

Tenth Annual William E. Petersen Symposium
University of St. Thomas Opus College of Business
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Thank you Dan, for the very kind introduction, I am delighted to be here in Minneapolis with you this evening. I was deeply honored when I was called by my friends Ken Paulus and Gordon Springer asking me to give this talk - honored not just because of my respect for them as individuals but because of all of the good things I have heard throughout the years about their health system, and about progressive developments in Minnesota across the board with regard to health care issues.

As fate would have it, it turns out that we are here tonight at a very critical juncture in the decades' long national debate regarding health care reform. I am sure you have all been following the significant and visible debate on health reform which began during last year's election campaign and has built to a crescendo as the issue has become, first the centerpiece of the fledgling Obama administrations domestic priorities, and then, over recent months, a near all consuming focus on both sides of Capitol Hill. As of today, with five bills reported out of various committees, one can say that the debate has never been so far along, and yet at the same time an incredibly difficult piece of work remains in trying to find common elements of these bills which can pass in the House and the Senate, and have differences between the two bodies reconciled prior to signing by the president. To get to the punch line of my remarks in the very first paragraph, I believe that within months we will conclude a very important chapter in this decades' long story with a bill signing at the White House, but I also believe that the book will not be completely written, and that we will be working on further chapters over the next two to five years. Said another way I think we will see that additional millions of people have been covered - more progress on this issue than we have made for decades - yet at the same time I fear we will fall significantly short of universal coverage, and that much work will remain to be done regarding costs, and the restructuring of our health care delivery system. In short I see

something far north of incremental change, but well south of completing the story on comprehensive health care reform.

(Slide 1) I thought what I might do this evening is reflect with you upon the history of the health reform debate, by talking about that debate as it relates to the two key issues which drive the discussion, coverage and cost. Then I will conclude with some thoughts about challenges for the future.

My remarks this evening will be guided by my own background and experiences. I have had an interesting dual perspective on these issues. I had the opportunity to work on health financing from a governmental perspective for over a decade in Washington and then for the last three decades from a provider perspective.

So I have had much to reflect upon, and I must tell you that these reflections have left me deeply troubled. Although I am very hopeful about the progress I see in the science of health care, I am concerned about what I see in health financing. It is, to lean on an old cliché, the best of times and the worst of times. The progress in science and our ability to translate that science into patient care is staggering. We do things every day in our hospitals that we could not have dreamt of doing ten or twelve years ago, and all of us in health care feel privileged to be a part of that. But the economics, financing, and organization of this system are very broken. Broken both because millions of our citizens remain without health insurance coverage, and broken because our very fragmented health system has not been able to keep pace with medical progress. The result too often is a chaotic delivery system providing uneven care with cost increases that are likely not sustainable.

Coverage Slide 2)

Let me turn first to a discussion of coverage, before turning my attention to costs. At the outset of these remarks, at the risk of seeming to be terminally cynical let me tell you, from my four decades of experience, that the secret to following the health reform debate has always been to follow the dollar. This debate has never been about health. It's always been about finance –

about who would pay to cover the un-insured. Aversion to higher taxes has always been the major stumbling block to expanded coverage.

So what should be a debate, at least in part, about values, about social justice as a moral value, quickly becomes a debate about who pays - about taxes, employer and individual mandates, provider cuts, and state contributions.

It's of interest that our discomfort in dealing with the moral dimensions of this issue begins with the sometimes tedious parsing of who the uninsured really are, a parsing by their worthiness, their health status, and the duration of their being uninsured. From the right we are told that the number of 47 million is too high because it includes ten million presumably "not worthy" undocumented aliens, and millions more young people who may not have a need for insurance. And from the left we are told that the number is too low because of the many millions of people who, though covered now, were without coverage at some point during the past year. What remains indisputable is that, however you count them, most of these people are poor or near poor, and most of them are employed or dependents of employed workers. They work hard often at agricultural, retail or service jobs. But they fall between the cracks of our health insurance system. They don't qualify for Medicare or Medicaid but their employers do not provide health insurance coverage or they cannot afford their share of the cost.

But regardless of the number you pick there is a more important question. What difference does the lack of health insurance make? I am convinced that an inability or unwillingness to understand the answer to this question has been one of the biggest obstacles to solving this problem. You see, many people assume that the uninsured get care when they need it. And in a sense they are right. After all for an acute dramatic health episode such as child birth or a broken leg almost everybody does get treatment. We as a society are uncomfortable watching childbirth in the street or ignoring those with an obviously broken bone. We are willing to pay the cost of moving that care indoors. But what is not well understood is that the uninsured often do not receive care for less dramatic chronic illness and in many instances defer care until their illnesses have reached an advanced stage. The definitive Institute of Medicine Report on the Uninsured in 2004 by a committee I was privileged to serve on, demonstrated that the uninsured are far less

likely to have seen a physician in the past year, far more likely to postpone or to go without care and far less likely to receive preventive care. They are much more likely to be hospitalized for avoidable complications of asthma, diabetes or hypertension. Uninsured working age adults have a 25% greater risk of dying prematurely than insured adults after adjusting for demographic differences. The result is over 18,000 excess deaths annually associated with un-insurance. So this is about peoples' health.

Before I leave this point I want to caution against assuming that this ignorance is merely a result of failed advocacy. There are economic reasons which I will describe that lead many people to be opposed to expanded health insurance coverage, and for many of these people, ignorance of the consequences of being un-insured is convenient – and they are decidedly uninterested in being further educated on the issue.

With regard to the revenue needed to deal with the un-insured, the Institute of Medicine sub-committee, which I chaired in 2003 estimated that the price tag of services not received by the uninsured would range from 35 to 70 billion dollars a year or about 3% - 5% of national health care spending – less than each year's annual increase in overall health care spending. Now the actual cost of any legislation would likely be higher anywhere from 70 – 100 billion dollars a year, because most bills would provide some subsidies to employers who offer coverage, state fiscal relief, or other support. In terms of our aggregate 2 trillion dollars of health spending these numbers would not seem insurmountable. And in terms of federal taxation levels this revenue could be raised and still leave taxes at or below levels of the 1990's, tax levels which underpinned one of our most productive economic eras.

So now I'd like to turn to a little straight talk on why we as a nation have failed to deal with this problem.

We have approached this problem of the uninsured three times in the past thirty years. In 1974, I was serving on the staff of the Senate Finance Committee when President Richard Nixon proposed to provide broad health insurance coverage. Interestingly, President Nixon had two options as to how to finance the coverage for the uninsured. One option was to increase taxes. The other option, which he chose – was an employer mandate – a requirement that employers

provide health insurance to their employees. This employer mandate was attacked by conservatives as just a hidden tax and Nixon's proposal was attacked by liberals as not going far enough and it died in the cross-fire in the Congress. In 1979, I was working at the White House when President Carter put forth a health insurance proposal, patterned after President Nixon's proposal, and his bill also failed to pass. And, sixteen years ago President Clinton early in his first term, as the central element of his presidential agenda, put forth a health insurance proposal, which like Nixon's and Carter's, was financed by an employer mandate. An extensive national debate ensued which focused as it always has before on how to pay for broader coverage. Our nation and the Congress faced this issue squarely and made a decision. As a nation we gave a higher priority to avoiding higher taxes and their closely related cousins employer mandates than we did to providing coverage for the then forty million uninsured.

But there was one other chapter to this story which was written in Massachusetts a few years back, where this unrelievedly bleak landscape for expansion of health insurance coverage was pierced by a ray of hope with the passage of state legislation aimed at substantially covering the uninsured.

You might ask how did this happen? How did Massachusetts break through the concerns about higher taxes and income transfers which have blocked action at the federal level? Well it is an interesting story. Essentially, Governor Romney proposed and the legislature adopted in a modified form an approach tailored to avoid taxes and employer mandates. The Governor adopted a different philosophic approach to coverage – he did not submit a bill which would provide health insurance coverage in the same way government provides services and benefits like basic education and police protection – he instead submitted a bill that would require individuals to have coverage – a bill built around the concept of an individual mandate or obligation to obtain coverage.

This more conservative approach to expanding coverage was not a new idea - it had been proposed for a brief period in the 1990's by Senator Robert Dole. But it is not a magic answer to the no new taxes dilemma, because you cannot, with a straight face, mandate the purchase of something as expensive as health insurance without proposing very significant subsidies for low

and lower middle income people. The large subsidies lead you right back to the need for higher taxes, and consequently Senator Dole dropped this approach in the 1990's.

But Governor Romney was fortunate enough to have some magic to apply – more than twenty years ago, the Massachusetts legislature had the courage to increase taxes on the general citizenry, insurers, and providers in order to support a pool of funds – the uncompensated care pool – to support hospital care for the uninsured. So the Governor was able to propose redirecting this substantial sum of tax dollars to subsidize insurance policies for the poor, as opposed to paying the hospitals directly. These funds also bought in additional federal matching funds and made the subsidies of individual mandates reasonable and a broad centrist coalition rallied around the concept.

As most of you know, this “Massachusetts Approach” has become the model for the current national discussion.

This brings me to the current situation. I am watching the current climax of this debate with a mixture of hope and concern. Hope that we will indeed add additional millions to coverage, but concern that we will fall well short of universal coverage. I will illustrate why I arrive at these mixed feeling with this chart.

(Slide 3) I believe that legislation will contain an individual mandate of some sort but I worry that the individual mandate itself may come under significant attack over the next few weeks. Although the mandate had been presented and defended by Governor Romney as not a tax, but personal responsibility - many on the right are now beginning to attack it as a tax, and to a certain extent, if an employer mandate is a tax, arguably an individual mandate is a tax. And people on the left attack the mandate, saying that without adequate subsidies the individual mandate will be too burdensome for many lower middle and middle income families. I fear that the mandate will be significantly delayed and diluted because of the need for many so called hardship exemptions granted to people, who because of inadequate subsidies, would have to pay a significant portion of their annual income to purchase the mandated coverage. Of course one

answer to this dilemma would be to have adequate funding from either an employer mandate or tax increases to provide for adequate subsidies. But these approaches have been off the table.

The employer mandate lacks the votes in either the House or Senate. The current situation with respect to taxes was best summarized by Speaker Pelosi who is seeking to change the House bill, which had proposed a tax on incomes above \$250,000 a year, to a tax only on incomes only above \$1 million a year. For those who doubt the thorough and complete triumph of the anti-tax Reagan revolution, just pause for a moment and consider that the democratic Speaker of the House, from the very liberal district of San Francisco, states that the only people who can be taxed in the United States are people with income over \$1 million!

While I will celebrate the coverage of additional millions of people, I worry that the inadequately financed individual mandate, with many hardship exemptions, will result in our falling well short of universal coverage. And at some point this will undermine the much talked about insurance reforms – such as eliminating pre-existing condition rules and policy cancellations for health reasons. Both of these things are difficult to implement in the absence of an individual mandate, because adverse selection, where only the sick take out insurance would ensue, driving up premiums for all. The pieces of this puzzle are all inter-related. So that summarizes my thoughts - hopeful and fearful about where we stand on coverage at this point in the debate.

Costs (Slide 4)

Now let me turn to issues involving health care costs. Cost control has been in the center of the stage ever since the mid-60's, for the simple reason that healthcare costs have been increasing at a rate which substantially outpaces the underlying rate of inflation throughout the past 40 years. The net effect is that healthcare has gone from about 6% of the gross national product in 1965, to about 17% of the gross national product 40 years later. Different analysts give varying reasons for this continuing escalation of healthcare costs. These reasons include escalating underlying inflation and the growth and aging of the population. But most informed observers believe that the major engine driving increasing healthcare costs has been advances in technologies and procedures which have led to a substantially different medical care product than that which was available 40 years ago. These changes in technology and procedures run the gamut from big

ticket items, like CAT scanners and MRI's, to the introduction of a myriad of new drug therapies.

Now if we are buying a different and better product – leading to an increased quality of life for many, who are having their cataracts treated or hips replaced in ways which would have been unimaginable 40 years ago – why do we not celebrate those advances rather than bemoan their economic impact?

So why has the steady increase in healthcare expenditures been seen as a problem? Well there are a number of reasons, and I will cite three. First, as individuals, we generally see an immediate benefit when we buy a car or computer. However, much of our health care expenditures are paid through taxes or premiums, and the benefits may not be apparent for some time. Health expenditures represent a huge income transfer from the healthy to the sick, the young to the old and the richer to the poorer. You tend to benefit from those expenditures not now – but when you are old and in poor health.

Secondly, people look at the fact that we spend significantly more than people in other countries to obtain similar results, raising real issues about value and efficiency.

A third reason for the concern about steadily rising healthcare costs has been the concern on the part of the payors, primarily the government and the business community. The government recognized that it would be difficult to move towards a balanced budget without achieving some control of increasing healthcare costs. Business, for its part, became increasingly concerned about the negative impact of what was viewed as one of their major uncontrollable costs.

So for the past 40 years, rising health care costs have been a major engine driving the health financing debate. In the period stretching roughly from 1965 to 1980, the major attempt to grapple with increasing health care costs was through a variety of government regulatory programs, which ranged from limits on Medicare reimbursement, through health planning statutes, to a brief period of wage and price controls under President Nixon. None of these had much impact on healthcare costs, because our national ambivalence about heavy-handed

governmental regulation meant that many of these regulatory programs left a great deal of room for manipulation and evasion.

From the early 80's on through today, the trends and forces which I described previously led us as a nation towards a different approach to controlling healthcare costs – an approach focused on letting the marketplace work to control costs, as it does in other sectors of the economy. This is certainly not to say that we have dropped the regulatory approach entirely. We have seemed instead to build the most complex structure imaginable, which contains strains of both a regulatory and a competitive approach.

Advocates of the marketplace approach argued that this new approach might succeed – and they have pointed to evidence that the rate of increase in healthcare costs had slackened somewhat in the mid 90's. Those of a more skeptical turn of mind pointed out that healthcare costs were still outstripping the underlying rate of inflation, and continuing increases in health care costs in recent years certainly support the skeptic's point of view. The sick and vulnerable patients need for services, almost regardless of price, coupled with the huge imbalance of information between the patient and the provider, are only a few of the reasons why relying on markets to control health care costs is a flawed concept.

So, we currently stand as a nation without a good answer to increasing health care costs. Heavy regulation does not fit with our political culture, and the free-market, as we know it, appears inadequate to the task.

(Slide 5) Controlling health care costs presents a significant challenge to politicians and policy makers, not least because every dollar of health care expenditure is another person's dollar of income. In addition the American people do not seem to want their care rationed or limited in any fashion.

Now, there is much that is being done regarding costs, although there is much more that could and should be done, in what I would describe as three areas of work:

- First is the need to focus on the appropriateness of services provided. The data on unexplained variance in practice patterns, across the country and within regions, developed over the decades by Dartmouth's Dr. John Wennberg, is stunning, and until recently has been largely ignored. This variance has a huge impact on costs and quality with the promise of both higher quality and lower costs if best practices were to be applied more evenly across clinical medicine.
- Next is the potential savings if our health system were to fully integrate the kind of process improvement activities widely adopted by other industries, to assure that those necessary services that we do provide are provided as efficiently as possible.
- And third would be to focus on the very high administrative costs of our system – costs, which I might add are driven primarily by our national desire to have a pluralistic, public private, fee for service based system, which leads inevitably to large costs for marketing to consumers, reserves, profits, billing and compliance costs.

We now have new tools – particularly the tools provided by information technology – which can enable us to move further in each of these three areas.

But the barriers to progress on cost are huge – I'll mention two.

The first is our national payment system, which remains basically a somewhat open-ended, cost based, and fee for service reimbursement system. Further progress on cost reduction is likely to depend on pay for performance, or on capitated or budgeted reimbursement, any of which would represent a tectonic shift in health policy, as they would begin to move towards limiting, in some fashion, health care expenditures.

The second barrier to further progress on cost reduction is the fragmented, chaotic state of our delivery system, consisting of tens of thousands of physician practices and thousands of independent hospitals. The larger more integrated systems like Kaiser, Intermountain, Mayo, Geisinger, Partners, and many others here in Minnesota, are in a better position to afford and implement the necessary information technology, and to adapt to and adopt real pay for performance. Further progress on costs will be dependent upon a more organized delivery

system, but that will also be a tectonic cultural shift, given the tenacious desire for autonomy among physicians and independent institutions.

(Slide 6) If you'll excuse a brief book plug, my colleague, Dr. Tom Lee and I have just had a book published on this topic titled "*Chaos and Organization in Health Care.*"

And one final note on costs. Even with the very difficult and tectonic shifts in health policy and culture necessary for progress on costs – shifts which would be challenging for any political leaders or parties – most of this progress would act only to reduce the baseline costs of our health care, and not the rate of increase in costs. Since the rate of increase is driven largely by medical progress – new drugs, devices, and procedures - I believe that even if we could achieve substantial reductions in baseline spending, our efforts could well be overtaken by the blessings of new drugs, technology, and procedures, and the ever increasing costs of care for an ever aging population, as we reap the benefits of medical progress.

The major known cure for controlling the trend of expenditures is arguably worse than the disease. I'm referring to rationing. Rationing by government, through budgetary allocations as is done in Canada and throughout most of Europe, is often arbitrary, and seems wildly inconsistent with our political culture. Rationing by markets favors the rich over the middle-income and the poor, to an extent even we can probably not tolerate in health care. Ultimately, controlling the trend of health care expenditures is as tough a policy challenge as I can imagine for political leaders; so, while I think it may be possible to make some of the tough policy decisions necessary to control baseline costs, I believe a rich country will probably wait some time – probably wisely – before plunging into over arching limitations on, or rationing, of health care expenditures. So with regard to the legislative discussions currently taking place on Capitol Hill, I believe that significant action on cost reduction and payment reform will likely not occur, though we will be faced with significant reductions in future Medicare increases as a partial mechanism for financing the bill.

(Slide 7) And finally let me return to the issue of the unfinished work on coverage which I predict will face us in the future. This will bring us right back to the issue of who will pay – to the issue of taxes and mandates. Further coverage expansion, if credible, would call for substantial additional revenue. I would predict that when we seriously address these issues again as a nation, we will inescapably be looking at a blend of tax revenues, employer payments, and individual payments.

The key issue will be, as it always has been, how much cross subsidy or progressiveness do you build into the legislation – are we each on our own, or to some degree, do we provide for each other when it comes to health care.

This is in a sense the debate that is at the very center of our capitalist political and economic system, about the balance between constructing appropriate incentives for those who win, and appropriate protections for those who lose, whether through their own fault, their poor health, their inherited talents, or their circumstances. The debate about whether the next 100 billion dollars should go to bolster incentives, such as tax cuts, for those who win, or to bolster protections for those who lose. The debate, in short, about the role of social justice as a moral value in our contemporary society.

(Slide 8) I would submit that this important values debate is actually a debate between competing values each of us internalize of individual liberty and “don’t tread on me” on the one hand, and equality, compassion and justice on the other. As school children, many of us memorized the Pledge of Allegiance to the flag – there it is in one phrase - liberty and justice for all. As citizens we have a lot to do to work out how individual liberty and justice for all sort out with respect to health care – about how the untouchable concepts of rationing and taxes fit with these ideals.

We can’t do this work easily in contemporary society. But ultimately we will be forced to do this work, as health costs continue to rise and the number of uninsured remains unacceptably high.