



Carol

THE SECRETARY OF HEALTH AND HUMAN SERVICES  
WASHINGTON, D.C. 20201

FEB 17 1995

Paul M. Ellwood Jr., M.D.

President

Jackson Hole Group

P.O. Box 350

Teton Village, WY 83025

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Dear Paul:

Thank you for the opportunity to review the new draft proposal of "Responsible Choices." I am looking forward to meeting with you and others in Jackson Hole to discuss our respective ideas for improving the nation's health care system.

I have appreciated the opportunity to work with the Jackson Hole Group in the past, in large part because we share a common commitment to improving both efficiency and fairness in the health care system. I think we all agree that health reform requires three elements to be effective — expanded coverage, lower costs and improved quality — and that a restructured marketplace is essential to achieving these elements. Our ultimate goal must be universal coverage in an efficiently operating marketplace.

You and your colleagues have made a significant contribution to the health care debate in this country by recognizing the critical role that consumer choice and private innovation can play in our health care system. I think that we both agree that choice is a critical element in improving quality and efficiency.

I was surprised, then, by the direction reflected in "Responsible Choices." The draft proposal seems to abandon your previous commitment to addressing the problems of the over 40 million uninsured in this nation. I understand that the political environment has changed, and that our strategies may need to change as a result. However, that does not alter the underlying fact that middle class people who lose their jobs, or working families struggling to get by, need some assistance to be able afford adequate health insurance.

The Jackson Hole Group has recognized this fact in the past, and has advocated substantial subsidies to assist the uninsured in purchasing private insurance. It deeply troubles me that the "Responsible Choices" proposal fails even to mention the need to move towards universal coverage, let alone suggest policies (short or long-term) to do so.

In fact, the arbitrary cap on funding for the Medicaid program proposed in "Responsible Choices" would actually decrease coverage. Over the past few years, enrollment in employer-based insurance has fallen by almost six percentage points (from around 66% to around 60% of the nonelderly population), while the percentage of the population covered by Medicaid has grown significantly. Between one-third and one-half of the projected annual growth in Medicaid spending results from projected growth in enrollment.

Furthermore, I am perplexed and disturbed that you would propose an arbitrary cap on the Medicare program. Like Social Security, Medicare is an inter-generational compact. Placing an arbitrary, pre-determined cap on Medicare spending, while at the same time eliminating its status as an entitlement, would put services to the elderly at risk and would violate that compact.

A cap on Medicare puts the elderly and disabled at risk. The vast majority of Medicare beneficiaries have modest incomes. Over 75% of beneficiaries have incomes below \$25,000; 30% of beneficiaries get 80% or more of their income from Social Security. So while a voucher program like that proposed in "Responsible Choices" may expand choice for some beneficiaries, it would in fact diminish choice for many by effectively forcing them into a low-cost plan and away from the providers of their choice.

This does not mean that we oppose improving Medicare — quite the contrary. We are pleased that, during the Clinton Administration, projections for the average annual rate of growth for Medicare spending for the period 1996 - 2000 have decreased — by more than a percentage point a year — just in the period between the Mid-Session Review last spring and the President's Fiscal Year 1996 Budget. We are pressing ahead with improvements in Medicare management, data processing, contractor oversight, and program integrity activities.

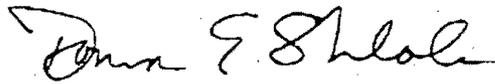
Among the other improvements we are making in Medicare, I believe that we share a commitment to expanding and improving the managed care choices available to Medicare beneficiaries. Today, about 74 percent of Medicare beneficiaries have access to a managed care plan, and 9% of beneficiaries have enrolled in one. Enrollment is increasing rapidly — by over 1% per month. We also are working on ways to make our existing managed care program work better. Examples include our work with the industry to improve quality measures and the AAPCC methodology for the Medicare risk contracting program, and our collaboration with Alain Enthoven to design a competitive bidding demonstration. And, as we have testified in recent weeks, we are in the process of developing new managed care options under Medicare, including a PPO option.

While managed care appears now to be reaching a critical mass in private sector health programs, at least in some areas, it has taken many years to achieve this state. Many employers that have embraced managed care have moved cautiously to avoid disruption, by maintaining a fee-for-service option at affordable levels or by offering out-of-network options through point-of-service plans or PPOs. Most Medicare beneficiaries — and particularly the most elderly among them — have not had the benefit of a gradual exposure to managed care. I am strongly committed to expanding the managed care options available in Medicare, but the emphasis must be on choice. We should learn from the private sector and recognize that we need to move prudently if we are to foster understanding and acceptance of managed care approaches among beneficiaries.

Page 3 - Paul M. Ellwood Jr., M.D.

I look forward to the upcoming discussions at Jackson Hole. We need to focus on how we can improve both the private insurance market and public programs. And we must discuss ways to expand coverage for vulnerable populations. I believe that there are many points on which we can agree. To me, making responsible choices means finding ways to improve what we have, not making arbitrary cuts in important programs that can leave the elderly, disabled, and poor at risk. I hope that we can work together over the coming months to accomplish meaningful health care reform.

Sincerely,

A handwritten signature in cursive script that reads "Donna E. Shalala". The signature is written in dark ink and is positioned above the printed name.

Donna E. Shalala



## JACKSON HOLE GROUP

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Paul M. Ellwood, M.D.  
President

February 9, 1995

Secretary Donna Shalala  
Department of Health and Human Services  
200 Independence Ave, SW, Suite 615F  
Washington, DC 20201

Dear Donna,

This is our first version of "Responsible Choices." We spent considerable time and drew on expertise in specific fields of relevance in devising the substance of these proposals. As you will see, the product is a hard-hitting document that lays out the actions that the private sector and government should take to: bring public programs into line with the private sector; increase consumer cost-consciousness; expand group purchasing for small groups and individuals; and establish a fair market with good, comparable information. Undoubtedly, "Responsible Choices" will produce differences of opinion within the Jackson Hole Group, particularly in the absence of political pressure for reform. However, I hope that we can reach consensus and offer the public a comprehensive proposal for incremental reform.

I think that the Jackson Hole Group is ahead of the curve with "Responsible Choices." I have not seen any other broad post-Clinton proposals for health reform, especially ones that take into account what is occurring in the private sector. Additionally, "Responsible Choices" will distinguish itself because it is based on actual clinical and operational experience gained from all participants in the Jackson Hole Group process. I cannot imagine another comprehensive proposal for reform that could include that level of experience and expertise.

The section of "Responsible Choices" that corresponds to your topic at the February meeting is **Bringing Medicare into the 1990's**. If you would like to discuss it or need further clarification, contact Graham Rich, MD of the Jackson Hole Group staff at 307-733-8781, fax: 307-739-9312. I would be grateful if you could ask someone to calculate the approximate savings which could be made if these proposals were adopted.

We will take up all of "Responsible Choices" in detail at the February meeting. I would value your comments, as soon as possible, to further revise our recommendations. Your

Mailing Address: P.O. Box 350 Teton Village, WY 83025

Fed-Ex/UPS: 6700 North Ellen Creek Road Jackson, WY 83001

307-739-1176 Fax: 307-739-1177

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feedback and that coming out of the February meeting will be incorporated before the document is ready for wider circulation and critique at the end of the month.

Sincerely,

A handwritten signature in cursive script that reads "Paul". The letters are fluid and connected, with a large initial 'P'.

Paul M. Ellwood, M.D.

**RESPONSIBLE CHOICES  
FOR ACHIEVING REFORM OF THE  
AMERICAN HEALTH SYSTEM**

**A Draft Discussion Paper  
from the**



**Jackson Hole Group**

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**February 1995**

## TABLE OF CONTENTS

INTRODUCTION .....	1
BRINGING MEDICARE INTO THE 1990s .....	5
Why Update the Medicare Program? .....	5
Parallels with the Private Sector .....	6
How Do We Get There? .....	7
Promoting Consumer Cost-Consciousness .....	7
Ensuring Plan Competition on the Basis of Price and Quality .....	8
Intermediate Steps .....	8
Stage 1: Fiscal Year 1996 .....	8
Stage 2: Fiscal Year 1997 .....	9
Stage 3: Fiscal Year 2002 .....	9
Benefits of Medicare Reform .....	9
ENCOURAGING STATE SOLUTIONS FOR ACUTE MEDICAID .....	10
Accelerating the Use of Competitive Managed Care for Acute Medicaid .....	10
The Federal Contribution .....	10
Minimizing Federal Reporting .....	11
INCREASING COST-CONSCIOUSNESS:	
REFORMING THE TAX TREATMENT OF HEALTH INSURANCE .....	11
Tax Credit Structure .....	12
Variation of Tax Credit .....	13
A Tax Credit Linked to Group Purchasing .....	13
Stage 1: A Tax Credit for the Individual Market in 1995 .....	14
Stage 2: A Tax Credit for Employer-Based and Group Purchased Coverage in 1998 .....	15
Target Goals .....	15
MEDICAL SAVINGS ACCOUNTS .....	15
MSAs Combined With Catastrophic Coverage Could Damage the Market .....	16
INSURANCE REFORMS AND GROUP PURCHASING .....	17
State Efforts .....	19
The Role of the Federal Government .....	20
A Tax Credit Linked to Group Purchasing .....	20
Insurance Reforms .....	20
The Role of the States: Certifying Voluntary Purchasing Groups and Enforcing Standards .....	21
Target Goals .....	22

BENCHMARK BENEFITS .....	23
The Need for Fair Disclosure and Comparability .....	23
Assessing Technology .....	24
An Independent Approach .....	25
Target Goals .....	27
A HEALTH ACCOUNTABILITY SYSTEM .....	27
A New Quality Accountability System for a New Health Care System .....	27
What Would a Health Accountability System Look Like? .....	29
Accountability Measures Clearinghouse .....	29
Health Accountability Foundation .....	30
Completing the System .....	31
Target Goals .....	32
HEALTH SYSTEM INFORMATION .....	32
Why Is Coordinated Health Data Needed? .....	32
Why Are the Current Data Inadequate? .....	33
What Should Be Collected? .....	33
Cost .....	34
Coverage .....	35
Vital Statistics .....	35
How Can the Goal Be Accomplished? .....	35
Target Goals .....	36
CONCLUSION .....	36
TABLES	
1. Functions of the Benchmark Benefits Group .....	26
2. Elements of a Health Accountability System .....	30

## INTRODUCTION

Paul M. Ellwood, MD

"Responsible Choices" identifies the actions that the private sector and government should take to improve the American health system. These suggestions build on the Jackson Hole Group's approaches outlined in "The 21st Century American Health System" (1991), which called for accelerating value-based competition in the health care marketplace.

"Responsible Choices" is not based on untested economic and social theory. The recommendations are taken directly from the actual clinical and operational experience gained in providing health care and health insurance to over 100 million Americans.

"Responsible Choices" spreads the benefits of better quality, lower cost health care with a minimum of prescriptive interference by government at no overall increase in cost.

The United States has been rapidly transforming health care by implementing a market-driven system that works—a unique approach that has resulted in significantly reducing rate increases for private purchasers and consumers of medical services. This evolution, turned revolution, which has been underway for at least twenty-five years, is being driven by corporate purchasers, and cost-conscious consumers. It has created an extraordinary array of health plans aggressively competing with one another on price and quality. Managed care plan enrollment has grown by 50 percent since "The 21st Century American Health System" was written. However, some consumers—such as most Medicare beneficiaries, individuals with preexisting illnesses, and the employees of small firms—are not fully benefiting from the health care revolution that is propelling us toward the twenty-first century. And, despite being the largest single purchaser of health care, the government has been slow in bringing public programs into line with those in the private sector.

It has taken at least twenty-five years for the new American health system to become established. As it continues to evolve, care must be taken not to disrupt its progress. The market works in health care because multiple purchasers, not only the government, are in

a position to introduce bold new methods of buying health care and because providers and insurers have substantial freedom to respond with new approaches to organizing and paying for care.

Keeping the market working in health care requires the consideration of factors that are unique to the health sector. When a day in the hospital can cost thousands of dollars, people need health insurance. But when this is fee-for-service insurance, there are few incentives for sick individuals and their trusted physicians to try to save money. Those who are poorly insured and have a great incentive to buy on price are in no position to shop for medical care based on price once they become sick. Medical care is a product that is best understood by doctors who are selling it and thus are in a position where they must make both the key clinical and economic decisions for their patients and their practices. "Responsible Choices" assumes that these factors, unique to the health sector, cannot be ignored. If they are disrupted by legislative fiat, the whole system of high-quality, market driven health care could come unraveled. "Responsible Choices" calls for intervention in certain facets of the marketplace to make it function better, while warning policy-makers that preventing further expansion of price and quality competition will disrupt the progress that the market is making.

As in any industry, genuinely lowering costs means vast increases in productivity. In this case, change threatens the livelihood of more than 100,000 specialist physicians, one-half of the country's hospital beds, and hundreds of health insurers.

The U.S. health system has been transformed thus far by adherence to the following principles:

- **Health plans should compete on the basis of price and quality.** Health plans that both finance and deliver comprehensive health care must compete on price and quality. Combining health insurance with health care is perhaps the most important change in the structure of the health system. It shifts the emphasis from increasing earnings by

subjecting the patient to more services to reducing demand for costly extended treatment by keeping people well. To effectively lower costs and improve quality, health plans must carefully select those providing care and match their numbers and skills to the needs of their consumers. This practice has been criticized for restricting doctor opportunities and patient choices, but shepherding resources remains as critical to health care quality and cost as the management of any enterprise.

- **Consumers can be cost-conscious when selecting health insurance.** Consumers can be motivated to be cost conscious at the time they select health insurance and choose lower cost plans when they are convinced that health care will be readily available and of good quality. Cost consciousness at the time of illness is less predictable and can cause expensive and dangerous delays in seeking care. This makes capping premium contributions better than high deductibles in motivating consumer choice.
- **Group purchasing of health care should continue.** Health care must be purchased by groups large enough to exert real leverage over competing health plans. Size allows these groups to exploit their knowledge of health plan performance and, above all, to spread the cost of insurance over both healthy and unhealthy individuals. As in any market, the presence of many powerful buyers and multiple competing sellers has been shown to be beneficial to consumers and encourages continued innovation and vigorous price competition. Diminishing the clout of group purchasers or dividing consumers into good and bad risks will destroy the burgeoning health market.
- **Information about the quality of care must be available to consumers.** For the health market to function properly, consumers, purchasers, and providers need understandable and comparable information on the cost and quality of care from various health plans. The quality of care information currently available to consumers is still incomplete and is perhaps the weakest link in the health care revolution. Because reliable and objective information is not available, the organizations providing the best quality of care are not necessarily attracting the most consumers. This

information gap jeopardizes the entire health revolution. The lack of comparative information on quality also makes the system vulnerable to unsubstantiated criticisms about costs being down because quality is deteriorating.

Without expanding entitlements or mandates, "Responsible Choices" expands the revolution in health care by asking government to play by the same rules as the private sector, by increasing the power of consumers, and by minimizing risk selection against individuals and small employers. "Responsible Choices" spreads the benefits of better quality, lower cost health care with a minimum of prescriptive interference by government at no overall increase in cost.

"Responsible Choices" has five objectives:

- Cost  
conscientious
1. Align Medicare and Medicaid costs with revenues while expanding choices by offering public beneficiaries the same cost-conscious choices now available to private consumers through employers or purchasing groups. Set limits on the per capita growth of Medicare and Medicaid expenditure linked to revenue growth and allow competition and consumer choices to do the rest.
  2. Make the tax benefits of health insurance coverage equitable, while increasing consumer awareness of cost and quality through a value-based tax credit for health insurance.
  3. Give individuals and the employees of small firms, regardless of their health status, the same opportunity to purchase reasonably priced health insurance as large group purchasers. Insurance reforms mean all purchasers, including the self-insured, and sellers of health insurance should be subject to the same marketplace rules.
  4. Ensure that consumers know what the various health plans offer in terms of benefits, satisfaction, access, and health outcomes.

5. Set timely realistic targets and measure results as reform proceeds. Manipulating a trillion-dollar enterprise may require a change in course if cost containment, health outcomes, consumer satisfaction, and access to health care do not improve as predicted.

## **BRINGING MEDICARE INTO THE 1990s**

**Graham Rich, MD, MBA**

As the largest purchaser of health care in the U.S., the federal government is responsible for the continual growth in Medicare cost by maintaining a dysfunctional payment methodology and by failing to encourage intensive price competition and cost-consciousness. Like any other purchaser, it needs to adopt some aggressive buying policies so that all taxpayers, including seniors, can benefit from better quality and efficiency through competition among health plans and a cost-contained traditional Medicare program.

Even with the present defective system for encouraging enrollment in managed care, the number of seniors choosing this option is predicted to increase from 2.2 million at the end of 1994 to 2.5 million at the end of 1995. To enable new seniors to stay in managed care and to provide more choice for current beneficiaries, we need a better Medicare payment methodology, better access to comparative information, and the option of participating in any available health plan. Only then can seniors make responsible choices.

### **Why Update the Medicare Program?**

The federal government's share of total U.S. health care costs was 28 percent in 1990, and 32 percent in 1993. Medicare expenditures were \$160 billion, or 2.4 percent of gross domestic product (GDP), in 1994 and are projected to grow to \$460 billion, or four percent of GDP, by 2005. Meanwhile, private sector HMO premiums, driven down by

employer purchasers, are projected to decline, on average, 1.2 percent in 1995.<sup>1</sup> For example, the California Public Employees Retirement System achieved reductions in premiums of 0.5 percent in 1994, 1.1 percent in 1995 and two percent for 1996.

Medicare's traditional insurance structure has a negative impact on the rest of the health care market because:

- Cuts in reimbursement cause cost shifting and drive up the cost of care for others.
- Hospitals suffer unpredictable changes in DRG rates.
- Physicians try to maintain income by increasing volume.
- Medigap policies that drive up use by covering first dollars become more attractive when consumer deductibles are increased in an effort to reduce program utilization.
- Low reimbursement rates make it difficult for seniors in some markets to find primary care physicians who are willing to accept new Medicare patients.
- The system rewards doctor's office visits and hospital stays instead of improvements in health.

Medicare cost problems will only get worse under the current system as managed care health plans, using resources efficiently, force nonparticipating physicians (particularly specialists) to depend on Medicare to earn a living. This will exacerbate regional variations in Medicare costs that have no corresponding premium differences in private sector managed care. For example, in 1995, the Medicare capitation rate is \$467 in San Francisco and \$559 in Los Angeles while the premium for a non-Medicare, non-Medicaid Kaiser plan is the same for both northern and southern California.

### **Parallels with the Private Sector**

When unsustainable expenditures on health benefits threatened competitiveness, enlightened employers made the transition from traditional health insurance to offering a choice of managed care plans. As a result, they have seen a consistent increase in managed care enrollment with a corresponding reduction in costs. The government could

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<sup>1</sup> Group Health Association of America (GHAA), 1994 HMO Performance Report.

experience the same savings by making consumers more cost-conscious, ensuring that plans compete on the basis of price and quality, and actively promoting managed care options.

### **How Do We Get There?**

The ultimate aim should be to reduce the rate of growth in Medicare costs due to mismanagement of the program. This proposal attempts to hold Medicare entitlements to the current percentage of GDP, adjusted for the increasing age and number of beneficiaries. It does not reduce the scope of benefits or deprive beneficiaries of access to well managed health care. It relies on price competition among health plans coupled with a government contribution limited to the GDP target. The proposal also requires health plans to offer a more appropriate set of benefits than the traditional Medicare program (the federal standard HMO package with a prescription drug benefit) so that Medigap insurance is unnecessary for seniors who join health plans. Seniors should be able to choose a health plan with comprehensive benefits while reducing or eliminating the need for supplemental insurance, deductibles, and copayments. A voucher ultimately set at the price of the lowest cost plan in the market area will give seniors access to a full range of plans.<sup>2</sup> The option to stay with traditional indemnity Medicare would still be available.

### **Promoting Consumer Cost-Consciousness**

The money for Medicare vouchers should be appropriated each year, rather than mandated as part of the federal budget. The voucher for Medicare health plans should be initially limited to the amount the government is prepared to spend on traditional Medicare and should ultimately be based on the lowest priced, high quality plan within each market area when the market price falls below the government's adjusted GDP target payment. Seniors who choose a more expensive plan would be responsible for making up the cost difference, be it traditional Medicare or a health plan. To ensure full choice, all

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<sup>2</sup> Competitive bidding to set the government contribution has been recommended by Bryan Dowd et al., in "Issues Regarding Health Plan Payments Under Medicare and Recommendations for Reform": The Milbank Quarterly, vol. 70, no. 3, 1992, 423.

plans should participate in a coordinated annual open enrollment. In some areas, especially rural ones, traditional Medicare may be the lowest cost or sole option.

### **Ensuring Plan Competition on the Basis of Price and Quality**

To enable comparison, the Health Care Financing Administration (HCFA), or its designee, should provide information, including quality and price comparisons of traditional Medicare and health plans, by market area on all available plans. Health plans should price and offer a standard benefits package while HCFA does the same for its own traditional Medicare product. Seniors should be given comparative information on out-of-pocket costs for care of common conditions, consumer satisfaction data, etc. Responsible marketing should be encouraged to ensure that seniors understand the options.

### **Intermediate Steps**

To facilitate the transition to managed care, incremental change in the government's contributions to health plans is suggested. Initially, the value of the government voucher for health plans would be the same as that for traditional Medicare. Where more than 20 percent of seniors are enrolled in managed care, the government's contribution in the next year should be based on average health plan prices (excluding traditional Medicare). In the following year, the contribution for traditional Medicare and health plans should be set at the price of the lowest priced, high quality plan.

### **Stage 1: Fiscal Year 1996**

The Secretary of Health and Human Services should establish market areas to calculate the value of the Medicare voucher, as counties are too small for stable prices. The value of the voucher should be capped at the current level of payment adjusted for GDP growth and age of beneficiaries within each market area. Legislation should allow health plans that cost less than the voucher to provide additional benefits or to give consumers rebates. A health plan that costs more than the voucher value should charge seniors the difference. HCFA should simplify its approval requirements so that it is less costly for new health plans to enter the Medicare market.

**Stage 2: Fiscal Year 1997**

HCFA, or designee, should establish and coordinate an annual open enrollment period to ensure that each individual can choose among all available plans. Voucher payments should be risk adjusted to allow for the extra risks involved in enrolling individuals with chronic diseases. All participating health plans should be required to offer at least the new standard benefits package.

**Stage 3: Fiscal Year 2002**

If the prices of competitive health plans in the Medicare market consistently exceed the value of the government's voucher, and if traditional Medicare cannot be controlled, the policy should be reexamined with a possible reduction in the scope of benefits, means testing, new controls on volume of services, etc. The cap on the government's voucher should move progressively from the market area to the national level within five years to smooth out price differences among areas. If employers do not encourage retirees to make a cost-conscious choice of Medicare health plan by giving them a defined contribution, then legislative reform of retiree benefits may be required. The federal government should consider relinquishing its responsibility for providing indemnity insurance by asking private indemnity plans to take over this function, as long as there is no restriction on access to providers.

**Benefits of Medicare Reform**

The phased introduction of premium competition, starting with areas of high managed care enrollments and where Medicare costs have tended to be high, ensures competition and early savings. Over time, there should be a reduction in regional Medicare price and utilization variations. Prices in today's populous high cost areas should come down first, while utilization and prices may go up in those areas (mainly rural) where seniors seem to be underserved. Allowing seniors to make the same responsible choices as the rest of the population will provide greater incentive for plans to improve their cost-effectiveness while maintaining or improving quality. Seniors and the health system as a whole will benefit from an expansion of choice and an end to the cycle of cost shifting.

## ENCOURAGING STATE SOLUTIONS FOR ACUTE MEDICAID

Graham Rich, MD, MBA

The dramatic increase in, and unpredictability of, costs in Medicaid programs is a persistent challenge to state governments. The nation spent \$82 billion, or 1.2 percent of GDP, on Medicaid in 1994; expenditure is projected to increase to \$234 billion, or two percent of GDP, in 2005. States should use the same methods as successful private purchasers of health care to encourage choice and effective price competition for the acute care portion of Medicaid. States are already ahead of Medicare in adopting price competition but have been impeded by the federal waiver process and the lack of health plan availability.

### **Accelerating the Use of Competitive Managed Care for Acute Medicaid**

States that received section 1115 waivers from HCFA have introduced innovations tailored to local needs and preferences. These changes brought variations in eligibility based on income, categorical requirements, new services, and a choice of managed care plans. In an effort to protect the Medicaid population from what it views as ill-conceived or hasty reform, HCFA developed detailed criteria for approval and set goals for implementation. Because criteria and goals can vary from case to case, the approval process may take several weeks, meanwhile state dollars support inefficient and ineffective financing mechanisms. To stop such waste, the 104th Congress should grant states the authority to make the transition to managed care for Medicaid while the federal government focuses on restructuring the Medicare program.

### **The Federal Contribution**

The federal government should give states block grants for the acute Medicaid program based on the number of eligible residents. To facilitate state management of the program, the federal government should specify the rate of growth in the federal capitation rate. If the current GDP growth rate and inflation remain the same, this could be set at 6.5 percent per year in 1996, six percent in 1997, and five percent in 1998. The only

circumstance that would necessitate a reconsideration of these ground rules would be for a drastic change in the number of people eligible for Medicaid.

### **Minimizing Federal Reporting**

Allowing states to define their own solutions puts at risk the comparison of quality, cost, and coverage information essential to enhance consumer choice and aid policy-making at the state and national levels. The problem can be overcome if states follow the example of other purchasers by requiring standardized reporting by health plans (see A Health Accountability System, page 27, and Health System Information, page 32).

## **INCREASING COST-CONSCIOUSNESS: REFORMING THE TAX TREATMENT OF HEALTH INSURANCE**

**Alain Enthoven, PhD and Sara Singer, MBA**

The fact that employer-paid health benefits are tax-free without limit has been a significant factor in the continuous escalation of health care costs. The tax break is expected to cost the government \$90 billion in 1995. This break disproportionately favors people with above average incomes over lower income people who need a more powerful incentive to buy coverage.

The need to motivate responsible, price-sensitive choice of health plan and limit revenue loss to the federal government underlines the advantages of abolishing the tax break and replacing it with a refundable tax credit for individuals purchasing health coverage. This would correct the government-created lack of cost-consciousness by encouraging employer contribution policies that force consumers to be more responsive to the full premium price, thereby promoting competition among health plans. To derive maximum benefit from a tax credit, a choice of plans is necessary. Additionally, it may be appropriate to encourage employers to make their contributions in fixed dollar amounts.

that do not vary with choice of plan to ensure that all employees make cost-conscious decisions.

A limit on employer contributions that are tax-free to the employee (a tax cap) is another alternative and would require the application of rules similar to those for the tax credit. However, a fixed tax credit has distinct advantages over a tax cap, including:

- It means portability for individuals, breaking the link between employment and health coverage.
- Both high and low income people would receive the same credit, though the credit could be structured to give low-income more.
- It can be readily characterized as giving something to people, as opposed to a tax cap, which is perceived as taking something away.

### **Tax Credit Structure**

A tax credit could be structured as follows<sup>3</sup>: In 1994, the average family received \$4346 in employer-paid health insurance, which allowed them to avoid \$1130 in income taxes (i.e., they received a 26 percent premium subsidy).<sup>4</sup> With a tax credit, the average family could still receive up to \$1130 in credit on their income tax; which would allow them to purchase or receive up to \$4346 in coverage without paying any more in taxes than they do now. If a family purchased or received coverage exceeding \$4346, the difference would be treated as taxable income. The tax credit could be adjusted in future years for inflation or other factors. Individuals would claim the tax credit when filing a tax return. Low-income individuals, who do not file a tax return, would claim the tax credit for health benefits when applying for other assistance programs.

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<sup>3</sup> For a discussion of tax cap design, see "Managed Competition II," March 1994 or Alain C. Enthoven, "A New Proposal to Reform the Tax Treatment of Health Insurance."

<sup>4</sup> "The Tax Treatment of Employment-Based Health Insurance," Congressional Budget Office, March 1994.

### **Variation of Tax Credit**

In a more complex version, the percentage of premium that a family could claim as a tax credit could be varied with income. The lower the income level, the higher the percentage of the health insurance premium that could be claimed as a tax credit. This solution has problems of complexity, financing, and work disincentives for those at the poverty level, as well as political problems associated with a tax increase. Additionally, the tax credit amount could be adjusted for regional factor price differences, although the added complexity would not be desirable or economically feasible.<sup>5</sup>

It would also be necessary to define rating classes (e.g., individual, couple, single parent with child(ren), and couple with child(ren)) and age categories to calculate the credit. Otherwise, a single credit would be too high for some (healthy young individuals) and too low for others (the elderly and families). Alternatively, by not adjusting the tax credit for age, the generous tax treatment would encourage more healthy young individuals and families to purchase insurance.

### **A Tax Credit Linked to Group Purchasing**

The employment-linked tax exclusion is an important part of the glue that holds insurance purchasing groups together as risk pools. Converting to a tax credit direct to individuals would weaken the glue and threaten the employment-based group purchasing system because good risks will seek better rates elsewhere and pooling will be destroyed. A market based on underwriting at the individual level would perpetuate many or all of today's pathologies for small employers and individuals. The unraveling of the successful employment-based market could lead to a political backlash and a single-payer system.

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<sup>5</sup> Adjusting the tax credit for factor price differences would fairly compensate individuals and families residing in high cost areas. While it would be possible to adjust the tax credit for medical cost variations, this would not be prudent as it would reward areas with inefficient utilization of health care resources and costly excess capacity. It would also be possible not to adjust the tax credit. This would be the simplest approach and would resemble the construction of the recently proposed education deduction. However, a flat tax credit may be too generous in some areas and not generous enough in others.

The tax credit can be structured so as not to dismantle the group purchasing based system. Standards governing the use of a credit would be necessary. For example:

- If your employer offers coverage, the credit should be available only if you buy insurance through your employer. Employers might be mandated to offer, but not necessarily pay for, several coverage options and could do this by contracting with a voluntary, certified purchasing group.
- If you are self-employed, non-employed, or employed by an employer that does not offer health care coverage, you should be able to use the credit only through a voluntary, certified purchasing group that would agree to take all comers and abide by the rules established for the rest of the insurance market.
- If an employer drops coverage, it should be required to offer, but not necessarily pay for, coverage through a purchasing group to provide for its employees. This approach would encourage the formation of voluntary, certified groups for those left out of the employment-based system and ensure the formation of alternative purchasing groups before allowing the dismantling of employment-based purchasing.

### **Stage 1: A Tax Credit for the Individual Market in 1995**

Since there is mounting urgency to reinstate the 25 percent tax deduction for the self-employed, this opportunity should be used to shift from tax exemption to a tax credit for this group. Tax policy changes should start with a tax credit program for the self-employed, non-employed, and employed whose employers do not offer coverage to go into effect in 1995. After three years, the tax credit should be restricted to coverage purchased through a purchasing group. This is attractive for the following reasons:

- A tax credit would give this group a greater tax subsidy than they received under the limited tax deduction. A tax credit would give these people tax-free health benefits while making them price-sensitive. It would eliminate the tax code inequities that the self-employed currently face, without expanding the cost-increasing incentives created by the present tax treatment of health benefits for employed persons.

- Anyone who does not currently receive employment-based health care benefits would benefit from the tax credit without threatening employment-based health care purchasing.
- By tying the tax credit to group purchasing three years after enactment of the tax credit, the formation of purchasing groups would be encouraged without penalizing people who do not have access to group purchasing in the interim.

### **Stage 2: A Tax Credit for Employer-Based and Group Purchased Coverage in 1998**

After successfully implementing a tax credit for individuals, employer-based tax deductions of health benefits should be replaced by a tax credit in 1998 with provisions to avoid unraveling employment-based health care purchasing. This should be done at the same time the tax credit becomes linked to group purchasing—three years after enactment of the tax credit for the individual market—to ensure adequate access to group purchasing arrangements.

#### **Target Goals:**

- Tax credit in place for the individual and employer-purchasing markets by 1998.
- At least 75 percent of people claiming the tax credit by the year 2000. If not 75 percent, the policy regarding tax credit eligibility should be reviewed.

## **MEDICAL SAVINGS ACCOUNTS**

**Alain Enthoven, PhD and Sara Singer, MBA**

The Jackson Hole Group is concerned that Medical Savings Account (MSA) theories, in the forms currently advocated, would undermine the market forces already under way in the health system and would increase tax revenue losses. MSA proposals would allow employers and individuals to contribute to savings accounts (tax sheltered or not) in conjunction with a health insurance policy that has a high annual deductible, such as \$3000, referred to as a "catastrophic" policy. Since consumers would have to pay the full

cost of their health care up to the amount of the deductible, this would make them health and cost conscious. In theory, MSAs seem to encourage saving for retirement or other purposes rather than spending money on costly medical care; however, in practice, they would destroy the ability of insurance to spread risks and would jeopardize health plans' ability to compete on cost and quality. It is difficult to make a proper assessment of the impact of different MSA proposals because of their variability. For example, if MSAs were tax deductible, this would create an enormous incentive to purchase a particular type of health insurance and could increase the federal deficit. As a consequence, the Jackson Hole Group is eager to analyze each specific MSA proposal to assess its impact. All of the proposals assume that the health care cost problem is fully attributable to factors that the individual can control and fail to acknowledge that the chronically ill would lose out as the healthy opted to leave risk pools.

#### **MSAs Combined With Catastrophic Coverage Could Damage the Market**

With catastrophic policies, people are cost-conscious only until they know their deductible will be reached, after which the cost of more care to them is zero. Since about 70 percent of national health care expenditures are spent on only 10 percent of the population, MSAs with catastrophic policies do not promote cost-consciousness where the majority of expenditures occur.

High deductibles only marginally provide financial incentives to encourage healthy lifestyles and to decrease expenditure on inappropriate medical care. If increasing deductibles had achieved this goal with an indemnity system, then the development of managed care would have been unnecessary. High deductibles discourage people from seeking preventive and primary care since they must pay for these services out of pocket. Delays in seeking care for serious illness increase costs for everyone. MSAs will disrupt the market by favoring catastrophic policies over other forms of health coverage.

According to an example used by the American Academy of Actuaries, if a family pays \$5000 for a typical indemnity plan, it could purchase the same policy with a \$3000

deductible for about \$3,200. The \$1800 savings is not enough to cover the \$3000 MSA that would need to be paid by someone, either the employer, employee, or the government. If the MSA is tax excludable, it would increase tax losses by \$1200 per family.

Anyone who is healthy and wealthy enough to afford the deductible will prefer the MSA, especially if there is favorable tax treatment.<sup>6</sup> This discriminates against the sick, the high risk, and the poor, who will be left in low deductible plans and health plans whose costs will increase as the healthiest people opt out. Experience in the FEHBP program showed that people with the worst risks chose the Blue Cross/Blue Shield low deductible option, while good risks selected the high deductible option. Even if MSAs could be redesigned to encourage healthy lifestyles and preventive care while limiting revenue loss to the federal government, people with cancer, diabetes, heart disease, and other chronic illnesses would face increasingly higher premiums, as the healthy, good risks opt for tax-favored MSAs with catastrophic coverage. Even a sophisticated risk adjustment mechanism would not be able to compensate health plans for this degree of adverse selection. However, it is hard to predict the impact of any MSA proposal, as they are all based on theory.

## **INSURANCE REFORMS AND GROUP PURCHASING**

**Jay Carruthers and Ellen Wilson**

The rising costs of health care over the last decade have affected the large and small group markets in two very different but instructive ways. Cost pressures on large groups have inspired major innovation, including greater use of managed care, incentives for cost-conscious purchasing, and better information for making choices. The same cost pressures when applied to the small group and individual market have had a deleterious effect.

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<sup>6</sup> Section 125 plans create the same problem, although mitigated by the fact that users lose unused funds at the end of each year. This has led many to call for the elimination of Section 125 plans.

Small groups are unable to spread risks, to achieve economies of scale, to benefit from competition, and usually to offer multiple plans. As a result, the small group and individual market is characterized by:

- High premiums or unavailability of coverage to high-risk individuals.
- Steep premium increases (especially for individuals or small groups with individuals who get sick): small and mid-sized businesses faced an average increase of 14 percent over the last twelve months. Over the last three years, it totaled about 57 percent.<sup>7</sup>
- High administrative costs: a carrier's administrative expense, by one estimate, reaches 40 percent of claims in groups of one to four, compared with less than five percent for groups of more than 10,000.<sup>8</sup>
- Segmentation of the market by risk (i.e., health status).
- An inability to influence the development of the market to better meet the needs of small groups and individuals.

If access to, and affordability of, coverage in the small group and individual market is to be improved, the state and federal government must act in concert to implement core uniform standards that foster the development of effective group purchasing.

Group purchasing offers a powerful tool for structuring a competitive, well-functioning market.

- Members are offered a choice of health plans.
- Competition is driven by side-by-side comparisons of health plans based on value (quality and cost).
- Risk is spread more broadly; the ability of health plans to discriminate on the basis of health status decreases.
- Administrative costs are significantly reduced. In addition, health plans avoid the high costs associated with marketing to a multiplicity of small groups.

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<sup>7</sup>Arthur Andersen, "Survey of Small and Mid-Sized Businesses: Trends for 1994."

<sup>8</sup>Congressional Research Service, "Private Health Insurance: Options for Reform," September 20, 1990.

However, before group purchasers are effectively able to drive the small group and individual market, certain uniform standards need to be applied across the entire health care market. Standards should be set by the federal government, implemented by purchasing groups through private contracts with health plans, and enforced by the states.

Despite current efforts to give states more power in developing local policy solutions in areas like welfare, there are several reasons why reforming the health system requires federal standards. First, health care markets do not adhere to state boundaries, making it impossible for states to structure rules that apply consistently across markets. Second, the preponderance of large multi-state employers reinforces the need for a federal framework. Moreover, with the rapid change in the delivery of medical services and the proliferation of varying levels of risk-bearing arrangements, state regulations designed to monitor traditional insurance carriers are outdated. Enforcing uniform federal standards, however, would be a logical extension of the state's traditional role as insurance regulator. It is important to note that federal standards could be spelled out without creating a new federal bureaucracy.

### **State Efforts**

Forty-five states have recently adopted some form of insurance reforms as a first important step toward improving access to coverage in the small group and individual market. Results, thus far, have been mixed. Some states have had success eliminating the most blatant forms of risk selection using basic reforms like guaranteed issue of all products, guaranteed renewal, portability, and limits on preexisting condition clauses. Nearly twenty states have gone even further by implementing some form of community rating and experimenting with purchasing groups across the small group and individual market. Private sector initiatives, such as the Cleveland Council of Smaller Enterprises (COSE) and Chamber of Commerce purchasing groups, have expanded access to affordable coverage for their small business members, but criticism has been directed at some of these arrangements for leaving the individual market largely untouched, rarely pooling risk, and in some instances, using medical underwriting to exclude the worst risks.

Despite some progress, states that have carefully crafted insurance reforms are finding their efforts undermined by the growth of self-insured plans. As states increase regulation in the small group and individual market to spread risk more broadly and expand coverage to the poor (e.g., premium taxes), the best health risks opt out of the pool and choose to self-insure (or drop coverage entirely, as was the case in New York). These plans, protected under ERISA, do not have to comply with state laws regulating health insurance. If self-insured plans continue to siphon off the best risks from the small group and individual market, a risk spiral within the state-regulated market is inevitable. The problems surrounding ERISA underscore the difficulty in reforming a voluntary health system with the current division of state and federal regulations. In making limited ERISA reforms, policy-makers should avoid engendering 50 different sets of laws regulating health benefits, nor should they permit states to finance expanded access programs by taxing self-insured plans. Doing so would penalize employers already providing coverage to their employees.

### **The Role of the Federal Government**

**A Tax Credit Linked to Group Purchasing:** If tax credit eligibility were dependent on purchasing coverage through an appropriate group, as recommended in *Increasing Cost-Consciousness: Reforming the Tax Treatment of Health Insurance*; page 11, efficient group purchasing efforts on the part of employers would be maintained while providing incentive to create other voluntary certified purchasing groups (defined below).

Employees whose employers offered coverage would have to purchase it through them to receive the tax credit. The self-employed, non-employed and employees whose employers do not offer coverage would be required to purchase coverage through a certified purchasing group to receive the tax credit. The individual market would be replaced by purchasing groups that would be able to pool risk sufficiently as people take advantage of the tax credit.

**Insurance Reforms:** The federal tax credit should be part of an incremental reform package that includes basic insurance reforms. By enacting those insurance reforms at the

federal level that have already been implemented in most states—e.g., limited guaranteed issue of all products, guaranteed renewal, portability, limitations of preexisting condition exclusions, and limited rating restrictions (not community rating)—the most blatant forms of risk selection would be eliminated while providing greater uniformity to the system. These reforms are designed to prevent health plans from discriminating on the basis of health status—a widely accepted principle—and should apply to all health plans regardless of risk-bearing arrangements, whether it is a traditional insurance carrier, a health plan, or an ERISA self-funded plan. The cost of overseeing reforms should be borne equally among all parties in the form of a federal premium tax remitted to the states and other entities created to apply standards.

#### **The Role of the States: Certifying Voluntary Purchasing Groups and Enforcing Standards**

The primary responsibility of the states would be to accredit those voluntary purchasing groups that meet the criteria to become Certified Purchasing Groups (CPGs), as well as to enforce compliance with insurance reforms. To receive accreditation and hence enable members to claim a tax credit, a purchasing group would need to adopt certain standards, such as:

- Accepting all who are eligible and wish to purchase coverage through the group.
- Offering a choice of health plans.
- Conducting an annual open enrollment period.
- Experience rate the group as a whole, with adjustments for age, family status, etc.
- Risk adjustment within the purchasing group (developing/adopting an actuarially sound methodology would be left to the purchasing group and participating health plans).
- Surveying members about their experience with their health plans and provide quality related information.
- Assure insurance reform compliance in contracting with health plans.

Many purchasing groups already perform several of these functions and could easily receive state accreditation as a voluntary CPG.<sup>9</sup>

With such federal and state provisions, employers, employees, and individuals should react to existing incentives and market forces to maintain and participate in the appropriate purchasing group. Employers who have been efficiently purchasing health care—primarily large employers who have been major forces of progress and innovation in health care purchasing—will find it in their interest to continue doing so. Employers who are inefficient purchasers, or who have not previously offered coverage, will likely want to offer coverage through a voluntary CPG. Extending access to purchasing groups for all small groups and individuals, in conjunction with the implementation of a standard set of market rules, is a critical step toward structuring an efficient market in which coverage is more accessible and affordable.

**Target Goals:**

- All fifty states should have at least one voluntary certified purchasing group by 1998—when the tax credit will be given to only those purchasing through the appropriate group. States without a CPG may need to consider offering incentives for their establishment.
- Everyone in the individual and small group market should have access to group purchasing by the year 2000.

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<sup>9</sup> When you have individuals choosing among health plans that sell different sets of medical services, there is the threat of risk selection. While insurance reforms and the extension of group purchasing to the small group and individual market attempts to minimize risk selection, in such a complicated and dynamic system the extent to which risk selection will occur is unclear and is something that should be closely monitored. For example, an upper size limit for employer groups has not been placed on CPG eligibility. But if it turns out that predominantly bad risk large groups purchase through CPGs, it may be necessary to impose such a limit.

## BENCHMARK BENEFITS

Nancy Ashbach, MD, MBA

### **The Need for Fair Disclosure and Comparability**

Health plans, consumers, pharmaceutical manufacturers, physicians, legislator, the courts, and others have struggled in the past with benefit plan offerings. In particular:

- Consumers have been unclear about the criteria for inclusion of specific benefits in their health plans. This has led to suspicion that managed care plans are motivated to skimp on needed care.
- Consumers have had difficulty comparing health plan offerings with differing benefits.
- Physicians and others have been unclear as to the benefit and technology review processes in health plans, leading them to view the process as secretive and unscientific.
- Health plans have been hampered in their ability to deny coverage for specific interventions clearly and concisely and to support such decisions with cogent reasons.
- Pharmaceutical and technology manufacturers have suspected that such decisions are based upon cost alone and that their products are not receiving a fair and open hearing by health plan policy-makers.
- The courts and legislators have received conflicting advice from interest groups.

It is for these reasons that a benchmark benefits package is needed. This product should be a voluntary, real, and valid offering of all health plans, but need not and should not be the only offering. Plans can and should be able to offer packages both richer and leaner to respond to the needs of purchasers. Many plans have had lengthy experience with the federal HMO benefits package, and we recommend that until the process for revising and improving upon it is in place, it serve as the initial benchmark package.

The process of defining and maintaining the benchmark benefits package should be open, fair, understandable, and for information purposes only. The criteria for additions and deletions should be available and the process should be clear so that coverage decisions

by the health plan would be protected from unreasonable challenge. Physicians, drug manufacturers, consumers, purchasers, health plans, and others who might wish to influence the process of coverage inclusion and exclusion would therefore be able to do so, and the public would be assured of appropriate care being provided and of coverage for expensive therapies not being denied solely because of cost. There should be no opportunity for collusion between health plans for the inclusion or exclusion of benefits. For the purposes of avoiding antitrust law suits, health plans may need to be excluded from the process.

In addition to disclosing criteria for coverage, a standard product must be available for price and quality comparison. In the absence of a voluntary benchmark, plans will vary benefits to satisfy the demands of various customers, and comparability to the consumer will remain elusive. By using a benchmark benefits package as a standard product against which the differing needs and requirements of purchasers can be measured, comparability of benefits and price offerings can be determined.

### **Assessing Technology**

The benchmark benefit package should be that collection of benefits that is most likely to produce health in the population. While the federal HMO benefits package is an excellent starting point, producing health in the population will require ongoing evaluation, revision, and updating of benefits. Technology assessment and cost-effectiveness analysis will be necessary to achieve this objective in a rational way. Currently, such assessments are performed by government, private organizations, and individual health plans. Such efforts are inefficient and duplicative and furthermore do not provide health plans with sufficient justification to offer or deny coverage. In the present environment, such decisions are suspected of being made for cost reasons. As a consequence, benefit decisions are being challenged and made by the courts and legislatures rather than on the basis of sound scientific evidence and efficacy. The absence of an open, clear, fair, and scientific evaluation process is detrimental to all parties.

Technology assessment and evaluation are necessary because:

- Technology in medicine is in a constant state of flux, with new technology entering the market at a staggering rate. The cost of such technology creates a strong economic requirement for a valid assessment process to determine coverage under a typical benefits package.
- Much existing technology has not been evaluated for effectiveness. To date we have had no mechanism for doing so, and many interventions in medicine are covered under existing benefits packages as a result of historical precedent.
- Cost-effectiveness has not been a major element of technology evaluation in the past but will surely become so in the future as group benefits are valued against individual demands.

Additionally, individual coverage decisions on the part of health plans often require an independent evaluation and recommendation, which plans could implement on a voluntary basis. Such individual evaluations would be carried out by experts in the appropriate field of medicine and would be free of vested interests to deny coverage based on cost considerations. Independent expert reviews would support removal of coverage decisions from the legal system, where judges and jurors often rule in favor of coverage if there is uncertainty or urgency.

### **An Independent Approach**

A new, independent organization, the Benchmark Benefits Group (BBG), should be formed to address these needs in the health system. The BBG's proposed functions are outlined in Table 1. It would be private and not for profit, although government collaboration would be possible in key areas, such as technology assessment, clinical trials, Medicare, and Medicaid. Representatives could come from purchasers, consumers, managed care organizations, self-funded employers, academic medical centers, physicians, and the government. Funding for the organization would come primarily from user fees—that is, per capita assessments of the participants and users of the organization's efforts. Special projects funding could come from foundation grants.

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**Table 1**  
**Functions of the Benchmark Benefits Group**

- Definition, updating, and maintenance of the benchmark benefits package using the criterion of production or maintenance of health.
  - Recommendation of inclusion or exclusion of new technology into the benchmark benefits package based upon technology evaluation done by recognized groups.
  - Recommendations regarding continuation, limitation, or exclusion of existing technology.
  - Cost-effectiveness information and recommendations based upon information from competent entities.
  - Individual disputed coverage decisions in defined situations. For example, an autologous bone marrow transplantation case for breast, ovarian, or cervical cancer denied as experimental by a health plan would be referred to a group of experts entirely outside the plan for scientific review.
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Since technology assessment is currently done in several different organizations, including many managed care organizations, careful consideration would be given to using existing expertise in the private market. This might mean purchasing technology assessment expertise from organizations such as the Emergency Care Research Institute or the Blue Cross/Blue Shield Technology Evaluation Committee or networking current expertise. A principle of the new organization would be to utilize expertise currently available in the private market in the most effective way without in any way regulating or discouraging the innovation of the private market.

A critical element to the success of the BBG will be its independence and autonomy. Many elements of the health care system are characterized by suspicion and doubt as to the methodology regarding coverage decisions in the policy-making and in the individual case. The autonomy of this organization will reassure doctors that an appropriate process exists, with adequate clinical input. It will reassure patients that their interests are being dealt with fairly, and it will reassure new technology providers —e.g., drug and device manufacturers—that a fair process exists, facilitating level playing field competition for all.

Thus, the processes and criteria of the BBG should be open, published, and available for revision as the health care industry develops and matures.

**Target Goals:**

- 90 percent of health plans offering the benchmark benefits package by 1998.
- 75 percent of health plans utilizing the technology assessment capabilities of the Benchmark Benefits Group by 1998.
- Reconsideration of decisions made in individual cases by the Benchmark Benefits Group upheld by courts in 60 percent of cases by 1998.

## **A HEALTH ACCOUNTABILITY SYSTEM**

**Sarah Purdy, MD**

### **A New Quality Accountability System for a New Health Care System**

The expectation that consumers would be able to choose among competing health plans, on the basis of comparable quality and cost information, has not been realized. This failure is partly due to information about the quality of health care being not as easily available, understood, or compared, as information about costs. Consumers have been inhibited from assuming responsibility for their own health care choices by inadequate information that does not facilitate side-by-side comparison of health plans or encourage participation in decisions about health care and treatment. To evaluate the impact of health care on the population it is necessary to measure the result, or outcome, of the interaction between individuals and health plans—to hold health plans accountable. At present there is a health care quality measurement industry that uses different definitions of quality and differing methodologies to measure quality. We propose a new health accountability system which would not rely solely on these traditional systems of quality assurance which fail to disclose health outcomes or assure consumers of receiving

excellent care by choosing a specific plan. The principles and assumptions upon which the new health accountability system is based are:

- Comparable, reliable, valid quality accountability data must be available to consumers.
- A move toward outcome based accountability data is feasible.
- Purchasers, consumers, and providers may have different information needs. Quality improvement activities should result from internal use of quality data.
- A clear distinction should be made between defining measurement and disclosure requirements and verifying that requirements are observed. Organizations that define data disclosure requirements, and those that audit data, should be independent of each other, with neither being subject to undue influence by the provider or insurance communities.
- Providers, health plans, and researchers create the capability for choices to be made on cost and quality, but group purchasers and individual consumers should have input on the requirements of the system.
- The same data on quality should be demanded by, and be available to, both private and public sector purchasers.
- Uniform data disclosure requirements could lead to the formation of regional and national data bases, which would inform providers, purchasers, and policy-makers.

These principles raise several potentially controversial issues. First, the intention of the system is to compare health plans, not individual providers. Second, there is debate on how to compare the results of care provided by different health plans when the health and demographic characteristics of the populations they serve are not comparable. This issue of severity adjustment, or case mix, requires continuing refinement. Third, the system would require health plans to collect additional information about quality and use some form of standardized record keeping. By cooperating with this, plans would potentially be putting themselves in a position of being unfavorably compared with competitors. Finally, the degree to which consumers want and understand information about quality of health care is still uncertain. However, those whose lives are impacted by health care—patients

and those who represent their interests—must have the dominant input into the quality accountability system.

The health accountability system would also require group purchasers, whether public or private, to provide valid, comparable information to consumers. To achieve this, and avoid further increase in the number of data sets requested by purchasers, collaboration is needed within the health industry.

### **What Would a Health Accountability System Look Like?**

Table 2 outlines the proposed system, which suggests collaborative efforts to address two areas: the research, design, and evaluation of health accountability measures, and the selection and endorsement of uniform data disclosure requirements.

### **Accountability Measures Clearinghouse**

Many groups and individuals have developed considerable expertise in devising and implementing health plan performance measures. Currently, no organization documents all of these efforts and evaluates them, or assists others with questions of methodology or implementation. A collaborative approach would achieve economies of scale, resulting in more funding for such projects, greater availability of information, and a reduction in the duplication of effort. It is proposed that an organization be formed that serves two main functions:

- To act as a clearinghouse for the collation and exchange of information about quality accountability measures and methodology.
- To call attention to the need for research, development, and continual evaluation and improvement of performance measures.

The clearinghouse is not meant to engage in research. It should be a private/public partnership, perhaps set up to collaborate with an existing organization, such as the Agency for Health Care Policy and Research (AHCPR) or a research institution, such as a

university. Funding would come from foundation grants, government agencies, and per capita contributions from the industry.

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**Table 2**  
**Elements of a Health Accountability System**

- 1. Accountability Measures Clearinghouse**  
Clearinghouse function, to collate and disseminate information about measures, methodology, and previous experience. Identify areas that need further research.
  - 2. Health Accountability Foundation**  
Select and endorse uniform data disclosure requirements. Purchaser and consumer dominated board, permanent executive staff, input from other players.
  - 3. Auditing of Health Plan Data Disclosure**  
Verification that data has been collected, analyzed, and interpreted in a reliable and valid manner.
  - 4. Selection of Health Plans by Group Purchasers and Consumers**  
On the basis of uniform, comparable data disclosed by plans.
  - 5. Quality Improvement**  
Assist health plans to be proactive in the improvement of quality, and to respond to the results of the measurement process.
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### **Health Accountability Foundation**

A Health Accountability Foundation (HAF) should be established as an independent collaborative body between the private and public sectors. Its responsibilities would include setting quality accountability goals and selecting and endorsing uniform measures of health plan accountability. These measures and the agreed methodology by which they are collected would then form the core of all health plan reporting activity. Care must be taken to ensure that standardization does not quash innovation, and that evolution of the core measures is assured as information capabilities improve. It is important to consider the clinical implications for plans and providers, and to build incentives and feedback mechanisms for quality improvement activities to result from the internal use of quality data. Standard setting should not be isolated from implementation. The experience of the

health plans and the accrediting bodies will be vital to ensuring a link between the foundation and clinical practice.

It is envisaged that the HAF would have a permanent staff of scientists, who would systematically consult with outside experts. They would present recommendations to the foundation's board, whose majority would be represented by purchasers and consumers from the private and public sectors. A mechanism needs to be devised, by which health plans, providers, researchers, the pharmaceutical and technology industry, and the health care quality organizations would have input. The closest existing model for the HAF is the Financial Accounting Standards Board (FASB). The recommendations endorsed by the HAF should be scientifically justified and subject to scrutiny at public hearings. It is important to link health plans into the system, in order to ensure that the data requirements specified by the board inform quality improvement and the furthering of medical knowledge, and are fair and feasible. Data that is valuable to providers is more likely to be included in medical records and incorporated in computerized medical information systems.

Funding of the HAF should preserve its independent status. Funding should be assured, but not dominated by health plans. A possible mechanism would be an annual subscription, and an assessment on the health plan premiums of those plans that choose to participate.

The two private sector initiatives proposed in "Responsible Choices" are the Benchmark Benefits Group and the Health Accountability System. These two functions could work synergistically under a private umbrella organization sponsored by a broad range of participants and involved parties and funded by user fees.

### **Completing the System**

The other criteria for the proposed system can be satisfied by well-established mechanisms already in place. Because organizations like the National Committee for Quality

Assurance and the Joint Commission on Accreditation of Healthcare Organizations have considerable experience in accrediting plans and providers, they could play a major role in auditing the process and facilitating quality improvement activities. The organizations that focus on internal quality improvement, such as the Institute for Healthcare Improvement, would be an obvious medium for the quality improvement role. Continuing education of physicians and other health plan staff members is important to each stage of the process. There will be considerable overlap between the components, and continuous feedback to the clearinghouse and HAF functions will be necessary.

**Target Goals:**

- Comparable information about the quality of care provided by health plans should be available to 100 percent of consumers purchasing through groups by 1998.
- Preliminary health plan data on condition specific outcomes by 1998.

## **HEALTH SYSTEM INFORMATION**

**Robyn Lunsford, MSE, Nancy Ashbach, MD, MBA and Sarah Purdy, MD**

### **Why Is Coordinated Health Data Needed?**

Making responsible choices will require that better information be available on who is insured, what it costs, and whether better health is the result. As the system changes, data must be collected faster and from different sources: per capita expenditures by health plans, for example, are becoming more valuable than the numbers of physician visits and hospital days. Attempts at federal health care reform last year showed that the data available was not sufficiently timely or accurate. In fact, inadequate data on consumers' responses to price competition tilted some proposals toward price controls.

Congressional Budget Office estimates of the cost of various bills were hampered by their inability to evaluate the effects of undocumented improvements that were under way and differences in inflation rates from community to community. In order for policy-makers to address the problems of attaining universal coverage while containing the cost of health

care, they must have data about the numbers and characteristics of the insured and uninsured and the cost of different delivery systems. Though multiple sources of health care data are available, one of the major obstacles is how to access, analyze, and compare this disparate information.

### **Why Are the Current Data Inadequate?**

- Multiple data sets are not comparable or accessible from one source: For example, information about coverage and utilization of services is collected in the annual National Health Interview Survey (NHIS), but it does not provide information about household income or costs.
- Data regarding costs and coverage is not timely: e.g., the information from the NHIS takes twelve months to process. The National Medical Expenditures Survey is completed only once every ten years.
- The validity and accuracy of some sources of health data has been questioned; e.g., the medical care component of the consumer price index (CPI) does not measure costs borne by third-party payers, hence it reflects price to the consumer, not true overall cost.
- Data are not available in useful formats: e.g., it would be very helpful to have data sorted by state to deal with issues such as Medicaid reform.

ated with the existing data sets and with setting up an alternative dged by federal agencies<sup>10</sup> and at the state level. We have set out some basic principles for the development of a coordinated system in the following sections.

### **What Should Be Collected?**

Data will be required in four basic areas in the health system:

1. Cost—What is the per capita cost of health care, to third-party payers and to the individual?

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<sup>10</sup> Physician Payment Review Commission, Annual Report, 1994.

2. Coverage—Who is and is not covered by the health insurance system?
3. Vital Health Statistics—Morbidity, mortality, reportable diseases.
4. Quality—What are the measures of quality of services provided?

Quality of services (health status, outcomes, and consumer satisfaction) was covered in: A Health Accountability System; page 27). This section focuses on the data needs of cost, coverage, and vital statistics.

The process of collection should be guided by some basic principles:

- Confidentiality of records and privacy rights of individuals must be preserved. Use a unique, encrypted identifier.
- Data must be exchanged electronically, either directly or indirectly.
- Data must represent the minimum required to serve the basic needs of the health system.
- The information needs of the health system will change as the payment system changes.
- Data collection must be timely.
- The aim of the uniform data system should be to reduce administrative cost in the health care system.
- Determination of which data elements are collected should be driven by a clear mission—to improve the health of the population.
- Data should be collected at the state level, and then aggregated nationally.

**Cost:** Information is needed on per capita costs for all covered individuals in the health care system. The purpose of information at this level is to determine the per member costs of health care—those borne by the health plan and those borne by the individual. It will be necessary during a period of transition to reconcile the methodology of data collection between capitated systems and fee-for-service systems. It will be the responsibility of a federal entity (see page 35) to define appropriate standards to integrate information from the two payment systems.

**Coverage:** Information will be required from health plans and self-insured groups with respect to numbers of enrollees (including dependents) and member demographics. Timely information on enrollment and disenrollment will be needed. Statewide information will be required both on the insured population, which should be available through health plans, and on the uninsured population. Data on the characteristics of both groups, such as employment or lack thereof, income, and demographics, should be collected. The basic questions to be answered in this context are: "Who is covered?" "Is their coverage adequate?" and "Who is not covered and why?"

**Vital Statistics:** The new health data system should continue to collect information on morbidity, mortality, reportable diseases, births, and other issues, possibly including immunizations. Such information should be collected in a standardized way and integrated with information collected by providers and health plans for purposes of comparability and to reduce administrative costs in the health care system.

### **How Can the Goal Be Accomplished?**

We propose the creation of a federal entity to collect uniform, timely, accurate health system cost and coverage data. Although some may oppose either a new federal entity or a uniform approach, we believe that the availability of such data is a goal that justifies a federal presence. Private industry collaboration alone will be neither comprehensive nor rapid enough. An apolitical Bureau of Health Statistics, analogous to the Bureau of Labor Statistics, should be established by Congress and report to Congress on progress toward the goal. It should be separate from all purchasers, including Medicare. The Bureau would be advised by a Health Data Commission, to be composed of a broad group of members with expertise in information systems, health care financing, health economics, and other scientific and technical fields. We propose that the Bureau of Health Statistics take responsibility for reporting on cost, coverage, and vital statistics. Information on quality reporting will fall within the purview of the Health Accountability Foundation. The creation of the Bureau of Health Statistics and the Health Data Commission will

require federal legislation and reporting of the chosen data elements by all parts of the health care delivery system as well as by states.

**Target Goals:**

- Health data system should be functioning by the end of 1996.
- Data on costs of health services should be available quarterly.
- Data on coverage should be available annually, and within the first three months of the following year.

## CONCLUSION

"Responsible Choices" recognizes that the health care market is moving rapidly toward reform and offers proposals to foster this restructuring. Private purchasers are driving the market and causing health plans to compete on price and quality. However, not all purchasers are exerting this force on the market. As the largest purchaser of health care in the U.S., the federal government has tremendous potential to drive improvement in the market which it has not yet exercised. Small groups and individuals have limited access to group purchasing arrangements that pool risk, provide choice, and achieve administrative savings that would enable them to be active, value purchasers of health care.

This demonstrates that market mechanisms alone are not solving all of the problems.

"Responsible Choices" depends on the willingness of government and the private sector to work together to improve the American health system. Federal involvement is necessary to bring public programs into line with the private sector, increase consumer cost-consciousness, establish a fair market, promote group purchasing that offers the small group and individual market access to reasonably priced health coverage, and provide information. "Responsible Choices" recommends a tax credit as the means for bringing structure to the market. Without the tax credit device, bringing order to the health care market will be much more complicated and require considerable regulation.

For its part, the private sector must be willing to be more accountable. Benchmark benefits and quality reporting are the first steps that the private sector should take to voluntarily hold itself accountable. Implementing these policies would bring comparability to the market and provide information enabling consumers to make informed decisions and drive competition. If the private sector cannot follow through, it may be necessary to link these proposals to the tax credit by requiring health plans to price and offer the benchmark benefits package and report on quality in order to receive tax credit eligibility for their plan.

"Responsible Choices" does not address the issue of achieving universal coverage but recognizes that other primary problems must be solved first, such as building a better marketplace so consumers and purchasers can make informed decisions. Other important issues, such as malpractice and antitrust, are not taken up directly since they are being actively addressed by others and dealt with in the market. These proposals are the necessary incremental steps forward in containing costs and fostering effective public and private purchasing. With these reforms in place, there will be more data and the capability to effectively and efficiently deal with those left out of the system. The elements of this proposal can be put in place rapidly and will accelerate the reforms already taking place in the market.

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We welcome, and encourage any comments you have on this draft document. If you have comments, questions or need any further information please call, fax or write:

**Jackson Hole Group**  
**P.O. Box 350**  
**Teton Village, Wyoming 83025**  
**Phone: 307-733-8781**  
**Fax: 307-739-9312**