policy. Mr. Stergios graduated summa cum laude and holds a Doctoral degree in Political Science from Boston University.

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