Introduction

Dr. Allen Sager is an Associate Professor at Boston University School of Public Health where he teaches courses in Health Care, Finance Regulation, and Planning in Solving Practical Problems in Health Care Administration. He holds an undergraduate degree in Economics from Brandeis University and a Doctorate in Health Policy and Planning from MIT. Ten years ago, Dr. Sager designed Time Banking as a model for mobilizing a volunteer home-care aid for disabled older citizens. This model is now being tested in half a dozen sites nationally.

As a researcher, he has studied the costs of home care as an alternative to nursing home care, and the causes of hospital closings in fifty cities over the past fifty years and the changing role of the public hospital. For the past five years, Dr. Sager has been monitoring the evolution of health policy in Massachusetts. He has studied the origins of the state's Universal Health Insurance Law euphemistically called "Health Care For All (HCFA)" and those of you that are into acronyms and into federal government that's HCFA. He has been scrutinizing its meanings for both Massachusetts and other states.

It is on this last subject that he will be speaking so I hope that one of the goals that I have asked Dr. Sager to accomplish is to try and put mandated, employer mandated, health insurance and massive government involvement into health insurance sector into a proper perspective for Oklahoma citizens so that we can benefit by the experience or benefit by the good things and bad things that are learned in Massachusetts.

Opening Remarks - Dr. Allen Sager

Good Morning. It's an honor to be with you today. My talk is officially titled "Universal Health Insurance in Massachusetts: Its Origins, Practicality, and Meanings for Oklahoma". It might have been subtitled: "Health Care For All: A Model or a Muddle or a Catalyst for Change". I would like to address four main questions with you.

- What were the origins of the Massachusetts law?
- What are its provisions?
- Will they work in Massachusetts?
- Do they make sense for Oklahoma and are there any alternatives?

Obviously, on the last point, I will be purely speculating in light of my understanding of Oklahoma health care problems and opportunities.

Because we will be covering a lot of ground, I will take questions for clarification after each section. Please defer other questions, comments, polemics, or strong personal attacks until the end.

You cannot believe everything you have heard about Massachusetts. If you do, you will probably come to the wrong conclusions about our morals, our sanity, and especially our new health care law. The truth about our new health care law is much better ... and much worse ... than most people think.

Origins of the Law

Let me now turn to the law's origins. How did the Massachusetts legislature become the first in the nation to declare health care for all citizens as a human right under the state constitution? And how did it legislate provisions intended to bring this about in 1992?

There are four forces in the background that help explain these legislative acts. They involve economics, politics, personalities, and values.

First, on the economic side, Massachusetts enjoys a relatively high income. Per capita personal income is probably 15-20% above the national average. Our unemployment rate is around three percent, and has for several years been lowest among the eleven industrial states.

Second, politically. Massachusetts is politically liberal on some issues, but on many fewer than you'd think. We are, for example, afraid of high taxes. We have legislated both local and state tax caps in the last eight years. Currently, as a result partly of the tax cuts but more owing to the booming of the economy, taxes are well below the national average as a share of income in Massachusetts. We rank only about 35th from the top in the share of personal income going to taxes. Another political point, our hospitals are unusually powerful, especially on the issues that affect them most closely and particularly as you expect, when other potentially powerful groups do not mobilize. This is very important to our story.

The third background point concerns personalities. We have had, in the last few years, a sort of idiosyncratic circumstances. Our Governor has been running for President, as many of you know, and maybe even more interesting, we have as Chair of our Senate Ways and Means Committee in the Legislature, a very powerful position, a woman from a blue-collar mill town called Lawrence on the Merrimack River and she is simply committed to health insurance for all working people and their dependents.

The fourth point in the background concerns values. There has been a growing commitment to equal access to health care in the Commonwealth. It has gotten stronger even during the evolution of intensive cost control that I will describe in a moment.

The Evolution of Health Policy in the Commonwealth

Now beyond these four background elements is a the piece in the foreground that I call "The Evolution of Health Policy in the Commonwealth". Looking at our current law just on its face, it's very hard to understand how anyone could write such a thing, but with a little appreciation of history, I think some of its elements make a lot more sense. Massachusetts has had, traditionally, very high costs of hospital care. We are currently 36% above the national average in hospital spending per citizen. We are first in the nation not only in that but also in the share of the health dollar, a very big health dollar, going to hospitals. We are also one of the lowest states in the share of the health dollar going to physicians, even though we have 40% more physicians per capita than the national average.

For health in general, we have the highest spending, again per capita, 20 to 25% above the national average. Back in 1970, almost 20 years ago, all of these figures were even higher relative to the

national average. Back then, health care was a great burden on the state's economy. It was a barrier to job creation. We tried almost everything to control costs of health care starting in the early l970's.

The first ideas did very little good: certificate of need, charge control for commercially insured patients, and a movement by Medicaid to prospectively pay hospitals by formula, and the concurrent abandoning of cost reimbursement. After these things didn't work so well, around 1978-79-80-81, we have what we call the second "oil shock" in New England (you probably have a different name for it here in Oklahoma). We suffered, as a result of very high inflation and moderately high unemployment in Massachusetts. We also had health insurance premiums that were rising a steady 15 or 25% a year. Because inflation was high the real growth in health insurance premiums wasn't that great but the numbers looked bad.

In this climate, there arose demands to slow the growth in hospital's revenue in order to hold down health insurance premiums. Partly as a result of business pressure, and partly as a result of some clever initiatives inside state government, we moved to adopt what is something very close to the Maryland model for prospective payment of hospitals.

It was started with Blue Cross, which is a very big payor in Massachusetts, and it was then extended under state law and with federal waivers to cover all payors, so we had an all payor prospective payment system.

It worked like this: It started from a cost base several fiscal years ago and from that base it automatically raised hospital budgeted maximum revenues each year. That is, maximum revenues were set with consideration of (a) prices hospitals have to pay for workers for supplies, for electricity, and so on; (b) costs of new technology; (c) changes in patient care volume (where hospitals received only marginal costs so there was no incentive to increase or decrease volume); and (d) apart from these increases there is a little squeeze put on hospital revenues. It was called a productivity squeeze. It was designed to ratchet-down growth in revenue.

This arrangement worked fairly well as near as we can tell now. It clearly slowed the increase in costs to a level well below the national average-- something we could certainly afford given we were 50% above the national average in 1975. It also improved bottom lines for hospitals.

Ironically ... and unexpectedly, it at the same time improved access to care.

<u>An Initial Digression:</u>
Ordinarily we expect that only more money can buy better access. In other words, a trade-off now exists where, if you want better access, you pay the price financially. Similarly, controlling costs you expect would tend to compromise access to care. In this perspective many people argue, that the only way to improve access to the health services is to first control health care costs.

I would like to argue instead that access and cost controls, rather than being antagonists, must be converted to allies. I've come to believe that only the obligation to serve all citizens will give us the willingness and ability together to control costs effectively.

As it happened, the Massachusetts prospective payment law did protect and improve access by guaranteeing hospitals reimbursements for free care and bad debts. Then, it got uncompensated care out of the price structure through a uniform surcharge on Blue Cross and commercial patients, establishing what we call the free care pool. This is very important because it meant for the first time that we didn't punish those hospitals that made good deeds. In the past, if you provided more free care you had to raise your prices to generate the revenue to underwrite the costs of uncompensated care. When we took free care out of the price structure, and funded it by a uniform statewide surcharge on Blue Cross and personally insured patients, a hospital that provided more free care was no longer at a competitive disadvantage.

These provisions together improved the generosity and the equity of financing free hospital care. Originally, they were responses to the fear that there was a trade-off between cost control and access under prospective payment, and that prospective payments' attempts to control costs would give hospitals incentives to dump uninsured patients. So, fearing that hospitals would respond to prospective payment by reducing their uncompensated care, the state acted to make it easier for hospitals to provide uncompensated care. So, access seems to have improved even as costs were controlled.

Now, I said a moment ago that I thought this law worked pretty well in controlling costs, improving access, and improving hospital's bottom lines, but a lot of people didn't like it for various reasons. Because the evidence wasn't strong, their opinions counted ... because the law was never evaluated.

A Second Digression:
It's un-American not to evaluate things and find out what really works. but we seldom evaluate, especially in health care. Our health care system sometimes reminds me of a $540 billion dinosaur with a huge spinal cord to move the muscles and excrete the money, but a tiny walnut brain to figure out what's going on, what care works, who needs care, how to get it to them, and how to pay for it. So ... end of digressions.

Toward Universal Health Insurance

A lot of people didn't like the Massachusetts law. They wanted to change it. In 1985 everyone wanted to change it, but in different ways to suit their different needs. Because they couldn't agree on one plan for change, they agreed instead on a 'word'. The word was "competition". They wanted a more competitive health care system and they promised themselves in state legislation that they would get competition by the 30th of September, 1987, a little over a year ago. This 1985 legislation called for the appointment of a study commission to write a comprehensive new law. Well, the commission talked for a year but there was no pressure to really negotiate or to compromise, so they studied the question instead.

• First, the problem with competition, they quickly realized, was that everyone used it to mean something different, something good for them. Hospitals, for example, wanted competition to regain some advantage from urgi-centers and HMO's. Hospitals would have a chance to compete profitably with one another for patients. I call that kind of competition the "opiate of the managers", where everybody thinks they are going to win competing for a smaller pot of money. Businesses and insurers

conversely thought they could use competition as a club to get hospitals to bid for their business and drive down hospitals' prices, and drive down hospitals' revenues. So clearly, hospitals and business had very different ideas about how competition would work.

• Second point: Everyone acknowledged that competition would rip apart the $300 million dollar a year free-care fund that had been financing access for uninsured citizens, so a replacement was needed.

• Third, everyone nominated universal health insurance as that replacement. Advocates liked up front entitlement to care with dignity. If you had a card, you could get care when you were sick; you didn't have to wait until you were horizontal. Cost controllers liked the chance, under insurance, for managed care to manage costs. Business thought that providing insurance for everybody was a way to compel those businesses that weren't providing insurance to pay for their "fair share", as it was called. The businesses that were providing insurance were paying twice ... for their own workers and dependents and for the workers and dependents that were getting care through the free care pool (because their employers were not providing insurance). This pool was no small sum. It was 13% of private sector hospital charges.

The problem with insurance was that nobody wanted to pay for it. You are not shocked? This led to a deadlock until about February 1987, a year and a half ago. Then Senator Patricia McGovern, the Chair of the Senate Ways and Means Committee, offered a plan for a payroll tax to finance insurance for everybody who lacked it. 90% of the tax would be rebated through employers offering health insurance, so this was called a "play or pay" approach. Insurance was not mandated but if you didn't go along you paid a little tax.

A few months later the legislature's Health Committee married this universal health insurance approach with a new and less regulatory way to pay hospitals. It promised hospitals more money and gradual deregulation. This went nowhere for a while but then it started to move. During the summer of '87 the governor thought that something might pass. so he promised to introduce his own bill. He did that in September of 1987, about a month before all the existing laws governing hospital payments were going to expire. Now this bill was similar to Senator McGovern's in a lot of ways, but it relied a lot less on state money and a lot more on business mandate (play or pay).

The governor's approach got a lot of people excited, and really raised the visibility of the law. It got a lot of people thinking that for the first time something might pass.

But because the Governor was trying, I think, in a responsible way (but maybe not politically very astutely) to try to control hospital costs, he built a lot of cost controls into the law. This clearly gave the hospitals as much less money than they wanted.

The hospitals were increasingly worried about the threat, as I know many of you are in Oklahoma, about the threat that Medicare increases in payments, even under DRGs, would not keep up with the increases of costs of caring for Medicare patients. So the hospitals wanted Blue Cross and commercially insured patients in Massachusetts to pay them more. The Governor wouldn't go along with that. Overall, his package was much too lean for them, so they lobbied against his universal health

insurance bill until they got more money. They got the bill tabled in the legislature by a huge margin (this was almost exactly a year ago).

Then, last fall and winter, Senator McGovern went back, negotiated, picked-up the pieces, and built a compromise that could pass. She, it was something like this. It included a lot of money for hospitals, starting right now, and financed mainly with private health insurance money "play or pay" money. That is, McGovern promised hospitals huge amounts of money for currently insured patients financed mainly by where hospitals get their money now: Blue Cross, commercially insured patients, employers, workers. This was a big increase. She also deferred the introduction of universal health insurance until 1992. It would be financed through the "play or pay" mandate on most employers, and through with a lot of new state money. No one knew ... or knows ... how much.

Politically, Senator McGovern realized that hospitals had the practical power to block any universal health insurance law until they got the higher revenues they wanted. She saw that no one, especially business, was organized to defend themselves against hospitals. Businesses, having tried to control costs through prospective payment, had gradually soured on the idea, even though it was working fairly well. They decided to manage their own health care costs through utilization reviews, second opinions for surgery, and generally harassing doctors and hospitals. So business was out of the public cost control picture.

McGovern saw that hospitals would probably get what they wanted from the legislature because they were that powerful. They had organized the strongest lobbying campaign in the history of the Commonwealth, and we've seen a few. She offered a deal. She would give them the money they wanted if they backed universal health insurance. They became the first hospital association in the country to back universal access to care, in part perhaps, because they had looked bad holding up the universal health insurance bill several months earlier, and now this was a free chance for them to look good.

Why not? It didn't cost them anything. It probably assured them (if the law worked) of a lot more patients who are covered and from whom they wouldn't have to collect. This law was passed in the legislature in March of this year (1988) ... signed on the 2lst of April, exactly six months ago today. It was probably the best universal health insurance law that could be achieved under the political and economic circumstances in the Commonwealth.

And that's more or less how we got it. Are there any brief questions now for clarification?

Question
What was the involvement of organized labor?
Answer
Very small, very small. From the Massachusetts AFL/CIO, the main block of organized labor, there was very little involvement, and almost nothing in the way of concrete support. There was not much opposition. Organized labor seemed to prefer retaining health issues as a subject for collective bargaining. A few unions representing nurses and hospital workers were actively in favor of the law.

Question

What was the role of the national AFL-CIO unions who were supporting Senator Kennedy's federal bill mandating that employers provide insurance?

Answer

Some people in Massachusetts who were advocating improvements in insurance were somewhat dissatisfied with earlier plans that were introduced, particularly with the Governor's first draft. These people in Massachusetts did go to organized labor elements, but largely not in the state but in Washington to try to gain support for an insurance bill that did have or seemed to have fewer out-of-pocket payments and premiums for the people who would be newly entitled. Organized labor in Washington also encouraged the Governor very strongly to rely on more than his original plan ... which was to seek a waiver from the ERISA prohibition against state mandates on insurance ... and to have this fall back "play or pay" position. They did nudge him along.

Question:

What did hospitals think of the idea of continuing the free care pool?

Answer:

The costs of financing the pool really didn't fall on them and they weren't held responsible. It gave no one a competitive advantage or disadvantage. They were fairly neutral on that.

Question:

Did business and labor pay into the free care pool?

Answer:

That's correct. Business and employees. I'd argue it's probably a more progressive way of financing health care than the universal health insurance approach given who pays and who benefits. That's just a suspicion though.

Question:

Are payments reduced or eliminated for those, such as Christian Scientists and some fundamentalists, who refuse to accept orthodox positions about medical care?

Answer:

The businesses, would be forced to "play or pay" either pay the tax (the surcharge that is, not a tax ... you never pass a tax when you are running for President) or provide insurance. The service is to be covered.

Question:

Do they have to provide insurance for those individuals who refuse all health care services?

Answer:

Yes. Christian Science services and sanitoria, and Christian Science practitioners are typically covered under health insurance in the Commonwealth. So that, in theory, would not be a special issue there and that, at least for us, has been the major group that would fall under your questions.

The Law's Provisions

Let me go on to the provisions of the Law.

First, hospital payments: The law promises hospitals, virtually guarantees hospitals, roughly $3 billion in increased revenues over the next four years for caring for their already insured patients (over 90% are insured). It comes from traditional private insurance payments. There is also a $50 million-a-year payment by the state, with state funds, to offset the slow increases in federal Medicare DRG payments. In other words, the state is coming to the rescue of the federal government. Nice of us, isn't it? Also on hospital payments, we retain a modified prospective payment method, with some regulations for four years. Then prospective payment ends and competition alone will set hospital prices. But starting right now, if hospitals increase their admissions, they get 100% of average cost for new admissions; not the marginal costs they had been receiving in the past which was typically only 50 or 60% of the average. This is an enormous incentive to increase admissions.

Second, in the area of cost controls the law calls for strong incentives and penalties that require bed closings and have had the effect of closing whole hospitals already. Bed closings join managed care and price competition as the three cost control elements. I have problems with each of these that I will detail in a moment. They all amount to a tendency to what I think is "painless cost control" ... wave a magic wand, nobody gets hurt ... cost control by efficiency only.

Third, in the area of access: The main achievement of the law is here. This is the first law, in the only industrial democracy that does not provide universal entitlement, to declare (and this is from the law), "the access of residents of the Commonwealth to basic health care services is a natural, essential and unalienable right which is protected by the Massachusetts Constitution". (They did say unalienable, we all know that its inalienable like we said it 200 years ago but we are progressive; we changed that). A natural, essential, and unalienable right protected by the state constitution.

We have a new Department of Medical Security with only a few employees that will develop new insurance products and broker them. They won't provide insurance; they will only broker insurance products with existing insurance companies actually writing the policies for the newly entitled citizens. There also will be phased-in demonstrations to test some of these ideas, a lot of studies, tax incentives for businesses to insure their workers before the 'play or pay' mandate starts, and also health insurance for all people who are unemployed but still part of the labor force-- people who are getting unemployment compensation. That will phase-in in 1991. And then finally there will be a big jump in April of 1992 to cover everybody who's now lacking insurance ... whether they are employed or unemployed or in or out of the labor market.

The law is extensive concerning benefits that are covered. It promises all preventative and curative services except long term care. There would be premiums and out-of-pocket payments that would be keyed to income; the higher your income the more you would pay out of pocket; the more premium you would pay. But there would be a lot of latitude for the new Department of Medical Security to set premiums and out-of-pocket payments.

How would access be financed? The "play or pay" works like this. There is now scheduled to be a 12% surcharge on the first $14,000 dollars of each full-time worker's income for a maximum of $1680 per worker, but only for firms with more than five workers. A lot of the small business opposition to this mandate was defused by eliminating those very small firms. You can see how the financing is regressive because the surcharge only applies to the first $14,000 of income. There would also be a lot of state money to pay for the insurance policies for the workers, and their dependents, in those firms with five or fewer workers; and also a lot of state money for people who were simply long-term unemployed or simply outside the labor market. Their numbers are substantial, even in the state with very low unemployment.

Please notice that not one of these improvements in access through insurance is tied directly to hospital prospective payment, or rate regulation. They are occurring in the same state that has both but the two are really not tied together. They are unrelated. It was the desired abandonment of the regulatory prospective payment system that threatened the free care pool (because of competition) and helped thereby to promote entitlement through insurance to make the world safe for competition. Thus we had an evolution of actions and reactions, with things really evolving in ways that people did not predict at all in 1985 and 1986 when this policy debate was seriously joined.

Here are some issues that persist regarding these provisions of the law. During the first four years, the law gives hospitals roughly seven times as much new money as it provides to improve access to care. Almost all of these hospital payments are guaranteed. They are locked in the insurance premiums (which you might regard as private taxes). On the other hand, protecting access during the next four years, before the universal health insurance is scheduled to kick in, relies on annual state government appropriations to augment the free care pool (the pool remains for four years). These state government appropriations are promised but they are hardly guaranteed because they depend on the adequate level of state revenues and on competing demands on state budgets.

Universal health insurance in 1992 itself depends on still more state money being appropriated and also on the adequacy of that maximum $1,680 per worker payment by firms with more than five employees. That sum is simply not enough. Very few firms, I bet, would provide health insurance themselves. It will be much cheaper for them to pay the $1,680 and let the state do it because the state is going to have kick-in a lot more unless the benefits of state insurance policy are very meager.

Finally, universal health insurance rests on the assumptions that the Massachusetts economy is recession-proof, in perpetuity, and that the bill's cost control elements work. Now, if you are willing to buy those assumptions, we can do a lot of business that is very profitable ... for me!

Do you have any questions on these provisions of the Law?

Question:
What about opposition from employers who self-insure or who raise ERISA objections to the "play or pay" mandate?
Answer:
The ERISA issue is a very large one. I don't want to say much about it because it demands almost two hours on its own. Firms that are currently self-insuring don't have a serious problem with the law because they are almost always, in Massachusetts, providing benefits at least as good as this law would require. So there would be few, if any, obligations falling on them.

It is rather, I believe, the firms that are not currently providing insurance that are guaranteed to challenge this Law on ERISA grounds. I regret that the law was not crafted as carefully as it could have been to withstand an ERISA challenge that it is an illegal mandate on employers to provide insurance. It was designed for political purposes not to resemble a tax. But it resembled a tax more. Most lawyers I've talked to tell me that it would have had a much better chance of withstanding an ERISA challenge under the argument that it was an exercise of the state's legitimate taxing power.

Question:
In 1992, once the coverage will be 100%, are there any existing or plans hatching that will be moved to restrict union trust funds that are presently committed to cover those expenses?
Answer:
Well, I would bet that most people who are currently providing insurance ... whether it is through an employer negotiated insurance policy or whether its through an employer/worker-funded union trust fund ... would continue to operate as they have been. I think the new big benefit would apply to people who are currently uninsured, though perhaps with some erosion, as people who are currently insured drop their benefits to try to take advantage of the state's subsidy that would be required under the state program, because the $1,680 is simply isn't enough. I don't think there would be a large disruption, and that's especially unlikely if the State's economy continues very robust with very low unemployment rates. Nobody's going to want to run the risk of losing workers to a competitor just to save a few dollars on health insurance. But if the economy deteriorates, if health spending continues to rise, we may see a lot of dumping into the state system.

Will the Law Work?
Let me move on now, to the question of whether all of this will work. Does it makes sense for Massachusetts? We won't know much until 1992, but for now my answer is "no", this does not make sense.

Recalling the history of the law: Our Governor got involved enough to raise the visibility of universal health insurance, but not enough to shape a bill that could pass the legislature over hospital opposition. Pat McGovern negotiated well enough to craft a bill that could pass the legislature but this was not enough, I think, to design a law that could work. Why won't it work? I have six general reasons.

First, the law's cost controls will not function as planned. They are inadequate. Bed closings don't save money. I know a lot of us think, have thought they do. Bed closings do not save money. One estimate is

that an empty bed that's unstaffed costs only about 13% as much as an occupied bed. We tend not to staff empty beds. What's left is the fixed cost and those costs are fixed by definition. They are there even when you close the hospital. Politically also, and this may be more important, when you reduce beds you often end up, usually end up, closing the cheaper beds. If we provide substitute care to the patients who are displaced, DPs (displaced patients), we tend to move the patients ... if they receive alternative care ... to more costly hospitals. (Of course you do save money if you don't provide alternative care. Not providing services is naturally very cheap financially). Also, if whole hospitals close, these again tend to be the less expensive hospitals and I have more evidence than you would ever want to see on a national pattern of closing (at least in urban areas), the least expensive hospitals.

Second, managed care. This had to be grafted onto the law as a cost control device because insurance-based financing really is antithetical at controlling costs. If managed care does control costs, it generally does so at the price of deterioration of access or outcomes of care for lower income people. The strongest evidence we have here is the Seattle HMO experiment. It was evaluated by the RAND Corporation. Apparently this very good HMO was just hard to use for Medicaid patients and they died and got sick in statistically significantly greater numbers. I personally prefer the old kind of managed care where you had a family physician whom you trusted to act as your agent. I am not prepared to give up on that one. I am very stubborn and conservative about that. Also, the evidence that managed care ... when it works according it its design ... saves much money is really not very good.

Third, relying on competition to contain costs won't work either, I fear. Competition under Massachusetts rules will raise spending. That 100% of average cost payment, for new hospital admissions, is a huge bribe to hospitals care for more patients. It is a significant financial incentive to increase admissions. There is no evidence that competition works well in most areas of health care in general. Trained as an economist. I believe in free market competition wherever it can be done. But I regret I have a list of about 20 reasons (that I won't rattle off for you) why I don't think it can work in health care. Therefore, I think the rhetoric of competition should be set aside in favor of something that does work. Let's expand a moment on these points.

The free market rhetoric as we have been using it in this country, especially in Washington, has been more a fig leaf to cover sharp cuts by payers or insurers in health care. If you believe that DRG's are a competitive solution, well, they have been an excuse for systematically underpaying hospitals. The federal HCFA (Healthcare Financing Administration) is not truth in advertising because their mission is to avoid paying for care.

When its Director and others use the rhetoric of free market competition, saying "We're going to pay less and we're going to see who survives after ten years and you are the good guys and gals because you competed efficiently." Baloney. Baloney. They are acting as an all oligopsinistic purchaser of care to try to drive some hospitals to the wall. That is not a free market; that's a corruption.

Pretending there is a free market when there is not one is a disaster. Witness, for example, the free market rhetoric in international trade policy. Do you believe that the Japanese are trading with us under the assumptions of a free market? Sure there is a free market, it's one way. The free market is

here. Their market is closed and cannot be bludgeoned open through competition rhetoric, but only by cutting a deal - called a trade treaty.

Now, the second reason this law won't work ... cost control elements failing is the first reason ... is that many insurers and businesses are hiding behind competition rhetoric, as I mentioned, to try to control their own costs but at someone else's expense. I went to a meeting of actuaries where the vice president of a very large and well-known insurance company said, "We have declared war on hospitals and doctors." Insurers act this way, in part for their own reasons, and partly as the agents of business. Well, this is trench warfare. This is World War I trench warfare. It's a war of attrition. Destructive on all sides, closing many needed hospitals, denying much needed care, and driving out many of our best physicians and many of our best administrators from the health care field - this competition rhetoric. Just as World War I killed off the best of a generation, a price we are still paying internationally. The consequences of that cannot be underrated and I think in our healthcare system they cannot be underrated either. The corrosive effect is throughout.

I think the competition is reducing waste, but not much. It's really not saving much money because caregivers, when they are confronted with competition, are very good at "gaming the system". Worse, competition adds a lot of administrative waste. Competition means institutionalized mistrust. It means matching my computer against yours ... gaming the system, unbundling, increasing revenues in the face of what seem to be sharper pressures. By one estimate we spent 10% of our health dollar on this administrative waste, something no other country tolerates. That's over 50 billion dollars per year. The estimate seems to have been calculated fairly reasonably.

What we are doing, apart from this gaming of the financing, is also hamstringing doctors and hospitals with increasing "green tape", private paperwork, suffocating utilization reviews, second opinion, and filing forms for this and that. Maybe worse yet, using patients as the shock troops to cross the no-mans land of trench warfare: Give those patients higher co-pays and deductibles and make them more sensitive to the price of care, make them mistrust everything a doctor or a nurse or anyone tells them. These are all symptoms of the payers' and insurers' growing mistrust of doctors and hospitals. They have decided that they can't trust doctors and hospitals to retain both clinical and financial autonomy.

I think they are right there. I just dislike their solution. I would much prefer a peace treaty; a new social compact in health care. I would prefer that to this Hobbesian state of nature that increasingly features a war of all against all.

I think that insurance simply exacerbates this problem. Also insurance is regressive in its financing. If you have a worker in a given industry who requires $2,000 worth of health insurance. Well, that $2,000 is 20% of the income of someone earning $10,000. It's 10% of the income of someone earning $20,000 and it's only 5% of the income of someone earning $40,000. Insurance-based financing is regressive. It's also a tax on jobs. It's a tax on job creation. Equal access to health care requires a measure of income redistribution. Poor people cannot afford health insurance. It is just too expensive. This may sound like "carrying coals to Newcastle" but as the greatest American of the 20th century said, "This is a great country but you can't live in it for nothing." So said Will Rogers.

The third reason the law won't work ... it is very complicated. Only a state with so many Ph.D.'s could have designed a law this complicated. It's terrible. There's the question of the ERISA challenge that was posed earlier. Also, there's the confusing and undesirable incentives that the law provides. It is so open to gaming. If you go from five workers to six, you fall under the play or pay and you get hit with a $10,000 per year health insurance bill. Similarly with part-time and full-time workers. There is a lot of room for manipulation.

Also, if the state is providing a decent benefit and it only costs $1,680 and unemployment rates go up a little, dump your health insurance altogether and let the state worry about it. So that's a pressure for the state benefits to be less inadequate and to favor high co-pays, deductibles and premium which is not the best way to boost access.

We are trying to do a lot in a hurry in Massachusetts. We have no experience in this. We are the first state. We have little capacity to gain experience quickly. We are really operating on the frontier of health policy in this country. Someone has to go first. We haven't even done much of learning from Hawaii yet, I think; but we are going to do some of that. Hawaii has a mandate for most people (you may know) to provide insurance through the job.

Now, this law is complicated partly because it has to do a lot. It has to cover every one. It has to control costs. It has to give hospitals a lot of new money. It has to rely on insurance to do the financing. This is like trying to refine a very old technology and stretch it to its limits; like the steam locomotive or the best 1960's mechanical calculator technology; the old desk-top crank-em up. What we need here is a new technology. We need an electronic calculator.

The fourth reason the law won't work is that universal health insurance will simply be too costly. Massachusetts has promised to buy tickets of admission for uninsured citizens into the world's most expensive health care system (in our state). The $1,680 per worker rate is inadequate now; it will be even more so in 1992; but small business will not tolerate an increase, politically. Also, the state will face a huge tax burden in paying for insurance for people (a) outside the labor market; (b) insurance for the workers and firms with fewer than five employees; (c) making up the difference between that $1,680 and the real cost of insurance; and (d) also paying hospitals for the continued uncompensated care they will have to provide for people who are not insured.

Fifth reason: There are other demands for higher spending in health care. Hospitals have already said that the $3 billion in new money they are getting under this law over the next four years is not adequate. They want more money. They say that 70% of them are facing operating deficits this year. Their workers want more money. We have a huge nursing shortage. Other workers say they are underpaid. Third, our physicians in Massachusetts are grotesquely unhappy. Their average incomes are well below the national average.

Now, let me add as an aside, though Massachusetts is not the "Beirut of Medicine" as some people say. Please don't believe the Wall Street Journal on this one. If it were on their news pages, I would say believe it. It's on the editorial page so please be skeptical. Our doctors do have very low average incomes. But it simply is not the fault of state policy. Basically, there just aren't enough patients to go

around for all those doctors and there are a lot of irritants concerning malpractice insurance and state regulations that doctors justifiably don't like.

But their low incomes are not attributable to state policy, there are just too many doctors. In fact if you have some underserved counties in Oklahoma, we might be able to solve some of our problems and yours at the same time.

The sixth reason this law won't work is that the Massachusetts economy will enter a recession some time. At the bottom of the next recession, our state will have a $3 billion deficit if it's only as bad as the last recession of '74-'75. Our tax revenues are constrained by a tax cap. We will have lots more uninsured people. During this recession, hospital revenues will shrink. Many institutions, including some whose names are familiar to many people, will face bankruptcy and this will have been, I hate to say it, largely the hospital's own fault.

Our hospitals and our physicians have almost become "money addicts". They are "mainlining" money. It is a sad addiction but it is very hard to break. The path of least resistance, regrettably, is to ask for more money, and they are so powerful they can get it ... and they know it. Regrettably, all this money has blown up their budgets like a balloon, stretched to the limit, so that even the tiniest jab ... and it won't be a tiny one in the next inevitable recession ... will puncture that balloon. That's my take on the prospects of the law working as written.

Do you have any questions on this part for clarification?

Question:
Do you have any ideas on what else could be done?
Answer:
You betcha. Coming right up. Wouldn't want to leave you hanging.

There alternatives for Massachusetts, or for Oklahoma, and I am clearly speaking much more for Massachusetts but I will try to point crudely in directions that might be promising for Oklahoma. You can take that for what it is worth.

In Massachusetts today - in the world's most expensive healthcare system - there is clearly enough money already. I believe you have in your folders a set of tables. It says "Tables to accompany 'Universal Health Insurance in Massachusetts." Would you mind extracting that and turn to the first table please. Why do I think that Massachusetts already has enough money? Well, first let's start with international comparisons. If you look at health spending, uses, and outcomes in selected industrial democracies in 1982 and you can see that the United States is substantially above, even then, these other industrial democracies, both in health spending as a share of gross domestic product and even more so in real spending per capita. These figures are six years old now but they really haven't changed that much. There has been some narrowing. All the other countries on this list, except for the United States, cover all of their citizens at these spending levels. They typically enjoy much better health outcomes. Even though they spend less, even though they cover everyone.

I believe equal access to healthcare does make a difference. I believe health services make a difference. I am not a clinical nihilist. Please don't believe for a moment that the Western Europeans and the Canadians are able to enjoy better health outcomes with less money and cover everyone with less money because they do all the right things that C. Everett Koop wants us to do. They don't smoke less; they smoke more; they don't drink less; they drink more; they don't exercise more; they exercise less and they certainly don't have a cleaner environment. Western Europe is the moral equivalent of a toxic waste dump (It's been industrialized for so long. They are cleaning it up and they're doing a good job).

I argue to a great extent that other industrial democracies' citizens live better and longer and healthier because they have more equal access to health services that are affordable. There are also differences in income distribution. People in those countries tend to have fewer problems of malnutrition and homelessness so there is a little more, not a lot more, but a little more economic leveling, particularly from the bottom up that helps to contribute, I think, to these health efforts.

Well, if the United States is spending so much more to enjoy unequal health care access and inferior outcomes ... even more so does Massachusetts, which is 20 to 25% above the adequate U.S. average.

Another piece of evidence - some researchers at Dartmouth Medical School compared Boston hospital spending on Boston citizens with New Haven hospital spending on New Haven, Connecticut citizens. Both of these cities rely very heavily on research and tertiary care teaching hospitals. There are very high standards of care in both places. The health outcomes were substantially the same There was only one major difference. Boston spent twice as much per citizen on hospital care. How? Beats me. Higher surgery rates are part of it. Higher rates of medical admissions are part of it. The Dartmouth researchers found that the extra care in Boston was provided in the areas where physicians agreed very little about whether the care was clinically appropriate. In other words, there were larger national differences in practice patterns in the very diagnoses where Boston hospitals showed high admissions.

The second factor is there, do you have the phrase in Oklahoma "the Boston death"? It's current in some parts of the country, where the patient does die, but every test has been done, all the electrolytes are in balance It's just a very expensive death, but a death just the same. We are very aggressive, very radical, in our practice patterns, very interventionist. There are the usual problems - the fear of malpractice, physician training to do everything - but that's a national issue. Boston health patterns are simply profligate. Now, if Massachusetts can't cover everyone at our current enormous spending levels, maybe there's no hope for anyone. If we haven't got the money, who does?

Change is hard. The fat in the Massachusetts health economy is marbled through the system. It's not like that fat that's around the edge of a roast or a chop you can just cut off. It's marbled through like it used to be in prime beef - remember prime beef? Do you still have it here? We don't. It's the fat that's marbled through. It's hard to simmer out and to make available for uninsured people, but there are ways.

In Massachusetts, we had the structure - to some extent we still do - for subtly moving the money around and giving hospitals and doctors both the opportunity and the incentive to make money fungible. In

other words, to squeeze out some of the unnecessary care, leave it within the health care system, and mobilize it on behalf of uninsured patients. Indeed the productivity squeeze I mentioned earlier under our perspective payment law could have worked that way. You give hospitals their payments, but pay them inflation minus a little bit every year. Drain the money out and give it back to the hospitals attached to the lapels of uninsured patients, so that hospitals' revenue stream would be converted to something like like budgets.

Every patient would be entitled but without insurance. The hospital is the guarantor of the entitlement. The patient has a card that says "I am entitled". You can even call it an insurance card. It wouldn't operate by insurance principles. The hospital with its close-to-a-budget financing would be the guarantor of access and it would have the opportunity to make trade-offs. Is that rationing? Sure, but everybody rations all the time. Will this mean that you will have to wait three years for a hip replacement in the "Peoples Republic of Massachusetts"? Hardly. We are a very conservative state for one thing. For another thing, nationally we spend 2-1/2 times per capita (in real resources) on healthcare what the British do.

Our rationing will be far less painful. It will be invisible for everybody. I think that we will have a lot more patients walking around with healthy organs, a lot less unnecessary testing, a lot less unnecessary surgery because physicians and hospital administrators will be watching one another carefully to make sure that the inevitably scarce resources are allocated wisely so that people don't go unserved at the end of the fiscal year. The money has got to last 12 months. In other words, I am recommending elimination of the insurance principle in health care. It does not work. Except, let's keep it as a conduit for raising the money, perfectly respectable in that way. Insurance companies want to have some role.

Insurance and health care are basically a messy marriage. Only divorce, I regret to say, will make both parties sane again. Insurance companies had the honestly to admit this 50 years ago before Blue Cross came along with the pretense that insurance could work in health care. The moral hazard, the adverse selection issues, the high probability of needing services, the predictability, the low average cost. Per service, all of these five elements undermine the workability of insurance in health care.

Just as I believe in free markets where they work, I believe in insurance. As our condominium's insurance agent, I am always urging to insure against things that are insurable. Health is not insurable, by and large. It's a sinkhole into which to pour administrative dollars and in which to drive clinicians crazy in this Hobbesian "trench warfare" state of nature. No, no. Insurance companies knew this until the 1930's - all of them.

Now, the politics for reform could be very interesting. We are facing huge increases in private insurance premiums in Massachusetts this year. This is in large part to pay for this law's very generous increase in payments to hospitals. Business may respond with more green tape or it may respond by jumping back into the public arena, where they were six years ago, to devise a system of care that is affordable for everyone. I fear that their green tape efforts have not been succeeding in controlling their own costs. This law proves that. I think they will have to jump back in, business will, into the public arena to defend themselves. And to defend all of us and make equal access affordable.

In other words I think that the high costs of this new state law will oblige reform. Hospital bankruptcies are inevitable at the bottom of the next recession. Reform may not come until then. It often takes a crisis. We are like that ... we're conservative ... it's human. Hospitals will appeal for relief, at the bottom of the next recession, from these bankruptcies but who will have the money to bail them out? On what terms? Especially since state government are fiscally handicapped very severely during recessions, since their revenues go down and their costs go up. If there is state money and a mutual willingness to make things work, there might be a deal negotiated where hospitals are guaranteed simple budgets, simple state financing, and adequate financing through budgets, in exchange for hospitals serving as the guarantors for universal access.

Hospitals and physicians would have to work together to make the money last. This is a simple technology to make health care affordable for all, and to make clinicians' and hospital administrators' and health caregivers' lives a lot more sane and a lot more simple. It's like the kind of simple technology that you use to get a screw out when it is embedded in a piece of wood. You know the old story you can't get levers strong enough to pry bar the screw out but if you happen to have a screwdriver and just twist, the resources are there. The caregivers are there. The hospitals are there. The money is there.

I am optimistic - maybe not over the next couple of years, but I am very optimistic that this law will help to generate a health care system that will be more satisfactory to everybody in Massachusetts. We've got some rough hurdles to jump.

Let me speculate for moment about what this might mean for Oklahoma. On the largest scale, is Oklahoma in a position similar to Massachusetts where there is already enough money in the system? Kindly turn to the beginning of the second table. I have pulled together from various resources some Oklahoma-Massachusetts-USA comparisons. These are cited from all the usual sources. The percentages - the Oklahoma-USA percentage in the fourth column and the Oklahoma percentage in the fifth column - are maybe the most instructive. In gross state product per capita in both '85 and '86, Oklahoma was behind, was less than 100%, of the USA product per capita and even further behind Massachusetts. In health spending per capita though, Oklahoma is a lot closer to the national average, 90% as much which puts Oklahoma well above most Western European and Canadian democracies.

Depending on the yardstick, how much is adequate? Compared to the US average, health spending in Oklahoma is not adequate. Compared to what other countries do, it is adequate. Compared to Massachusetts ... well, that's no standard! In the share of gross product going to health care, Oklahoma is almost on the national average in 1985. In the percentage uninsured, as Governor Bellmon said, the people under 65, Oklahoma is much worse than the national average. Hospital spending per capita on the next page ... 80-85% as much as the U.S. national average but again more than other industrial democracies. On the bottom of this page, you have adjusted expenses for admission - fourth line from the bottom. Here's Oklahoma at about 88% of the national average. In other words, the average admission in Oklahoma (not case mix adjusted) is only about 9/10ths as expensive as the average admission nationally and much less expensive, only three-fourths as expensive as the average admission in Massachusetts.

In workers per patient actually occupying a bed, Oklahoma is right on the national average so there does not seem to be an understaffing problem, at least for patients who are admitted. But there are only about 86% as many workers per thousand citizens of this state. Average payroll per worker is about 90% of the national average. Then on the final page of this handout, in admissions, Oklahoma is almost at the national average again - 95%. Patient days quite a lot lower. The length-of-stay is shorter here. Average daily census therefore is also lower. Surgery rate - about 90% of the national average and only 3/4 of the Massachusetts level, so that's a very conservative surgery rate. In physicians, patient care physicians, the middle number - 87% of the national average. Pretty good. Low percentage of people enrolled in HMO's.

Well, this is a mixed picture. These comparisons send mixed signals. By many measures, Oklahoma seems to be spending a reasonable amount of money on health care, possibly enough to cover everyone, if those international comparisons are valid and I think they are. By other measures, Oklahoma is spending less, providing less care, has less resources, especially physicians and hospital workers, than other states. What's the right number? It is hard to tell. Maybe a little more money to grease the wheels of improved access is necessary.

If there that were to be attempted, one of my favorite ways of spending incremental money would be to try to improve access and tackle some of our rural hospital problems at the same time. I think a well distributed network of rural hospitals is a good idea and losing a lot of those hospitals may reduce access to care badly. It may also undermine the willingness and ability of physicians to remain in practice in rural areas and small towns.

Why not make grants of state money to hospitals in rural areas, in light of their financial distress, in light of the unavailability of substitute hospitals, in light of management competence, whatever you like. There might even be a corps of skilled hospital administrators who offer troubleshooting technical advice from the state to go along with money. Hospitals would get the money and, in return, have to serve everybody in the county who needed hospital care that that institution could appropriately provide. You're covering people, but you're doing it through a responsible institution. In other words, your are building up the delivery system and giving it the ability to make clinical tradeoff to spend its money wisely. This is the radical notion of a budget. This is radical pragmatism. We're talking about giving institutions budgets and ... responsibilities to citizens ... to spend the revenue wisely. That would be my favorite idea for getting a little incremental money into the system. I think it would be politically popular. It would help local people hold local organizations accountable, which is a nice democratic impulse. People are watching. It would support endangered species of rural caregivers.

Would there be a risk of dumping patients with problems to larger hospitals? Sure. That would need to be watched. It would need to be negotiated until the old atmosphere of trust and responsibility among hospital administrators ... which hasn't been lost altogether ... returns.

I have a few other ideas, and I certainly agree with many of the incremental proposals that have been offered. This seems like a perfect time for me to end my prepared remarks since we have a break now.

I have concluded my prepared remarks and would be delighted to throw myself open to your questions and comments. I hope you don't hold back. Have I gotten anyone angry? I'd be disappointed if I didn't.

Question:
There are three and a half years before the Massachusetts Law becomes effective. Do you fear there are going to be some political pressures to slow the pace of implementation? What pressures would they be?
Answer:
The legislature has pledged universal access by April 1992. They will not gladly renege on that pledge. They mean it seriously and are proud of having passed this law, even though some of them do have honest questions about its affordability.

We might see a stretch-out ... more testing, more demonstration projects, even on a large scale, to see what works. Those are now planned into the law. Unfortunately, it may be very hard to organize large demonstrations that could be evaluated well, from which people could learn something. People might argue we need more experimentation to find out what works. If this did happen, some legislators would be upset.

Another possibility would be to cut back on benefits. Some might think that only catastrophic coverage would be affordable. Here, so much depends upon the economy and state revenue picture. The law will probably wouldn't have passed, certainly not as written, had it come up only a couple of months later, when the state was beginning to experience a small cash flow crunch. In response, some of the state's budgeted contributions to the free care pool were cut.

There might be subtle cuts. The benefit package might be trimmed a little, he co-pays raised a bit, and the premiums increased slightly. In all fewer people would enroll. Those who did would pay more. More costs would be thrown back to sick people.

The state also has an obligation to begin managing the free care pool. It could take the $300 million and end its laissez-faire approach of paying whatever costs hospitals write off and require hospitals to submit itemized bills. Also, the state could create even more uncertainty about whether it will stand by its obligation to back up the pool up to the legislated level. Hospitals could respond by providing less free care because they are less confident they will be paid. As less is provided, the state can say, "well look at this, we are managing the pool better. So we need to spend less on free care because fewer patients need it." (Currently, except in emergencies, provision of free care is entirely at the hospital's discretion.

In all of these ways, the law could be made "more affordable", in the short run. Especially to the state and to business. These are temporizing answers, but I think the instinct will be to temporize in making cuts, until and unless the law is seen to have failed badly.

Question:
What are the law's provisions concerning public health and prevention?
Answer:
The law says nothing about public health, and very little about prevention. There is a fear that if more

health dollars are vacuumed up out of the state budget by this law, there will be less money available for traditional public health activities. On the prevention side, the proposed benefit package should include a list of useful services. How that gets into regulation, particularly in a fiscal crunch, remains to be seen. Prevention could be left behind in the dust.

Question:
What were the roles of physicians in the debate over the law?
Answer:
Physicians were not involved, either organizationally or individually. The Massachusetts Medical Society was a full member of the Governor's Study Commission in 1986-87 that conducted early and inconclusive debates on access and hospital financing.

The Medical Society's main concern was to remove the state's legislated ban on "balance billing", especially for Medicare patients, that is legally linked to licensure. Blue Shield and commercial insurers have parallel bans. This amounts to a mandatory "assignment" for virtually all payors. The legislated ban drives many physicians crazy ... it's an emotional issue.

But why focus upon the ban? How much money would be gleaned if it were discontinued? The real issue is with the fee schedule, not the ability to bill above it. Would physicians fight solely for the right to dun a patient?

Physicians have also focused upon their immediate problem with high malpractice premiums. Base line premiums are relatively low in Massachusetts, but we are in a five year bulge in rates due to physicians paying retroactive premiums for earlier years. This is due to premiums being set artificially low at that time. This was at least partly because physicians had litigated to block a normal, gradual rise in rates.

So the mandated assignment and insurance issues obsessed physicians and their organizations. This is a shame because it is likely that the main cause of low incomes (aside from the large number of physicians) is high hospital spending. If hospital costs could be controlled, more money would be left for physicians. Organized medicine did not, and does not, see this link. Hospitals are so powerful today, partly because physicians have abdicated the field and behave in ways that alienate potential allies (in part by ignoring the public interest and by focusing upon narrow physician interests) that when high costs prompt cost control attempts, these efforts bounce off hospitals and land on physicians.

Question:
With all these things going against physicians, why do so many practice in Massachusetts?
Answer:
They love it in the state. So many were trained there. They like their colleagues and the hospitals and the patterns of practice. So they have been traditionally willing ... for at least the past two decades ... to settle for relatively low incomes.

Also, many Massachusetts physicians like to think that money doesn't matter so much to them. It's part of their culture. "We don't think like physicians in Houston, Los Angeles, or Miami." They have been happy to do this until recently when the balance billing bans, malpractice insurance crunch, and some

new and irritating Board of Registration in Medicine regulations (on quality assurance and patient rights) collectively annoyed them enormously. For decades this Board did nothing. Today, perhaps, they are too aggressive or misplaced in their aggression. Even a settled malpractice claim (settled by an insurance company to avoid jury trial even though the physician is not at fault) goes on the physician's record. These records are open to public inspection.

I worry that Massachusetts physicians are focusing upon symptoms, not causes, and making themselves unpopular in the process.

Question:
Concerning the "more than five full-time employees," am I right to assume this means employees working a 40 hour week? Is there a growing tendency for employers to hire workers for fewer hours to escape the regulatory net of mandatory benefits?
Answer:
This hasn't been visible yet, at least partly because the "play or pay" provisions don't take effect until 1992. Employers may start positioning themselves by then.

There were debates on all these matters. The definition of "full-time" is around 25 hours per week. It drops for family heads, and if someone has been employed for six months or longer. These provisions create clear incentives to employers close to the edge of compulsion to "play or pay." A simpler approach, without rigid notches or cut-off points, called for by Sen. McGovern in her original bill, was a flat 5% payroll tax, with up to 90% credits for firms providing insurance. This would have been much simpler to administer.

Question:
If Governor Dukakis were elected President, would he support extending this approach nationally?
Answer:
He has supported the Kennedy-Waxman bill to require all employers to provide health insurance.

Question:
In the promise of universal access, are there barriers to getting what you want?
Answer:
Across the spectrum of human need, very few of us get what we want now, except in health care, where open-ended entitlement through insurance provides the pretense that unrestricted access without trade-offs is affordable. The law's benefit package is very broad ... as good as the Blue Cross/Blue Shield package, plus prevention. If that were implemented through regulation, there could be no brakes to slow any physician from providing or authorizing, whatever care he/she thought appropriate.

Question:
You are heightening consumer expectations, and if this thing falls apart, like you say it could, a lot of people will be disappointed.
Answer:
Passing the law did raise some expectations. But most uninsured people, as others, are not too specific in

their understanding of the law. Uninsured people today have such low expectations that if they got an insurance card in the future, it would almost certainly represent an improvement for them. People would be very disappointed if they were hit with premiums and out-of-pocket costs that were unaffordable. They would then feel it was a travesty ... give a card and then cut it in half!

Question:
If it takes years to fall apart, wouldn't this law increase expectations along the way.
Answer:
I don't think so. I expect the law's high costs to undermine the implementation of the universal access provisions that are scheduled for 1992. In other words, I expect a revolution of falling expectations to hit before the visible revolution of rising expectations is ever allowed to take hold.

Question:
Governor Bellmon started off by talking about small business covering more workers through insurance. What do you think of that approach?
Answer:
I think that given the problems of the insurance market in health care, I don't have a problem with pools among small employers in order to gain purchasing power, to reassure insurers about adverse selection, and to spread risk. But I fear this is so regressive, and also does nothing to spur clinical trade-offs that are our only hope for responsibly controlling health care costs, that I don't think it will be affordable in the long run.

Question:
But isn't insurance a good short term solution?
Answer:
I am much more comfortable with a gradual, incremental evolution toward a budget for each hospital, negotiated annually. The Canadians felt their way toward this, for very practical reasons.

In Saskatchewan, which ... if you look at it ... bears a strong resemblance to Oklahoma (commitment to agriculture, lot's of hospitals going broke, depressed economy, lots of uninsured people), they simply decided on tax financing for hospital care. Taxes are seldom popular, but when you are getting something for your money, they are viewed more favorably.

Barring that, a gradual evolution using pool financing can give hospitals the financial and clinical trade-offs to cover all and control costs. But the budget is simpler. It's the way every business operates.

Question:
Could you elaborate a bit more about the flexible or the fixed budget?
Answer:
The flexible budget would mean that more admissions would mean more money, paid for at the variable cost, so as not to give a financial incentive to provide more or less care.

A state-wide cap on payments to hospitals for a given year would be a good place to start. Everyone would see how much is available. There could be admission targets, so both admissions and intensity of services would be keyed to those targets. If one hospital gains admissions, and another loses, that may

be a reason to reallocate budgets.

But if the system overall is increasing in volume, that would have to be fought. It's a budget buster. It removes the constraint on doctors and hospital administrators to make the trade-offs that are necessary to control costs so that we can afford health care for all.

Thanks for all of your challenging questions, and interest in this topic. And thank you for the opportunity to speak with you this morning.