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Creating Market-Based Health Insurance Reform: An Interview with Stephen T. Parente

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Stephen T. Parente, PhD, is professor and Minnesota Insurance Industry Chair of Health Finance in the Department of Finance, as well as director of the Medical Industry Leadership Institute, Carlson School of Management, University of Minnesota, Minneapolis, where he specializes in health economics, health insurance, medical technology evaluation, and health information technology. He has studied market-based health insurance changes for over a decade, leading studies of "consumer-driven health plans" and other approaches to improve patients' decisions about the efficiency and quality of the health care they purchase. He was an advisor to John McCain's Presidential campaign in 2008, and continues to advise members of Congress about strategies to improve the U.S. health care system. We had the opportunity to ask Dr. Parente about his research, health reform, and the importance of mentors in shaping his career.

The Value of Mentors

Christine Kovner (CK): Tell us about your background. How did you get into health economics?

Stephen Parente (SP): I got into health economics due to a really great mentor, Chuck [Charles] Phelps, from the University of Rochester. I was interested in health care at the systems level. When I was working on my master's degree, I was doing a lot of computer programming because it was faster for some of my class assignments and I had done a lot of programming in high school. Chuck noticed, and we started doing a lot of work together. My master's thesis was published in *Medical Care*, and became a good chunk of what motivated my doctoral research. Chuck was instrumental in describing what sort of doctoral program would be the best for my interests, which was Johns Hopkins.

Joanne Spetz (JS): Did you work between the master's degree and doctoral program?

SP: I did, and that was essential. I worked at BlueCross BlueShield in Rochester, New York. It was a very interesting environment on how health policy and health dollars went to work. You saw the large employer market because Kodak and Xerox were there. We were ahead of the curve compared to most other plans, having both staff-model HMOs [health maintenance organizations], as well as IPA-model [independent practice association] PPO [preferred provider organization] systems. My job was to write the computer code to create physician profiles, much like what we're talking about for incentive-payment systems now.

CK: At Hopkins, did you focus on economics again?

SP: Yes. The Hopkins program was one of the first health economics programs in a School of Public Health. In the first 2 years, you were with the economics department's doctoral students. Once you got past the comprehensive exams, health economics becomes your field of study. I did a secondary specialization in health finance. My dissertation was focused on what physician practice style looks like, from an econometric approach, and to what extent there is "welfare loss" from physician practice variations. What got me even further into health economics was my dissertation advisor, Marty [Martin] Gaynor, who's now at Carnegie Mellon. Right after I defended my dissertation, Marty asked me to present the paper at the National Bureau of Economic Research spring meeting. I had a chance to present my paper in front of a cast of characters I had only read about, but never actually talked to before.

CK: Do you think it's fair to say that mentors or sponsors were really important in your career?

SP: Absolutely. It's hard for me to unwind what my career would have looked like without Chuck Phelps and Marty Gaynor. When I think about the very specific doors they opened, it's hard to imagine someone else stepping into their roles and doing the same. The third person who helped a lot was the person I worked with when I was a project coordinator at CMS [Centers for Medicare and Medicaid Services], Jonathan Weiner. Jonathan was instrumental in opening professional doors for the careers I had at the University of Minnesota and Project Hope.

CHRISTINE T. KOVNER, PhD, RN, FAAN, is a Professor, College of Nursing, and Nurse Attending at NYU Langone Medical Center, New York University, New York, NY.

JOANNE SPETZ, PhD, FAAN, is Professor, Philip R. Lee Institute for Health Policy Studies, and in the School of Nursing and Department of Family and Community Medicine, University of California, San Francisco, School of Nursing, San Francisco, CA.

Welfare Loss

CK: You mentioned the term "welfare loss," which is an economics term. Can you define that for our readers? And how is it connected to policy?

SP: Welfare loss is the idea something is going on in the economy that benefits nobody. It doesn't really benefit the consumer; it doesn't benefit the producer. When you use economic graphs, it's an ugly little triangle that is also called the "deadweight loss." In our paper in *Medical Care*, we showed that if physicians did too much medical care, or patients received too much, then it would create a welfare loss, because there would be waste. But the clever thing was that there could also be a situation that you do too little, then there would be an access problem. This can also create a welfare loss. This connects to the idea of "pay for performance." At first, this idea was approached by issuing clinical guidelines. But, the guidelines were changing all the time, and were so complex, it was driving everybody crazy. Once each specialty started making up its own parameters over what defines quality, you could apply these parameters to databases such as Medicare claims data. Then, you could really make pay-for-performance work. You could finally say, "We've looked at your data and it seems as though you're light on what you're supposed to be doing for diabetes now. And thus, since we know it's an economic welfare loss for you not doing this for your diabetic patient, you should be compensated less until you change your behavior. And then we'll pay you for performing."

JS: A related area of your work is on consumer-driven health plans. I expect many of our readers aren't familiar with what consumer-driven plans are and why they are expected to affect behavior. Can you explain this?

SP: Consumer-driven health plans, at their root, are based in trying to alter consumer behavior. The idea is that insurance itself could potentially lead consumers to use too many resources. The reason why is that you've lowered the price of medical care so low with insurance, that consumers aren't as careful about the use of the services because they think they're free – or cost only $5 or $10. In reality, the care or product – like a prescription – could cost hundreds or thousands of dollars. This is called "moral hazard" by economists. What gave birth to consumer-driven health plans was the sense health care costs could be controlled better by trying to make the consumer feel the costs of the system more. One way to do this is the traditional thing that's done in insurance, which is a deductible. You use a bigger deductible, which is a bigger part of the consumer's income, so that consumers think twice about using so many services. These plans connect to the findings of the RAND Health Insurance Experiment of the 1970s. In that experiment, they gave enrollees one of a set of insurance designs, including high deductibles, low deductibles, and HMOs. They called the high-deductible health plan a "catastrophic health plan." Patients had a very large deductible which they had to pay first before insurance paid anything. The experiment found that the deductible did affect behavior a lot and did not make health any worse, but consumers didn't like this type of plan.

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Consumer-driven health plans came out of a recognition that consumers needed to be, for lack of a better term, bribed. That is, if you give them a tax-protected account of money that they can use for whatever health services they want, they feel as though "that's my money and I'll manage it." So, it's more accepted than the old catastrophic plans. These plans emerged initially as a dot-com innovation in health insurance. During that boom, some people thought we could create an insurance contract in which people could manage their accounts online, they could access wellness coaches, and use the Internet to shop for health care by price as well as quality. It would be a whole new consumer experience; hence the term "consumer-driven" was motivated by all these e-tools. When these plans emerged, I was in the health IT [information technology] field in Minnesota, where there were a lot of dot-com firms. We had a few consumer-driven health plan designs that were getting a lot of attention in Washington. I was seeing these CEOs more often in Washington than I would see them in Minnesota. Another fabulous mentor of mine, Jon Christianson, who recruited me to the University of Minnesota, said, "These programs could make a nice evaluation study once we get enough data." We managed to get funding from the Robert Wood Johnson Foundation to first qualitatively examine what these plans were and the results were published in *Health Affairs*. Later, once the plans had survived the dot-com era, we did a full-blown experimental design to ask, "Does it really save you money?" A big concern was that these plans would save way too much money and then only really healthy people would sign up and all the sick people would be left in the street. These were meaty research questions that I could apply my skills to, and answer relatively quickly since I knew how to work with the big insurance claims databases. Later, these plans evolved into Health Savings Accounts as part of the Medicare Modernization Act in 2003. After that, they really took off, but they also became very political. Before 2003, consumer-driven health plans had no political

baggage. They were bipartisan, if anything. They were seen as something really cool created by IT people that were fueled by venture capital. Once the Bush administration started advocating them, they were seen as an instrument of the Republican party.

CK: What did you find in your research about how these plans affect patient behavior and spending?

SP: We found the exact opposite of the stories, at least initially. The people who were choosing the plans were not the young and healthy. They were usually wealthy, which some people predicted would occur. But they tended to be folks with chronic conditions who were a little better educated than most. Furthermore, we saw the people who signed up for these plans and stayed in them started to have much *higher* health care costs, even compared to the PPOs and other plans that were thought to be expensive. We were working with several different employers that had given us access to their data, and we could predict the costs and expenditures. I remember going to one and saying, "You know, this thing is going to blow up on you." And they said, "No, no, it's looking great every month. It's ok." To which I said, "You're seeing month by month data, but you're not seeing that people who are staying in the plan have gotten wise on how to manipulate it." But they continued to say, "No, no. That's not a problem." But it was a problem. We ended up writing two articles, one in *Health Services Research*, which said the data suggest that these plans do not save as much money as people thought. It does work well for pharmacy, though, since patients can really look at the prices of those products, and compare them. We wrote a subsequent article in *Inquiry* that looked at the same employers' data for 4 or 5 years, and found that the consumer-driven plans were much more expensive. Now we're looking at over 70 firms, a very large population, and finding the same story.

Politicized Health Plans

JS: You mentioned how politicized these health plans became. During the health reform debate, you had your toe in the political waters, and you published an estimate of the cost of an early version of the Affordable Care Act. What did you learn both from an analysis standpoint and about how politics are played?

SP: Health reform really had an operatic quality to it. When it started around 2009, I thought I was not very naïve. I had done some work as an advisor for [John] McCain in 2007 and 2008. Some of my research on consumer-driven health plans allowed us to have

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enough data to produce a simulation model, very similar to what the CBO [Congressional Budget Office] used to estimate the effects of different plan designs. One of the first things that I learned was that if you have a model that can actually simulate changes in health insurance enrollment and costs, you become a very popular person.

I had done much of the consumer-driven research with Jon Christianson and Roger Feldman, who is another of the great mentors I've had at the University of Minnesota. We had a contract with HHS [U.S. Department of Health and Human Services] to try to figure out the impact of what President Bush was proposing on Health Savings Accounts. We'd finally honed the econometric models and made sure that everything was right, and were getting into the simulation models. My first thought was, "We can't do this. We are making estimates that are way beyond the data we've analyzed." Roger said, "You can do it, just force an intercept term in the model." My response was, "What do you mean force an intercept? Do you mean we're going to make an intercept up?" And, of course, that's what he meant. He said, "We've got to get this done." Roger knew when to go into the government mode of, "We have a week to go. We need a number." That was one lesson that was critical. There are times when you're, in a sense, forced to come up with a number. I know that Jon Gruber and I have shared this unease as well as the satisfaction of being able to do this and get good estimates.

During the Presidential election of 2008, we were running models for McCain. I think many people didn't expect that McCain would have models. Our model showed that the Obama proposal wasn't so bad. But, once Obama was elected and the health reform effort really started, I was getting a "call to duty," meaning McCain's office and other people I had previously met, wanted me to score the legislation. So, we put the models back into action and that got controversial very quickly. Usually when we do these things, even during the [2008] campaign, you wouldn't see that much of an immediate response. Normally, we'd release a report, and then we'd see the Internet hits go up, but it was pretty calm. But in the summer of 2009, we produced numbers that were taken from our reports and put into the GOP response immediately. The Minority Whip would walk into a Congressional room saying, "This is what we think the costs are for [Senator] Kennedy's plan."

There became a news media cycle and we found our numbers entering the debates at town hall meetings throughout August, basically condemning the health plan at the time. I think by fall, Roger and I – me

in particular – were tired of throwing bombs. We didn't expect these bombs to go this far. We wanted to get good health reform done, and there was a really nice opportunity to do something. Fortunately, about that time there were actually a few Republican senators and one or two Democrat senators who were moderates, who knew we had this model. They reached out to us and asked if we could come up with a plan B. We later found that one of our proposals had been scored by CBO's cousin, the Joint Committee of Taxation. We had our numbers validated by them to small rounding errors. After having been through the muck the whole summer, to be able to come up and say that our numbers were good, and that we aren't really just political hacks, was nice at the end of the day.

We came up with a revenue-neutral health reform design that was somewhat bipartisan and had some quiet Republican support. It didn't have Medicaid expansion, but it was actually not a bad design. The sad part of the story was that it got completely shelved by the leadership inside the GOP, but not without a lot of fight and a lot of swearing, from what I understand. The broader party's sense was that there was larger political gain for not compromising.

Where Are We Headed?

CK: So what are the possibilities over the next decade? One is that the Affordable Care Act (ACA) stays in place and there are efforts to modify it. The other is that there actually is a repeal, though I would suspect that this is a less likely scenario. But let's start with the repeal scenario. In that case, what was your proposal?

SP: The replacement we have in mind doesn't have an individual mandate. It does have guaranteed issue, so if someone applies for insurance, they have to be at least offered a plan at some price. When people say "guaranteed issue," that doesn't mean everyone is going to get coverage. You may not like the premium you get, but you'll still be offered a premium. There would be a subsidy that would be less than 400% of the federal poverty line (which for a family of four is $88,000), which is in the current law. Ours would have gone up to 300% of the federal poverty level, which is $66,000. We would not tie the subsidy to the benefit generosity of one particular plan design. We would instead put a fixed dollar amount on the subsidy, and have that amount move up with inflation. Basically, it would be a voucher with a dollar value. To fund it, you'd tax employer-sponsored health coverage if it's above what federal employees get now on average. That idea has had bipartisan support.

JS: In the other scenario, which is where the Affordable Care Act doesn't get repealed, what are the kinds of amendments or regulations would improve health reform?

SP: The biggest thing that the ACA is not addressing is cost inflation. It's still 8%. Just to give you some perspective, we estimated that the typical family premium for 2011 was on average $15,000. In 2000, it would have been $5,500. If extrapolate it out, you get $28,000 for that same health plan by 2019. This is far above of the poverty line. There has to be something to address that issue. This is going to be the most vexing challenge: Do we have the budget wherewithal to withstand what is being proposed? There is not an explicit cap on the subsidy in the ACA, so the cost could be much higher that what the CBO said. The other major piece that's lurking is health IT (HIT), which is not going to work the way everyone hopes it will.

CK: What do you mean by that? How is it not going to work?

SP: What people expect HIT to do is link everything together virtually, the same way you or I, or anyone who uses a Blackberry or iPhone can get to our email account on the cloud, and it's all seamless and integrated. That's what people want medical health data records to become. You go from care system to system, and can track what's going on, letting the data move. The problem is that I don't think most hospitals have really embraced the concept of letting data leave. Furthermore, the IT vendors haven't designed the platform for data to leave. The fault is really on the hospitals because the hospitals have the greatest ability to dictate terms for the products they will buy. They should say to vendors, "Look, things have to link." Physicians and nurses play a role in IT success as well – the nurse champion, and the physician champion, are the change agents to help things go forward. **$**