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Controlling Health Costs and Improving Health Care Quality for Retirees

by Jim Jaffe and Paul Fronstin, EBRI

- The problem of how to pay the increasingly costly medical bills of retired Americans is rapidly rising as a national priority, not just among policymakers, but also among the general public. As a result, deeper thinking within the health policy community on two broad issues is taking place: How changes in government programs will affect the delivery of health care in the United States; and whether the coming changes that are made to control costs—especially within Medicare—will ultimately improve quality of care delivered as well. These topics provided the focal points of a policy forum sponsored by the Employee Benefit Research Institute Education and Research Fund in Washington, DC. This *Issue Brief* summarizes the policy forum discussion and puts it in the context of these issues more generally.
- The increase in health care costs slowed in 2003, but this trend hit a plateau during the first half of 2004. Currently, employers are trying to control health care cost increases by giving employees more responsibility for paying a growing proportion of their medical bills. Concurrent with this shift in cost sharing is a renewed focus on managed care strategies, such as utilization review, disease and case management, limited provider networks, and provider incentives designed to encourage efficient clinical practice.
- The issue of rising health care costs is even more prominent in the Medicare program. The Medicare hospital program faces an estimated shortfall of \$8 trillion over the next 75 years. When the costs of outpatient services and the new prescription drug program are added, the unfunded liability is near \$28 trillion. Medicare's financial problems are much more immediate—and more difficult to solve—than what the Social Security program will face in several decades.
- Investments in information technology could reduce some of cost pressures that both the private and public sectors currently face. Clinical information technology systems typically include four components: electronic patient medical records, physician order entries, electronic reporting of test results, and decision support tools for providers. While the idea of providing medical services in the most efficient way possible has long been a top priority for those interested in health economics, the primacy of this concept has never been accepted more broadly by the health care community.
- The quest for a better health care system is a process that has no end. The challenge lies in creating a climate where there is momentum to fuel the continuing quest for progress. A major challenge is that the health care system is extremely fragmented. Trying to fix separate parts of the system, rather than approaching it as a whole, seems destined to failure.

Jim Jaffe is director of Special Projects and Paul Fronstin is director of the Health Research and Education Program at the Employee Benefit Research Institute (EBRI). Jaffe and Fronstin wrote this *Issue Brief* with assistance from the Institute’s research and editorial staffs. Any views expressed in this report are those of the authors and should not be ascribed to the officers, trustees, or other sponsors of EBRI, EBRI-ERF, or their staffs. Neither EBRI nor EBRI-ERF lobbies or takes positions on specific policy proposals. EBRI invites comment on this research.

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Introduction

The problem of how to pay the increasingly costly medical bills of retired Americans is rapidly rising as a national priority, not just among policymakers but also among the general public.¹ As has been well documented, employers are significantly less likely to provide health insurance coverage for retirees than they once were.² They are also asking workers to pay higher premiums for health benefits, which creates new economic stresses for employees and their families and is a major cause of the recent increase in the ranks of the uninsured employed.³ And government programs that help pay for such coverage are under growing financial pressure, which ultimately is likely to lead to cuts in public health programs.⁴

These troubling trends have also provoked some deeper thinking within the health policy community about two broader issues:

- How changes in government programs will affect the delivery of health care in the nation generally.
- Whether the coming changes that are made to control costs—especially within Medicare, the federal health insurance program for the elderly and disabled—will ultimately improve the quality of care delivered as well.

Medicare, which insures nearly all retirees over age 65, casts an enormous shadow over the entire American health care system, consuming an ever-increasing share of the government budget and having a tremendous impact (because of the enormous number of beneficiaries it covers) on the very definition of “adequate coverage.”⁵ Medicare spending, as a percentage of total health spending, appears to have peaked in late 1990s (Figure 1),⁶ but when other government programs (especially state-run Medicaid programs for the poor), are added to the mix, the impact continues to grow.

For decades, reimbursement decisions made by Medicare and Medicaid administrators have determined whether health providers operate at a profit or a loss.⁷ The generosity of such reimbursement payments also inevitably influences the prices charged to other patients who lack the government’s purchasing clout.

These government decisions also influence coverage decisions and thus play a big role in determining the parameters of appropriate medical treatment in the United States.⁸ A decision that a given test, procedure, or drug should be covered by these government programs influences the practice of medicine for all.

A case in point is the new Medicare prescription drug benefit enacted by Congress two years ago. As it becomes effective, the government is poised to exercise the same control over prescription drug spending that it has had for years over hospitals and physicians. In each area, a government decision to pay less for a procedure, product, or service often provokes a provider effort to try to make up the lost income from other buyers of health care: The ultimate result is cost shifting to patients outside the government programs.

With America’s population aging and the baby-boom generation on the cusp of retirement, the percentage of the elderly’s medical bills paid by government agencies inevitably will increase, despite efforts by the current administration to moderate projected increases. Ironically, any efforts to “privatize” Medicare will lead to increasing mandates on what types of coverage must be included in private insurance packages (the government-imposed definitions for Medigap policies are an instructive precedent here).

Despite the fact that government health care expenditures will continue to exceed the overall rate of inflation in the entire economy, American retirees face a growing challenge in finding high-quality affordable health care. That’s partly because health insurance coverage provided by former employers is becoming increasingly rare for retirees, who are being forced to finance a growing part of a health care bill that continues to increase significantly faster than inflation. These topics provided the focal points of

a policy forum sponsored by the Employee Benefit Research Institute Education and Research Fund (EBRI-ERF) in Washington, DC, on Dec. 2, 2004, which dealt with question: “Controlling Costs and Improving Quality for Retirees: Can It Improve the Health System Overall?” About a hundred health industry, government, and policy experts attended the daylong policy forum, and while many participants agreed that better cost controls and quality *could*, in theory, improve the U.S. health care system, few were sufficiently optimistic to bet that it *would*.

Health Care Cost-Drivers

Paul B. Ginsburg, president of the Center for Studying Health System Change, reported that the growth in health care costs slowed in 2003, but this trend hit a plateau during the first half of 2004. He also said he does not expect large changes from current trends. Specifically, during the first half of 2004 health costs were up 7.5 percent from the previous year, while the nation’s gross domestic product (GDP) grew by 5.9 percent, Ginsburg said (Figure 2).⁹

Spending on inpatient hospital care and physician services lagged behind GDP growth, but hospital outpatient costs grew nearly twice as quickly (by 11.4 percent) and rose twice as fast as hospital inpatient services (Figure 3). However, prescription drug spending rose by only 8.8 percent, ahead of the broad GDP growth but well below the double-digit norms recorded in 1998–2003, Ginsburg said.

Changing Patterns of Cost Growth

These data confirm that while health care costs regularly outstrip the inflation rate or growth in the nation’s GDP, the patterns of growth have changed over time. For instance, despite this cost growth, the *percentage* of total private spending paid out-of-pocket by individuals has been declining for years—and continues to do so (Figure 4). That is not to say the *amounts* that individuals have to pay for health care are falling, but only that their *share* is (while the consumer slice is shrinking, the total health-care pie is growing at a faster rate; in short, everyone is paying more, although the bills are rising more quickly for some than for others).

According to government data, the percentage of the nation’s private hospital bill paid by insurance rose from 89.6 percent in 1990 to a projected 91.9 percent in 2003. For physician bills the figures rose from 69 percent to 83 percent, while the comparable numbers for prescription drugs more than doubled, from 29.2 percent to 62 percent.¹⁰

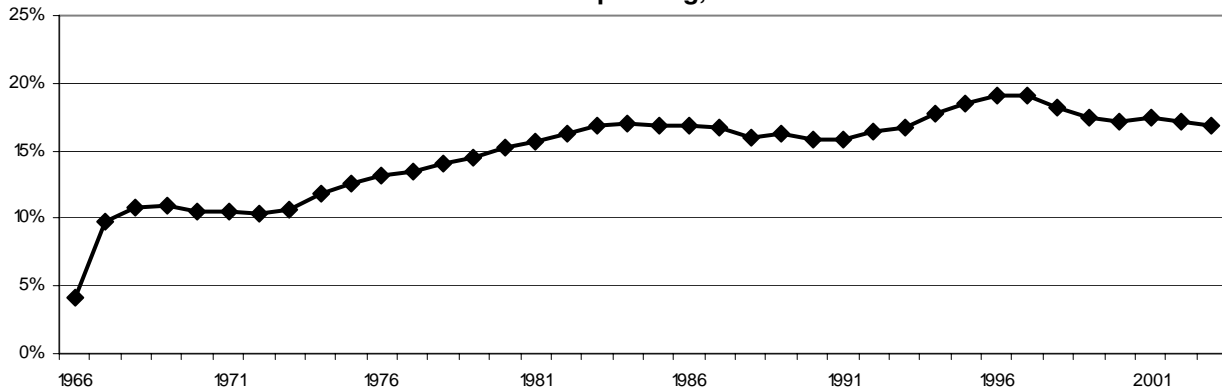
What is driving these cost increases? In the case of prescription drugs, a 10 percent increase in the amount spent could suggest either that 10 percent more pills were being taken while the price per pill remained constant, or that the same number of pills were used but the price charged for each one rose by 10 percent. In reality, both of these factors are generally reflected in any increase.

A look at the data confirms this relationship. Hospital spending rose by 8.6 percent during the first half of 2004, but only 0.8 percent of this increase is attributed to greater utilization, according to Ginsburg. In fact, the average length of a hospital stay has been declining for several decades, as is the number of “hospital days” per thousand people. So hospitals can increase revenues only by raising prices, by increasing the intensity of services provided to patients, or by winning patients away from competing health-care facilities.

With prescription drugs, by contrast, 5.5 percent of the 8.8 percent total increase in drug costs in the first half of 2004 resulted from greater use of drugs, according to Ginsburg.

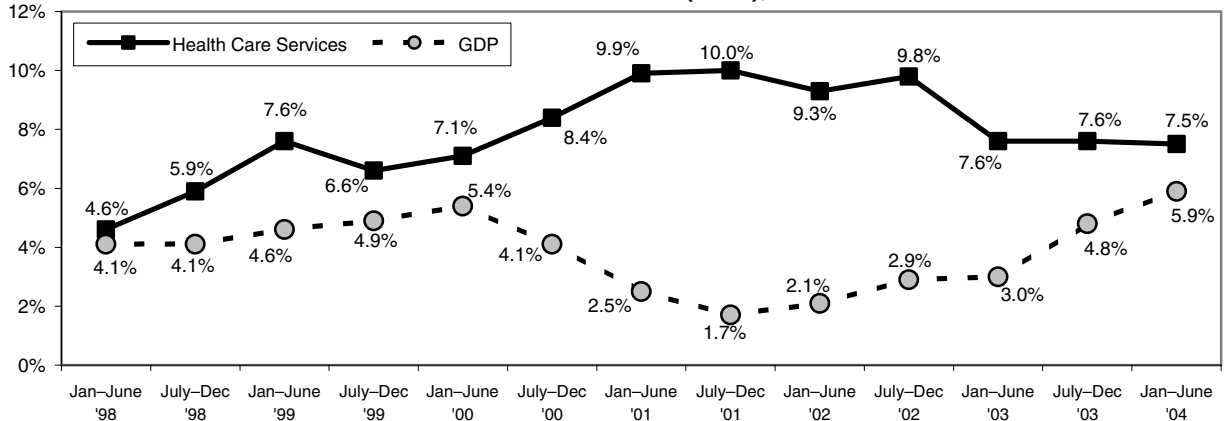
Not surprisingly, health care providers point out that with the nation aging, older Americans require (or at least are consuming) more care at a time when new and expensive treatment options are becoming available, and ever-more-costly medical technology continues to be developed. As many experts have noted, the growing number of Americans living beyond age 80 (often thanks to medical remedies that didn’t exist a decade ago) is simultaneously both a success and financial challenge for the American

Figure 1
Spending on Medicare as a Percentage of Total Health Spending, 1966–2003



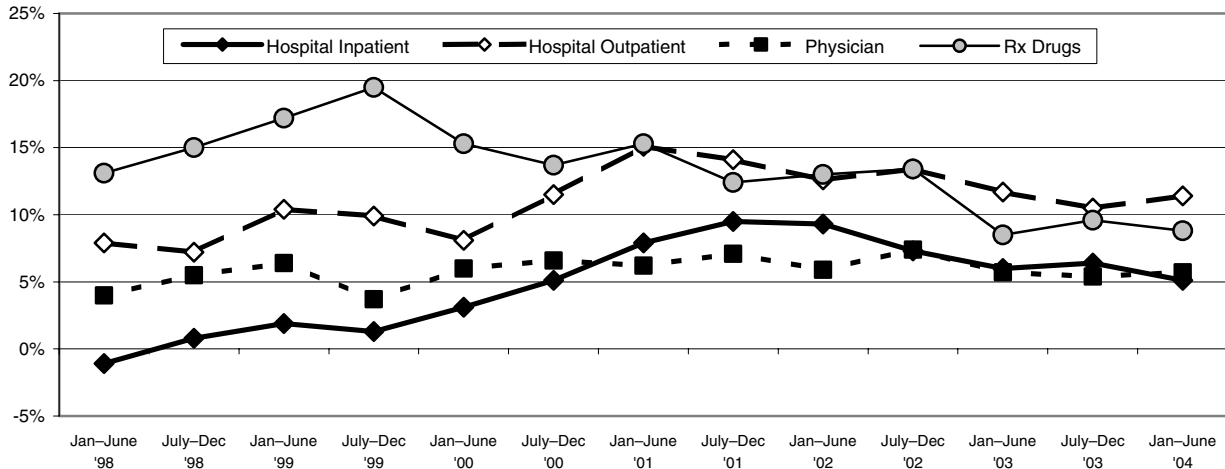
Source: Centers for Medicare & Medicaid Services, Office of the Actuary.

Figure 2
Growth Rate Trends for Health Care Services and Gross Domestic Product (GDP), 1998–2004



Source: Bradley C. Strunk and Paul B. Ginsburg, "Tracking Health Care Costs: Spending Growth Slowdown Stalls in First Half of 2004," *EBRI Notes*, no. 12 (Employee Benefit Research Institute, December 2004): 2-4. Data on prescription drug spending are from the Milliman Health Cost Index (\$0 deductible).

Figure 3
Growth in Health Care Spending by Category of Service, 1998–2004



Source: Bradley C. Strunk and Paul B. Ginsburg, "Tracking Health Care Costs: Spending Growth Slowdown Stalls in First Half of 2004," *EBRI Notes*, no. 12 (Employee Benefit Research Institute, December 2004): 2-4. Data on prescription drug spending are from the Milliman Health Cost Index (\$0 deductible). Prescription drug prices are from the Bureau of Labor Statistics' Consumer Price Index (CPI) for prescription drug and medical supplies. Data accessed on Oct. 7, 2004.

health finance system.¹¹ Whether many of these new services could withstand a rigorous cost-benefit analysis is a difficult question: Patients and their families tend to believe that such an analysis is inappropriate—and politicians tend to agree, even as they struggle to control health care costs.

The Economics of Health Care

In the health care area, more than in many other sectors of the economy, prices are set in negotiations between buyers and sellers. Not surprisingly, the biggest players on either side of the transaction tend to get the best deals—and with the Medicare and Medicaid programs, the government is regularly the biggest buyer. Yet, there are no formal negotiations in the case of government programs: Instead, the process begins with administrative mechanisms designed to create a fair and mutually acceptable price, and ultimately is resolved in the political arena of Congress and the state legislatures (the 2003 Medicare Modernization Act (MMA), for instance, significantly increased the promised Medicare reimbursement for many hospitals, thereby deepening the program's existing fiscal imbalance).

Cost-Control Strategies

Ginsburg said the biggest—and most popular—current tool to control health care cost increases is to give employees more responsibility for paying a growing proportion of their medical bill. This trend is reflected not only in adjustments to out-of-pocket payments in conventional employment-based health insurance but also in the restructuring of health benefits using high-deductible plans and individual health accounts (such as health reimbursement arrangements and health savings accounts) that have recently appeared on the market. The new Medicare capitation program (Medicare Advantage), included in the MMA law creating a prescription drug benefit, moves in this direction as well, by offering new incentives for beneficiaries to shift out of traditional Medicare coverage and into plans with economic incentives to hold costs down.

“Over the last three years there have been substantial changes in the benefit structure toward more patient cost sharing,” Ginsburg said. “For the last three years there’s been about a 3 percent annual shrinkage of the benefit structure, (which is) becoming less comprehensive because of higher deductibles, copays, and coinsurance.”

Concurrent with this shift in cost sharing is a renewed focus on managed care strategies designed to both control costs and promote high-quality health care. The recent slowdown in the economy, combined with rising health care costs, has given many health plans the opportunity to refine and refocus the use of utilization review, disease and case management, limited provider networks, and provider incentives designed to encourage efficient clinical practice.¹² And a recent survey found that Americans appear to be receptive to some managed care practices.¹³ Health plans hope that by combining certain managed care techniques with financial incentives for individuals to control spending, health care cost increases will continue to moderate. Tiered hospital networks are one new strategy designed to encourage patients to use more efficient facilities.¹⁴ Ginsburg challenged those who suggest that improvements in information technology would lead to significant cost savings, pointing out that such efforts carry an inherently high price tag and have improved quality (not cost-control) as their primary goal.

More Uninsured

How will Americans react to rising premiums and out-of-pocket health costs? Ginsburg predicted that if premiums continue to increase more rapidly than income, it will lead to continued declines in coverage. This ultimately will create pressure for expanded government assistance programs. In fact, there’s already data confirming that both the number and percentage of Americans who lack health insurance has been rising in recent years, concurrent with higher health care costs.¹⁵ Family coverage now costs about \$5 per hour worked, an increasingly unaffordable price (from either an employer or employee perspective) for jobs that pay only modest wages, Ginsburg noted.

The Medicare Program

Paul Fronstin, director of the Health Research and Education Program at EBRI, analyzed Medicare's fiscal condition. He stressed the growing reliance retirees have on Medicare as employers back away from providing health benefits to Medicare-eligible retirees.

"What we've seen is fewer employers offering retirees health benefits. As of 2000, only about 12 percent of all employers in the country offered retiree health benefits to Medicare eligible-retirees," Fronstin said, "and when those benefits are still offered, retirees often have to pay more for both the benefit and health care services." He said the declining trend of employment-based retiree health care will not be reversed any time soon.

In 2004, the Medicare trustees predicted that the program would confront bankruptcy in 2019, seven years sooner than it projected in 2003, absent major changes (Figure 5). The addition of a prescription drug benefits—along with increased payments for certain services— included in the MMA law may accelerate the program's financial shortfall.

The Medicare hospital program faces an estimated shortfall of \$8 trillion over the next 75 years.¹⁶ When the cost of Parts B (outpatient services) and D (the prescription drug program) are added, the unfunded liability is near \$28 trillion.

The trustees are joined by others in stressing that Medicare's financial problems are much more immediate—and difficult to solve—than what the Social Security program will face several decades later. But the political system has been slow to respond, and, in fact, few ideas beyond "empowering consumers" (discussed below) have been proposed.

Assets in the Medicare trust fund will begin declining in 2010, the trustees predict, and be exhausted within the subsequent decade. The politics of the issue are illustrated by the fact that the last major piece of Medicare legislation—MMA, enacted in 2003—also increases hospital reimbursement rates in addition to creating a new prescription drug benefit. Both will exacerbate the financial problem of the program.

Analysts estimate that Medicare will claim a growing share of the federal budget in the decades ahead, increasing from about 3 percent now to 5 percent by 2020, 7 percent by 2030, and 14 percent by 2080 (Figure 6). As a result, while Medicare's annual costs are currently 2.7 percent of GDP (or about 60 percent of Social Security's share of GDP), they are now projected to surpass Social Security expenditures in 2024 and reach almost 14 percent of GDP in 2078 (more than twice the share of Social Security in that year).

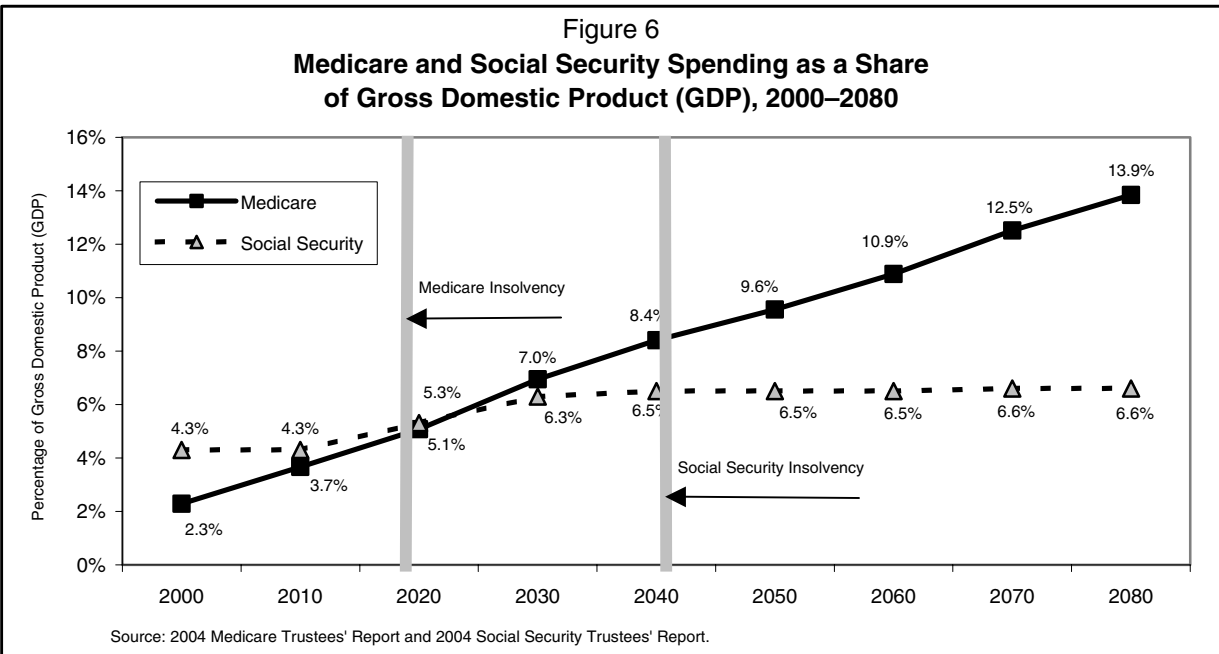
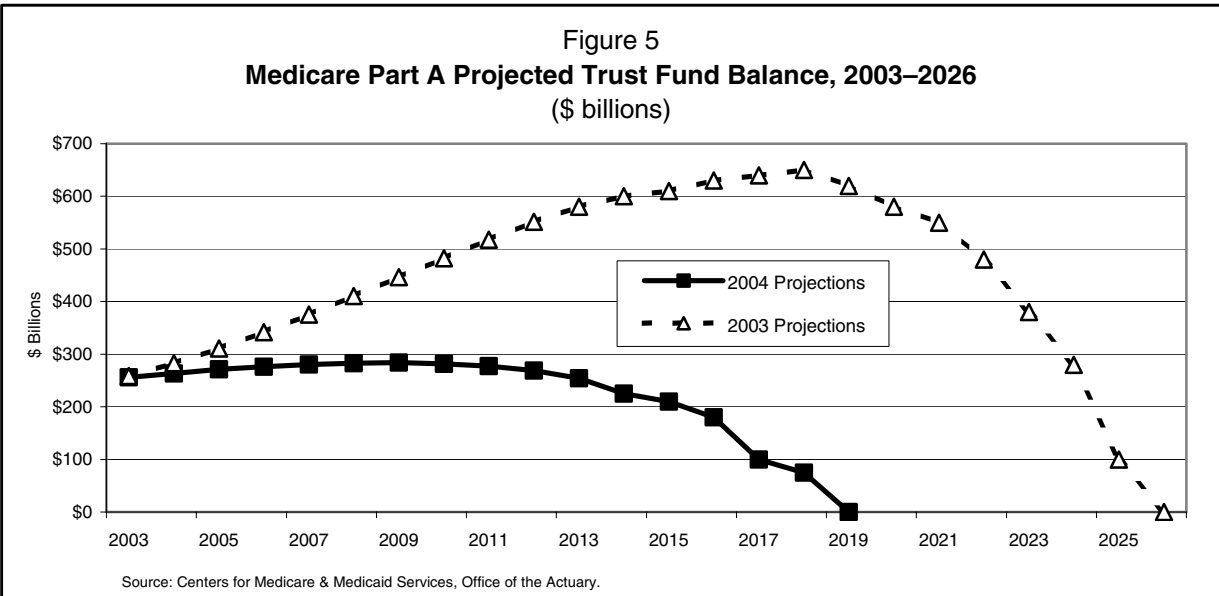
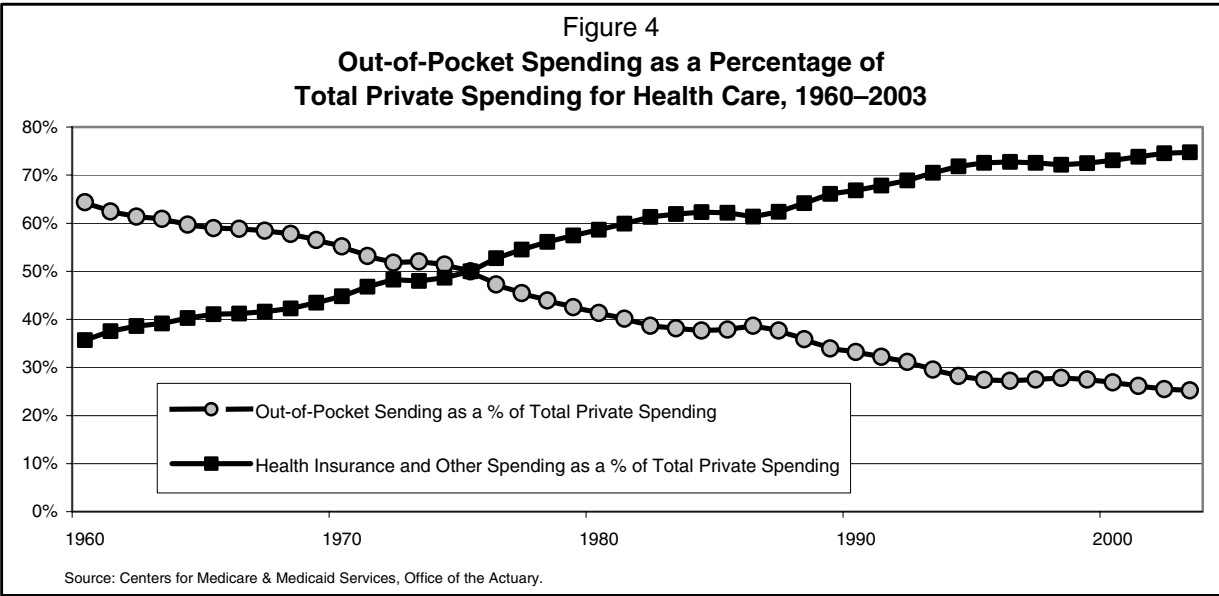
Basically, Fronstin said, Medicare is providing expanded coverage for a growing population even as the cost of caring for each individual relentlessly increases—while the program's already inadequate revenue structure is left unchanged.

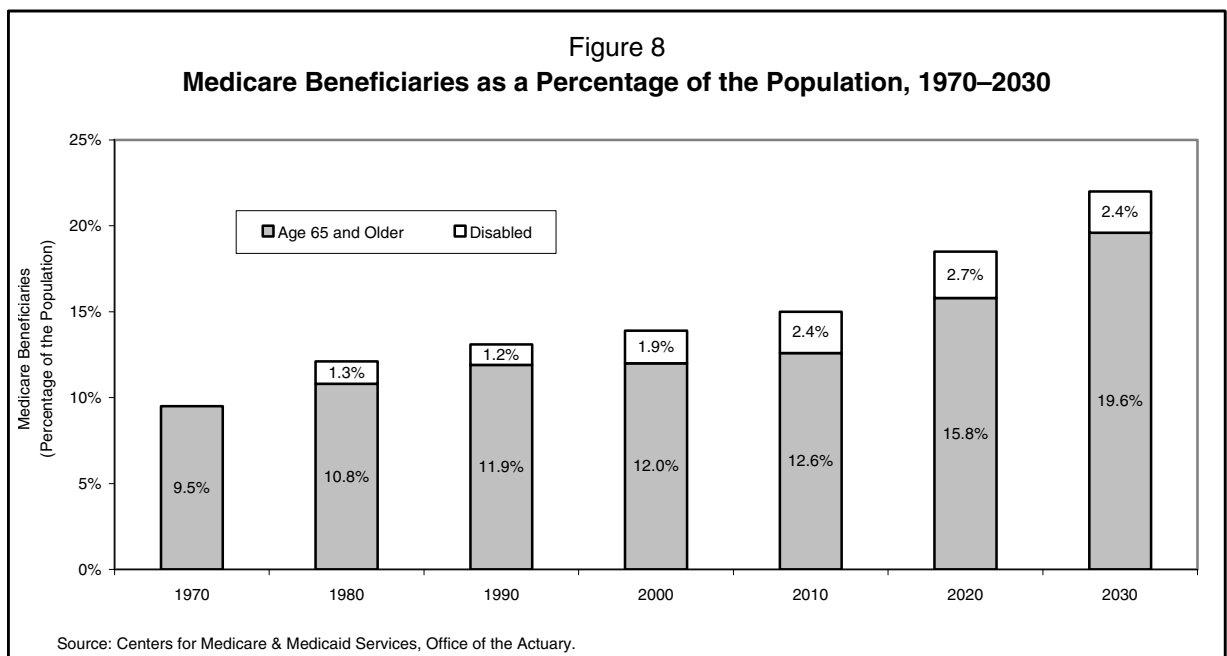
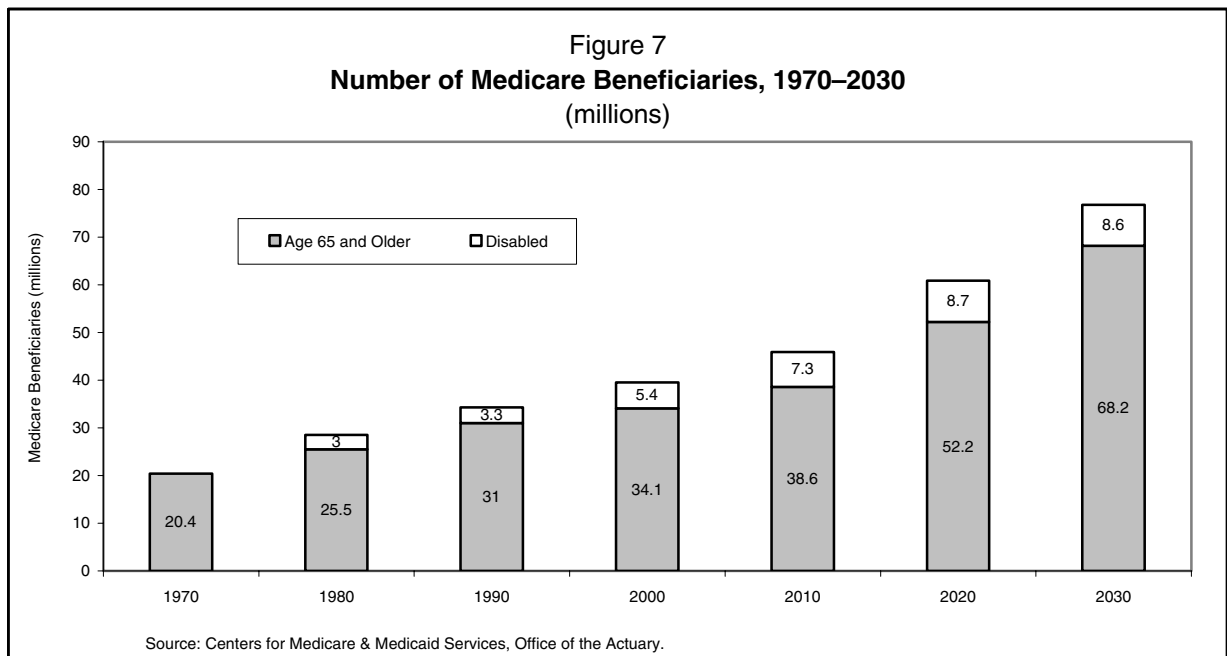
The number of Medicare beneficiaries has doubled to 40 million since 1970 and is projected to nearly double again—to 76.8 million—by 2030 (Figure 7). In 1970, less than 1 in 10 Americans was a Medicare beneficiary; in 2030, more than 1 in 5 will be covered (Figure 8).

And, as is true of the Social Security funding problem, this takes place in an environment where the ratio of workers (who fund the Part A hospitalization program) to senior citizens (who receive the benefits) is declining. The cost of providing Medicare services to a beneficiary continues to grow, generally outpacing wage or GDP growth.

These often-cited trustee figures understate the magnitude of the broader problem because they apply only to Part A, the hospital insurance program funded by employment taxes. Part B (which finances outpatient services and is largely funded by general tax revenues) and Part D (the new drug benefit), add to the total. Unlike the Part A program, which is financed directly by payroll taxes, both Part B and Part D require growing, annual appropriations of general revenues.

Big increases in the Part B program are partially passed to beneficiaries through premium increases. Such payments are calibrated to equal one-quarter of Part B costs.





The Part D program, which isn't operational yet, is too new to allow a reliable projection of costs. Historically, Congress has tended to underestimate the cost of new benefits, and many believe this will be true of the drug benefit as well.

Medicare trustees, who have the luxury of not courting voter approval, point out that the projected problem could readily be solved by increasing the payroll tax to 6.02 percent (from its current 2.9 percent level) or cutting Part A benefits nearly in half (48 percent is their precise calculation). But neither of these options is politically viable; in fact, the options that generate serious discussion involve much more modest tax increases or benefit cuts.

It does appear that the Part B premium, which beneficiaries pay for outpatient coverage, will grow steadily and reach \$120 monthly by 2013.¹⁷ For rich seniors, a new income-based premium mechanism included in the MMA prescription drug law means that premiums will rise even more steeply.

Fronstin contends that all of these data will generate increased interest in Medicare cost variances among regions; for instance, trimming reimbursement rates in high-cost areas to conform to the norms in other areas could go a long way toward solving future fiscal problems. Medicare spends \$3,500 per beneficiary per year in Santa Fe, NM, or Salem, OR, but nearly triple that amount (or \$9,200) in Miami. Numerous studies have attempted to explain these differences, but little progress has been made in narrowing them.¹⁸ As a rule, where Medicare costs are above average, other prices tend to be high as well.

In the past, tinkering with the reimbursement rates has been the first line of attack by Congress when Medicare spending appeared to be rising intolerably quickly. But this can only solve an immediate problem; there's an ongoing debate about finding a way to keep costs under control over time.

Fronstin discussed two basic strategies: One would restructure the program in an effort to make patients behave like smart shoppers; the other is to stop making payments each time a service is delivered and, instead, make a large annual fixed payment to a provider regardless of the services consumed. Theoretically, this would encourage providers receiving such payments to control costs to avoid losses.

Over the years, there have been repeated efforts—including one in the 2003 MMA—to encourage beneficiaries to join capitated care plans operated by providers who receive a flat fee annually for providing all covered services. Proponents argue that capitation should save the government money, but it isn't clear they are right.

Historically, insurers have entered markets when Medicare pays a high capitation rate, and left them when reimbursement is lowered, causing disruption for beneficiaries who seek continuing coverage. Some cities have a relatively large capitated segment, others have virtually none. Capitation rates are based on local costs. As a result, capitation is most successful in urban areas with high costs. This raises a question of whether capitation represents a problem or a solution.

There's also a basic question if a link exists between payment or reimbursement amounts and the quality of health care services provided. One might ask whether spending more money on care results in a better or healthier outcome: Are people in Miami getting better or more appropriate care than those in Salem or Santa Fe?

Few would argue that they are.¹⁹ "Substantially higher per capita spending results in no positive difference in quality, access, or patient satisfaction with care," Fronstin said.

Analysts are intrigued by findings that more than half of the regional cost differences are explained by practice patterns (which might be called "habits") and supply creating demand. If other things are held equal, the mere fact that one lives in an area where there's an extraordinarily high amount of surgery increases the odds that any patient will end up on an operating table.

Improving Medical Quality

Information Technology

Robert M. Crane, director of the Kaiser Permanente Institute for Health Policy, focused on efficiency issues and the question of whether investments in information technologies can resolve some of today's problems. He listed four components that are typically included in a clinical information technology system:

- Electronic patient medical records.
- Physician order entries.
- Electronic reporting of test results.
- A decision support system that allows those providing care to quickly check on what current knowledge views as an optimal response.

One of the paradoxes of contemporary American medicine is that awesome technological advances have been made in solving medical problems even though health care providers have lagged far behind

other industries in making their administrative processes more efficient by using technology. If the Internet giant Amazon.com is viewed as being at the leading edge of efficient use of technology, medical providers generally are at the opposite extreme.

Among the implications of this are wasted time and money, as well as potential health risks: Patients may have the same expensive new test repeated because the results of the first test are not readily available to a new physician they have been referred to. These avoidable repetitive tests create extra income for providers. The lack of a common comprehensive patient record can lead to different physicians prescribing different drugs that have negative or even dangerous interactions with one another.

But few providers are affiliated with a system where it would be financially advantageous to write fewer prescriptions or order fewer tests. It is hard to see how a noncapitated hospital could justify an investment that reduced the number of tests the facility would perform. Most hospitals are more similar to auto repair shops that would face bankruptcy if cars never broke down—or were always fixed right on the first visit. From an economic perspective, more is better for most providers.

For more than three decades, policymakers have been trying to encourage Americans to join capitated plans that would have incentives to minimize costs. Offsetting this push is a fear that capitated plans would cut corners and compromise quality to keep their expenses down.

While various laws have been enacted to fuel the trend toward capitation, membership in capitated plans peaked in the late 1990s and has been declining since. The number of Americans enrolled in health maintenance organizations (HMOs) declined by more than 8 million between mid-1999 and mid-2003,²⁰ and more than 1.5 million of these were in the Medicare capitation programs. That represents a Medicare capitated enrollment decline of nearly 25 percent, much of which reflects the withdrawal of plans from the program.

There seems to be limited enthusiasm for capitation from both buyers and sellers, although there are significant regional disparities. Nearly half of Californians are in capitated plans, compared with about 30 percent of New Yorkers, 25 percent of Floridians, and just 11 percent of Texans. In each state, enrollment in capitated plans has declined in recent years.

Of course, traditional insurers paid a flat fee per insured employee confront similar logic, but they lack the direct control over providers that HMOs have. Various intermediate steps they have attempted to impose, including mandatory second opinions prior to surgery and using primary care physicians as gatekeepers, have typically failed to deliver anticipated savings, at least partly because of consumer backlash.

Many large employers self-insure as a cost-savings device (and as a way to lower regulatory costs), assuming the financial risk themselves while leaving administrative details to health insurers. But in self-insured plans, controlling cost increases is even more complex, and such efforts have led to such adverse consumer and political reactions that those attempting to use such techniques have backed off in recent years.

Consumer resentment apparently grows out of a belief that incentives to control costs will result in denial of needed care rather than creating a more efficient system. That's partly because providers that would be disadvantaged by such changes generally have closer relationships with patients than impersonal institutions such as insurance firms.

Selling the goal of health care efficiency is particularly challenging when the general population seems to believe that more care yields better results. Complaints are numerous about denial of care that is perceived as appropriate, while allegations of over-treatment are few. Both patients and providers believe that more is better.

“In the U.S., we still have a cottage industry that has poor coordination of care. Our paper-based system is increasingly nonviable...and hazardous to our health,” Crane said. “Not only is much of the paper that's created within a medical system not readable—and a review of any selected chart could underscore that—but the paper increasingly falls through the cracks.” He added: “Patients and

Medical “Quality” and Cost-Effectiveness

At the core of the current debate about the quest for medical cost-effectiveness and quality is a disagreement about which of the many stakeholders in the health care industry can best bring pressure to bear to achieve these results.

In a capitalistic system like the United States, there's a general belief that efficiency is best achieved by millions of decisions made by individual shoppers. Sellers that meet the demands of buyers thrive. Those who don't fail to survive. That's the discipline of the market.

A trend toward deregulation in recent years has tested this theory. Deregulation has been reasonably successful (at least from consumer and systemic perspectives), in the telecommunications and airline industries; in the energy sector, where deregulation is stalled at the moment, there's been more pain than progress.

Regardless of ideological perspectives, experience to date suggests that transformation is never an easy process, and mapping the transition in any industry is particularly challenging.

The nation's health care system is in a unique economic category for several different reasons, the most important being that today's consumers have never directly paid the bulk of the bills for services provided. Whether health care could—or should—be made to resemble more traditional economic markets is the topic of political and policy debate. In any event, it has been nearly a century since health care deviated from the economic mainstream.

For instance, the “product” in health care is hard to define, making comparisons to other sectors very difficult. Selecting a specialist or therapy or drug to deal with a potentially deadly disease is a very different decision than choosing a cell phone provider; product dissatisfaction is not the same.

In the past, Americans have often delegated these decisions to those believed to have greater expertise—physicians in the individual case, and institutions like insurance companies, unions, or human resources executives for larger populations. But these two classes of experts have different economic interests.

Today, many argue that the system would work better if patients were more involved in making their own decisions as consumers, as they are in other types of markets. Deregulation in many other industries, such as airlines, has shown that consumers are willing to shop to get the best possible deal. This trend has been fed by the ease of researching the competition by using Internet resources.

Despite these advances, it remains very difficult to determine how much medical services will cost in advance and, unlike airlines, health care providers don't seem interested in making sales by making price information readily available. Varying discounts are routinely given to large purchasers (such as insurance companies or federal programs like Medicare), and most patients are affiliated with a large purchaser.

Data on quality, where available at all, tend to be very dense and is not presented in a consumer-friendly format. The Internet is a two-edged sword, simultaneously making it easy for the general population to access large amounts of data while failing to make clear how to separate the trustworthy wheat from the commercial, frivolous, or even dangerous chaff.

Some evidence hints that the collection of quality data is beginning to affect the provision of health care—but not in the way imagined by analysts who thought such ratings would improve it: Physicians concerned about their ratings say they shy away from taking tough cases for fear that it will reduce their reported success rate (Santora, 2005).

The push for greater consumer choice and responsibility is real and growing. It has a certain resonance both among consumers (who see it as liberation from restrictive coverage rules), as well as insurers and employers (who view it as a cost-containment device). Those with a strong belief in market forces believe that both goals can be achieved simultaneously. Some would argue that the tax exclusion for employment-based health insurance should be repealed so that consumers would understand the full cost of what they are selecting. Others argue that individuals should be able to fully deduct the cost of health insurance in order to have treatment equal to that of employment-based plan participants, while still others advocate tax credits and refundable tax credits for individuals at low income levels to give them a better incentive than what is provided through employer or individual deductions.

But there's no plan on the horizon that would have the majority of consumers paying for the majority of their medical bills out of pocket. This means that intermediaries like insurers, employers—or both—will continue to play a large role in the health care system.

What would happen if a large number of consumers in health plans that required them to pay half of all costs elected to have procedures that the intermediaries were convinced were incredibly expensive and nearly useless? Allowing this would increase costs that health care managers are trying hard to control.

Consumers have exercised control over the health care system, but usually in a defensive fashion that impaired (rather than encouraged) movements toward efficiency. Strongly negative consumer reactions to managed care encouraged many proponents of this strategy to back off.

In the past, consumer control over the health care system has been more likely to involve politics than economics. Laws mandating specific benefits for Medicare beneficiaries (such as mammograms, or initial physicals for instance) or other types of health coverage (like mental health parity, or mandating the option of overnight hospital stays for maternity cases) have responded to consumer demand.

Consumers could have chosen, of course, to push for such standards via the marketplace rather than the political system. But using this strategy would have resulted directly in higher costs for them. Using the political system shifted much of the cost (at least temporarily) to others. That's probably why this technique had greater appeal to them—and it's another example of why health care is unlike any other market sector in the economy.

consumers of health care are asking legitimately why health care can't adopt some of the small changes that banking, retailing, and most other service-providers have adopted."

Part of the answer is because of a digital divide that splits the provider world into large organizations like Kaiser, the Veterans Administration, and the Mayo and other clinics that acknowledge the problems and are trying to respond to them (and can see the potential financial benefits of doing so) and smaller operators that lack the capital, expertise, and incentive to respond.

Those making reforms are convinced that efficiency results, although it is sometimes difficult to quantify. When Kaiser created a new system to summarize optimal ways to treat patients and avoid common mistakes, outpatient visits declined by 7 percent. In many noncapitated provider organizations, however, such a shift might be viewed as a problem rather than good news. And many analysts would immediately ask for evidence proving that the patient population is, at minimum, no sicker than it was before.

Crane acknowledged this tension: "A 7 percent reduction in outpatient visits within our system is a capturable benefit. But in the fee-for-service system, it's looked at with horror because it means 7 percent less income for fee-for-service physicians." The major challenge, he said, is dealing with the imbalance between those who have to spend the money to invest in these systems and those who get the benefit. Given the economic structure of the medical delivery system, not all providers benefit by eliminating unneeded tests.

Crane cited other goals in improving medical information technology, including:

- The need for a faster transfer of knowledge into practice. This is becoming particularly acute because of the explosion of research. It now takes a decade for new knowledge to be widely accepted by providers, regardless of the financial impact it will have on them.
- To assure that patients get optimal care. He cited research showing that barely half of care now provided to patients meets this goal.²¹

Some participants at the policy forum questioned whether it made sense for hospitals to adopt information technology systems before there was an agreed-upon universal standard that allowed the seamless electronic transmission of patient information from one facility to another. This provoked questions about whether today's antitrust laws would bar hospitals from talking with one another in an effort to achieve such standards.

The idea of providing medical services in the most efficient way possible has long been a top priority for those interested in health economics, but the primacy of this concept has never been accepted more broadly by the health care community. Clearly both dollars and lives could be saved if patients could be directed to the most appropriate therapies in optimal settings. Economic reasons for opposing this movement are mentioned above, but they are not the sole impediments. Some patients believe that the quality and quantity of care are linked. Certainly it is easier to measure the latter.

Defining an "appropriate therapy" or an "optimal setting" has proven to be a daunting if not overwhelming challenge. It is difficult and expensive to compile the information, which is constantly challenged by providers who, for various reasons, are determined not to appear on a list of those providing sub-optimal care.

One is reminded of the conclusion shared by tax reformers of all stripes who agree that it would be much easier to create an ideal tax system for a new society than to impose one on an existing system with many vested interests.

That is why there are many pressures in American society to provide care for sick people, but less enthusiasm for measures that would keep the well from getting sick in the first place. The first generates more revenue more directly than the second.

Evidence-Based Medicine: The Case of Prescription Drugs

For several reasons, much of the recent focus in defining "optimal care" and trying to control rising medical costs involves prescription drugs. With pharmaceutical firms increasingly advertising directly to patients, prescription drug decisions that were once made entirely by physicians now involve several

other players. For instance, whether a doctor chooses to prescribe a drug can be strongly determined by whether insurance plans include it in their formularies—the list of specified pharmaceuticals insurers agree to cover, based on price and efficacy. Formularies can be described as the prescription drug iteration of a preferred provider organization: Out-of-pocket payments are lower when an individual uses drugs that are in the formulary and are sharply higher when they are not. The new Medicare prescription drug program will also use formularies.

Mark Gibson, deputy director of the Center for Evidence-Based Policy (CEBP) at the Oregon Health and Science University, explained how a multistate group has sponsored research on the comparative effectiveness and safety of various drugs used for common conditions. The project began in Oregon in response to a projected two-year, 60 percent increase in Medicaid drug spending which the state's budget could not tolerate.

Other states and purchasing groups with an interest in obtaining high-quality comparative information on drugs they purchased joined the Oregon effort. They reasoned that comparing the effectiveness of drugs was the foundation for value purchasing: If the drugs were clinically equivalent, then they could demand price competition among manufacturers; if a drug was found superior, they could improve health by preferring the superior drug.

Key to the project was employing the emerging science of research synthesis and its principle product, the systematic review. Central to a systematic review is the process of finding all clinical evidence on a given subject, sifting through the evidence and eliminating poor-quality studies, then synthesizing the good-quality research into a cumulative analysis of what is known about the drugs involved. The research project began by examining four drug classes:

- Heartburn medications.
- Long-acting opioids (pain relievers).
- Cholesterol-lowering statins.
- Nonsteroidal anti-inflammatory drugs.

The group's research found insufficient evidence to favor any of the opioids. At first it concluded that only three statins had demonstrated true clinical outcomes (prevention of heart attack and stroke). As more research became available, it found that in some cases a given statin may be better for a given patient. No significant difference was found among heartburn remedies. As Gibson put it, "There's a reason that most gastroenterologists are more loyal to their shampoo than they are to a PPI [proton pump inhibitor, the technical designation for a heartburn relief drug]," Gibson said. "And that is because they're all basically the same."

The research on anti-inflammatory drugs, a class that includes the expensive and newly controversial Cox-2 inhibitor drugs like Celebrex and Vioxx, as well as older, cheaper generic drugs like ibuprofen, also found that there was no significant difference in reducing arthritis pain and stiffness, Gibson noted: Whether one selected a pill that cost less than a dime or more than a dollar, the result was the same—a finding that potentially could save a substantial amount of money.²²

While such research can be helpful to individuals making purchasing decisions, it also invites further discussion among those involved in benefit decisions—both labor and management—about the relative importance of price and efficacy in such decisions, Gibson noted. He also noted the potential benefit of similar research in the areas of medical devices and surgical procedures.

There's widespread interest in this type of research within the health policy community, and translating it into a format useful to consumers would seem key to the success of insurance approaches emphasizing consumer choice, Gibson said, but there is little such information available at present.

And there's little evidence to date that significant numbers of people will, on their own, access and be influenced by such medical efficacy information when it is available.²³ While many state programs restricted the use of Cox-2 inhibitors based on the CEBP's efficacy and safety findings (Oregon reported risks with Vioxx two years before additional information caused it to be removed from the market), outside of these programs the report had little impact. Even though some employers and

insurers have shown interest in the research, they have been hesitant to join the collaboration, Gibson said. He also noted that using research to determine the right treatment response to any given medical problem is a very different challenge than assuring that patients receive that treatment. And there are many significant factors—including sophisticated marketing and providers lacking sufficient decision support systems—that stand in the way.

Nevertheless, Gibson said Oregon's drug efficacy consortium was clearly successful, especially since participants could use the results to quickly save significantly more than the \$288,000 cost each state had to pay over the initial three-year commitment; by spending thousands of dollars, they could save millions—especially by implementing drug formularies for Medicaid patients, who are switched to an equally effective lower-cost alternative, and through vigorous price-based competition among manufacturers with similarly effective medications.

Bruce McPherson, executive director of the Alliance for Advancing Nonprofit Healthcare, stressed that “there is no free lunch in terms of trying to better control costs or improve quality,” adding: “It all requires very significant investments—investment for management, staff, and often physician time, investment of capital and other resources—often with the returns not necessarily clear nor within the timeframes for realizing those returns.” Real improvements usually require advances in information technology but also a complex re-engineering of administrative and clinical processes, as well as overcoming the inevitable institutional resistance to change.

McPherson stressed the value of nonprofit hospitals and health plans, noting that research literature has shown they are performing well on cost, quality, service, and access compared with their for-profit counterparts. This is particularly noteworthy, he mentioned, because of the nonprofits' greater burdens, such as providing greater access to care for the poor and uninsured, promoting health to the broader community, keeping up with technology changes, and modernizing aging facilities.

Discussion

Providing a rather bleak assessment of the day's debate, Jim Bentley, senior vice president for strategic policy planning for the American Hospital Association, made several key points:

- Public policy, regulation and even legislation by Congress have had little success in stemming the steady rise of health care costs. Instead, he argued, much of what is claimed as spending reductions are only reallocations to other sectors: “A lot of people who look at cost *control* are really just looking at cost *shifting*, from somebody to somebody else,” he said.
- By their very nature, health care costs inherently will increase on both the demand and supply sides, since “in our society we are not very successful about persuading people that they ought to accept suffering or disability.” Given the rapid rise of obesity in the United States, the fact that overall smoking rates have not declined so much as they have shifted (from the old to the young), the only way to genuinely reduce health care costs is to “think upstream” and “begin to work on healthier lifestyles, prevention, early detection.”
- Because so many employers are eliminating or reducing their health coverage benefits for retirees, the United States is about to witness “one of the largest offloadings of health care costs from [employer] books to the public-sector books, as the baby boomers move from employment to retirement.” It is a legitimate public policy question, he said, to ask: “Should that all accrue to the profitability and financial benefit of the private sector, or should the private sector as employers begin to do something to help the public sector afford that?”

Stephen Schoenbaum, executive vice-president for programs for the Commonwealth Fund, argued that intellectual leadership in health care comes largely from the not-for-profit academic health centers, and “they've not been in the vanguard for quality improvement, cost reduction, or efficiency.” He added: “We need the private-sector—particularly academic—health centers as our intellectual focus, to be proactive and not reactive.”

Others have observed, though, that academic health centers have had fiscal problems of their own in recent years. In many instances, medical schools have forced for financial reasons to sell the affiliated teaching hospitals they once owned, and the inherent nature of teaching hospitals does not mean they will benefit from the a more efficient health system; for instance, the fact that they engage in new medical research and feature cutting-edge technologies will inevitably drive up their operating costs.

Schoenbaum called for carefully selecting areas to reform in the health care system and rejection of superficially attractive and easy “solutions” that simply shift the problem rather than dealing with underlying causes. For instance, paying Medicare health providers less is a strategy that is both short-term and shortsighted, he suggested, and often merely convinces providers to charge other customers more. He asked “whether it is ethical for Medicare (or any other public program) to underpay for services and then force cross-subsidization to come from other payers, which is really a hidden tax on those other payers.” But with most hospitals and many physicians virtually locked into the Medicare program because of the large number of patients it provides, few can afford to not participate in it. He praised both pay for performance and disease management techniques as having significant potential to improve medical quality, but expressed doubt that either would have much impact on decreasing costs.

But Schoenbaum had a few new ideas of his own, starting with a proposal to make employers and residents in high-cost areas pay more taxes to support Medicare’s health services in the hope that they would react by putting pressure on providers to lower costs. He did not, though, cite any precedents where patients had succeeded in changing the behavior of providers to make health care more cost effective; however, his argument is consistent with the one made by many Republican reformers in Washington who are pushing for greater financial responsibility to be shifted to the users of a program’s services.

And Schoenbaum pointed out that it takes money to save money, which explains why it is difficult to free up funds for needed research at a time when government funds are in short supply and the uninsured population is growing. “We need to increase our R&D budget if we’re going to increase quality and decrease costs or improve efficiency,” he said.

Martin Sepulveda, vice president of Global Occupational Health Services and Health Benefits at IBM, argued that cultural changes in American society are making it more difficult to reform the nation’s health care system, partly because people are less willing to accept leadership from experts. “We are mankind’s model of capitalism and by definition that means that we have an infinite belief in the power of economic levers and we deploy them relentlessly,” he said. “Behavior has to change amongst all participants in the system, not just consumers, but payers and providers. Changing behavior requires varied and non-economic approaches and not just using economic levers. This is particularly true for patient consumers who are affected by a host of value and socio-cultural factors in healthcare decision making.”

Sepulveda expressed concern that over the past quarter-century, employers have gone from being “a trusted source of information to our employees to, despite our best efforts, not being a very trusted source of information anymore, and a lot of it has nothing to do with health care. It has to do with excesses and shortcomings of corporate America.” The regrettable result, he said, “there’s a limit to the impact that we’re going to be able to have in changing behaviors” since workers tend to distrust their employers, despite the fact that employers can be “a powerful lever for long-term sustainable change.”

Conclusion

One point that policy forum participants all seemed to agree on was that the quest for a better health care system is a process that has no end. The challenge lies in creating a climate where there is momentum to fuel the continuing quest for progress. Some critics argue that health care in America today is too fragmented to be fairly called a “system” at all, which is why it sometimes functions in seemingly irrational ways. Certainly, the problem of uncontrollable increases in health care costs—and

the inability to find a lasting solution—is not unique to the United States; nations in Western Europe with more centralized systems are facing similar cost pressures.

But as Bentley of the American Hospital Association concluded, trying to “fix” separate parts of the U.S. health care system, rather than approaching it as a whole, seems destined to failure. As research by EBRI and others have pointed out, there is an increasingly fuzzy line between “retirement” costs and “health” costs,²⁴ especially given the imminent retirement of the baby boom generation, the projected deficit for Social Security, and the more immediate unsustainable costs of Medicare.

“Where’s the money going to come from? In the end, it’s pretty simple: It’s going to come from the tax base in one sense or another; the people in the society are going to have to come up with the money,” Bentley said. “If there is a shell game going on here, we all ought to be concerned about it.”

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⁶ Because Medicare is the largest health insurance program in the nation, the annual budget decisions made by Congress inevitably cascade through the rest of the nation's health care system in several ways: If Medicare reduces anticipated reimbursement levels, providers accelerate their efforts to have other buyers pay more; if Medicare decides to pay for a procedure or treatment, that decision imposes immediate pressure on other insurers to do likewise. Private health insurers are affected either way.

⁷ The basis for Medicare hospital reimbursement rates is a calculation of what it should cost an efficient operator to perform a particular service. While there is continuing criticism about whether this number accurately reflects actual costs, the reality is that providers with abnormally high costs tend to lose money when dealing with Medicare patients.

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⁹ These figures represent total spending rather than price changes for a given item.

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