The Changing Health Care Delivery System
An EBRI/ERF Policy Forum

• “The health care delivery system is really a community-based activity, and local health care markets have become the arena, rather than the national markets.”
  —William Link, The Prudential Insurance Company of America

• “We’re concerned that if we overregulate what’s already been created in various markets, we will essentially recreate just a different form of what we’ve always had, which is health care providers complying with a set of rules put in place by people who don’t understand the delivery of care.”
  —Dan Leach, Lutheran Medical Center

• “Physicians basically want to do well. If we’re given good clinically credible data, the physicians will modify their behavior in a heartbeat, but the incentives have to be there.”
  —William Mohlenbrock, M.D., Iameter, Inc.

• “We always understand that every year our subscribers can choose some other plan. That is the important dynamic that keeps us working hard at trying to provide cost-effective care without irritating our subscribers.”
  —Harry Cain, Ph.D., Blue Cross and Blue Shield Association

• “Medical education should change in order to train physicians how to be gatekeepers. Not fiscal agents, but gatekeepers who are guides into a very complicated and intimidating health care delivery system.”
  —Cynthia Hosay, Ph.D., The Segal Company

• “It is critical that an independent watchdog maintain comparative cost and quality performance evaluations to keep alliances and health plans on their toes to best serve their memberships.”
  —Clark Kerr, Bank of America

• “While removing employers from the ‘loop’ is vastly preferable to requiring them to be in it, the ideal solution is to allow employers to participate or not as circumstances demand.”
  —William Dennis, National Federation of Independent Business

• “If anything comes out of health reform, the most important thing has to be the disclosure of information. Information about quality should be passed along to the people who use the programs that they provide.”
  —Charles Inlander, People’s Medical Society

• “If we are really concerned about improving health status and public health, then we need to think about integrated systems that look at chronic care, that take into account the role of prevention in public health as much as, or even more than, the need to integrate the acute care parts of the delivery system.”
  —John Rother, American Association of Retired Persons
As Congress and the state governments grapple with health care issues, the health care delivery system continues to undergo dramatic change. As a result of private initiatives and the promise/threat of comprehensive health care reform, the health care delivery system has been fundamentally restructured over the past few years.

The Employee Benefit Research Institute-Education and Research Fund held a policy forum on October 6, 1993 to examine the changing health care delivery system. This policy forum brought together government officials; corporate executives; insurers; physicians; hospital administrators; consumer advocates; and representatives from labor, academia, elderly, and research organizations to discuss the impact of changes in the health care delivery system from their respective perspectives.

This EBRI Special Report integrates the papers and proceedings of the policy forum into a single work. It is organized into three parts. First, EBRI Research Director Bill Custer provides an overview of the changing health care delivery system. Second, a Clinton administration spokesperson discusses the impact of the President’s proposal on the health care delivery system. Third, insurers, health care providers, employers, and consumers explore how the system has changed and how it will continue to change in the future from their own perspectives.

On behalf of EBRI and its Education and Research Fund, I wish to thank the policy forum speakers and participants for their substantial contributions to this report.

Dallas L. Salisbury
President
Employee Benefit Research Institute-Education and Research Fund

April 1994
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Kevin Anderson served as the White House spokesperson on health care at the time of the EBRI/ERF policy forum. Before joining the White House, he was consultant and editorial advisor to the Alliance for Health Reform. Prior to that, he was a senior writer for USA Today. There, he created the award-winning “Health & Money” beat—a continuing series of in-depth articles aimed at explaining the breakdown of the health care system and prospects for its reform in ways the average reader can understand. Anderson was a premedical student at Brown University and worked as a surgeon’s assistant after graduation until returning to graduate studies in history and political science and, ultimately, journalism. Since the policy forum, Mr. Anderson has left the White House to work as an independent consultant in health policy communications, and continues to serve the Clinton administration as an outside adviser.

Harry Cain, II, Ph.D., is senior vice president, business services, for the Blue Cross and Blue Shield Association. He joined Blue Cross/Blue Shield in 1982 as executive director, Office of Government Relations. Currently, Dr. Cain is responsible for four Blue Cross and Blue Shield Association divisions: Medicare, Federal Employee Programs, National Account Services, and Strategic Consulting Services. He received a B.A. from Stanford University, an M.A. from the University of Washington, and a Ph.D. from Brandeis University.

William Custer, Ph.D., is EBRI’s director of research and conducts research related to private health insurance, public health care financing, and health care costs. He has been with EBRI since 1988. Prior to that, Dr. Custer was with the Center for Health Policy Research at the American Medical Association and at Northern Illinois University. He received his Ph.D. from the University of Illinois at Urbana and his B.S. from the University of Minnesota.

Helen Darling is manager, Healthcare Strategy and Programs, for Xerox Corporation, with responsibility for developing the broad strategic directions of health programs, for continuing the implementation of the Xerox innovative health care strategy—called HealthLink—and for expanding managed care elements within the fee-for-service plan. Previously, Ms. Darling was principal in the health care practice of William M. Mercer’s Stamford, Connecticut office. In 1986–88, she served as the senior health policy and health benefits advisor to U.S. Senator David Durenberger (R-MN). During her career, she has also held high level positions at the Government Research Corporation, the Institute of Medicine of the National Academy of Sciences, U.S. Department of Health and Human Services, and Rhode Island Health Services Research. Ms. Darling has a Master’s degree in demography/sociology from Memphis State University and has done doctoral work in health administration at George Washington University.

William Dennis, Jr., is a senior research fellow at The National Federation of Independent Business (NFIB) Foundation in Washington, D.C. He has been affiliated with NFIB for 17 years, where he has written extensively on small business and public policy. His latest publication is A Small Business Primer.

David Hurd is chairman and chief executive officer for The Principal Financial Group. He also serves as chairman of the board of directors and chief executive officer of Principal Mutual Life Insurance Company, the parent company of a number of life subsidiaries. In addition, he currently serves as chairman of the Health Insurance Association of America and as a member of the board of the executive committee of the American Council of Life Insurance. He joined The Principal Financial Group in 1954 as a trainee assigned to the group department. He was elected an officer in 1960, vice president in 1971, senior vice president in 1985, president in 1987 and to his present position in July 1989. Mr. Hurd received his B.A. degree from Michigan State University.
Charles Inlander is president of the People’s Medical Society. As chief executive officer since its founding in early 1983, Mr. Inlander has guided the People’s Medical Society to its status as the largest consumer health advocacy organization in the country. Mr. Inlander is also a faculty lecturer at the Yale University School of Medicine. He is the co-author of many best-selling books including: Take This Book To The Hospital With You; Medicine On Trial; How To Evaluate And Select a Nursing Home; Medicare Made Easy; Your Medical Rights, Getting The Most For Your Medical Dollar; Take This Book To The Gynecologist With You; Take This Book To The Obstetrician With You; The People’s Medical Society Healthy Body Book, and Good Operations—Bad Operations. Mr. Inlander is a graduate of the American University in Washington, D.C.

Clark Kerr served as vice president, Government Relations, at Bank of America, at the time of the EBRI/ERF policy forum. In this role, he coordinated corporate policy development and advocacy for state and federal health care reform legislation. He is president of the California Business Group on Health and chairs the California Health Policy and Data Advisory Commission. Mr. Kerr is a commissioner on the Prospective Payment Assessment Commission (ProPac) and a member of the boards of directors of the Washington Business Group on Health and the National Committee for Quality Assurance. Since the policy forum, Mr. Kerr has taken a new position at HealthExcellence, a public benefit corporation, as vice president, Quality Improvement.

James Lane is a senior vice president of Kaiser Foundation Health Plan, Inc. and Kaiser Foundation Hospitals. He is the leader of Kaiser Permanente’s Health Care Reform Team, which is charged with leading Kaiser Permanente’s efforts to influence reform legislation. He also is a member of the Health Care Task Force of the California Business Roundtable. Before joining Kaiser Permanente, he worked for eight years with the California State Assembly in Sacramento. There he served as director of the Office of Research, coordinator of the Health and Welfare Committee, and a consultant for the Public Health Committee. He received his B.A. from the University of Northern Colorado and his J.D. from the University of the Pacific, McGeorge School of Law.

John Rother is director of the Legislation and Public Policy Division for the American Association of Retired Persons (AARP). He is responsible for AARP’s federal and state legislative advocacy activities and for the policy research and public education programs supporting that effort. Prior to coming to AARP, Mr. Rother served eight years in the U.S. Senate as Special Counsel for Labor and Health to former Senator Jacob Javits and as staff director and chief counsel for the Special Committee on Aging, under its chairman, the late Senator John Heinz. He is an honors graduate of Oberlin College and the University of Pennsylvania Law School, where he was editor of the Law Review.

Jerald Schenken, M.D., a pathologist in private practice from Omaha, Nebraska, was reelected to the AMA Board of Trustees and to its Executive Committee in June 1988. Until his election to the Board in June 1985, Dr. Schenken had served since 1978 as an alternate delegate to the AMA House of Delegates from the College of American Pathologists. He had been a member of the AMA’s Council of Legislation since 1981, serving as vice chairman in 1982–84 and as chairman in 1984. In 1980, he served as vice chairman of the Committee on Health Care and Service of the White House Conference on Aging. He has served on the U.S. Office of Technology Assessment Advisory Committee on Physician Reimbursement. He is a past president of the Metropolitan Omaha Medical Society. Dr. Schenken graduated from Tulane University School of Medicine.

Peter A. Wilson, Ph.D., is vice president for policy development at the American Hospital Association. Prior to joining the American Hospital Association, he was with the Michigan Hospital Association as senior vice
president, and before that was assistant professor and associate director of the Program in Hospital Administration at the University of Michigan. His research activity and publications have focused on community variations in the cost and use of hospital care. In 1988, he spent a year as consultant to the New Zealand government on the reform of national health planning objectives and processes. He received his Bachelor’s degree in chemistry from Lafayette College, a Master’s degree in hospital administration from the University of Michigan, and a Ph.D. in philosophy from Duke University.
I. Reforming the Health Care Delivery System
I. Reforming the Health Care Delivery System

By William S. Custer, Ph.D.,
Employee Benefit Research Institute

Introduction

The health care delivery system has been evolving rapidly in the last decade in response to health care cost inflation. Increasing health care costs have led both private and public purchasers of health care services to change their relationships with the health care services market. This in turn has affected the practice of medicine. Care has moved out of the hospital to a variety of sites, referral patterns of physicians have been affected, the relationship between hospitals and their medical staffs has been altered, and the way providers market themselves has changed due to changes in the way payers purchase health care services. A cost management industry has arisen composed of utilization review (UR) firms, provider networks, data analysis firms, and other vendors whose services track medical decision making and assess the quality of care.

Rising health care costs have resulted in an increasingly segmented health insurance market, leading fewer employers, especially small employers, to offer health insurance as an employee benefit and also resulting in an increase in the number of Americans without health insurance coverage. Changes in health care financing have limited providers’ ability to provide uncompensated care, limiting uninsured persons’ access to care.

The number of Americans without health insurance increased slowly through the 1980s, reaching 38.5 million individuals in 1992. The shift in the number of nonelderly individuals with employment-based health insurance has been more dramatic in recent years. Partly as a result of the recession beginning in 1990, 2 million fewer Americans had employment-based health insurance in 1990 than 1989. That event coincided with the rise in health care reform as an important political issue. While a number of proposals for reforming the health care delivery system had been advanced before the 1992 election campaign, none of them garnered enough support to suggest that they might be implemented. Since the election, the Clinton administration and congressional groups of both parties have advanced health care reform proposals that incorporate elements of managed competition models.

Managed competition is a model of health care reform that reorganizes the market for health care services. As a general concept, managed competition is appealing to a wide variety of groups because the level of government regulation can be built into any managed competition model. Thus, those who believe that the market for health care services can never work efficiently can design a model with a high degree of regulation, while other models can be designed with much less government regulation.

While health care reform will have important effects on the future evolution of the health care delivery system, the promise/threat of health care reform has already had an impact on the health care delivery system. Health care cost inflation has already set in motion forces that are moving the health care delivery system toward a more concentrated, more vertically integrated, system. The increasing likelihood that some type of health care reform proposal will be enacted has accelerated the evolution of the health care delivery system. It is widely believed that vertically integrated coordinated systems of care will be in the best position to compete in a managed competition system. As it has become more likely that a health care reform proposal will be enacted there has been a corresponding increase in the number of mergers and cooperative agreements among health care providers and health services organizations.

This paper examines the changes the health care delivery system has undergone in the past decade and discusses the elements of health care reform and their implications for the evolution of the health care delivery system.
The present system of financing health care services began with the spread of health insurance after World War II. Unlike other types of insurance, health insurance benefits are based on expenditures for health care services rather than on the actual loss due to a particular ailment. As a result, health insurance lowers the relative price of medical services to insured individuals, increasing patient demand for health care services (chart 1). This change in consumer behavior due to the presence of insurance is a form of "moral hazard." The increased demand for health care services due to moral hazard is one source of health care cost inflation.

The characteristics of provider reimbursement policies of private and public insurers have had important implications for the health care delivery system. Hospitals have been regarded as quasi-public institutions and as such were traditionally reimbursed on a cost-plus basis to ensure that they were able to maintain high quality services. However, reimbursement under fee-for-service for physicians or cost-plus systems for hospitals gives providers little incentive for limiting the potential range of diagnostic and therapeutic services available to a patient or to limit the quantity of services they provide. Increased health insurance coverage has raised the demand for medical services. All of these features of the health care delivery system have been cited as contributing to increasing costs.

The increasing demand for health care services has led to a corollary increase in the demand for new medical technology. Medical researchers, with financial assistance from the government and other sources, have responded impressively. The number of diagnostic tools a physician can employ on a given set of symptoms and the number of potential therapeutic procedures for a given diagnosis have increased dramatically in the last 25 years.

New technology lengthens the list of procedures a physician can perform for a given condition and increases the number of conditions a physician can treat, increasing the number of services purchased. Concurrently, as the supply of physicians increases, they tend to specialize, performing fewer types of procedures.¹

The sensitivity of the demand for health care services to changes in price is lessened by the spread of health insurance, which lowers the effective price of health care services to patients. Physicians have long considered price competition unethical. Providers have competed in quality or, more accurately, in quality

signals. Lacking the information necessary to evaluate the technical quality of care, patients look for signals they hope relate to technical quality such as location, office attributes, and the physician’s hospital affiliation. Hospitals compete with each other for physicians and patients by offering the ability to perform more procedures and to deliver more amenities. The cost of the more expensive new technology required to perform new procedures is often spread across all other procedures.

The result is that new technology is introduced with little or no evaluation of its benefits relative to costs. Providers adopt practices based on personal preferences, resulting in the well-documented variation in practice patterns among physicians practicing in the same geographic area. Patients and payers lack the information necessary to evaluate the quality of care they received before, during, or after an episode of illness. Medical researchers have had little or no incentive to assess the relative benefits of the procedures they developed; to be adopted new procedures did not have to be more effective or less expensive than existing procedures.

Medical research has produced a rapid expansion in treatment options without concurrent research on the relative efficacy of each option. This has prevented the formation of a medical consensus on the proper treatment of a given set of symptoms. Large variation in practice patterns has been documented among physicians practicing in the same geographic area. Many physicians see too few patients with any specific condition to evaluate the relative efficacy of competing treatments. The paucity of research on medical outcomes results in the practice of medicine as an art rather than a science and limits the ability of purchasers of health care services to differentiate among providers on the basis of quality.

Cost Management Strategies

The preceding discussion provides some of the reasons health care costs have risen so rapidly over the last 20 years. Private health plans and public programs have been evolving rapidly in the last decade in response to health care cost inflation. The reaction of employers to increases in health care costs has varied depending on the labor market they face, the amount of competition in their product market, and their level of market power in their specific health care services markets. In general, employers have adopted four types of cost management strategies: cost sharing, UR, packaging provider services, and selectively contracting with providers. These strategies have been combined in the various managed care plans employed by many employers.

Cost sharing is effective in reducing health care expenditures by reducing the utilization of health care services. For example, the Rand Health Insurance experiment found that individuals in plans with a 25 percent coinsurance rate had 15 percent lower per capita costs than individuals in plans with a zero coinsurance rate. Cost sharing is most effective in reducing the use of outpatient care. However, some of the care forgone may include preventive care, the lack of which may result in larger inpatient costs. The Rand study found that low-income individuals with lower coinsurance rates experienced specific health gains for three prevalent chronic problems—high blood pressure, myopia, and dental care—that are relatively inexpensive to diagnose and treat.

UR includes a number of strategies for intervening in the decision to purchase health care. These may include pre-admission certification, in which care is reviewed before it is given to determine its appropriateness; concurrent review, or case management, in which

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3 Donald R. Cohodes and Brian M. Kinkead, Hospital Capital Formation in the 1980s (Baltimore, MD: The Johns Hopkins University Press, 1984).
care is monitored as it is provided; and retrospective review, which reviews care after it is given. In all cases, care is reviewed against criteria to determine if it is necessary and appropriate. These criteria are either developed by UR firms internally or are licensed from outside sources and modified by the firms.

Another strategy for managing health care costs attempts to steer patients to cost-effective providers. Plan design elements that reward patients for choosing cost-effective sites of care, for example, ambulatory surgery provisions, and preferred provider organizations (PPOs). Although the actual structure of PPOs differs greatly, in theory PPOs combine three broad cost management strategies: a limited panel of providers, negotiated fee schedules, and UR.

Finally, many employers offer employees a choice of an indemnity plan and a health maintenance organization (HMO). Depending upon the HMO, total costs for enrollees have been found to vary between 1.4 percent and 31.8 percent lower than more traditional health insurance programs (table 1). These costs differences result from lower rates of service, especially lower hospital admission rates.6

There are a number of HMO models, but they generally fall into two categories: group (or staff) models and independent practice arrangements (IPAs) or network models. In group models the physician is either an employee of, or receives a majority of his/her patients from, the HMO. In an IPA model, the HMO contracts with physicians or physician groups who also maintain a fee-for-service practice. Physicians in IPAs are typically reimbursed on a blended fee-for-service/capitation basis. Although IPAs have been the fastest growing HMO model, the research literature has generally focused on the older, more established, HMOs, which are more likely to be group or staff models. However, the few studies of IPAs that have been done suggest that these HMOs have more admissions per thousand members and thus are less effective in constraining costs.7

Some employers offering an HMO option in addition to an indemnity plan have claimed that employees who represent lower risk opt for the HMO, while higher-cost patients remain in the comprehensive plan, resulting in higher overall health care costs. Buchanan and Cretin found that families selecting HMOs were younger, had lower income, and had lower claimed health care expenses before enrollment than families selecting a fee-for-service plan.8 Studying the impact of various benefit options on premiums, Jensen and Morrisey found that a group health plan offering an HMO option had significantly higher premiums for its fee-for-service plan.9

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Finally, two widely cited studies using data from the late 1970s or early 1980s have found that the rate of cost inflation is the same for HMOs as it is for more traditional insurance plans. The authors of one of these studies argue that this result indicates that HMOs must adopt new technology at the same rate as the fee-for-service plans. One possible explanation of this result may be that the information necessary to evaluate the cost effectiveness of a new procedure is simply not available, even to providers with a clear financial incentive to adopt cost reducing techniques. Another possibility is that maintaining the HMOs’ market share in competition with fee-for-service care requires the adoption of the same types of practices. Conversely, recent surveys of employers found that HMO premiums increases have been about 5 percentage points lower than indemnity plan premium increases (table 2).

The enrollment in HMOs of all types has increased from 9.1 million Americans in 1980 to 37.2 in 1992 (table 3). This increase in market penetration by HMOs has not been evenly distributed. HMOs have not been established in rural areas, in large part because these areas lack the population size necessary to maintain an independent health plan. The market penetration of HMOs also differs considerably by region. Almost 30 percent of Californians were enrolled in an HMO in 1989 and just under 24 percent of the residents of Massachusetts, but only 10.6 percent of Floridians and 7 percent of Texans (table 4). In less populous states the percentage of residents enrolled in HMOs was even smaller, with less than 1 percent of the citizens of Alaska, Montana, and Wyoming.

The need to evaluate providers for selective contracting and to evaluate care as it is being provided has led to the development of a health information industry. This industry supplies providers, insurers, employers, and consumers with information on the quality, appropriateness, and cost effectiveness of the care they are producing or consuming.

Table 2
Average Annual Increase in Employment-Based Health Benefit Costs per Employee

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<tbody>
<tr>
<td>Total Plans</td>
<td>16.7%</td>
<td>17.1%</td>
<td>12.1%</td>
<td>10.1%</td>
</tr>
<tr>
<td>Traditional Indemnity</td>
<td>20.4</td>
<td>21.5</td>
<td>13.0</td>
<td>14.2</td>
</tr>
<tr>
<td>HMO</td>
<td>16.5</td>
<td>15.7</td>
<td>13.5</td>
<td>8.8</td>
</tr>
</tbody>
</table>


New health care plans have been developed that combine attributes of PPOs and HMOs with UR and objective performance criteria for selecting providers. One of the most important features of the selectively contracted networks is the criteria used to identify providers for inclusion in the network. Most networks require that providers agree to accept UR procedures, refer patients only to other providers in the network, and accept the network’s reimbursement procedures. The networks also have quality standards, such as board certification, that the provider needs to meet in order to be considered for participation. Finally, providers’ practice patterns may be monitored while they are in the network to identify and remove providers with unjustifiably high costs.

Objective information on the quality of care is being used by some employer plans to identify providers for selectively contracting. Employers are contracting with specific hospitals for high cost procedures such as open heart surgeries and transplants and are using a number of criteria, including mortality and morbidity rates, to select hospitals. In selectively contracting on the basis of these criteria, employers are explicitly using outcome measures for determining reimbursement.

Managed care networks typically employ medical directors who develop or implement treatment protocols. These protocols determine the practice patterns of physicians employed or under contract with the network. Many of these new networks and network models of HMOs also employ primary care physicians to act as gatekeepers to manage health care costs. These gatekeeper physicians provide primary care for insured patients and control their access to specialists and sometimes to hospital care. A number of different financial arrangements have been developed between networks and gatekeeper physicians. Under some of

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these arrangements, the gatekeeper bears some of the risks. For example, the gatekeeper might be reimbursed on a capitated basis. As a result, the gatekeeper physician has a financial incentive to manage the patients’ care as cost effectively as possible. Gatekeepers thus have an incentive to limit patients’ access to specialists and other expensive health care services.

Changes in the Medicare Program

The federal government’s efforts at controlling costs in the Medicare program has differed greatly from efforts by private payers. The Medicare program instituted the prospective payment system (PPS) for reimbursing hospitals in 1983 and began reimbursing physicians using a relative value fee schedule in 1992. Prior to the 1983 Social Security Amendments, Medicare paid hospitals retrospectively on a cost basis. That is, a hospital’s reimbursement rate was determined by its historic costs. PPS represented a fundamentally different method for reimbursing hospitals than was commonly used by either public or private payers. The prospective payment system hospitals moved from being reimbursed per day based on the hospital’s historic costs to being reimbursed per admission at a prospectively determined rate. Thus, the incentives that Medicare’s reimbursement methodology presented hospitals changed in two distinct dimensions.

The change from a reimbursement rate based on the individual hospitals’ historic costs meant that hospitals could no longer influence future reimbursement rates by incurring higher costs in the present. PPS thus removed one disincentive for hospitals to restrain their costs of provided health care services.

The second dimension along which PPS changed hospital incentives was the bundling of the services provided a patient during a single admission. Historically, cost-based, per diem reimbursement provided hospitals with a financial incentive to lengthen the length of stay of Medicare patients and to provide more services per stay. Conversely, under PPS hospitals have
### Table 4
Health Maintenance Organization (HMO) Enrollment by State

**Combined Pure and Open-Ended Enrollment in HMOs, by State, July 1991 and July 1992**

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Total United States</td>
<td>36,482,090</td>
<td>14.7</td>
<td>38,841,693</td>
<td>15.2%</td>
</tr>
<tr>
<td>Alabama</td>
<td>240,361</td>
<td>5.9</td>
<td>217,314</td>
<td>5.3</td>
</tr>
<tr>
<td>Alaska</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Arkansas</td>
<td>63,073</td>
<td>2.7</td>
<td>65,574</td>
<td>2.7</td>
</tr>
<tr>
<td>California</td>
<td>9,394,346</td>
<td>31.6</td>
<td>9,769,031</td>
<td>31.6</td>
</tr>
<tr>
<td>Colorado</td>
<td>698,634</td>
<td>21.2</td>
<td>740,994</td>
<td>21.4</td>
</tr>
<tr>
<td>Connecticut</td>
<td>658,703</td>
<td>20.0</td>
<td>652,270</td>
<td>19.9</td>
</tr>
<tr>
<td>Delaware</td>
<td>122,440</td>
<td>18.4</td>
<td>115,476</td>
<td>16.8</td>
</tr>
<tr>
<td>District of Columbia</td>
<td>477,539</td>
<td>e</td>
<td>488,594</td>
<td>e</td>
</tr>
<tr>
<td>Florida</td>
<td>1,562,398</td>
<td>12.1</td>
<td>1,819,577</td>
<td>13.5</td>
</tr>
<tr>
<td>Georgia</td>
<td>383,543</td>
<td>5.9</td>
<td>378,685</td>
<td>5.6</td>
</tr>
<tr>
<td>Guam</td>
<td>39,789</td>
<td>e</td>
<td>74,137</td>
<td>e</td>
</tr>
<tr>
<td>Hawaii</td>
<td>253,072</td>
<td>22.8</td>
<td>259,671</td>
<td>22.4</td>
</tr>
<tr>
<td>Idaho</td>
<td>20,351</td>
<td>2.0</td>
<td>20,351</td>
<td>1.9</td>
</tr>
<tr>
<td>Illinois</td>
<td>1,486,422</td>
<td>13.0</td>
<td>1,716,593</td>
<td>14.8</td>
</tr>
<tr>
<td>Indiana</td>
<td>339,735</td>
<td>6.1</td>
<td>359,313</td>
<td>6.3</td>
</tr>
<tr>
<td>Iowa</td>
<td>282,937</td>
<td>10.2</td>
<td>107,178</td>
<td>3.8</td>
</tr>
<tr>
<td>Kansas</td>
<td>182,734</td>
<td>7.4</td>
<td>165,444</td>
<td>6.6</td>
</tr>
<tr>
<td>Kentucky</td>
<td>300,952</td>
<td>8.2</td>
<td>248,955</td>
<td>6.6</td>
</tr>
<tr>
<td>Louisiana</td>
<td>264,757</td>
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<td>Wyoming</td>
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<td>0</td>
<td>0</td>
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</tbody>
</table>

(continued)
In fact, a number of studies have found that PPS reduced both the average length of stay per admission and the number of admissions. Findings of a recent study by Schwartz and Mendelson, for example, indicate that the PPS may be responsible for a reduction in the average number of inpatient hospital days between 1981 and 1988. The cumulative reduction was 28.1 percent. The study also found that PPS is responsible for reducing the number of inpatient admissions. Between 1981 and 1988, the cumulative percentage decrease was 23.6 percent. Other studies indicate that there has not been a concurrent reduction in the quality of care provided to Medicare patients. While PPS reduced the rate of increase in Medicare Part A costs, it may have increased the rate of growth in Part B costs.

Growing concern about increases in physician service expenditures, exacerbated by the shift from outpatient care to inpatient care due to the advent of PPS in Medicare Part A, resulted in legislation in the Omnibus Budget Reconciliation Act of 1989 (OBRA ’89) to change Medicare’s methodology for reimbursing physicians. In 1992, Medicare began reimbursing physicians using a resource-based relative value scale (RBRVS), which is an index of the resources necessary to provide a given medical service. The relative value scale used in determining reimbursement is based on research performed at Harvard Medical School. Like the PPS for hospitals, RBRVS makes physician reimbursement prospectively determined. It removes incentives for physicians to charge higher fees this year in hopes of achieving higher reimbursement levels next year. Unlike PPS, the new physician reimbursement methodology does not bundle services. Physicians are still reimbursed on a fee-for-service basis. The financial incentive to provide as many possible services within each episode of care remains.

The Market for Health Care Services

The efforts of private and public payers to manage their health care costs has affected the insurance markets, the market for hospital services, physician practice arrangements, and treatment patterns. The growth of enrollment in staff and group model HMOs in the early 1980s and the development of UR techniques set the stage for the evolution of managed care plans that combined some of the reimbursement features of HMOs with selective contracting, gatekeepers, and treatment protocols. These developments have resulted in changes in the marketing strategies of hospitals, consolidation of hospitals and sharing of equipment, changes in hospital-medical staff relationships, rise of physician groups-demise of solo practitioners, and changes in career path of young physicians.

Hospital care accounted for 38.4 percent of the nation’s health expenditures in 1991. That is a decrease from the almost 41 percent of national health expenditures devoted to hospital care in 1980. Hospitals have

I. Reforming the Health Care Delivery System

Table 4 (continued)

<table>
<thead>
<tr>
<th>Health Maintenance Organization (HMO) Enrollment by State</th>
</tr>
</thead>
</table>


aPure HMO members include all categories of prepaid membership (employer groups; individual, direct-pay, members; Medicare; Medicaid; and Federal Employee Health Benefits Program (FEHBP). Pure enrollment figures reflect the number of “covered lives”; covered dependents are included in these data. Self-insured enrollees are not included in these data. Open-ended members meet all of the requirements of pure members, but enrollees have the option of self-referring to providers outside of the HMO network at any time (at point of service).
bThe District of Columbia has been excluded from the state ranking due to the cross-state nature of its enrollment. Guam has also been excluded. However, enrollment for both D.C. and Guam remain in the U.S. total enrollment figure.
cApril 1, 1990 population figures provided by the U.S. Department of Commerce, Bureau of the Census. HMO enrollment represents July 1, 1991 data.
dJuly 1, 1992 population figure provided by the U.S. Department of Commerce, Bureau of the Census. HMO enrollment represents July 1, 1992 data.
eData not available.

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12 The actual reduction in the number of inpatient hospital days was 18.6 percent. The cumulative reduction in the average number of inpatient hospital days refers to the difference between current levels and the levels that would be occurring without the PPS. See William B. Schwartz and Daniel Mendelson, “Hospital Cost Containment in the 1980s: Hard Lessons Learned and Prospects for the 1990s,” New England Journal of Medicine (April 11, 1991): 1037–1042.

13 The actual reduction in the number of inpatient hospital admissions was reduced by 13.4 percent. The cumulative reduction in the average number of inpatient hospital days refers to the difference between current levels and the levels that would be occurring without the PPS. See K.L. Kahn et al., “Comparing Outcomes of Care Before and After Implementation of the DRG-based Prospective Payment System,” Journal of the American Medical Association (October 19, 1990); 1984–1988.
generally competed with one another for physicians (and the patients they admit) on the basis of quality signals. These quality signals included the range of services or technologies available at the hospital. Hospitals thus have an incentive to invest in new technologies as they are introduced, to create overcapacity, to provide instant access to care, and to create amenities that are attractive to patients and physicians. As a result, 36 percent of hospitals with more than 200 beds have magnetic resonance imaging and 86 percent have CT scanners—expensive technology that in many cases is underutilized.

Changes in the reimbursement methodologies used by public and private payers have altered the incentives for hospitals to invest in new technologies, reduced their ability to subsidize uncompensated care, and changed the relationship between hospitals and physicians. Changes in reimbursement have lowered hospital operating margins and reduced their ability to finance the purchase of new technologies. Concurrently, many hospitals faced with prospective payment from public payers and selective contracting by private payers are attempting to restrict access to their services by the uninsured and place limits on their medical staffs’ treatment patterns. Physicians, partly in response, are giving more care on an outpatient basis and are treating patients they have admitted to the hospital more intensely.

The number of hospitals decreased by 8 percent between 1981 and 1991, while the number of admissions fell by 14.7 percent and the number of inpatient days fell by 20 percent in the same period. During that same time period, the number of outpatient visits at the hospital alone increased by 58 percent. This increase does not include utilization in physician offices, independent surgery centers, and other facilities that also experienced an increase in utilization during this period.

Hospitals have been confronted by employers and insurers seeking to selectively contract, competition from managed care plans, changing public plan reimbursement methodologies, and changes in technology that permit care to be moved to outpatient settings. As a result, they have had to change the way they market their services.

Hospitals rely on their medical staffs to provide patients and determine the volume of hospital services they will purchase. Both hospitals and physicians supply inputs to the production of hospital services. Yet the relationship between hospitals and their medical staffs is complex and not usually determined by an explicit market relationship. As the health care delivery system has evolved, the relationship between hospitals and their medical staffs has changed as well.

Changes in the health care delivery system have also changed the physicians’ practice arrangements. The percentage of physicians in groups increased from 26 percent of physicians in 1980 to 32.6 percent in 1991. The size of the groups also increased, from an average of 8.2 full-time equivalent physicians per group in 1980 to 11.5 in 1991. The number of employed physicians increased from 426,000 to 575,000 during this period.

Pharmaceutical and medical technology companies have begun to change both the content of their marketing materials and their targets. Historically, they have marketed their prescription products to physicians on the basis of efficacy. Increasingly, their marketing efforts are based on the cost effectiveness of treatment, and these efforts are often targeted toward medical directors of managed care networks.

The evolution of the health care delivery system led to the creation of relatively concentrated organizations. The threat/promise of health care reform has accelerated the trend toward vertical integration in the health care delivery system. Recent mergers in the pharmaceutical industry and the hospital industry demonstrate the desire of many stakeholders in the health care to position themselves for health care reform.
President Clinton has developed a health care reform model based on managed competition. The proposal would move the health insurance market toward community rating, mandate that all employers contribute to their employees' health coverage, change the tax code, and impose some budget controls on the health care delivery system. The basic element of managed competition is the creation of sponsors who act as collective purchasing agents for large groups of individuals. These sponsors negotiate with insurers or health plans and then offer their subscribers a menu of choices among different insurance plans, with information on each plan's quality of care and price. Managed competition is intended to shift the market for health insurance from competition based on risk to price competition. As a result, competition in the health care services markets will also theoretically move toward price competition.

Given the lack of consensus on the part of Congress, the stakeholders, the general public, or even within the Clinton administration, on the best design of a health reform proposal, it seems unlikely that the President's proposal will be enacted without considerable change. Following is a discussion of the various elements of health care reform and some of their effects on the health care delivery system.

Insurance Reform

Small groups often face higher costs per participant because of their higher per capita administrative cost and insurance companies' limited ability to pool risks. By removing barriers that prevent insurers from pooling small groups, employment-based coverage may expand to include many of the employed uninsured in small firms and their dependents (who constitute 39 percent of the nonelderly uninsured).

Although there are significant differences among small group reform proposals, there is agreement on some basic principles: small groups should be guaranteed access to insurance, restrictions on preexisting conditions should be limited, new restrictions should not be imposed when individuals change jobs or when groups change insurers, coverage should not be canceled because of high utilization of services, insurers should be required to offer coverage to all small groups (if they offer insurance to any), premium rates should be stabilized, and policies should be renewable (except for reasonable cause such as nonpayment of premiums).

Most proposals include some means for guaranteeing that all small groups have access to insurance and are not denied coverage based on individual characteristics. However, proponents of insurance market reform recognize that guaranteed availability alone accomplishes little unless premium rates for small groups are stabilized. Without some limits, insurers could use rating practices to raise the cost of coverage for riskier groups until the price becomes so high that these groups choose not to purchase insurance. Some proponents suggest moving toward community rating so that insurance would be offered to all small groups at fixed rates. Others would allow insurers to adjust community rates for factors such as age, sex, geographic location, and industry type (class rating). Generally, proposals would limit medical underwriting and restrictions on preexisting conditions.

Implications—It is generally accepted that moving to a community-rated insurance market will reduce the number of insurers in the market because of the need to create larger risk pools. In order to remain viable in a community-rated market, an insurer must have a sufficient market share to insure that enough good risks are in the pool to make the costs of the coverage affordable. The result is likely to be fewer insurers in any given...
market, with each remaining insurer commanding a significant market share. Fewer insurers in more concentrated markets may increase the speed with which managed care networks are introduced and increase leverage of the payer over provider behavior.

Managed Competition

Under managed competition, the health insurance market would be altered by the substitution of the sponsor as a knowledgeable negotiator with health insurance plans in the place of individual consumers or employee benefit managers. The sponsor would represent a group of consumers, whether they be the employees or dependents of employees of large employers or all individuals in a geographic area. Insurers would be required to accept any individuals who purchase health coverage through the sponsor. In theory, the health insurance market would be fundamentally changed under managed competition in that insurers could no longer attempt to avoid poorer risks and would need to find ways to control the costs of providing care.

Individuals under managed competition would be offered a menu of choices of health plans and given price and quality of care information for each plan. Theoretically, they could then choose the plan whose price and quality combination most suited their preferences. Such a choice requires that insurance policies be standardized to facilitate consumer choice, consumers be given a financial stake in their choice, and quality measures be developed that consumers can use to make choices.

The Clinton administration’s proposal creates health care alliances, which are either public or quasi-public entities (which will be determined by the state), or are employers with more than 5,000 employees. These alliances are required to offer at least three choices of insurance plans, with one of the choices being a fee-for-service plan. Each of these plans is required to offer a standard benefit package (see table 5).

Implications—The creation of a health alliance or sponsor changes the way health insurance plans are marketed. The alliance presents consumers with prices of standardized health plans and measures of quality of care and patient satisfaction. Insurance plans will thus compete on the basis of costs and those quality measures. The insurers’ increased market power in the health care services market will force providers to alter treatment patterns to conform to the insurers’ desire to attract patients on both the cost and quality dimensions. It seems likely that one result of these pressures will be lower real physician incomes, at least for some specialties.

The net effect on the health care delivery system will depend on the measures of quality used to evaluate plans and on relative values consumers place on these measures. If consumers value unlimited choice of providers, the ability of insurers to affect the health care services market may be constrained. While this may be an important factor in some markets, the growth of HMOs and managed care networks implies that consumers are willing to make some tradeoff between costs and choice. The need to assess the quality of care may hasten the development of quality assessment tools. The use of these quality assessment tools may standardize the practice of medicine, resulting in higher quality, lower cost care.

The regulation of quality assessment techniques may also limit the ways that the quality of care is evaluated. These measures once put in place may be difficult to amend or replace. The measures of quality actually employed in the health care system will determine in large part the incentives faced by insurers, providers, and consumers. Once a definition of quality is developed, health plans will be required to provide the alliance with specific information that will be used to ascertain the quality of care, and the plans will then compete along the dimensions of quality defined by the system. To the degree that they are inaccurate or inadequate, lower quality care may be mandated into the system.
### Table 5 (continued)

Overview of the Clinton Administration’s Health Care Proposal

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<thead>
<tr>
<th>Low Cost Sharing Plan</th>
<th>High Cost Sharing Plan</th>
<th>Combination Cost Sharing Plan</th>
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<tr>
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<td><strong>Limitations</strong></td>
<td><strong>Cost Sharing</strong></td>
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<td>Rem. in 2001 restoration</td>
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<td>Removal of age limit on prevention</td>
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<tr>
<td>Orthodontia</td>
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<tr>
<td><strong>Prescription Drugs</strong></td>
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<td>$250 per year deductible; 20% coinsurance; out-of-pocket maximum applies</td>
</tr>
<tr>
<td><strong>Mental Health/Substance Abuse</strong></td>
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</tr>
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<td>Initial inpatient services</td>
<td>Full coverage</td>
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<tr>
<td>Hospital alternatives&lt;sup&gt;a&lt;/sup&gt;</td>
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<td>Brief office visits for medical management</td>
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<tr>
<td>Psychotherapy</td>
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<tr>
<td>Rem. in 2001 inpatient services</td>
<td>Full coverage</td>
<td>20% coinsurance; out-of-pocket maximum applies</td>
</tr>
<tr>
<td>Hospital alternatives&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Full coverage</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>Outpatient including psychotherapy visits</td>
<td>$10 per visit (1–12)</td>
<td>20% coinsurance</td>
</tr>
</tbody>
</table>

**Source:** Employee Benefit Research Institute compilation from the unpublished draft of the Clinton administration’s health care reform proposal.

<sup>a</sup>Intensive nonresidential treatment services, including partial hospitalization, day treatment, psychiatric rehabilitation, ambulatory detoxification, home-based services, and behavioral aid services.
Universal Coverage

The Clinton plan mandates that all employers contribute to their employees' health insurance coverage, and that all individuals purchase coverage. It requires that all Americans not covered by Medicare purchase coverage through either one of the regional health alliances or an employer health alliance (which the employer can form only if it employs more than 5,000 individuals).

Implications—This requirement clearly redistributes income in the financing of health care services in two ways. First, employers who do not now offer health insurance coverage and individuals who do not now purchase health insurance would be required to contribute. Second, the move to community rating and inclusion in the insurance risk pools of individuals now excluded from the insurance market due to poor health or low income means that the cost of insurance would change for most Americans.

Universal coverage would also redistribute income on the provider side. The currently uninsured, those covered by the Medicaid program, and those with employment-based health insurance coverage would all present similar financial incentives for treatment to providers. Providers would no longer have an incentive, or the ability, to price discriminate across different payer groups.

Universal access would obviously increase the demand for health care services, although the degree to which that would occur is unclear. Currently, the studies have found that the uninsured use on average between 63 percent to 73 percent of physician services and 31 percent to 81 percent of the inpatient hospital resources used by privately insured individuals. A number of studies have estimated that providing universal coverage would increase the amount of money in the health care delivery system by between $40 billion and $60 billion annually.

Budget Caps

The Clinton health plan caps the amount of money going into the health care delivery system in two ways. First, there is a limit on the amount that individuals and employers would pay for health insurance. This limit is set at 7.9 percent of payroll for employers. Employed individuals and families would pay 20 percent of the premium, while nonworkers and self-employed individuals would pay the full premium. The cap on employer contributions would significantly decrease the amount of money going into the system. Currently, employers contributions average over 10 percent of payroll.

Second, the proposal would cap insurance premium growth over the base projected premium to the growth in consumer prices. It seems unlikely that health care costs would not grow faster than consumer prices in the near term for several reasons, and if the base premium is estimated without taking into account the new populations being insured and the new community-rating system, insurance premium growth may exceed the cap in the first or second year of implementation. Once the premium cap is exceeded, insurance premiums would be rolled back to the level of the cap.

Implications—The intent of the budget cap is to force insurers to manage health care costs. Given that price would no longer be a factor for competition, health plans would need to find a way to lower costs without reducing the quality of care in such a way as to reduce the number of individuals desiring to enroll in the plan. Alain Enthoven has suggested that global budgets would rob managed competition of its major cost management feature: price competition. Since the intention of managed competition was to develop a mechanism that would allow the market for health care services to operate efficiently, imposing price controls on that market means that the market would not determine the

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allocation of health care resources.

The reduction of resources flowing into the health care system would inevitably reduce the amount of capacity in the system. In the short run, the excess capacity of the U.S. health care system would probably mitigate some of the adverse affects on the quality of care that many analysts have suggested would be the result of binding budget caps. Budget caps would also slow the introduction of new technology. Again, there may be benefits to society if the new technology that is not introduced is of small marginal benefit.

It seems likely that budget caps of this type would lower the incomes of workers in the health services industry. One of the results of the wage and price controls imposed by the Nixon administration was a decrease in the real wages paid to hospital workers. It seems likely again that physicians and other professionals would also see their incomes decrease.

The net effect of a budget cap on the quality of care would depend critically on the measures of quality used by the alliances to assess care within the plans. If these measures do not adequately capture some dimensions of quality, then restricting the amount of resources that flow into the health care delivery system is likely to reduce quality of care along those dimensions. If the measures capture all relevant dimensions of quality competition among health plans for enrollees, they may prevent a reduction in the quality of care. Many areas of the country would not have an adequate population to support competition among health plans, however. In those areas, regulatory oversight would be necessary to assure that quality does not erode as a result of budget caps.

The health care delivery system is evolving rapidly. There have been changes in the way health care is financed, the types of treatments available, the sites of care, and the physician patient relationship. These changes have resulted primarily from reactions to health care cost inflation.

Health care reform is likely to accelerate some of these changes. The threat/promise of health care reform has already accelerated the consolidation of the health care services market. Health care reform is likely to reduce the number of insurers, increase the number of Americans in managed health care plans, increase the number of physicians in group practice, change provider income, and in general make the health care delivery system more concentrated and vertically integrated.

Summary & Conclusions

The health care delivery system is evolving rapidly. There have been changes in the way health care is financed, the types of treatments available, the sites of care, and the physician patient relationship. These changes have resulted primarily from reactions to health care cost inflation.

Health care reform is likely to accelerate some of these changes. The threat/promise of health care reform has already accelerated the consolidation of the health care services market. Health care reform is likely to reduce the number of insurers, increase the number of Americans in managed health care plans, increase the number of physicians in group practice, change provider income, and in general make the health care delivery system more concentrated and vertically integrated.
II. President Clinton’s Proposal and the Impact on the Health Care Delivery System
II. President Clinton’s Proposal and the Impact on the Health Care Delivery System

By Kevin Anderson, 
The White House1

Introduction

I would like to share with you the common points of the Clinton administration’s vision regarding the delivery system and how we think it will evolve under the President’s proposal.

This is a very appropriate conference because most of the attention has been focused on financing and the problems of costs and access. Delivery system reform is an issue that most Americans are not really in touch with.

Let me describe four broad changes in the delivery system for which we have specific policies and then give a brief sketch of the local health plan market and how we see the typical urban/metropolitan alliance and its participating health plans operating, as well as some of the differences between the proposed system and managed competition as it exists now.

Gathering and Dissemination of Medical Data

One of our proposal’s most important innovations is a sort of national circulatory system that gathers outcomes data and systematic evaluation and disseminates this information to the practitioner. I have heard Mark Pauly at Wharton liken where we stand today in terms of knowledge of health services and health systems, and the crucial question of what consistently works and what does not work in medicine, to where we were in biomedical research around the turn of the century. We have learned something, but we have a very long way to go.

The alliance’s purpose in gathering clinical data would be not only for use in quality measurement and the dissemination of information on quality but also to funnel this information up to the level of the National Health Board and the agencies such as the Agency for Health Care Policy Research, the National Institutes of Health, and the American Medical Association, which are developing practice guidelines.

I think the implications of this effort on the delivery of health care are rather profound, and one of the important ones is that it represents an attempt to get the lawyers out of the examining room. With regard to what our proposal does for malpractice, you should look not at the section that deals with tort reform but rather at the one concerning the development of guidelines and parameters in a quality control mechanism, because this will be more effective than the tort system in policing the quality of our health care system.

Primary Care

The second profound change consists of a number of policy efforts to push primary care back to center stage in American medicine. We need to build a health care system in which the primary care professional is at the center, not as a gatekeeper but as a care manager—the focal point of the delivery system. The thing we would like to see the most is the restoration of the old-fashioned, long-term relationship between the patients and primary care physicians. This relationship has been increasingly damaged over the last 20 or 30 years, not only by bean counters and lawyers in the exam room but by the accelerating erosion of choice as employers who select health care plans for their employ-

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1 Since the policy forum, Mr. Anderson has left the White House to work as an independent consultant in health policy communications, and continues to serve the Clinton administration as an outside adviser.
ees, in their efforts to keep a lid on costs, make changes that frequently force people to change physicians.

If I can be permitted a personal note here, one of the reasons I got out of the press box and onto the playing field in this battle was because of what I witnessed happening in my own father’s practice. My dad is a family practitioner in Memphis, Tennessee. He has had a solo practice for much of his career, and he talks about patients who come in and say, “I’m only here because my boss changed health plans, and I had to stop seeing Doctor Smith and now I’ve got to come see you, and I want you to know I don’t really like it.” What a great basis to build a relationship of mutual trust and respect! For a man who really is sort of Marcus Welby reincarnated, if I may brag about him, this is painful, as was the loss, in some cases, of large chunks of his practice when employers changed plans and shifted to the hospital at the other end of town.

We are focusing a lot of the effort on redirecting some of the $5.5 billion in graduate medical education money that represents the 600 pound gorilla of post-graduate education financing for physicians. I have often noted with amusement that the federal government spends $100 million or so a year to help medical schools establish departments of family medicine and recruit students to become family practitioners and generalists, and meanwhile the Graduate Medical Education funds, amounting to some 50 times as much money, flow mostly to specialties. It will take a long time before we have the 50/50 balance that I think is a widely agreed optimum, but we think our policies will make a beginning.

It is also worth noting, in terms of delivery system changes, that there is an overall intent to pull down some of the artificially erected barriers regarding who does what, that keeps qualified professionals in many states and areas from rendering health care services they are capable of rendering often better and less expensively. We designed a benefit package that specified services to be rendered, but not necessarily who should render them, leaving that up to health plans. Profound changes are going to occur in the areas of undertreatment—mental health and long-term care, especially continuum style long-term care (i.e., home-based care and community-based care). One of the limiting factors, aside from money, that has caused us to phase in both the long-term care and mental health benefits over a five-year period is not just the up-front cost but the need to develop an infrastructure that in many places doesn’t exist. We are talking about undertreatment rates of 40 percent in the case of many of the most treatable and common mental illnesses, and even if we were to go to a full parity immediately, access would be constrained for several years. We also envision the creation of several hundred thousand new jobs in the latter part of this decade in these two areas.

Just a couple words in closing about health plans and the market mix in a metropolitan area within the regional alliance system we envision. A lot of the mass media have seized on the misconception that there would only be three plans in an alliance area. There is a lot of confusion because what we intend as floors in our policy are perceived as ceilings, and that includes everything from the 80 percent employer contribution to the fact that in corporate alliances, and in regional alliance areas that adopt a managed competition model, there must be at least three plans. In most metropolitan areas, we envision far more. Today, there are more than 60 managed care organizations doing business in the Washington area. There probably is not enough market...
share for all of them, but there is no reason to believe there would not be one or two dozen plans to choose from in most large metropolitan areas.

Our alliance system will localize medicine more extensively than is the case now. The current trend is toward managed care organizations offered by large insurers who are marketing to national companies that have a presence in several different cities and need a plan with a network in every city. The corporate alliance market will remain there for organizations such as that, but we think there will be a lot of new health plans that can succeed in a single market. The entry barriers will come down. We intend to lower these barriers for physician groups that want to organize health plans by funding a low-interest loan program, because physician groups have said they do not have access to the capital that the hospitals and the insurance companies do.

There are profitable and effective health maintenance organizations (HMOs) in the marketplace today with as few as 10,000 members. We envision a medical marketplace that overall is less dominated by the insurance industry than it is now. New plans organized by physician groups and hospitals will form contractual relationships with insurers to handle the financing flows and the financial administration, but the physicians, hospitals, or other provider group will be in charge. This will also build on the current trend among many of the larger national managed care organizations toward a less centralized administration, with less reliance on the “1-800-May-I” system, and toward locally hired practitioners to serve as medical directors, and less after-the-fact utilization review on a claims basis and more emphasis on concurrent utilization review by professionals who make the same rounds in the same hospitals every day.

We want to change the rules of the game in health care delivery. For all the good intentions of many insurers and providers and other organizations, far too often today health delivery remains a game where the ultimate goal is to pick the cherries, skim the cream, dump the risks, and shift the costs. We hope that the only game that will remain in the new health care system and the only way to prosper will be to manage the risks, control the costs, and do the best job possible of keeping patients healthy and satisfied for a competitive price.

We see these motives changing for hospitals. We see hospitals shifting from being revenue centers to being cost centers within larger organizations, a shift that puts physicians in the driver’s seat. Not only will enrollees be able to vote with their feet, so will physicians, especially primary care physicians. I think there will be an acceleration of the trend away from micromanagement and toward practice profiling, dealing with outliers, and living within a budget. Finally, the guarantee of an inclusion of a fee-for-service arrangement in every alliance area and the shift to marketing directly to consumers will greatly expand point-of-service choice options among HMOs and preferred provider organizations, and the use of a universal, locally developed fee schedule will lead to an end to medical underwriting and promote administrative streamlining and a competitive health care delivery system.
II. President Clinton’s Proposal and the Impact on the Health Care Delivery System

Policy Forum Discussion

MS. HOSAY: Kevin [Anderson], in Bill Custer’s paper he pointed out that the expansion and development of technology has encouraged medical specialization. In light of the administration’s goal of expanding primary care, don’t you face something of a dilemma? Can we enhance quality, encourage growth in primary care, and still assure that we use this new and sometimes very valuable technology appropriately? In other words, can those primary care providers learn how to use all this new technology effectively?

MR. ANDERSON: I would hate to see a health plan that said the primary care doctors can’t avail themselves of technology. One of my favorite lines of Bob Blendon’s is that, “Americans are to medical technology as the French are to wine.” I don’t think much will slow down our love of gadgetry and our faith in science. And, there’s already a rather pronounced trend toward technology that applies at the primary care level. Ultimately, at some point, when we have a lean health care system, when the efforts to decelerate the growth of health care spending by motivating health plans and enabling health plans to shed fat, and bloat, and waste and move from micromanagement to better management, at some point what is left is the eternal, irreducible driver of health care spending, which is the march of science.

Right now, that is shrouded in so many layers of increasing administrative waste that it’s tough to say exactly how much health spending needs to grow as a result of technology. With technology that’s mainly being brought in right now for its revenue-generating potential, rather than for its potential to improve productivity and effectiveness and efficiency, at some point in the future we may need to let up on the brake pedal a little bit.

The deceleration we’ve projected in health care spending, that we think is achievable from now to the end of the decade, is achievable because of the fact it can be shed, and that we’ve been assured by many hundreds of providers that it will be shed if we’ll just get out of the way, but at some point that technology begins to bump against the ceiling and you see the phenomenon that we see in so many other countries with single-payer systems, where technology has, for many decades, been bumping up against an arbitrarily legislated overall dollar limit on health spending. For example, I point to the case of changes in policies in hemodialysis for chronic renal failure of people over 55 in Britain over the last 15 years or so, where it took long crusades about poor Aunt Sadie by Britain’s newspapers to finally pressure Parliament into bumping up the level of health spending enough to accommodate those needs. We want to avoid that in this country. We need to maintain a health care system that is flexible, and innovative, and adaptable, not only to the changing needs of society, but to the new opportunities that technology will present. And, that’s why we haven’t really taken the simpler route of going to single payer.

MR. HUNT: I’m concerned that the Clinton plan kills the idea of centers of excellence, and prevents the person who wants to go down to Houston and have the very best heart transplant from doing so because he lives in Maryland.

MR. ANDERSON: As to the centers of excellence, we think quite the contrary. This is going to enhance the centers of excellence concept that Medicare has been pioneering, because, based on early results, that’s a very cost-effective way to administer health care. If I were setting up a health plan in my town, I would want to contract with, say, Mayo Clinic, or M.D. Anderson, or Sloan-Kettering, so that part of my catalog offering says if you get really sick, or you have something that’s tricky to diagnose, we’ll send you to the Mayo Clinic, or we’ll send you to M.D. Anderson or Sloan-Kettering or whatever. An increasing number of health maintenance organizations (HMOs) are doing this now. I think the Mayo Clinic has contracts with about 800 of them across the country, to serve as sort of a tertiary care center, and people find that it’s cost-effective because of the efficiency of Mayo, and because generally health care
organizations that do a lot of one thing tend not only to do it extremely well, but to do it more cheaply. The efficiencies multiply with the number of cases.

I think you are going to see an acceleration of the trend toward centers of excellence. You know, it’s a lot cheaper to fly somebody in a plane to Rochester and put them up in a hotel room when the health care or the particular service is markedly less expensive than what’s available in your own town.

DR. CAPER: I’d like to return to the issue of cost and technology because I think it’s going to be an important theme throughout the upcoming political debates surrounding health reform. Certainly, the use of technology is one of the major drivers of the increasing costs of health care, and the ways we use technology are probably going to have to be changed. But, in my experience, in the work we’ve done over the last ten years or so, it’s clear that the real issue is the rates of use of technology rather than the existence of technology. As new technology becomes less intrusive and more effective, the incentives to use it increase both for physicians and patients. As physicians, and I think as patients too, we tend to look only at the question of whether the clinical benefit exceeds the clinical risk. There’s no feedback in the system to factor cost into that equation, other than on a very gross level. That’s really what’s missing. I think that’s often the way HMOs and other well-managed health plans are successful in reducing the use of technology being used without much benefit, but often with high costs. The technology is often very effective, but it’s used in a way which is not very efficient. We often use technology to achieve some positive but very small benefit without regard to the cost of that benefit. And, I think it’s very important that feedback regarding costs/benefits ratios be built into the system. Certainly, we all have to be willing to give up some small level of benefit if it means a large level of savings and cost.

I think the recently published study on the use of fetal sonograms is a good example. The results are not an attack on the technology itself; it’s a very good technology. It’s an attack on the way it’s used and the cost implications of a marginally appropriate use of that technology. So, I think that’s one example of ways in which large quantities of money can be saved in this system. What universal coverage in the presence of cost constraints implies is that we are all going to have to be willing to give up some finite but very tiny potential benefit in order that somebody else who may need it more can have access to a technology. Whether or not we, as individuals or a society, are willing to do that is going to be one of the unspoken agenda items in the upcoming debate.

Health care reform will also provide a very exciting opportunity for the development and application of efficiency enhancing technologies. That’s a term which is not often well understood in the health care system as it now exists, simply because there are few rewards for improving efficiency. Every time meaningful cost containment is brought up, people say it will stifle the development of all this wonderful technology. I don’t really see that happening at all. I think that what will happen is that there will be a real opportunity for developers and entrepreneurs to do quite well by introducing efficiency enhancing technologies.

MR. ANDERSON: I couldn’t agree more.

MS. DARLING: Xerox is in the middle of implementing a system that looks a lot like what we think the President is talking about. And, on Phil’s [Caper] point, one of the things that happens very quickly, if you have any care management, for example, and don’t give monthly sonograms to 23 year-old pregnant women who are not at high risk becomes defined by the public and the American people, fed by other forces, as discount medicine or inferior care. As long as the assumption is that doing more, without regard to efficacy, usefulness, or cost effectiveness is quality care, then everything else we are trying to do in the area of managed care will consis-
tently be seen as inferior care. Everybody trying to implement those systems will be fighting an uphill battle.

We hope that even if there is a fee-for-service system, we get everybody to understand the costs of that system and the forces that are driving it. To the American people, and Xerox people, more care, especially high tech care, gets seen as good quality care, and everything that’s even a tiny bit less than that is a “take away” that the “bean counters” are trying to keep patients from having. And, we, the purchasers, won’t win unless we educate people to be skeptical about too much care and be as concerned about the impact of false positives as the impact of “too little” care. It’s such a political system, you can be assured that everybody would go to the Congress and get authorized weekly sonograms during a pregnancy.

MR. ANDERSON: I think in many ways we have substituted machinery and pills for care, and we do need to be disabused of our national notion that more is always better in health care. If there’s a way we can restore the physician/patient relationship to primacy, we may not miss our machines so much. If we can open up the channels to allow “health care” to happen, rather than “disease cure,” the presence of a caring provider who is justly and adequately compensated for spending time teaching, counseling, helping you take better care of your health in a trusting partnership, I don’t think we’re going to miss the extraneous machines at all.
III. Perspective of Insurers
III. Perspective of Insurers

By David Hurd, The Principal Financial Group

The United States is in the throes of redesigning its health care system—both how we obtain care and how we pay for it. Sometime in 1994 Congress will probably enact major legislation on health care. We can’t forecast today what might be in it, but major change will occur.

A new federal law will likely be just one step in a series of steps to change the nation’s health care system. Why? Because the problems are many and complex, and they call for a variety of solutions. The history of legislative solutions to complex social problems can be called, for lack of a better analogy, “hovering” around the problem. As opposed to what good businesses try to do—get to the heart of the problem before developing a solution—government moves in a circle around it. Sometimes it hones in on a particular component of the problem, but rarely does it act on its entirety. Because of this tendency, universal access to health care coverage has been debated in this country nine times during this century.

What is different about this, the ninth, time we have engaged in this nationwide discussion? How is this social policy issue changing the way we, in the private sector, are doing business or positioning ourselves to stay in business? Some historical perspective may be helpful.

Introduction

Health insurance was originally considered to be a commodity, a commodity defined differently from one common meaning today. Webster defines commodity as something that provides convenience or advantage, something useful or valuable, an economic good. As with most economic goods, there are certain things the buyer must be able to do to obtain it—be able to pay for it when payment is required, for instance. Most important, however, is that the offer and purchase of a commodity is voluntary in the private sector.

The initial value of insurance came from the belief that, by pooling their resources, private individuals would have access to the pool funds in the case of large loss. Inherent in this was the belief that each person came to the pool in reasonably good health, so that enough monies could be accumulated over time to cover losses. The pools covered catastrophic loss. Day-to-day health care needs were the individual’s responsibility.

Those who chose not to participate in the pools, or who were excluded from participation by lack of resources or inability to satisfy other requirements, paid providers directly or sought care from public hospitals and clinics or those run by religious groups. There was still that sense, however, that how one arranged for health care was an individual responsibility—not an issue for the greater society.

As groups and employers started to provide coverage for their members or employees, so grew a noticeable differentiation between those with third party coverage and those without. This differentiation was most notable as providers were perceived to prefer patients with insurance to the detriment of those without coverage, whether or not they could pay directly for the care. Insurance was a commodity, something that provided an advantage to those with coverage.

The changes in the 1960s began an inextricable relationship between private commodity and social policy. Medicare and Medicaid, among other public programs, were instituted to protect certain groups that were believed to be unable to provide for their own health care. While this was the first real step toward the redefinition of access to health care coverage as a right, the rest of the population was still expected to pay for its own coverage. Government would take care of the elderly and the poor. Each sector essentially stood on its own.
Federal Legislation

During the late 1970s a series of federal laws was passed that actively sought to involve private insurance and self-insured health and welfare plans in social policy. More importantly, however, these laws eased the demand on public financing to cover health care costs otherwise not covered under private plans. Consider:

- 1982. The Tax Equity and Fiscal Responsibility Act of 1982 made Medicare secondary to a private health plan if the Medicare eligible person was still an active employee, regardless of age, up to age 70. This intentional cost shift made the private sector partially responsible for the elderly’s health care, increased costs for private plans, and has allowed Medicare to “save” millions of dollars.

- 1985. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) kept qualified beneficiaries out of public health care systems and in private plans by making the employer responsible for them. This legislation has been amended several times to make private plans responsible for people who never had a relationship with the employer. (For example, a divorced spouse of a former employee covered under COBRA could remarry and cover a new spouse and children under COBRA.) It also provided a means for the employer to be responsible for disabled people until they become eligible for Medicare.

- 1990. Probably the most dramatic example of this very active shift of general taxpayer (government) responsibility to certain parts of the private sector was the 1990 U.S. Healthcare Financing Administration (HFCA) ruling that people with end stage renal disease may keep their prior coverage under COBRA, even though Medicare eligibility terminates COBRA coverage for people with all other diseases. Why? Because end stage renal disease is very expensive, and HCFA found a way to save budget dollars—thus far, about $56 million.

The Americans with Disabilities Act and the Family Leave Act both have components that shift responsibility for a social policy—universal access to health care—to private industry. Once again, rather than address the complex problem directly, these “hoverings” allow the federal government to exact social policy without having to pay for it. Health insurance begins to look less and less like a commodity.

State Legislation

The states have also contributed to this social movement. With their mandated benefits, including continuation laws, ever-expanding definitions of dependents and covered services, they, too, have pushed their own social agendas onto this commodity. They, too, have purposefully shifted responsibility for public coverage to employer plans. Consider the approximately 10 states that, because of the Omnibus Budget Reconciliation Act of 1990, pay for private-sector COBRA coverage (at its inadequate premium rates) for terminated employees rather than have these persons go on Medicaid.

Currently, more than 40 states have enacted insurance laws to accomplish a stated social goal: if universal access cannot be accomplished, to increase the number of individuals covered by making coverage more accessible and affordable to small employers. Many of these laws reduce the “commodity” nature of health insurance and move it closer to becoming a right through reduction in risk evaluation in the issuance or rating of coverage, guaranteed availability for employees, restrictions on use of limitations for preexisting conditions (in Maryland the eventual elimination of such limitations), and portability of coverage. Attempts to pool small employers into purchasing pools are growing. Some states are going further by taking a good look at the entire issue of access to and delivery of health care in their state and attempting to solve specific problems by increasing rural and inner city residents’ access. Some states are moving toward single payer systems, and some are passing legislation giving preferential treat
ment to nonprofit HMOs—a clear indication that health care may no longer be a commodity and that a private concern’s right to make a profit is subordinate to the right to universal health care.

Do we welcome changes that are coming? Yes, but with qualifications:

- The change in health insurance from commodity to a right should be considered a *fait accompli*.
- A critical element in the change to a right is that everyone pays their share.
- Individuals must be required to pay their share.
- Government must pay for those who cannot pay and not continue to shift costs selectively to others. There is no sign yet that this will happen—in fact, cost shifting from government (general taxpayers) to private insurance buyers was intensified by the 1993 budget act provisions.
- Concern over the trend toward absolute community rating.
- Should low income young people have to subsidize higher-income elders?
- Shouldn’t the practice of healthy lifestyles be encouraged and rewarded?
- Should those who elect to live in low-cost areas have to subsidize those who live in high cost areas?

Private industry is seen as a necessary part of the U.S. solution, as opposed to passing legislation to directly create government benefit plans. Clear evidence of this preference is our past de facto rejection of the Canadian system. In fact, the United States appears to be moving toward more of a public/private partnership, perhaps with some similarities to the German system.

Under the German system, government mandated financing and private plans combine to provide universal coverage. Their sickness funds are similar to the health alliances under discussion here. There are 1,147 such funds in Germany, ranging from large businesses to regional funds. According to *Europe* magazine, each year the funds determine the cost they need to be self-sufficient. Monies other than for overhead are passed along to regional associations of physicians that reimburse eligible physicians based on negotiated fee schedules. Interestingly, many people purchase private insurance, which gives them better and faster access to medical care. The bottom line, however, is that it is a government system administered privately. The United States, too, may wind up with private administration under government rules.

### Adapting to Change

What, then, is in the future for the insurance industry? Private health insurance will survive but not without significant change:

- Insurers must become risk managers rather than risk avoiders.
- Premiums will be less reflective of individual risk characteristics such as age and sex. This is already occurring with small group market reform in the states.
- There will likely be a new world of products supplementing whatever core medical plan is established by law (specialty supplemental coverage for a narrow area such as drugs, pediatric dental, etc.).
- The primary role of health insurers will tend to change from financing health care toward the delivery of health care.
- The cost of administering health insurance will become a more important element in pricing insurance products. Insurers that manage their costs well will have a distinct competitive edge.
Managed care will be the favored form of health insurance.

- Managed care includes HMOs, preferred provider organizations (PPOs), and managed indemnity plans.
- Because of the capital intensive nature of HMOs, smaller insurers will have to seek alliances with established HMO plans, or joint ventures with one another, in order to present competitive products in urban areas.
- Because managed care is local in nature, insurers will have to focus on the “right” markets. We will simply not be able to compete effectively in all markets.
- Insurers will have greater accountability for the quality of care delivered in the networks they market.
- Thinly populated areas will be handled differently from densely populated ones.
- There will be a greater focus on customer needs. Customer satisfaction survey results will be included on network report cards.
- Government rules for urban areas will likely allow less flexibility than those in other areas.
- Our ability to be “creative” will likely be restricted, at least to the extent that all insurers, HMOs, etc. will be required to offer an unvarying basic package of benefits.
- The focus on HMOs means selected and restricted provider panels, which means less freedom of choice of providers by the patient.
  
  Rules will vary by state.
- All signals from Washington indicate that the states will have a major responsibility for reducing health care costs.
- By the time any federal package is passed, many states will be far down the road with their own reform efforts. For them, it would be even more disruptive to switch directions.
- Some of the provisions of the Employee Retirement Income Security Act of 1974 (ERISA) may be relaxed for the purpose of state experimentation. This has implications not only for the insurance industry but also for multistate employers.
- Whether health insurance purchasing cooperatives (HIPCs) are *benign* or *regulatory* may also vary from state to state.

The Principal Financial Group

The Principal Financial Group is responding to these changes in a number of ways.

We no longer market traditional indemnity plans to employer groups. All our indemnity benefit packages are “managed” in some fashion (e.g., preauthorization of surgery, utilization review, hospice alternative to hospital, etc.).

We have become more aggressive in our purchase and development of HMOs and PPOs. We now have 13 HMOs and 17 PPOs owned, and 76 PPOs contracted. In addition, we have 12 dental PPO arrangements and 5 mental health network agreements.

We are also moving into new generations of managed care relationships. Specifically, we are working toward:

- More gatekeeper PPO arrangements,
- Greater risk sharing with the providers, and
- The use of outcomes and quality data to work with providers to develop and improve delivery of care practice parameters.

As part of our strategic movement in the area, we are devoting greater resources to rural initiatives. In addition, we are planning a move into Medicaid managed care. Medicaid seems likely to be incorporated in a number of state level plans and in congressional legislation on a national plan.

We are closely monitoring state health alliance legislation for opportunities to offer coverage through their entities. We plan to be certified as accountable health plans under the Florida alliances. We have not ruled out the possibility of acting as administrator for
We are stepping up our efforts to diversify our portfolio of offerings, with increased emphasis on products other than medical coverages, as well as supplemental medical coverages. We think the small group market reform laws will cause more employers to buy medical coverage and open opportunities with them for other coverage.

We are increasing our resources devoted to electronic submission of medical claims by providers and also to automatic adjudication of medical claims. Not only does this enhance customer service, but it reduces expense levels that directly impact our ability to compete in the future. Furthermore, state and federal decision makers are actively pursuing legislation to mandate these administrative cost savings techniques.

**Conclusion**

Most important, however, is a conscious effort to be more proactive, flexible, and nimble. We can no longer afford to be as reactive as we have been in the past. This effort has taken a number of forms:

- We are devoting more resources to market analysis. We have concluded we can no longer be many things to most people and remain viable. One of the lessons of small group market reform is that sometimes it costs more to stay in a market than the returns provide.
- We have become more politically active, not only in Washington but also using key field personnel as a national network to keep us informed, early on, of possible changes within certain states.
- We are doing a better job of educating and consulting with our employees and customers on the issues. They are our partners in change and need much more information than was provided previously.

*Newsweek* columnist Robert Samuelson recently wrote in the *Washington Post*, “The gritty reality about health care is that while everyone waits for President Clinton’s mega reform, the system is changing beneath us.... In health care the status quo is dying. Either we will orchestrate change or change will orchestrate itself.”

Moving our industry from one that sells a commodity to one that administers social policy will be difficult for many. While we recognize these changes will bring a 5- to 10-year period of tumult, we are prepared to help orchestrate and flexibly adapt to our changing future. If we can do a good enough job in showing customers, however defined, that we care and provide cost-effective excellence to them, we will continue to grow vigorously and adapt to the changes in the financing and delivery of health care.
III. Perspective of Insurers

By Harry Cain, Blue Cross and Blue Shield Association

I would like to reflect on some changes in assumptions and in attitudes that have occurred over the last 5 to 15 years and try to illustrate the point with two large existing programs. I am going to take you back to the era of health planning, from the mid-1960s to the early 1980s, and highlight four assumptions that were made by the health planners, insurers, hospitals, and policy wonks.

The first assumption was that the health care system’s fundamental character and dynamics were in place, they were not going to change in any serious way, and our task was to figure out how to contain existing arrangements.

The second major assumption, and probably more important than the first, was that price competition in the health care industry would not work, for a number of reasons. We felt strongly that the incentives were all wrong, and that they were fundamentally hard, if not impossible, to change. The suppliers—the providers of health care—were too strong for price competition to work. The purchasers and consumers were too un­sophisticated ever to be able to understand the product and make good choices. In addition, we felt that health insurance, particularly as provided by employers as health benefits, so shielded the consumers from the cost of health care that they would not ever become truly price sensitive. We also felt that part of the reason why price competition would not work was that insurers and other buyers would not or could not make cost and quality discriminations among hospitals and physicians.

Our third assumption was that, because price competition would not work here, and because the demand side—the consumer—is impossible to control, we needed to focus on the supply side, particularly to find a way to control the supply of investment capital. To control the allocation of new capital, we needed a plan. We understood that the health care system was very complex but felt it was not so complex that a group of well-informed citizens, assisted by health planners, could not understand the fundamental dynamics, get a fair sense for how much health care a community required, and put together a reasonable, rational plan for the future. Some of us at the time also felt that controlling capital was important, but it was not sufficient. We would also have to control prices somewhere down the line.

Fourth, when it came to implementing health planning ideas, we assumed that it would be relatively easy to create new institutions in which the public could have trust and confidence. You provide some federal money, establish a set of rules concerning who can participate and what they must do, and create some new public or semi-public organizations. It seemed a feasible thing to do. We did not call them health alliances; we called them HSAs, SHCCs, and SHPDAs.

These four assumptions were widely shared in the 1960s and 1970s. Many of us no longer accept any of these assumptions. Let me summarize why I do not.

I have been involved with both Medicare and the Federal Employees Health Benefits Program (FEHBP) for the last 10 years. When I was first associated with these programs, I felt much more comfortable in Medicare, because it shared all of the old assumptions of the 1960s and 1970s. The federal employees program did not share any of them. Medicare is the prototypical
single-payer system in this country, and FEHBP is the prototypical managed competition program. I would ask you to explore what has happened in these two programs during the last five years, when the health care industry has been changing so dramatically. My opinion is that on every performance indicator of any importance whatsoever, the federal employees’ program has outperformed Medicare hands down—in areas such as cost containment, customer satisfaction, and product enhancement. For instance, for the last five years, the average annual per capita cost increase in FEHBP has been about 5 percent, or approximately one-half the comparable rate of increase in Medicare—even with all the price-setting and cost shifting for which Medicare is famous.

Both Medicare and FEHBP “work” in the sense that they cover all the people they are supposed to cover, offer good benefits, and are available everywhere in this country. Why has one outperformed the other so dramatically? I would assert it has nothing to do with the people involved in the programs, either in terms of who is covered or who is in the federal agencies that make them work. It has to do entirely with these programs’ structure, incentives, and processes. Why is that germane to what we are talking about here today? I have tried to pay close attention to what I have heard the President and Mrs. Clinton say about health care reform. Their talk sounds like the federal employees program, but when you read the proposal, it reads like Medicare and health planning put together. That may not be a bad combination—if you still hold those four sets of assumptions from the 1960s and 1970s.

Conclusion
I do not know whether it is ironic or prophetic that the largest private health provider in the country is listed as an insurer for this purpose. Kaiser Permanente consists of large physician groups, hospitals, and health maintenance organizations (HMOs). We are the largest health insurer in California, one of the largest in the United States, and we are also the largest HMO in the country.

I would like to comment on something Bill Custer said in his paper about why group and staff models have not grown more. He attributed this to consumers’ resistance. I think a more probable cause is that almost all the prototypes are nonprofit, locally based organizations. There is only one organization that has gone national, and that is Kaiser Permanente. But, of course, as the competition moves more to local markets, locally based organizations will be strengthened.

We have observed a number of changes in this growingly competitive environment. In the good old days, both employers and employees were primarily interested in increasing benefits and getting broader coverage, and certainly that was a wonderful world to live in, when all that was needed was to deliver additional benefits. Currently, we see employers focusing much more on costs, but as they learn that they have to have less wide-open choices they are becoming more concerned about the quality of these choices. Organizations such as Xerox are taking the lead in asking very tough questions of organizations like ours in terms of performance.

Another change is that the interests of employers and employees are diverging. Employees do not like deductibles, copayments, and coinsurance, and anybody that thinks they do is wrong. These measures have become the popular cost containment devices and are among the issues driving this debate.

Another change is that formerly group practice HMOs had little or no effective competition, and now we have very effective competition. We are like the American motor car companies—we loved competition when we did not have much; now that we are getting more we sometimes yearn for the good old days. And, for those policy wonks in Washington who do not believe independent practice arrangements (IPAs) can control costs, you ought to try to compete with them. It is not an easy world out here and, in fact, we are learning things from our IPA competitors as they strive to become more like us in many ways. We look at the new emerging forms of provider organizations with both respect and concern as competitors, and I am talking not just about IPA and network HMOs but also about physician/hospital organizations and other forms yet to be designed, where providers will get together to rationalize the delivery of health care as we do.

We see the emergence of new information services capabilities. We are trying to be a pioneer in the use of our massive data bases to look at outcomes and develop practice guidelines. One of the more exciting prospects of this effort is changing quality assurance from hunting bad apples to finding stars. In the past, quality assurance systems have tended to focus on finding the deviants on the down side, but now we are looking for the people who really know how to make things work. I will give you one example. We did a large outcomes study in our Southern California region on hysterectomies. We found one medical center had very low complication rates and, therefore, very low length of stays. We talked to the surgeons who were doing this surgery and asked them what they were doing. They had no idea that they were better than anybody else. Now the challenge for us and others, and it is not an insignificant one, is figuring how to move that practice to the other
medical centers, not only in Southern California but elsewhere. One of the reasons we are adopting total quality management is as a way of accelerating that process.

And, finally, we are seeing the development of newer and friendlier computer capabilities. Our physicians are way ahead of us on this, and we are trying to catch up. They are putting together their own PC-based information systems and developing their own automated medical records far faster than we can, and they are learning how to use them very effectively.

To adapt to the market, we adopted adjusted community rating, which provides groups specific rates based on their experience. We are looking at exclusive dual choice and point-of-service products, and we are developing strategic alliances, particularly with providers. The most noted is the alliance with the Cleveland Clinic in Ohio, but we have developed others and more are coming. We are also looking at strategic alliances with insurers. Moreover, we are a leader in the development of performance-based information reporting such as HEDIS, and as I indicated, are accelerating our outcomes research and guidelines development. All of this is on the provider side of the business, not on the insurance side. We are slow followers on the insurance side.

In terms of the Clinton proposal, I have a number of comments. Competition should increase. Significant reform is already underway. We think the Clinton proposal would augment and facilitate continued reform. I have one big question: is this the last chance for privately organized and financed delivery of health care? From our perspective, group practice HMOs, and HMOs in general are uniquely American. They fit the American model, and I think they should be, and will be, the foundation on which the privately based reform continues in this country. It is ironic that Kaiser Permanente is often visited by Europeans and Canadians looking to find out how we make things work and trying to figure out how to take what we do to their countries.

Conclusion

I agree with the statement that we are going to have locally based competition, and that is how costs can be reduced; national organizations are going to struggle unless they are locally based. Competition should focus on demonstrated quality, member/patient satisfaction, and cost. Products will be less important. Report cards such as HEDIS will be more important. Providers will have to demonstrate that they have satisfied members. I believe group practice HMOs start with a disadvantage in this regard, and we are trying to improve. We have an advantage on cost. The loosely organized organizations, such as IPAs, seem to do better on member satisfaction, and they need to improve on costs.

Primary care physicians, nurse practitioners, and physician assistants are also going to become more important, not in gatekeeper roles, but in helping to manage the use of specialists. What is really important is not how many specialists or how many technologies, but how wisely they are used, and for that a combination of science and judgment is needed. We think general acute hospitals are declining in importance. We are building smaller ones. Things are going on outside of the hospital setting more and more—hospitals without walls. There will be more emphasis on prevention. We are working actively in this area, as are others, and especially the management of chronic illness such as diabetes. This is one of the big cost drivers in the system, and we are looking at total management of chronic conditions by teams of providers. Finally, I hope that new technologies will be more rigorously evaluated.
III. Perspective of Insurers

**Policy Forum Discussion**

**MR. GRADISON:** In order to make the system work, we should focus on the delivery systems, and one of the great defects of the plan that is apparently coming out of the administration is that there is built into it, in my opinion, a sense that we have reached the end of history in the development of delivery systems. I think we all really know that is not true, but if one analyzes the way in which the purchasing alliances are set up, it is going to be virtually impossible to enter if you are not in there in the first year.

In other words, we are creating a system where those pesky Microsofts, the Davids that come along to challenge the Goliaths, are going to seek something other than health insurance or health delivery systems as a field to energize them, and the question really comes as to whether that is smart in the long run or whether we should have a system that makes it a little easier to participate.

As has been indicated, the key to this whole thing is local market share, not the overall size of an enterprise. If I had 15 percent of the market in my home town of Cincinnati, and I run my business well, and I know my providers, and I know my customers, I think I’ll be in the business for a long time. If I’ve got one percent of the U.S. market, which is a much larger number, and it’s spread evenly, I am gone, folks. I do not know how many health insurers there are in this country, but lots of people say there are somewhere between 1,200 and 1,500. The best number I have is that 275 health insurers, including the Blues, write 94 percent of all the health insurance. What that means is that if a thousand participants go away tomorrow, we move from 275 companies providing 94 percent, to 275 providing 100 percent, which isn’t a real big difference in terms of the way in which this competition takes place, and I think that’s worth thinking a little bit about.

With regard to the bean counters and lawyers in the examination room, the definition of what is covered under the President’s plan is the same definition that we deal with today, medically necessary or medically appropriate. There will be denials in the future as there are denials now.

The big difference is that now if there’s a denial, and you want to do battle with the insurance company, you may have an agent who has an economic interest, you may have a business agent of your union who has an economic interest in helping you, you may have an employer who has an interest in helping you fight with your insurance company. Under this new system, you have an 800 number, and the state ombudsman is really all you have that has an economic interest, because otherwise the other people really have nothing to say about whether that plan continues to be the one of choice.

As an example, I’m going to cite one of my children who is a physician and her practice is about half managed care and half fee-for-service. I was out visiting her at her office in rural Colorado, and she was beside herself, and I said, “Why are you so exercised?” She said, “I spent an hour on the phone with one of the health plans arguing that one of my patients needs carpal tunnel surgery.” She was not going to make any money out of that, somebody else was going to do the surgery. I said, “Well, how did it work out?” She said, “Well, after this hour of argument, the person at the other end of the line said, ‘We’ll give you this one, Maggie.’” Think about that. What happens to the next one? I’m just saying that there are going to be decisions made under any of these systems that are not necessarily optimal, and that the notion that by changing from one system to another that all our problems are going to go away is not realistic.

**MR. LINK:** In their presentations, all of the speakers described the changes in their organizations, and although those changes were different, I thought there was an interesting pattern as to what they had to say. First, David [Hurd] and also Harry [Cain] suggested the changes in their organizations were making them look more like Kaiser, and Jim [Lane] even described a few changes that were making his organization look a little more like Principal and Blue Cross. David said they no longer sell traditional indemnity insurance. I think he
said they have 13 HMOs at this point, and they plan to spend a lot more money (in the absence of price controls) to have even more in the future, and that the primary role of health insurers will tend to change from financing health care toward the delivery of health care.

Harry said they were moving much more toward individual consumer choice, more integration of the system, more capitation, away from fee-for-service, and changing the financing concept from insurance to prepayment. And, Jim said, even reluctantly, they were adopting adjusted community rating for larger groups, rather than pure community rating. They were developing exclusive dual choice, out-of-area and some point-in-service options, and they were developing strategic alliances with providers, even insurers, although he wasn’t sure how long that might last.

Another critical factor driving change, I think, is this quality in data, and employers, like Xerox and AT&T, and many others, are really driving that. I think it’s becoming increasingly possible to define, measure and compare the value received for the money you spend on health care services. The fact that the major purchasers of health care using state-of-the-art technologies to look at what kinds of health outcome their money is buying, I think is very significant and a very positive step to the future. I think those parts of managed competition have been happening and will continue to happen, even without the federal government, or regardless if a plan called “managed competition” passes.

A few final comments on these major changes and what’s going on in the Prudential might be appropriate. More and more, we’re developing and carrying out our competitive strategy on a market-by-market basis, rather than a uniform national strategy, with a uniform contract and uniform product. This is because the health care delivery system, as Jim and others have mentioned, is really a community-based activity, and local health care markets have become the arena, rather than the national markets. We are still trying to maintain consistency in those areas that we think need to be consistent, and where national employers are saying they would like to see consistency. But, for the most part, this is being driven at the local level. As a consequence, that means we are considerably less centralized organizationally and from an accountability standpoint. We are seeing a changing mix in the job categories and competencies that are needed inside our organizations, much more in the area of provider relations, in membership services type people, and much, much less in the area of underwriting, and risk selection, and that. We are also seeing people from a wider variety of backgrounds in our organizations. We have examples of doctors and nurses, and dentists who actually have line responsibility in our organization, and I see more and more of that happening in the future.

One final comment on Harry’s observation about Medicare and the FEHBP program. I agree with what he said. One difference in the FEHBP that isn’t exactly like the President’s program is, FEHBP pays 75 percent of the premium for every plan, instead of 75 percent of the average plan. If it paid 75 percent of the average plan, you’d even see greater cost efficiencies in the FEHBP program, because people would have a bigger incentive to select more cost-effective plans.

MR. DEWSNUP: Mr. Gradison spoke about the history of the delivery of health care and utilization review (UR). With the price competition that is expected under the President’s proposal, basically insurers have to manage their risk and their cost by regulating utilization in some way, shape, or form. Currently, that is happening with various UR programs where the UR staff discusses the appropriateness of the proposed procedure with the doctor. The consumers, the ultimate receivers of the care, do not see the insurance company as their advocate in holding down costs; rather, the insurer is seen as an enemy, preventing them from obtaining the care they believe their provider has so diligently prescribed for them.

My question is what role do you or should you as insurers, or risk bearers, or risk managers in this sense, play in educating the consumer about your advocacy role
and how do you think the consumers can help you in managing that utilization if they received appropriate information?

**MR. LANE:** Well, it’s very interesting, because as a provider organization we struggle with this all the time. We compete on the basis of, generally, comprehensive benefits and price. So, we have to balance those issues in terms of resources all the time. And, I think you are right, generally, we have not paid enough attention to member and patient expectation. We need to focus on that. We’ve had traditional health education programs, stop smoking, all of the wellness programs available to everybody, generally, free or for very low price, but now we are trying to look at some of the clinical issues around expectations and developing with others videos that explain to people the risks and benefits of treatments and other things that help people make choices. Often, they make the choice not to get the treatment of their own volition, and for some people that’s probably a more effective way than having a doctor explain it to them, and I think that’s a very important area to move into. However, unless you have the science of medicine, the information from outcome studies and all, you can’t do that very well. It’s just three doctors, each giving you a different opinion.

**MR. HURD:** The Principal now runs a service for our customers called “Health Information Line,” and it’s an 800 number, and the individuals that are covered under our programs can call in and visit with the person at our end about what their upcoming medical need is going to be, and is it covered, or is it not covered, and are there other alternatives, and so forth, as a means of getting pre-educated, at least as to how the insurance program relates to their medical events. This is a service that has grown dramatically over the last decade, and I guess I would see it as expanding in the future.

**MR. CAIN:** One of the challenging, but very positive, parts of the Federal Employees Health Benefits Program is that individual consumer choice among plans means that if you want to keep or expand your market share, you cannot irritate the individual customers. At the same time you have to try to contain costs. That combination poses a major challenge. We have gotten much further into consumer education in the last five years as one way to respond, and we have put as much of the decision-making and risk on the provider as possible, but we always understand that every year our subscribers can choose some other plan. That is the important dynamic that keeps us working hard at trying to provide cost-effective care without irritating our subscribers. It’s healthy, but it isn’t easy.

**MR. DEWSNUP:** In an ideal market, the supplier and the demander of services have a direct link and appropriate information about one another, so as to close an appropriate deal. In a situation where there is a mandated intermediary, such as a utilization reviewer, there must be an increased flow of information, not just for the purpose of not angering or aggravating subscribers, but for explaining the possible outcomes, the utilization concerns, the risks, etc. By so doing, the insurance industry can change its image from a utilization regulator to a patient advocate. That change in perception will go a long way, in my opinion, toward resolving some of the conflict about utilization review that currently exists between the insurer and the patient.

**DR. SHINE:** My question is for David Hurd. Bill Gradison told us about some consolidation of insurance companies from 1,500 to 275. What we are talking about, even though there are local markets, are enormous capital requirements, systems of care, information systems and so forth. Why, after the 10 years of turmoil, won’t we have the oft-cited 4 or 5 major insurers controlling all of this, because they are so effective in terms of doing what they are doing.

**MR. HURD:** To respond to the last point, the question, which I take it to mean, isn’t it going to be a terrible
world when just the Prudential and two or three others have all the coverage in the United States and exert all this pressure. But, I'd say, let's just go back, we've discussed again and again here today the localization of this business, rather than the nationalization of it, and I think that's going to make it easy for lots of competitors to stay in the market.

**MR. LINK:** Prudential doesn't have any intention to try to be a player in every local market, we just can't be. If a smaller insurance company tries to be in every local market, they are likely to go under. But if a smaller insurance company decides to pick one or two places and really competes very strongly there, they are going to thrive. You know, a 10 percent market share in St. Louis, or Cincinnati, or Des Moines, Iowa, will be a tremendous way to do it. But, if they get a third of a percent in 75 markets, I think they'll quickly come to the conclusion that that can't work. You are going to come down, I think, to maybe a dozen competitors in some local markets. In southern California you'll have many more than that, but in Jacksonville, Florida, you might have eight. But, it won't be the same 8 or 10 in each market, and when you add up all competitors in all markets, you could easily have 300 different entities operating.
IV. Perspective of Providers
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By Jerald R. Schenken, MD, American Medical Association

Introduction

“You can lead a horse to water, but you can’t make him drink.”

This old saying has great meaning as we move to resolve the many challenges of health care. Ultimately, many complex interactive factors will determine whether those involved in maintaining and improving the nation’s health will be able to focus on positive, meaningful changes or whether we will be mired in unintended consequences.

In spite of the importance of health care in our own and our country’s life, the debate is currently being fueled, not by objective analysis, but by fear:
• fear of a catastrophic illness,
• fear of loss of coverage,
• fear of losing one’s job, and/or
• fear of financial ruin of one’s company or one’s self.

In this atmosphere of fear and demagogery, it is critical that there be a careful look at the most fundamental aspects of health and medical care. Among the most basic are the incentives therein.

Incentives for medical care come in many different sizes and shapes and affect many people and institutions:
• fiscal or emotional,
• direct or indirect,
• positive or negative, and
• circumscribed or expansive.

Physicians, patients, and payers usually recognize the incentives that have an impact on them and respond accordingly. Unfortunately, they often do not recognize or appreciate the impact that those same incentives may have on the other parties involved, or even how others perceive them.

Workers’ compensation reform presents additional challenges due to the inherent social compact implicit in the workers’ compensation system. This system is the result of a compromise reached in the early 20th century between employers and employees in which employees waived their right to tort relief from employers for work-related injury or illness in exchange for the employers’ agreement to compensate them for their medical costs and lost wages. The goal of workers compensation medical care is twofold: optimum recovery and rapid return to work. Many are concerned that applying the cost containment initiatives used in the general health care sector to workers’ compensation will interfere with the goal of rapid return to work, and that cost containment incentives may also conflict with incentives for rehabilitation. These differences must be considered whether or not workers’ compensation is actually included in a reform proposal.

Within our health care system, significant and persuasive incentives are present that have an impact on medical care.

The effect of these systematic incentives varies, depending on the party involved (e.g., the patient, the family, the employer, the insurer, the community, the taxpayer, the government, and the physician, and other providers).

Cost

This nation spends about 14 percent of the gross domestic product (GDP) on health care. Most Americans feel they have access to quality care. Unfortunately, costs are going up 10 percent to 15 percent per year or more—a rate that is not sustainable long term. Most people
believe some change is required. In addition, all costs are relative and depend on who is paying what, when, and how. Can money currently spent on health care be productively spent elsewhere without injuring patients? If so, how? In other words, are we spending too much, too little, or not in the right way?

The Federal Deficit and Debt

The federal government finances current services for Americans in a way prohibited in most states—by assuming debt to be paid in perpetuity by taxes on future generations. In the face of mounting debt and deficit, Senator Dave Durenberger (R-MN) estimated that the average male Medicare recipient receives an estimated $44,000 lifetime subsidy (in excess of premiums and taxes), only part of which is paid by current federal income tax receipts. The result is that the interest on the federal debt is now about $200 billion per year and rising, using up tax revenues that could formerly have been spent on such important functions as medical research and education, immunizations, public health, indigent care, and Medicaid. Although factors other than health care contribute to the deficit, this increase in debt and deficit cannot continue.

Taxes

Taxes are known to influence behavior. Employer-provided health insurance is a tax deductible business expense and is a nontaxable benefit to the employee—a strong incentive to increase coverage, to insure more nonmedical benefits, and/or to promote utilization, whether necessary or not. Failure to allow similar tax treatment for out-of-pocket expenses and premiums paid by individuals (within certain limits) has impaired innovative benefit design that could reward individuals for prudent health care choices. Adverse tax treatment has made the net cost of those premiums prohibitively expensive.

Some feel that the current unlimited business tax deduction for premium benefits has a similar disturbing effect. Uniform tax treatment for everyone would tend to eliminate some of the perverse incentives.

Third Party Payment

Most medical care is insured, either by a private or a government program. While insurance is essential to assure that care is available and affordable, third party payment has removed both patient and physician from direct contact with cost sensitivity at the time services are provided. Unfortunately, most patients perceive insurance as an asset to utilize rather than as protection available for use only when absolutely necessary. Chances are that utilization (and thus costs) will increase simply as a result of providing coverage of a particular benefit. Furthermore, individuals with preexisting conditions are often penalized because insurance premiums are actuarially experience-based rather than community rated. This problem is most acute with individual and small group insurance coverage.

The Uninsured

Two-thirds of our nation’s uninsured are employed, either full time or part time. Some of the uninsured tend to postpone routine physician visits. They generally receive acute care only—paid for, in part, by cost shifting to those with coverage (employers and/or private payers). In addition, some of the uninsured may well be functionally uninsurable (i.e., having an insurance policy alone often does not get them to proper care) because of drug dependency, psychiatric conditions, alien status, etc. Recent studies show that the uninsured tend to be young and low on the income scale and are usually without insurance for short periods of time—in most cases, less than nine months. Many choose to receive current income rather than employer-subsidized insurance coverage, gambling on “self-insurance” because they are young and “relatively healthy.” However the problem is
viewed, it must be classified as a significant one because whenever care is provided, the payment is often cost shifted.

Life Styles

It has been estimated by some that 20 percent to 30 percent of health care costs are closely related to unhealthy life styles—choices made by people that increase their medical costs. Much of that cost is paid for by others who make wiser choices. Alcoholism, smoking, drug abuse, lack of exercise, obesity, violence, unsafe sex, crime, lack of safety belts, etc., are all problems that often can be addressed by individuals, thus freeing up billions of dollars for needed care. The real challenge is how to change unhealthy behavior. Perhaps healthy lifestyle choices should be rewarded with lower premiums, lower costs, cash rewards, etc. Or would penalties, such as higher premiums, higher costs, reduced access or taxes serve as a deterrent for making unhealthy choices? In both cases, incentives are at work.

Technology

The explosion of medical miracles, such as CT scans, transplantation, artificial body parts, etc., are a direct outcome of advances in medical technology. Unfortunately, the capacity to provide costly care, even when the chance of cure is slight, has far outstripped society’s and an individual’s ability to deal with the choices and challenges they face. Who wants to deny a friend or relative a 10 to 1 chance? 100 to 1? 1,000 to 1? These are the moral and ethical choices that must be addressed before our ability to provide care to the few whose condition is hopeless prevents us from providing basic care and thus hope to the many. Nonetheless, the economic challenges of advancing technology must be faced.

Aging

The American public is aging, in part because of the success of our health care system. While such measures of health as infant mortality show us in a poor light, everyone agrees that most of its causes are socioeconomic—poverty, teenage pregnancy, drug abuse, etc.—and not lack of health care. At the other end of the spectrum, we find that the cost of care goes up directly with the patient’s age. In fact, it costs over four times as much to care for a person over age 65 as it does for one below that age. The success of our medical system in curing disease and prolonging life has the unintended consequence of leading to serious cost and access problems.

Expectations

Public and professional expectations with respect to health care seem to be skyrocketing, in part because of our medical success and in part because of public exposure to medical miracles through personal experiences and through television and the print media. We all tend to expect cure, even when the odds are very long. Unreasonable expectations fuel our already overly litigious society.

Public Ambivalence

Public opinion polls show clearly that Americans like their health care, that they want it available to everyone, that they’ll approve of others paying more for expanded care, but that they themselves do not wish to pay much more in taxes or otherwise to expand services for others. Respondents to polls approved a national health insurance plan paid for by a 5 percent increase in payroll tax but only when they were told that the employer would “pay” 80 percent. This response occurred in spite of the fact that employer-paid payroll taxes eventually come from employee wages foregone and, if the cost of an employee becomes too great, employment is foregone as well.

Employment

The engine of our economy is the creation and nourishment of productive, rewarding employment for more and
more Americans. Ever-increasing productivity has permitted us to expand the quality and quantity of health care that is available through either employment-based or tax-supported programs. We all want both employment and insurance. But what if the cost of insurance and/or health care itself makes employment too expensive or even impossible?

Liability

Medical liability actions and settlements, the cost of insurance premiums, and the resulting increase in medical services caused by defensive medical practices all sharply increase the cost of care. There is little question that our society has become more litigious overall as well. The challenge is to decrease the unfair and unreasonable costs and to properly compensate those negligently injured without preventing patients and their relatives from addressing legitimate grievances.

Productivity

Professor William Baumel has for years supported the notion that health care is a personal service sector and that the basic reason for its relative cost inflation (in the United States and worldwide as well) compared with manufacturing, etc., is its relatively small increases in productivity even in the face of astounding technological advances. This is true in all personal services. That is why they are personal. Under these circumstances, arbitrary limitation of annual cost increases to the rate of general inflation will of necessity lead to rationing, delays in technology and other advances, and public and professional dissatisfaction.

To solve our health care “cost-quality-access” dilemmas, we have to agree that we are dealing with everyone’s problem and that everyone must participate in the solution. Issues must be subject to public discussion based on facts, without demagoguery and finger-pointing, and with problems and challenges clearly understood by all concerned. There can be no villains. We can’t develop a system that separates us into winners and losers. Everyone must benefit in some meaningful way. This can be done most effectively by considering all the incentives and focusing them in the right direction.

Costs of Health Care

Surprisingly, many people talk about the costs of health care, yet few agree on how these costs are defined. In a general sense, the costs are often defined as that which is charged and collected. More specifically, costs can be divided into basic costs and marginal costs. After a physician provides 20 mammograms in a day, what is the cost of the 21st? In the end, costs are like beauty—in the eye of the beholder. In defining the costs of health care, one must first ask the question, “Costs to whom?” The question is difficult to answer and will vary depending on who is asking it. Thus, everyone has an opinion on the question of costs, a stake in the answer, and a set of values into which the external incentives for medical care have to be made to fit.

Individuals and Families

Health care costs to individual patients consist of insurance premiums, taxes, out-of-pocket expenses, income lost, etc. A program that decreases total cost but increases the individual’s out-of-pocket payments may save money for someone else, but it is more expensive for the individual patient. This happens when deductibles are raised or covered services are limited. This problem is compounded by out-of-pocket payment of expenses using after-tax dollars. The same is generally true of families, who sometimes have to draw on their savings to finance health care expenditures not covered by insurance. For example, medical care for a family member at
home is commonly not covered by insurance. The overall health care system may save money by using home care as an alternative to lengthy hospital stays, but the individual family bears a great out-of-pocket expense when home care is not insured and early hospital discharge occurs.

Employers and Employees

In addition to insurance costs, health care costs to the employer include loss of productivity, sales, and/or profits due to time off from work. If modifications in insurance coverage reduce the patient's out-of-pocket expenditures, the employer's costs may go up. In some cases, if the patient/employee chooses medical therapy instead of surgery, the immediate cost to the employer may be lower but the long-term cost may increase. If the employee's out-of-pocket payments are limited, the cost of insurance usually goes up. If employer costs are great enough to reduce profits, decrease employment or even drive the employer out of business, the resulting unemployment loss of taxes paid, and increased public assistance may devastate other sectors of the community.

Hospitals

Hospitals use their revenue to pay overhead, including salaries, possibly taxes, capital improvements, insurance, the cost of care for the uninsured, etc. If hospital utilization is reduced, hospital employment may be reduced as well. Although decreased hospital utilization may reduce costs to insured individuals and their employers, the costs to the community may be increased as tax revenues are lost and unemployment increases as hospital employment drops. Moreover, the hospital's ability to respond to subsequent emergencies may be reduced as well. Where do the uninsured go for care and at what cost?

Physicians

Physicians faced with cost containment measures must anguish over how to provide the fewest services necessary to patients without the risk of providing unacceptable care or inviting an expensive lawsuit. When the best interests of the patient are sacrificed in favor of the short-term savings gained by some cost containment initiatives, the overall costs of the health care system may increase and the physician's basic responsibility to the patient to provide quality care may not be discharged. When a cost-containment measure presents the physician with this type of conflict of interest, the health of the patient should be put first. With some circumstances, this is not always clear or possible.

Physicians are generally well compensated for their services. Physicians use their income to pay their cost of education and education-related debts, practice overhead (including personnel and ever-increasing liability insurance premiums), continuing medical education, and their salary and benefits. Reducing health care utilization could reduce physicians' income. This, in turn, would limit physicians' ability to pay off the debts associated with 13 to 15 years of postsecondary education and to maintain a residual income adequate to raise a family, buy a home, and educate their children. If income reduction is severe enough in the future, a career in medicine may no longer seem as desirable as it once was and the best and brightest of tomorrow's potential physicians will be looking elsewhere for a career.

The Community

Hospitals and other health care providers are often, as a group, among the largest employers in a community. The services of professionals, skilled and unskilled workers, and those who sell goods and services to hospitals and physicians are needed in order to keep hospitals open. These employees pay taxes, consume products and services, contribute to the community, and support the schools. Cost containment activities that conserve money for the patient, family, or employer but threaten the viability of the hospital or its physicians may have a negative economic impact on the community. The disasters that have occurred in the hundreds of small communities around the country when they faced closure
of their largest employer (i.e., the hospital) are clear examples of the impact of the health care industry on the community's viability. The same thing can happen to producers and suppliers of services to hospitals and the health care community.

The Federal Government and the Country

The government and the country in general have other economic and social concerns. Some cost containment activities have resulted in cost shifting. The government and the country as a whole may either benefit or suffer from cost containment measures in health system reform plans. For example, failure to include some preventive health services in a reform plan could lead to short-term economic gains but will probably lead to losses in the long run. Providing unlimited access may make cost containment difficult, if not impossible.

In spite of the complexity of the problem, some cost containment activities are essential. Employers have to stay in business in order to provide insurance benefits. Individuals need jobs. A conflict will always result when individuals want to decrease their taxes and their medical expenses but also want to spare no expense when a friend or family member needs care. These conflicts can be resolved if proper planning and public policy place the incentives for medical care in their proper perspective.

Cost Containment

Cost containment initiatives have been introduced to respond to the constellation of incentives for medical care that are perceived to have unnecessarily increased both unit cost and utilization. Unfortunately, the total impact of cost containment initiatives is often overlooked. A brief discussion of some of the more common cost containment initiatives may provide a more global view of the impact of such measures.

Deductibles and Copayments

Deductibles and copayments transfer costs from employer and/or insurers to the employee/patient in an effort to make the patient more cost conscious in his or her health care decision-making. Aside from the possibility of creating a financial barrier to needed care, copayments and deductibles also change employer tax-sheltered (pre-tax) premiums into employee/patient out-of-pocket (post-tax) payments, which effectively doubles the actual cost to the employee/patient.

Employee Participation in the Premium

The employee effectively pays the insurance premium by his or her productivity whether or not the premium is directly employer provided. The problem is that most employees do not understand this or believe that they actually pay. Therefore, asking the employee to pay some, more, or all of a premium inflicts both the same tax penalty as do deductibles and also asks the employee to pay for something that he or she assumes to be “free.”

Managed Care

Managed care is primarily a form of cost containment. Regulations, administrative barriers, and educated second guessing may interfere with the ability of patients and physicians to agree on a medical care plan. In addition, some plans use primary care physicians as “gatekeepers” to determine whether further consultation and/or specialist treatment will be provided, regardless of the desires of the patient. Out-of-plan services may be prohibited or made unreasonably expensive. Will these decisions be made on the basis of medical need or fiscal considerations? In the end, we need patient understanding, public disclosure, and proper incentives to assure quality care.
Clearly, incentives for everyone are present throughout the health care system. The impact of such incentives depends on the parties involved and their perception of the impact that incentives may have on them.

As we have discussed, incentives for medical care come in all shapes and sizes. In spite of these incentives, physicians are generally governed by their professional obligation to provide quality medical care. Unfortunately, many physicians make decisions using medical indications in a “grey zone” where indications are unclear and medicine is an art. Some say that fee-for-service is a financial incentive to provide more care. Others argue that capitated plans, such as health maintenance organizations, provide financial incentives to reduce care. Both arguments may prove true, depending upon the circumstances of a particular situation. The challenge is to provide care that is both necessary and affordable.

Every medical decision involves the evaluation of probabilities and the management of risk. Both physicians and patients would like to eliminate risk from the process of diagnosis and treatment, but that isn’t always possible. The challenge is to make sure that both physician and patient understand the nature and degree of risk before decisions about insurance, life style, medical care, etc., are made. Unfortunately, this mutual understanding is often lacking. Both physicians and patients incur risks when unnecessary care is provided or, conversely, when necessary care is withheld. Physicians also face financial risks, injury to their reputations and exposure to liability. The patients, too, incur financial risks, as well as dangers to life and limb.

Finally, quality is the goal of all parties concerned. Unfortunately, the definition of quality will vary depending on who is defining it. Physicians, in defining quality, look to the process by which care is provided because that is what they can control, as they pray that their patients will recover. Patients, on the other hand, often define quality according to whether they get well. These various definitions of quality explain why we are beginning to look at both process and outcome in our deliberations over health system reform. When cost containment enters the picture, we must be sure that incentives for medical care do not introduce unintended consequences that work against quality and pose unacceptable risks to patients and/or physicians.

Incentives for medical care do exist; they have an impact on all involved parties. Thus, incentives must be considered carefully, positive impacts aligned, their negative effects minimized or eliminated, and unintended consequences prevented in any proposal to change the nation’s health care system.

**Conclusion**
IV. Perspective of Providers

By Peter Wilson, American Hospital Association

This discussion addresses how the delivery system has changed in recent years, particularly as it has affected hospitals, and how health care reform may further affect what is important to hospitals.

I would like to summarize how the delivery system has changed in recent years from a hospital perspective. I can highlight this change by saying that 10 years ago or so, whenever I heard a hospital administrator being introduced, the tag line always was, “Mr. So and So runs a 294-bed hospital in Texas,” or something like that. You did not hear the person’s name without being told how many beds his or her hospital had.

Today, that is no longer the case. As a nostalgia item, sometimes bed size comes up, but it is not front and center. Why? The reason is that in recent years there has been a significant integration of the delivery system. It happened in fits and starts, but I think if you were to pick one event from which that integration can be dated, it is the kickoff of the prospective payment system and diagnostic related groups (DRGs), which occurred on October 1, 1983.

I think three things happened at that point that pushed forward the integration of the system. First, hospitals became at risk in a way they had not been before for the behavior of the physicians working in them—their medical staffs. That led to a great increase in the interdependence of the fates of the hospital and its associated physicians. Second, it became very important that hospitals be able to discharge patients, because if they could not, patients stayed in the hospital, which was not good given that there was a fixed DRG price for the episode of illness. That led hospitals to start creating interdependencies with nursing homes, home health agencies, and other organizations—a process that is generally called vertical integration. Third, a shift occurred from inpatient acute care to all sorts of other modalities of treatment that can collectively be called outpatient. Here we have a situation where technology aided and abetted the incentives of the payment system. From a payment perspective, you often wanted to treat patients on an outpatient basis. Technology permitted that to occur.

Adding up all these things sums to a relative decline in the importance of acute care and of the importance of the organization that focuses on that care. Hospitals had to learn other things to do if they wanted to stay vital and engaged and important. As a result, I think for years now hospitals have become less and less a pile of bricks surrounding a bunch of beds with a specific street address and more and more an organization whose essence is the integration of disparate delivery sites and resources.

The organizational evolution has been from a free-standing hospital focused on its beds to a series of strategic alliances involving hospitals and physicians, ambulatory centers, home health services, durable medical equipment, and nursing homes, etc.

The capstone to this evolution, a last step that some hospitals have taken, has been to develop a direct marketing function, i.e., to bypass the insurer as the middle man and become a health plan—an integrated delivery system coupled to the capacity to market the bundled delivery package.

How is health care reform likely to affect three things that I think are important to hospitals: universal coverage, a restructured delivery system, and fair payment?

Universal Coverage

First, we need universal coverage. Both for solid busi
ness reasons and for more compelling ethical and social reasons, we need to achieve this as soon as possible. I do not know how it can be done—through employer mandate, government mandate, or individual mandate. But some kind of mandate is necessary, backed up by appropriate subsidies.

Restructuring

Two, we need a continuing restructuring of the health delivery system. Our preferred candidate for that restructuring is a community focused and controlled integrated delivery network. A delivery system is needed that is operating downstream of a capitation payment or a per member per month premium. Only then can you begin erasing the barriers and discontinuities among treatment sites toward seamless care. Only then can you start aligning incentives among the whole set of individuals and organizations involved in delivering health care. Only then can you get proper investment in primary and preventive care.

You have to start off with a capitation payment and the transfer of risk to the organization that takes that capitation payment. Maximum scope should be given to encouraging providers to act with economic self-discipline so that economic self-discipline becomes the major cost control technique operating in the health delivery system rather than the chief alternative, cost containment, which represents centrally driven external micromanagement of prices and use. We think economic self-discipline by a provider organization is the road to go because that is the road that gets us to the desired destination—an efficient and effective health delivery system; the other road leads to a swamp and I do not know how you get out of that.

There are clearly different kinds of provider organizations and different ways to be downstream of a capitation payment. It is going to be a crowded field. We have two concerns. First, that some of these delivery organizations operating downstream from that capitation payment may be fly-by-night and give the whole thing a bad name and lead us into the regulatory swamp. Our other concern is that there are going to be over-the-horizon operations driving discount contracts with providers and giving everybody an 800 number to call, which also ultimately discredits itself and leads back into the regulatory swamp.

Fair Financing

The third element important to hospitals is fair financing. The suppliers of money usually feel that there is adequate financing and that the only problem is that the providers are frittering it away and not using it efficiently and effectively. The providers usually think that the only problem is that there is not enough money, that they know what to do and how to do it, and if they were not getting short sheeted everything would work out. I have been all over the world and I will tell you whether it is the national government talking to local government units, the public sector talking to the private sector, or private insurers in dispute with private providers, that is the basic dynamic. The question of adequate financing has to be looked at against that steady background.

The Clinton proposal includes a global budget. It basically comes down to the Consumer Price Index, which means zero growth. Can that be done? Absolutely. At an alumni meeting of people I graduated with many years ago—most of whom are hospital administrators and other managers in the health delivery system—I found these people to be eager to manage to zero growth or negative 5 percent growth or whatever. They are managers. You give them an assignment and they figure out how to do it. Basically, the sense they conveyed to me was, “We have not even started to scratch the surface yet. We have basically been squeezing out nickels and dimes. If we get into the real issue, of work redesign, there is no telling how much bang we can get for the buck.”

That leads us to a second consideration. Do we want it to be done? Do we want to manage to zero growth? Who knows? That is the kind of question to be
answered by the people there at the point of application. We need a mechanism to make these kinds of decisions, but it ought to be a real time mechanism. Maybe that is the national health board. It should not be 1994 formula legislation for what we are going to spend on health care in the year 2000 because that may not be what we want.

**Conclusion**

Health care reform, as it involves system development, just steps on the gas. The road does not change, the scenery just goes by faster. On the other hand, without health reform, we fear that we may get further away from universal coverage, as vulnerable populations grow and the vulnerable providers serving them shrink.
IV. Perspective of Providers

Policy Forum Discussion

**MR. LEACH:** I’d like to address the issue of gatekeepers. I think that the health care system has done a very good job of doing what it’s been asked to do, which is essentially chase reimbursement and drive up costs. If you want to create incentives in the system to make it financially driven, we’ll find a way to make that work. But what it’s got to boil down to is not the issue of gatekeeping, which has a bias built into it on the front end. What we need to do is medical management toward an outcome. So, we comply with all the concepts and all the regulations and all the plans and everything and we end up making a lot of money in the health care delivery system doing exactly the wrong thing.

So, what is the objective that we’re trying to achieve? If we’re trying to add value, deliver care at an appropriate cost, we can do that. But the systems that we create, the people we have to respond to put us in a position of not achieving that objective. So, where did the gatekeeper concept come from? It came from a bias that you have to watch the health care profession because they’re going to drive up costs, period. Nobody is fundamentally addressing the issue of the relationship between a health care provider and a patient who needs services.

If you want to talk beyond incentives and talk about risk and accountability, if the accountability, financial and otherwise, truly rested with the person who actually delivers the care, we wouldn’t have to worry about complicating our systems with all these intricate benefit blend designs that give you incentives for this, that, and the other thing.

We believe the pressure that’s been created by health reform has already started a great many positive changes in the delivery system. But have we really changed? The activities we’ve been engaged in have changed, but we’re still chasing reimbursement. We’re concerned that if we overregulate what’s already been created in various markets, we will essentially recreate just a different form of what we’ve always had, which is health care providers complying with a set of rules put in place by people who don’t understand the delivery of care.

**DR. MOHLENBROCK:** I’m a practicing orthopedic surgeon and I’ve been involved with outcomes research for the last 20 years. Ten years ago I founded an organization basically to help physicians hold themselves accountable to themselves for just the reasons that have just been brought forth. Physicians basically want to do well. If we’re given good clinically credible data, the physicians will modify their behavior in a heartbeat, but the incentives have to be there. In Cincinnati, we had a recent experience where the payers of care asked for volunteers in the hospital community to say, “Who will hold yourselves accountable to your outcomes of care?” When I’m talking about outcomes, I’m talking about severity adjusted mortality rates, severity adjusted indicators of quality such as nosocomial infections, returns to surgery, et cetera.

Given the clinical information, those physicians, because of the incentives, realize that either they started to hold themselves accountable, be willing to share that information with those payers or they weren’t going to get any business. Well, what happened, over the next 12 months literally hundreds of thousands of tests were not ordered. Thousands of chest x-rays were not obtained. You say, “Well, what happened to the quality?” Quite frankly, the severity adjusted mortality rates were unchanged and the clinical indicators of quality improved. Every single test and treatment that we do has a downside complication rate. Each test has a benefit, that’s why we order it, but each also has a complication. That’s why we should avoid unnecessary testing and treatments.

This type of outcome information is in its infancy. But the point is physicians are willing to hold themselves accountable to objective outcomes and will respond to proper incentives. And there is now evidence to back this up from Cincinnati and other hospitals.

So, as health care reform moves forward, let’s not lose the incentive of getting the physicians and hospitals in a position of competition.
MR. LEACH: If we overlegislate what we’re supposed to be doing, then the things that won’t happen are examples of Friendly Hills in California, which had a capitated product. Friendly Hills had one individual who was overutilizing the system because of asthma problems. Well, the solution to this was Friendly Hills bought an air conditioning unit at their expense and installed it in the patient’s home. You’re not going to put benefit plan design in place that causes people to do things like that. But if you define what the outcome is, what the framework is we’re going to work underneath, hold us accountable financially, a lot of things will happen. Let’s not drive the opportunity for creativity out of the system by overregulating it.

DR. SHINE: For purposes of identification also, I’m a cardiologist. I think that the point that Dan [Leach] has just made is critical. The outcome should be health and right now we’re not designed to deal with health. We focus on healing, but not on health and so systems have to be designed differently.

One of the fundamental issues relates to whether or not the physician and the patient and the family have a partnership, an alliance by which they’re going to go through the care system in which the patient can get good advice as to what’s value. Is the test worth it? Is the procedure worth it? What are the alternatives? There’s a big generation gap in that regard. Young physicians are comfortable with that. Many older physicians want to be able to tell their patients what they ought to do. The notion that patients need to participate in that activity is critical because, in fact, if you ever want to control inappropriate care, one of the best ways to do it is to give patients the options in a sensible way and they’ll often pick the more conservative approach, far more conservative than their physician.

The data are that physicians choose a more conservative treatment for themselves than for their families and a more conservative treatment for their families than for their patients.

With regard to primary care, the notion that the quality of our health care system depends on subspecialists is nonsense. I’m a subspecialist but the fact is the way many subspecialists are supporting themselves today is by doing a lot of what they call primary care. This often costs more because it’s charged for at subspecialist rates and often is not good quality of care because they’re not trained to be primary care providers.

I’m not interested in the good old fashioned family doctor. I don’t want somebody who sits by the bedside and ponders. Primary care doctors can do a lot for patients. They will have to be high tech doctors. They’re going to have to be able to work at computer terminals and learn what the outcomes of prostate surgery are by all the urologists to whom they may refer and advise their patients as to what the best place is to go in terms of their procedures. They’re going to have to have access to high tech communication systems so they can take care of patients in rural communities and use image processing and consultation in a substantial way.

MR. INLANDER: Dr. Schenken, I want to stress that we consumers can understand outcomes pretty well. We get the unnecessary hysterectomies because doctors tell us they’re necessary. We have caesareans because physicians decide that they can get paid more for caesareans. We have high malpractice rates because the malpractice insurance company is doctor-owned and completely hides negligent physicians from the public.

The consumer can understand quality, but we’re not given any data. We’re not told by hospitals what their infection rates are. We don’t know the doctors who have lost their privileges at hospitals. We don’t know the nurses who are in drug rehabilitation programs.

Johns Hopkins recently announced that they’re going to start doing mastectomies and vaginal hysterectomies on an outpatient basis. Now, the debate is not whether Johns Hopkins should do it on an outpatient basis. The debate is that some schmo is going to open up a clinic next to his lens extracting clinic and start saying, “While your husband is getting his cataract removed,
come on in and we’ll do a hysterectomy on you while you wait.”

We have 19th century licensing laws that were written by medical societies that won’t let us certify doctors on their competence to do specific things. We don’t certify whether doctors can use lasers; any doctor can go out and buy one and use one. We don’t certify specific specialties in the hospital on an outpatient standpoint. Hospitals are buying medical practices, not based on quality, but rather on volume of business. Some hospitals are very responsible about the practices that they’re buying. Others aren’t responsible at all.

So, I think when we’re talking from a provider standpoint, we’d better be talking about what the provider world is going to be in the future. The high tech physician is the future. The primary care doctors, today, are what nurses can be and are what other kinds of extenders can be. If the Mayo Clinic does something well, it shouldn’t be that we have to go to Mayo to get that high quality procedure. That information should be going out everywhere and the public should have access to it.

If anything comes out of health reform, the most important thing has to be the disclosure of information. It’s not the disclosure of information to employers that is important because employers are ultimately looking to save money. Information about quality should be passed along to the people who use the programs that they provide. They’ve got to tell me, “Don’t go to the University of California San Francisco Hospital. Don’t go there for this procedure. They’re more costly, they have worse outcomes, they have a higher infection rate.” That kind of information will direct me to the kinds of services where I can get a better chance of getting quality.

Consumers are treated as if we’re too dumb to be able to handle that information and I think that’s something we have to really take into consideration and that providers should take into consideration, as we move into this next century. Even today, I can plug in a PC and get a lot more information about conditions and issues than any single practitioner or expert has available. This transferring of information is where the difference will be.

**DR. SCHENKEN:** I think when we have things that are overstated, unexplained, and confused, it really doesn’t help with the substance of the debate.

I’ll just pick one example, hysterectomies. Virtually all hysterectomies, with the exception of those that are cancerous, can be put off. Most hysterectomies are performed because of complaints of the patients. There’s no question that the rate of hysterectomy can be decreased, but it’s a public policy and patient issue question as much as it is a medical question.

If I was interpreted by the rest of you as indicating that patients couldn’t understand because of some fundamental nature of the patient, then that’s absolutely wrong. What I did say is that the terminology was so confused, the system is so complicated that most people, including doctors, have difficulty understanding it.

**DR. CAPER:** I’m troubled by the AMA’s position on health care reform. The things that the AMA favors are employer mandates to expand insurance coverage, more public money for the underinsured and so on. The things the AMA opposes are global budgets, fee schedules, control over numbers of specialists, technology control, micromanagement of medical care, and, above all they say, please get the lawyers off our backs. I understand the relationship between micromanagement and cost containment. I agree many of the utilization review activities which are now going on are both onerously intrusive and ineffective. The reason we have as much micromanagement as we do is because as physicians, we’ve systematically and successfully resisted any attempt to constrain the capacity of the system over the years. By capacity, I mean the amount of technology, the number and types of doctors, the amount of bricks and mortar in the system, and the amount of money available to the system, all taken together.

Micromanagement of clinical decision making is
a direct result of medicine’s success in resisting attempts
to control capacity. To expect it go away without accept-
ing the need for control of capacity is an oxymoron. You
can’t have both. Neither doctors nor patients can expect
to have complete freedom to do whatever they want and
continue to drive up costs without expecting some kind of
reaction. The attempts to micromanage medical care is
that reaction.

This discussion reminds me of an experience I
once had when I was running U. Mass Hospital. We had
the best utilization statistics in the state at that time—
the shortest lengths of stay, the highest occupancy rates
and so on. We were selected for an award for that
performance, which we accepted. But in fact, when
somebody asked me what we were doing to achieve such
outstanding utilization statistics, I said, “Actually, we
haven’t done a damn thing.”

The low utilization rates were due to overall bed
capacity constraints. The hospital was just opening at
the time. We had recruited a faculty capable of staffing a
150-bed hospital. The legislature at the beginning of the
year suddenly said, “You can’t open your other 50 beds
because we’re not going to give you the money to do it.”
So, we essentially had constrained bed capacity. The
physicians themselves worked utilization constraints out
informally among themselves, essentially competing for
the available resources, driving down lengths of stay,
driving up occupancy rates and so on. They did it with-
out micromanagement. Nobody came in and reviewed
their charts or clinical decisions, and told them they
could do this or not do this and so on. The kind of
micromanagement that’s evolved over the past 10 years
or so really is objectionable and really is intrusive into
the doctor/patient relationship. It’s a direct result of
medicine’s successful efforts to defeat effective control of
overall system capacity.

DR. SCHENKEN: I think everybody appreciates the
need for budgets under certain circumstances. The
problem I think we face is that there is absolutely
nothing as far as we can tell that is being done on the
demand side, other than to tell doctors to cut the demand
down, and furthermore the demand side is being fueled
in great part, perhaps properly, for all the people that
are underaccessed, underinsured and so forth and so on.
I guess our concern is that absent some kind of a balance
there, until we see that balance we need to oppose global
budgets, just like we need to oppose price controls
because supply side alone controls, absent other changes,
haven’t worked in the past.
V. Perspective of Employers
V. Perspective of Employers

By Clark Kerr, Bank of America

I am in government relations, not in the benefits world. So, before the EBRI policy forum, I talked to benefits managers from nine San Francisco companies to get their input as to what changes they saw in the health care delivery system and how these changes are affecting their companies. I talked to two Silicon Valley computer giants, a national food retailer, three banks, a general merchandise retailer, a worldwide engineering company, and a large public employer.

In general, these employers told me it is easier to shape the delivery system than to control its costs. For example, changes in benefit plan design caused a dramatic shift to the outpatient setting, but outpatient costs are now sometimes higher than inpatient costs.

California is sort of the managed care capital. Employees have been moving on their own. For many years the employers did not give them the incentive to move into managed care because we have been partly subsidizing the extra cost of fee-for-service, so there was not that financial incentive from a premium standpoint. But people moved anyway. In fact, in the Bay Area, about 60 percent or 70 percent of the employees of most of the big companies are in health maintenance organizations (HMOs). Employees moved because of paperwork hassle, the scope of benefits, and their dislike of the deductibles and copayments of fee-for-service.

That increased movement is going to become an avalanche because employers have finally figured out that managed care really is saving them money, and there is no reason to subsidize fee-for-service. For a long time, people simply said that the reason the costs were lower for Kaiser and other HMOs was that they were skimming and getting the best risks. We are finally doing some decent risk analysis and finding that is not the case.

What companies are now doing is twofold. More companies have recently expanded HMO availability to their retirees and are introducing or significantly upping the employee’s premium contribution to their self-insured fee-for-service plans to entice employees into managed care.

In addition, the marketplace and health reform together are causing remarkable health plan consolidations that promise improved performance (“the cream is rising to the top”). Health plans that only a couple of years ago would not have been caught in the same room together are now looking for allies so they can compete successfully with the Kaisers of the world. For example, Health Net (strategic thinking and marketing responsiveness) has combined talents with QualMed (excellent medical management). Unihealth (strategic savvy and information systems) has combined with Blue Shield (extensive provider network).

The Bay Area Business Group on Health, which currently consists of 19 major companies, is putting together a plan to potentially jointly purchase HMOs in 1995. This is not just to negotiate better premiums. I think most of us have done a pretty good job on our own on that. It is really to negotiate quality standards, and there have already been some very positive results. We have gotten the major health plans of California to agree on what should be done in terms of preventive services. We have set performance standards and are going to be measuring health plans against them.

Generally, employers are seeing increased market competition among health plans leading to more client responsiveness, lower premium rate increases

1 Since the policy forum, Mr. Kerr has taken a new position as Vice President, Quality Improvement, with HealthExcellence in San Francisco.
(averaging around 5 percent–6 percent), and more innovation (some health plans are becoming more active in demand reduction/wellness, etc.)

The prospect of national health reform has caused some employers to delay any medical plan changes until they see what legislation passes, but others are making assumptions and corresponding modifications now.

The threat of health reform’s promised “freedom of choice” caused at least one large employer not to drop its fee-for-service plan as it had intended in favor of all managed care plans (but they will price fee-for-service according to cost and expect most employees to continue migrating out on their own).

The prospect of national reform is making it easier to introduce premium sharing in companies that formerly paid 100 percent (moving to an 80/20 employer/employee split). However, other employers have limited planned increases in cost-sharing (both employee deductibles and premium contribution), when it appeared they would exceed the Clinton plan.

Several employers who were direct contracting (or considering doing so) have decided against this micromanagement approach in favor of more macroperformance management (i.e., setting result expectations at the health plan level and letting plans micromanage the processes to accomplish the objectives). The idea of leaving it to the health plan to determine how to make things work out is really the way that California is going, and as California goes, for good or bad, so goes the nation.

Employers realize more clearly the important role of the individual in controlling health costs and are moving to educate employees and involve them as appropriate in healthy lifestyle programs (including dollar incentives) and informed decision-making vis-a-vis their own medical care.

Some employers said they see national health reform borrowing from their own actions (rather than vice versa).

Large employer group purchasing alliances have been given a boost by health reform as big employers realize they could become small fish in the market vis-a-vis the proposed regional alliance.

There seems to be a general feeling among the companies that the way the market is moving and the threat of national health reform have been very effective. Maybe that is enough. If I were the Clintons, I would continue to threaten on and on and on because there is a concern that actual implementation of reform legislation may foul this all up.

I think there is an increasing understanding that, although we all talk about cost and access as big issues, quality is a huge issue too. Companies are finally starting to realize there is a problem. We are hearing more about the study in New York that adverse events or medical mishaps may be killing 198,000 Americans every year. Bluntly put, if that is true, our health care system is killing three to four times more people than car accidents every year, and that is kind of scary, especially when the estimates are that two-thirds of these deaths are preventable.

A study that we did in California, looking at ranking quality in hospitals, was released in December. We brought in Hal Luft, a national researcher, and his team to risk adjust as much as possible cases of treating heart attacks. After every risk adjustment possible was made, there still was a difference—several times the
likelihood of death, depending on the choice of hospitals. There are some tremendous quality questions that have to be considered.

Why did the U.S. health care system go wrong?

- Health care purchasers neglected too long to question performance. Performance standards? “Health care is different.” You can ask ball players and teams their batting averages, but doctors and health plans are different. (Maybe that was true: whenever they struck out, we lost. They still got paid.)
- Health professionals sometimes lost sight of the patient. It became what you did to, not for, the patient that brought in the money.

The key to reforming the health care delivery system?
- “It’s the system’s performance, stupid.” How are we going to improve the system’s performance? I think in two ways. One is getting into competition for results and the other is paying for performance or starting to reward people for doing a good job.

How to spur positive competition?
- Establish performance measures: Initially, at the purchase level (i.e., health plan), then at the individual choice level (i.e., doctor, etc.). Specify outcomes desired, but give plans/providers flexibility in how to achieve them. Comparative measures range from immunization rates to surgery outcomes to smoking cessation success rates. Establish a base of national measures for consistency in evaluating interregional performance. Encourage additional innovative local measures. Select primarily outcome measures rather than process measures (to encourage innovation in achieving best results). Measures should be selected jointly by consumers of health care, purchasers of care, and providers.

- “Report cards” score relative “value” in four major categories: (1) keeping you healthy; improving/maintaining health status; (2) once ill, getting you well, functional, without pain or fatigue; (3) meeting your service and emotional expectations (satisfaction); and finally, (4) at what comparative cost in dollars.

Pay for Performance

Local purchasers (health alliances, employers) over time would establish their own minimum performance standards that health plans must meet in order to qualify to be offered to members. Standards could be raised periodically. Consumers would choose among the qualified health plans according to who seems to offer the best results for areas they value most (just as consumers make decisions in the rest of the economy). Local purchasers could establish incentive pay arrangements whereby the best performing plans (best risk-adjusted surgery outcomes, best success in smoking cessation or prenatal care, etc.) are paid more than lower performing providers.

In corporations we have exceptional performance awards, and I do not see any reason why providers should not be paid for performance. In addition to the minimum requirements, in addition to having consumers make choices, why not pay providers more if they do an exceptionally good job in certain areas? Why not set a certain percentage of the pool that goes into paying all the plans to the plans that do the best job? I can assure you if you do these things the quality of health care in this country will be eminently better than it is now.

I have some concern about the idea of having a single alliance per region with essentially a
locked-in membership and whether or not the alliance would do as good a job as it needs to do. One employer compared its rates against those of the new Health Insurance Plan of California (California’s health care purchasing cooperative (HIPC) for small businesses) and found the HIPC’s rates to be “much higher.” This raises the question of whether or not state-sponsored alliances will be as cost/quality aggressive as many large employers have been.

If you do not have competition, then you certainly need some sort of watchdog group to look over the alliance and make sure that its cost and quality performance is on a par with others. The watchdog needs to be an independent entity, with consumer input, and it should be a group that is not tied in with the financial incentives. Under fee-for-service, you make more money by doing too much. But the way you are going to make money potentially in the future is to underserve. Somebody has to be a watchdog on that. I do not think it is going to be the health plans. I do not think it should be the alliances. I do not think it should be the state either because states will be under tremendous pressure from the federal government to meet certain cost targets. An independent entity is needed to guard the quality of care.

Finally, this independent entity should have a hotline and an appeals board to judge consumer problems impartially. I do not think the alliance should be the only recourse if there is a problem. There should be someone who does not benefit financially by underservice who can judge decisions. I want to also stress the importance of the computerized medical record for the future of the delivery system. I think that is absolutely critical in terms of being able to monitor quality of care but also in terms of assisting the provider to do a better job.

In summary, I believe significant improvement could be made in the health care delivery system by establishing national performance standards, report cards on health plans and providers, and local performance standards and incentive pay arrangements. And it is critical that an independent watchdog maintain comparative cost and quality performance evaluations to keep alliances and health plans on their toes to best serve their memberships.
Xerox has experienced the growing rate of high cost procedures (i.e., procedures costing more than $100,000), in addition to the other forces driving the health system that were discussed at this policy forum. In one year alone in our fee-for-service plan, the rate of high cost procedures doubled. This is due partly to selection and partly to the increased availability of transplantation to our population. I do not think we suddenly in one year (epidemiologically) became much sicker. What we are finding is we have very high utilization on the outpatient side because almost everything that can be done on an outpatient basis is being done, but the smaller number of admissions that end up in the hospital are really very large, high cost cases. Many range anywhere from $100,000 to $1 million in a year. That is hurting us a lot.

Xerox’s reaction to these escalating costs was to conclude that we had to find a way to provide comprehensive care in an organized setting for a reasonable price, with emphasis on selecting providers on the basis of quality and accountability. We are a paternalistic company but one that must face very tough global competition.

Xerox decided that “policing” programs, which represent command and control micromanagement, have been necessary in the short term in our fee-for-service system to get us to the point where clinical case management helps to ensure that we are paying for the most appropriate care in the most appropriate setting. But this policing is certainly not at all attractive, and it makes everybody mad, particularly our employees. While the doctors hate them, they will accept them, at least in our program, for the payment. But our employees complain to us and see every step that we take in these areas as a take-away. This happens even when we spend time with them and have clinical professionals talk to them, walking through the options; we encourage our employees to talk to other providers. Even if, for example, they conclude that in fact it was a bad idea to be hospitalized for routine diabetic management, they are mad at us because we somehow put them through this. If they are in a health maintenance organization (HMO), they attack the people in the HMO.

However, we found that at the very least we were, all things considered, better off encouraging people to select accountable health plans or HMOs that met our requirements, the most important of which is that the plans be willing to be accountable to their members. For example, this year we have, on the open enrollment summaries, the member satisfaction score for every HMO offered in each health service area. We think that is important but it is not nearly enough. Also, each year as our employees have migrated to HMOs, we find more and more are generally enthusiastic about their HMOs and the many enhancements they offer.

Accountability

In terms of performance measurement, we obtained from our HMOs for last year (calendar year) rates of mammograms, prenatal care, immunizations, etc. Using these data, we are going to create our own report card. Before next year’s open enrollment, our consumers will have a list of measures. We take the need for accountability very seriously.

We believe that HMOs should actively assume responsibility for the members’ health. That does not only mean taking care of them when they show up at the door. It means, for example, training the staff to pay attention to whether or not someone has had a mammogram, to make sure the information is available on the record, and to see that a clerk fills out a postcard or even
asks the member to fill out one with a reminder of the next checkup. We want to be able to tell our employees, “If you join these health plans as opposed to other plans, you are going to get the kind of health plan that is spending as much time and energy working on your health as they are curing you when you are ill.”

**Member Satisfaction**

We also insist on contracting with plans that actively work on ensuring member satisfaction. That means annual surveys, using standardized instruments, which is much harder than it sounds. But we can do it, and we are insisting on it. We are being resisted by some, however. Few really want to ask the hard questions, and we are insisting that they be asked. We think it is going to be in everybody’s interest—ours, the plans, and the public’s in the end—but it is very important that the plans really work at it, and that they also have performance improvement targets based on employee feedback.

The health system, if you look at it from the purchaser’s perspective, is still much like the U.S. auto industry in the 1960s and 1970s: “Don’t tell us our customers want something we are not giving. We know best.” Unlike the old auto industry, we believe the health plans will not watch their customers walk away and join the other side while they are wondering what they did wrong.

**Costs**

We also hope that the plans will slow down escalating costs. We put our emphasis and base our employees’ subsidy on what is known as the benchmark HMO in each health service area in the country. We are increasing the numbers of HMOs we deal with, not reducing them.

In most service areas, depending on size, the employees’ option includes anywhere from 2 to 12 HMOs. However, we tie our subsidy directly to the benchmark HMOs and HMOs whose premiums are within 5 percent of that benchmark, which means that our benefit allowance will give the employee money back. A Xerox employee who chooses the benchmark HMO will get almost $400 back out of his or her benefit allowance to spend on vision, dental, dependent coverage, life, or medical spending accounts or the employee can take it in cash (and pay taxes).

An employee who chooses the fee-for-service system, which we still permit, will spend somewhat more money. It is still a relative bargain by U.S. national standards. But the bad news to employees is that there is a 1 percent of pay deductible, with no cap (except at the out-of-pocket limit, which is 4 percent of pay or $4,000, whichever is lower). Not surprisingly, some of our highly compensated people never see a claim paid. The fee-for-service plan also does not cover as many services as the HMOs. So, it is not surprising that close to 80 percent of our employees who choose family coverage are now choosing HMOs because they are a much better buy.

**Quality**

We also require that HMOs that we contract with be committed to total quality management (TQM) and that they make a commitment to continuous quality improvement (CQI), which is a long way from the concept of quality assurance. We were impressed at how many of our plans and how many of the providers we deal with are as enthusiastic about this as we are.

We also require that providers be willing to document their value, cost effectiveness, and quality. They do this on a regular basis, using standardized definitions. They report data to us using the HEDIS 2.0 methodology that we spent 13 months collectively developing. They regularly measure member satisfaction, and they are accredited by the National Committee for Quality Assurance.

We expect HMOs to compete with each other on customer service, quality, price, access, location, conve
nience, and efficiency. As a result, Xerox employees are voting with their feet.

Effectiveness

In terms of premium increases, in 1992, overall, all of our HMOs increased 14.9 percent. But in 1993, all of our HMOs countrywide were 8.9 percent over the prior year. In 1994, all of our HMOs increased 5.3 percent over the prior year. But our benchmark HMOs, the ones on which our subsidy is based, in 1992 increased only 7.7 percent, when it was 14 percent for all. In 1993, benchmark HMOs increased only 5.5 percent in contrast to 8.9 percent. And in 1994, benchmark HMOs increased 3.6 percent, in contrast to 5.3 percent. So people are figuring it out and are moving. We think our system is working.

In terms of the President’s plan, we, like everyone, are very pleased with the universal coverage aspect. I do not know of anyone who does not want all Americans covered for the kind of coverage that most of us enjoy, with some reasonable limit. A concern I have, though, is what is going to happen to the 20 percent to 40 percent cost shift that is in every price that we are now paying to providers? Do we get a onetime rollback when we cover everybody? In Connecticut they make it easy. Bills include a line that is called “uncompensated care,” which represents 30 percent of the bill. If, in January 1995, we have a new plan and every American has his or her own coverage, is the 30 percent going to come off? Every person who walks through a hospital door is going to be carrying a health security card and is going to be paying the full price. At least in the places I am familiar with, we are not going to need that uncompensated care payment.

We all want reform in the small firm employer market. I think we all want emphasis on total quality management, which the President stressed, and we all want attention to documentation of quality, value, member satisfaction, using standardized data sets, which he also stressed.

We are worried about a few things. The cost is a serious concern and also the role of the states. We are very concerned about such things as a provision that says, if you are a corporate alliance, and maybe even if you are not, there will be an option of identifying a whole set of problems in the health system, including “essential providers,” which can be paid for by taxes or any deep pockets that can be found to cover these costs.

When I was at the Institute of Medicine, we did a study called “Health Services Integration,” and we found some of the most wonderful programs in this country serving people nobody else wants. I don’t know of anybody who looked at those programs who would not want to support them. But in doing our original search we found a lot of “essential providers,” public general hospitals that may or may not provide high quality care. They are certainly terrific places for jobs, and politicians at the local level control them. We do not want additional money being pulled out of our companies to pay for the slush funds of some of these cities, particularly when there may already be 50 percent–80 percent more hospital beds than are needed in the community. To give the states the power to tax corporations to pay for this kind of program is of deep concern.

The final concern is the mental health benefit. We understand that we need to take care of the seriously mentally ill, schizophrenics, the people who are wandering the streets or are in and out of institutions and are very sick. However, we are concerned that the President’s plan extends an extensive mental health benefit to the entire population. We used to provide this benefit and our experience shows that the number of opportunities for a lifetime of psychotherapy for the insured and their blended family members is endless. People are having trouble with their marriage so they...
get psychotherapy. They get a divorce and everybody has to get in psychotherapy because of the divorce. Somebody remarries so the blended family has all this unhappiness because there are teenagers, and they have psychotherapy. And then that does not work out, so they get another divorce so everybody has to be back in psychotherapy. This kind of thing in fact happens in the real world of employed people. It is not the same as the tragedy of the really mentally ill, and I can promise you the coverage benefit in the administration’s plan mixes up those two groups.

Conclusion

We want plans that compete on quality, customer service, efficiency, and price, and we want public accountability on all of these points. We believe the President’s plan has that in it. We hope the Congress agrees and supports the kind of managed competition that we think is workable.
V. Perspective of Employers

By William J. Dennis, Jr., National Federation of Independent Business

Introduction

Not long ago, I was reading an article describing business views on a series of health policy issues. Using survey data collected by a California research organization, the article’s author divided businesses into a typical small, medium, and large classification scheme in order to compare and contrast judgments of various segments of the business population. Some of the views attributed to small business seemed odd, and as I read on I discovered why. Large firms in the author’s classification averaged 45,037 employees, medium firms 3,205 employees, and small firms 317. It was then I decided that I would devote at least a few paragraphs of this paper to some basic demographic material on the small business population. For, if one has no idea of the composition of the business population as the author of this article apparently did not, one has no idea of how current health care reform proposals will impact small businesses and the people who work in them.

The Small Business Environment

There are approximately 5 million businesses in the United States that employ someone other than the owner. Fifteen thousand of these businesses employ more than 500 people (0.3 percent of all employers), and another roughly 80,000 employ between 100 and 499 (1.6 percent of all employers). If these numbers appear astounding, look at the distribution of employing businesses from the other end of the size spectrum. Somewhat fewer than 60 percent employ just one to four people other than the owner. Another 20 percent employ 5–9, and yet another 10 percent fall in the 10–19 employees size classification.

Though 9 of 10 employing businesses have fewer than 20 employees, they constitute less than 20 percent of the private sector employee base. Firms employing 500 or fewer people engage just over one-half of all private-sector employees. If the self-employed, nonemployers are included, the small business share rises to about 57 percent. Moreover, despite recent publicity to the contrary, small business remains the principal generator of net new jobs. The precise share changes with the business cycle as well as with improvements in the data base used to produce the numbers. However, no doubt exists about the importance of small business to employment growth among those familiar with the data.

The final demographic point is that the income produced by small businesses varies enormously. Data from the 1991 Survey of Income and Program Participation (SIPP) show business owners working in their firms 35 or more hours per week drew a lower median income from their businesses than wage and salary workers working at their jobs 35 or more hours per week. On the other hand, small business owners drew higher average earnings from their businesses than did wage and salary workers from their jobs. The result is that incomes derived from business ownership are much more likely to fall at the ends of the distribution. Owners are more likely to do much better and much worse than wage and salary workers.

1 Steven Findlay, “Employers to Clinton: Proceed Cautiously on Reform,” Business & Health (July 1993).
2 See William J. Dennis, Jr., A Small Business Primer (Washington, DC: The NFIB Foundation, August 1993), for a review of the most commonly asked questions about small business, including “how many are there?” and “how many new jobs do they generate?” A more detailed and technical treatment of many of these questions can be found in the annual The State of Small Business (Washington, DC: Small Business Administration, Office of Advocacy).
3 The survey is conducted periodically by the U.S. Bureau of the Census. Its unique value in calculating small business owner income is that it permits integration of those owning corporations with those owning proprietorships and partnerships.
Health care policy operates in an environment in which there are millions of decision-makers and business owners controlling firms of vastly different sizes, abilities to effectively purchase and manage health care benefits, and capacities (and willingness) to underwrite coverage or to absorb taxes to pay for it. Crafting a new, detailed one-fits-all health care policy for such diversity and for 14 percent of the gross domestic product requires ego of unbridled proportions. Modesty and prudence counsel that the wisest course for reformers is to alter a few basic rules of the game and let individuals pursue their interests.

The National Federation of Independent Business (NFIB) periodically conducts surveys of its 600,000 small business owner members to determine what they consider to be their primary problems and/or most critical business issues. The surveys list approximately 70 potential problems, including management as well as policy-oriented concerns, and asks sampled members to evaluate the severity of each. The first of these surveys, conducted in 1982, did not contain cost or availability of health insurance as a separate problem. Rather, health insurance was wrapped under the broader issue of “Employee Benefit Costs,” and even then the average rank that owners assigned the problem was 18th from the top (out of 66).

Conditions changed. The 1986 survey offered the “Cost of Health Insurance” separately. It also offered “Workers’ Compensation” with its significant health care component as a separate problem. When the results were tallied, the former ranked first and the latter seventh. Nearly identical results were achieved when still a third problem survey came out of the field in late 1991. The cost of health insurance not only retained its first place ranking, but 61 percent termed the problem “critical.” The only problem to have even half as many so deeply concerned was the related “Workers’ Compensation” problem, which 40 percent termed “critical.”

This series of surveys, as well as others, makes two important points: first, small business owners are very concerned about the health care and health insurance. This is not a peripheral issue for them. Health care is a continuously pressing matter. Second, the primary owner concern is cost, not quality or coverage. While some owners have been affected by renewability problems and other problems peculiar to smaller firms, cost is the critical issue. However, understand that small employers assume timely, quality health care. Challenge that assumption and small business owners could reevaluate their preoccupation with cost very quickly.

Small Business Provision of Employee Health Insurance

W. David Helms, President of the Alpha Center and

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4 The most recent problems and priorities publication contains the ordering of small business problems for each of the three surveys in the series. See William J. Dennis, Jr., Small Business Problems and Priorities (Washington, DC: The NFIB Foundation, 1992).

5 The health care component of workers’ compensation has been rising and now consumes approximately 40 percent of its $50 billion employer cost. (See Marilyn J. Field and Harold T. Shapiro, eds., Employment and Health Benefits: A Connection At Risk (Washington, DC: National Academy Press, 1993). One characteristic of workers’ compensation that allows its health care costs to rise faster than health care costs generally is that the system contains no deductibles or copayments.

6 Most Americans are familiar with the general inflation in health care occurring over the last 5 to 10 years. However, small business owners have experienced additional problems that have raised the costs of their health insurance more rapidly than those of larger firms. Among the differences: higher insurance administrative costs, which were calculated by the Congressional Research Service to be at least three times higher for firms with fewer than 25 employees than for firms with more than 1,000 employees; a lack of expertise and bargaining power; health insurance representing a larger percentage of payroll; and the inability to capture the benefits of self-insurance.
consultant to the Robert Wood Johnson Foundation small employer experiments, once characterized the health insurance problem as one that “lies with the very smallest employers...the 1–10 employee size group, even more the 1–5 employee size group.” These sentiments find support in calculations of the number of employers providing employee health insurance by firm size. The Health Insurance Association of America (HIAA), for example, surveyed a sample of businesses in 1989 and found that 26 percent of those employing 1–4 people offered employee health insurance while 54 percent of those in the 5–9 employees size group did so. The percentage offering it rose with firm size until 99 percent of those with more than 100 employees did so.

The most recent survey of small business health insurance provision that I could find approximated the HIAA numbers in all relevant size classifications. Jensen, et al., surveyed a sample of small firms in the spring of 1993. The authors found that 44 percent of the 1–9 employee size class, 70 percent of the 10–24 size, and 85 percent of the 25–49 size offered some type of employee coverage. The differences in these two surveys are modest and within the error term for each size class.

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These two surveys raise two points: the first is that relatively few of the very smallest businesses provide employee health insurance. Among the very smallest, about one in four provide it. Less than one-half of those with fewer than 10 employees do. Thus, a simple mandate effectively raises taxes for a majority of the small employer population, assuming everyone providing insurance covers all employees (which they don’t) and possesses “minimum” coverage (which they don’t). Eliminate those assumptions and the affected population rises. This significant tax increase, of course, comes prior to any other levies sought from a broader tax base (i.e., individuals/consumers and businesses) to help subsidize expanded coverage.

Changes over Time

The second point raised by the surveys is that the number of small employers providing employee health insurance has changed little over the last few years. That represents an important alteration in the prevailing trend. Health insurance coverage appeared to steadily increase in small businesses at least throughout the late 1970s and early 1980s. Progressively larger numbers of firms offered the benefit and more Americans were covered. However, the increases ended sometime in the mid-1980s, particularly among the very smallest businesses.

Table 1 was developed from surveys conducted by NFIB across samples of its members. Since NFIB members are somewhat more mature and larger than is the small business population, the frequency of provision is greater than for the population as a whole. However, the data clearly show an increase in the proportion of

<table>
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<th>Employee Size of Firm</th>
<th>1978</th>
<th>1985</th>
<th>1990</th>
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<tr>
<td>1–4</td>
<td>30%</td>
<td>49%</td>
<td>39%</td>
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<tr>
<td>5–9</td>
<td>66%</td>
<td>79%</td>
<td>68%</td>
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<tr>
<td>10–19</td>
<td>84%</td>
<td>83%</td>
<td>80%</td>
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<tr>
<td>20–49</td>
<td>90%</td>
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<td>50+</td>
<td>92%</td>
<td>92%</td>
<td>92%</td>
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<tr>
<td>All Firms</td>
<td>57%</td>
<td>65%</td>
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Source: National Federation of Independent Business.

10 Unfortunately, a gross misunderstanding of this simple fact occurs too frequently. The primary obfuscation comes in the number of employees working in firms with fewer than 10 employees who have insurance (about two-thirds) and the number working in firms with fewer than 10 who have insurance provided by their employer (about one-quarter). A typical example of the error occurs in, “Too Soon to Panic,” Newsweek, August 30, 1993, p. 45. The importance of the distinction is that one implies a more severe impact on smaller firms than does the other.
firms offering health insurance between the late 1970s and mid-1980s.\textsuperscript{11} The number appears to erode modestly throughout the late 1980s with the very smallest businesses experiencing the most significant deterioration.

This erosion (or stabilization) occurred at a time when the annual increase in health insurance premiums reached double digit levels, although there is evidence small business premiums reached those levels earlier.\textsuperscript{12} Thus, so long as health insurance was relatively cheap, small business owners were able to add it to their employee compensation package. But when premiums rose and the more financially successful businesses already offered it, the trend could not be sustained.

Perhaps more important than the number of firms offering coverage is the number of people who are covered. The March 1993 Current Population Survey (CPS) permits an assessment of who has health insurance coverage by a number of personal characteristics including the size of the employer. Note on chart 1 that the proportion of employees receiving health insurance directly from their employers is not the same as the proportion of employees who have coverage from any source. Take the fewer than 10 employee size for example. Just 22 percent of employees working in these firms obtain health insurance directly from their employer.\textsuperscript{13} However, 67 percent of those employees have coverage from all sources. In contrast, 69 percent in the group with 1,000 or more employees obtain their health insurance directly from their employers, and 90 percent of these workers obtain it from any source.

These data reaffirm the pervasive nature of any employee mandate in terms of small business firms. The smallest firms would have to increase the number of people covered by 300 percent, for example. Those in the 25–99 employee size class would have to about double
the number covered. Such expansion of coverage represents enormous cost increases for small firms even should they be subsidized.

**Principal Issues for Small Business**

**Costs**

Small business owners are primarily concerned about health care and health insurance costs. Costs to most owners mean out-of-pocket dollars. However, costs are far more encompassing than insurance premiums or doctors’ bills. Waiting line is a cost, as are restrictions on provider choice. Since Americans experience neither waiting lines nor limitations on providers (for the most part), small business owners, as the public in general, overlook these kinds of costs. Thus, when small business owners express concern over health care and insurance costs, they make critical assumptions which should not be ignored.

If small business owners assume little change in the health care delivery system, how do they propose to limit costs? On this issue, small business owners have less to say directly. However, when pressed, they fall back on tested solutions.

**Markets**—The place to begin is with markets just as it is with other goods and services we purchase. Last year The NFIB Foundation asked Michael Morrisey to review the literature on the role of prices in health care. We were interested to know what the corpus of academic work tells us about the relationship. And while it is never totally fair to reduce a lengthy monograph to a few sentences, Morrisey summarized his own work well when he wrote, “... it is clear that there is a fair degree of price responsiveness in the demand for health services and substantial sensitivity for health insurance.”

And, “The only way to induce people into taking the cost of health care into account when considering what to buy and whom to buy it from is to give them a financial stake in the outcome.”

The way to give patient/consumers a financial stake in health care is to let them purchase health care as they would any other good or service. That implies at least caps for employers and employees on the amount of premium that can be either excluded from income (for employees) or deducted (for employers). Many believe the tax subsidy should be eliminated entirely. Moreover, more effective use of markets argues for greater cost sharing by those who ultimately purchase health care.

It should be made clear that the use of markets to control costs is compatible with various mechanisms to account for the problems of poorer Americans. Furthermore, it is good that markets force consumers to make choices in health care because the alternative is having government or a large private bureaucracy do it for them.

Market solutions assume information about the cost and effectiveness of alternative providers and treatments. Little is now readily available to patient/consumers. That must change. Here is one place where government could play a positive role to stimulate the functioning of markets and thereby the control of health care costs.

**Underwriting Small Groups**—Small business owners pay significantly more for their health insurance on a per employee basis than do larger firms. Most of the disproportionate cost occurs precisely because groups are small. Owners must, therefore, find a means to take

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15 Ibid.
advantage of their collective size and purchasing power without voiding incentives at the firm level to keep health care costs at a minimum. But how this is to be done in practice is another matter.

Fashionable thinking currently revolves around HIPCs (health insurance purchasing cooperatives) or the equivalent. The idea of a large purchasing group using some form of community rating is attractive to many small business owners. The group's structure would provide owners a measure of market power that they have never had; it would reduce or eliminate the inherent underwriting problem; it would give those facing availability problems recourse; and, it would reduce administrative costs to an undetermined extent. The result is that HIPCs per se (not in combination with a mandate) could lower total costs as well as costs for a significant number of individual small business owners.

But HIPCs also raise relative premiums for a set of small business owners. The reason is that these small firms have had a favorable claims experience and have enjoyed relatively low insurance premiums. Some of their favorable claims experience is the result of chance and some is the result of calculation, e.g., wellness programs. But by community rating these firms with all others, HIPCs effectively throw them in a pool with firms that have a less favorable claims experience. (Less favorable claims experience also results in part from chance and in part from calculation.) The result is relatively higher premiums. Yet, higher relative premiums are not the same as higher actual premiums, and small business owners concern lie with the latter. A key issue, therefore, becomes how HIPCs will benefit (or not) owners with different claims histories.

It would be wrong to community rate absolutely. That step would provide no incentive to alter behavior and reduce costs. The question of nonsmokers subsidizing smokers comes to mind. Furthermore, absolute community rating incorporates inequitable subsidies. Why should young Americans just getting started (lower risks) subsidize Americans in their prime earning years (higher risks)?

Some proposals make individuals responsible for procuring their own health insurance. The employer may or may not play a role, depending on the plan. While removing employers from the “loop” is vastly preferable to requiring them to be in it, the ideal solution is to allow employers to participate or not as circumstances demand.

Medical Malpractice—Revision of our medical malpractice laws is obviously a place to save. Cost reductions resulting from malpractice reform stem not only from fewer direct litigation costs but also from a reduction in the frequency of “defensive medicine.” Lewin-VHI, Inc., estimated the savings that could be realized from provider behavior change as a result of malpractice reform and estimated a $7.5 to $76.2 billion saving over a five-year period. The mid-range estimate was $35.8 billion over five years, or about $7 billion annually. In the $700 billion health care sector, saving from a reduction of defensive medicine is rather small, but it is important for its symbolic value as much as for the dollars.

Cost Shifting—Cost shifting is not an issue of saving money; it is an issue of who spends money. Furthermore, it a more complex issue than is generally recognized and will be addressed later in this presentation. Its importance here lies in the failure of government to accept its legislated financial obligations. Through the Medicare and Medicaid programs, the government, particularly the federal government, has explicitly assumed responsibility for financing a considerable portion of the health care for the aged and the poor. Total cost for these two programs alone amounted to $174 billion for Washington and $43 billion for the states in 1991. Add other health care spending and the federal government underwrites more than $200 billion in health care. Two hundred

billion dollars represents market power and Washington is not bashful about using it.

Federal cost shifting is transparent. Ask the governors or private physicians. Cost shifting of health care costs by the federal government has been a theme of governors from both political parties. Recently, Raymond Scheppach, executive director of the National Governors Association, broached the situation directly. He wrote, “Because Medicare and Medicaid do not pay their fair share, costs are shifted to private payors.” See Raymond C. Scheppach, executive director of the National Governors Association, broached the situation directly. He wrote, “Because Medicare and Medicaid do not pay their fair share, costs are shifted to private payors.”

The answer is the same. The federal government shoves its costs onto others. While it probably changes total cost relatively little, it implies private insurance costs are higher than they would otherwise be. The effect is to raise premiums at the cost of relatively lower taxes. But although federal cost shifting raises premiums, the net impact on small business depends on how the offsetting revenues are raised.

Costs and Additional Demand—The United States has approximately 37 million people not currently covered by health insurance and additional unspecified millions “underinsured.” Conventional economic thought argues that if we add 15 percent to 20 percent to the demand for health care (the uninsured and the underinsured), then health care prices will rise as will total health care costs. Driving prices even higher is, of course, the exact opposite of what small business owners are concerned about. (On the other hand, if prices don’t rise after adding 37 million new people to the system, what is the problem? Without additional demand, we never had a serious coverage problem and the need for action was grossly exaggerated.)

The evidence suggests the United States does have a coverage problem. That means bringing new people into the system will raise demand for health care, which in turn will result in even more rapid price increases. Higher health care prices will drive small business owners, and other employers, to further limit hiring, depress wages, restrict nonmandated benefits, and generally arrange their affairs to avoid the new costs. These steps will, of course, adversely affect small business employees, many of whom are supposed to benefit from the broadening of coverage. As a result, prudence dictates that price reduction activities be undertaken initially, with expanded coverage to follow.

The Selective Tax Increase

Broadened coverage will require that additional taxes be levied in order to finance new benefits. Discussion of new revenues has focused on payroll taxes and sin taxes. However, it is likely that efforts to raise the greatest amount of revenue will occur elsewhere.

The proposed employer mandate is, in the first instance, simply a tax increase on employers not providing employee health insurance or not providing enough employee health insurance. It is, in the second instance, a tax increase on the working Americans, because while the tax must initially be absorbed by employers, it will ultimately be passed back to employees in the form of lower wages, reduced nonhealth benefits, and fewer jobs. The employers and employees who would be most affected by the tax are those currently without health insurance. People without health insurance tend to draw the lowest wages and have the least profitable businesses. In short, health insurance mandates equate to taxation based on the inability to pay.

Taxation Based on the Inability to Pay—A direct link exists between business profitability and the provision of employee health insurance. Owners who take more from their businesses in salary, earnings, draw, etc., are more likely to provide insurance, while those who take out less are less likely to provide it. In fact, cross-tabulating owner takeout with provision of health insurance produces a stairlike effect. Every $10,000 increment of income increases the proportion who provide insurance.
and the proportion who provide it to all employees.\textsuperscript{18} Thus, only one in three NFIB members who took $10,000 or less out of the business in 1989 provided employee health insurance compared with 90 percent of those taking out $70,000 or more (chart 2).

Some may argue that while the relationship just demonstrated may exist, most small business owners earn considerable sums from their businesses; therefore, the relationship, though interesting, is largely irrelevant. The data suggest a different scenario. They show many owners doing very well, but they also show many not faring well at all. In fact, full-time business owners tend to exhibit a bipolar income distribution compared with wage and salary earners. (See previous discussion under “The Small Business Environment.”)

Then what about affected employees? What is their income status? In 1992, 53 percent of the uninsured were in families with incomes of under $20,000, compared with 12 percent of those with incomes of $50,000 or more.\textsuperscript{19}

Comparatively poor employees work for comparatively poor employers, and vice-versa. So, if you believe that mandates are an employer tax, the tax is levied on weak businesses and vulnerable employers. If you believe that mandates are an employee tax (passed on from the employer), the tax is levied on the working poor. In either case, the mandate is a highly regressive tax even when a subsidy is included.

If the working poor and more vulnerable firms are those most likely to be affected by a mandate, what is the magnitude of the effect? The NFIB Foundation asked CONSAD Research Corporation of Pittsburgh to provide it estimates of the impact of various proposals on smaller firms and their employees.\textsuperscript{20} The objective was not just to provide estimates of job losses but to review the entire set of impacts and estimate the number of people affected by size of the firm for which they work. Impacts included job loss as the most extreme effect as well as more common effects such as foregoing wages, working fewer hours, encountering reductions in other benefits, etc.\textsuperscript{21}

CONSAD’s estimated “floor” job losses ran at 400,000 to 900,000 depending on the mandate assessed. The report concluded, “...estimates of job losses exceeding 1,000,000 from the more rigorous employer mandated proposals are not unrealistic.”\textsuperscript{22} Others have

\textsuperscript{18} For a more thorough discussion of the argument and data supporting it, see “Taxes Bases on the Inability to Pay: Another Effect of “Play or Pay,” The NFIB Foundation, 1991.

\textsuperscript{19} Sarah Snider, “Sources of Health Insurance and Characteristics of the Uninsured,” EBRI Issue Brief no. 145 (Special Report SR-20 (Employee Benefit Research Institute, January 1994).


\textsuperscript{21} CONSAD’s methodology was developed for the Health Care Finance Administration (HCFA) a year earlier with the establishment size estimates specifically produced for The NFIB Foundation.

produced higher and lower figures, and CONSAD's projections are clearly reasonable. In fact, the administration reportedly faced job losses in seven figures with its proposal, although a spokesman heatedly denied the news stories and labeled estimates of substantial job loss as “partisan.”23

But CONSAD’s estimates of the number of jobs “at risk,” i.e., impacted, proved 9 to 10 times the job loss. Depending on the severity of the mandate, 9.4 million to 19.6 million employees will be affected.

Cost Shifting—One of the issues that often arises in the discussions of mandates is cost shifting. The argument is that when someone does not pay his or her bill to a medical provider or he/she does not pay enough, the cost of uncompensated treatment is shifted onto others. This argument is popular among providers, e.g., American Medical Association, and employers who offer very expensive coverage, e.g., Chrysler.

The ability of many providers to cost shift is probably overblown.24 Moreover, the direction of the various shifts that do occur is not always clear. For example, does the purchasing power of a large company allow it to shift costs to other insured patients? Or does the large company end up subsidizing the cost of uncompensated care? What happens when Doc Smith provides pro bono services to the little old lady down the street? Is he doing volunteer work or cost shifting? And, what about the federal government? Is Washington shifting health care costs from federal taxpayers to state taxpayers and/or paying patients as previously noted?

Once the term cost shifting is removed, however, the issue boils down to who is responsible for paying an individual’s debts—the individual or the individual’s employer (or the government in cases where it has expressly assumed the responsibility, e.g., Medicare). If the question were posed in any context other than health care, it would sound silly. For example, if an individual did not make the mortgage payment, who would be responsible, the individual or the individual’s employer? If an individual did not pay the electric bill, who would be responsible, the individual or the individual’s employer? If the individual did not make the car payment, who would be responsible, the individual or the individual’s employer? Health insurance does not differ.

Unfair Competition—Perhaps the silliest argument in favor of a mandate is that firms providing employee health insurance face “unfair competition” from those who do not. (At the cross-national level the argument that American firms absorb health insurance costs where firms in other countries operate under national health systems is similar and equally untenable.) The “unfair competition” argument ignores the simple proposition that compensation equals wages plus benefits. It also assumes that some employers are compelled to provide insurance and others are not. How else could it be “unfair?” If I pay $9.00 per hour and you pay $10.00, for example, am I unfairly competing? If I give my employees three weeks vacation a year and you give them four, are you unfairly competing? If I conduct my business in a state with relatively low taxes and you conduct yours in a state with relatively high taxes, am I unfairly competing? And, what if I pay more than you do, but you provide health insurance and I don’t? Who is the “unfair” competitor? The fact is that this argument’s only rationale is to eliminate competition through government fiat.

Availability

Some small employers experience availability problems. They want to purchase employee health insurance but are prevented from doing so by a number of circumstances: the serious illness or medical history of a single employee, the first months of a firm’s existence, the industry of some businesses. Most consider availability problems as an “in” or “out” decision, but more likely it is the rapid escalation of premiums that creates a de facto availability problem.

The reason these efforts have not been successful is that they have not been promoted either to employers or employees; most legislation enabling the sale of these policies occurred during the 1990–1991 recessionary era, when pressure was on employers to contract employment, not expand employee benefits; and, few employers want to make commitments to employees that they may have to revoke in the next year or two.

Take something on which we have data, the personal computer (PC). The PC has revolutionized the way many small firms conduct business. In 1980, these machines were oddities. A tiny number of small firms employed them. By 1985, approximately 40 percent of all small businesses had at least one PC.26 Five years later, the number had risen to 56 percent and another 7 percent reported more sophisticated computer equipment. Almost all firms employing 50 or more people used computers by 1985, let alone 1990. However, only one-half of firms employing fewer than 10 people had one in 1990.

Computer manufacturers have spent hundreds of millions promoting their products. You may remember the Charlie Chaplin caricature advertising IBM products to small business owners. No similar promotion is occurring for catastrophic health insurance. In Virginia (outside the national capital region), for example, only the Blues offer the program and they have about one-

Much attention has focused on “bare bones” or “catastrophic” policies designed to alleviate the cost problem of many small employers.

Several states have permitted versions of these policies in an effort to increase the number of people with some coverage. To date, few eligible small business owners have purchased these policies, which although cheap by conventional norms cost as much as $2,000 for family coverage.25 The failure to sell large numbers of these policies is not surprising, nor does it justify the conclusion that incentives to increase voluntary provision of employee health insurance are a bust.

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third of the market. There is no visible evidence of promotion. Moreover, employees, the ones who ultimately must demand it as part of their pay package, rarely know it is available.

These programs were introduced in the 1990–1991 period. Small businesses were struggling and still are. Few owners want to provide health benefits, no matter how modest, in an atmosphere when poor economic conditions and rising health care costs mean you may have to revoke the benefit in the future. It is worse for employee morale to revoke a benefit than to have withheld it from the beginning.

The state experiments are much too new to draw long-term implications from them. They still hold promise if they are handled properly.

Conclusion

I expect small business will actively participate in the looming health care debate. While some may presently view its position as locked-in-concrete, that is not the case. It does have views on specific issues, some strongly held. But it neither supports nor opposes any plan. I suspect small business will be open minded and very concerned with measures to reduce cost, so long as cost means dollars out of pocket. It may be less flexible if attempts are made to substitute one type of cost for another. However, on mandates there is no flexibility. Small business will oppose them, period.

27 Jensen, et al., op. cit., recently raised eyebrows when they suggested that small business owner views on health care were changing. The “change” of greatest import was the increase in support of employer mandates. Yet, the authors appropriately raised the possibility that the “change may stem from our question’s format.” It is more than a possibility. The question’s format suggested that mandates may reduce overall costs by eliminating “free-riders” from the system. The authors argued that the change may have occurred due to a sense of guilt, particularly among the 29 percent without insurance who expressed support for the mandate. A better explanation is that the result was another reflection of cost’s dominating influence over small business owners. Those without insurance who expressed support could easily have been among the group who would like to provide employee health insurance if they could afford it.
V. Perspective of Employers

Policy Forum Discussion

MR. KNETTEL: I’d like to make two comments in particular on the discussion. The first one is merely to say explicitly what I think was implicit in the discussions of the other business representatives. And that has to do with the issue of why employers are involved in the business of health care to begin with, financing it and so forth. It essentially comes down to this reality. The cost of health care as well as the cost of the lack of access to health care, is not measured exclusively in terms of the cost of health insurance. Its cost is measured in terms of increase in unnecessary absenteeism from work. It’s measured in terms of decreases in productivity. It is inevitable that employers will be part of the health care system and the health care decision making process and the health care financing process, because health care is inevitably tied up with their very bottom line in terms of the cost of producing whatever it is they produce. And so in the view of ERIC members companies, their involvement in the health care reform debate is not only understandable, it’s absolutely necessary, because it goes straight to their bottom line and to their competitiveness.

The other comment I’d like to make on the three employer presentations is to pick up on Helen Darling’s reference to continuous quality improvement and the issue of measuring and making available information on health care quality, satisfaction, outcomes, and so forth. There is an expectation, for example, in collecting and publishing data on mortality and co-morbidity and so forth that individual consumers will use that information to vote with their feet and thereby drive the marketplace to become higher quality and more efficient over time. The question that I would like to raise is whether that is, in fact, enough.

Incentive has also been created to learn how to become a better test-taker. That doesn't mean improving cognitive skills; it just means figuring out how to work the system better. Quite frankly, it also creates an incentive to cheat. Which out of those three different responses (study harder, improve test taking skill, or cheat) the child selects has a lot to do with things that are external to the financial incentive itself. It has a lot to do with the kind of values that have been instilled in the child in terms of a work ethic, and a joy in learning, and so forth.

If we look at the issue of data publication, and sharing information and encouraging individuals to vote with their feet, certainly that information is necessary and important and needed. But the question is, does it get us all the way to continuously improving quality over time? There’s not any question that it provides health care providers with an incentive to develop better study habits, if you will, to improve practice and efficiency right down to the clinical level. But that’s not the only incentive that it creates. It also creates an incentive to learn how to be a better test-taker or to manipulate the choice of measures that we’re going to make publicly. And it also, frankly, creates an incentive to learn how to be a better test-taker or to manipulate treatment modalities in ways that will influence the information that’s being collected, things like discharging terminally ill patients to nursing homes in the hope that their eventual death is not captured in your mortality data, and a whole range of various other things that can go on.

My question is: how do we get the health care providers to respond productively to this incentive, rather than counter productively?

MS. DARLING: We had all sorts of debates in developing the Health Plan Employer Data and Information Set, but what we were trying to get at were measures that would be actionable in a performance improvement sense. So, for example, you could take something like the rate of mammograms for women and if you found, as we found, that the rates are low for our health plans, then we can say, “If your rate is low, then we want to know
what you’re doing this year to change that rate.”
We also know that what we really want to know is not the rate of mammogram but the stage of cancer when breast cancer is detected. We know that we can’t get that this year, because providers will tell you they don’t have that information, but that’s really what we want to get to. So continuous quality improvement is both in the data and in the measurements and what we’re measuring and studying.

MR. O’BRIEN: I am from General Motors Corporation. Obviously, health care for us has a major impact on large employers as well. Cost is an issue. It was driven home last year. At the beginning of 1992, our net worth was $27 billion. At the end of the year it was $6 billion, so we wrote off 80 percent of our equity because of the impact of health insurance in the FAS 106.

Health care has an impact on us nationally, obviously, with companies that are competing in international markets. I sat at lunch with an individual from Japan who indicated that their health care costs are 6 percent of their gross national product (GNP). That’s one in sixteen dollars. Ours is one in seven dollars. Every one percentage point of GNP equals $60 billion and that’s a $60 billion shift from the nonhealth care sector to the health care sector of the economy, $60 billion for every percentage point that is not available to spend for cars and trucks and computers and everything else that others may purchase in the economy, so that’s one major impact.

The other is in terms of not only the interest in cost containment but who pays for it and how is it paid for. In Clark’s [Kerr’s] case, it may be “it’s performance, stupid.” In our case, “it’s demographics, stupid. We cover 1.7 million within the General Motors family. If we were a state, we’d be the 32nd state. Only 340,000 are actively working. We’ve got 380,000 retirees who came into the system when conditions were different. We have over a million dependents under our health care plans, many of whom are working for other companies so that while other companies may be providing coverage they’re offering opportunities to employees to accept or opt out of that coverage, so that’s caused an enormous concern for us. As we look at our age 64 employees, our cost for health care is $8,000–$9,000 per employee. Our age 25 employee is about $2,000–$2,500 per employee, so age is a factor and we are not hiring new people because it doesn’t make sense to compete in this country anymore. We have not had one new Social Security number come into General Motors since 1986, at least in the nonskilled area, so we’ve been doing a lot of retraining and we now have two and a half times more retirees over age 85 than we have employees under age 30.

We have a system where it makes sense for mature companies to get out of the country in order to compete, while at the same time we’re encouraging foreign firms to come into the country to compete with us. A company like BMW, which just announced that they’re starting up in Alabama, is starting up there because their cost in health care in their car will be significantly less than GM’s cost simply because of the age of their participants. It’s not a competitive factor that they earned. It’s simply based on the age of their employees.
VI. Perspective of Consumers
VI. Perspective of Consumers

By Charles Inlander, People’s Medical Society

Introduction

This discussion will primarily address the issue of quality. In the 10 or 12 years of our organization’s existence, that has been the subject of 98 percent of our 2,000 letters a week from consumers. When they mention cost, it is usually related to the quality. “Boy, do I get lousy quality for what I paid,” in essence. “I cannot believe this audiologist charged $300 for me to come in there and for him to put a little headset on my head for two minutes.” Their concern is related to the issue of quality and to the issue of outcome.

Certification of Competence

One thing that we propose, which I think has been on the table for a long time but has been absolutely opposed by the medical profession, is the development of a certification system of competence for certain procedures. Today, anybody who graduates from medical school can hang out a shingle and call themselves a psychiatrist or a general surgeon. Recently, a report came out that showed that more money was paid for gall bladder surgery in 1992 than ever before. We have moved to laparoscopic procedures, and more people are having gall bladder surgery because doctors can go out and buy a laparoscope. We are not saving any money, and many of these procedures are done unnecessarily. Whether the benefit is palliative or responds to a medical need is uncertain.

What we really need to do, besides the disclosure issue, which I feel is essential from the standpoint of consumers or businesses or alliances making choices, is to develop a system that says, “If you are going to be doing coronary bypass operations, we have to know what training you have gone through—on that particular procedure.”

Providers

Another issue I think is important is the way the provider community is being revered as policymakers attempt to reform the system. On the night of the health care speech, I was amazed that all the members of Congress were standing up and congratulating each other on what a great job they are doing on health care reform before the President even walked into the room. And then when he walked into the room, the camera shifted up to Hillary Clinton, who was sitting with three doctors—Dr. Koop, Dr. Elders, and Dr. Brazelton.

From a consumer perspective, the symbolism of three doctors and the First Lady is a problem. It suggests that the Clinton plan is designed to placate the provider community. It was very irritating. We did some polling the next day and the same result came back. Consumers asked, “What is the provider community going to give us back if we are expected to pay more, limit choices, or make changes?”

This does not mean that physicians or hospitals should take a hit on income. The issue is what are we going to do about the 40 percent of hospital beds that are empty? What are we going to do about the Cook County hospitals of this world that are providing free care? What are we going to do about that doctor who does not provide good care? What are we going to do to change licensing laws to protect consumers?

States’ Vs. Federal Involvement

The issue of licensing is critical to the
position I hold that states should not be involved in these health plans. The state of Pennsylvania is a perfect illustration. Four doctors lost their license last year, three because of rape, which had nothing to do with their medical practice. You cannot get rid of an incompetent doctor. A board gives them a sanction. It can slap them on the hand. Maybe the health plan will not include them. But bad doctors can go out there and hang another shingle up and no action is taken. I was on the Oprah Winfrey show with a plastic surgeon who lost 33 lawsuits in two years. Every insurer paid him. He did not lose his license in the state of Michigan. They gave him a suspension.

The public is turned off by the fact that they cannot get satisfaction from the states that are supposedly regulating doctors and hospitals. I think the backlash is going to affect the President’s plan, when consumers realize how incompetent their state governments are. To me, the state approach in the Clinton plan is more of a device for the states, as opposed to the federal government, to impose taxes to pay for the program. The new system must be standardized, and only the federal government can do that.

Although it is difficult for me, as a consumer advocate for 24 years, to say this, I think the alliances should be in the hands of big business. Big business has better reasons than almost anybody else to want this system to become efficient and to work for all employees. They also have the resources to use data without worrying about the politics involved, as governments would do, and more importantly, they are not in bed with the provider community.

Even consumer groups often have a conflict of interest. Many either sell insurance or distribute drugs or represent specific diseases or disabilities. They are not necessarily clean. Business has a better way of operating. That is not to say all of them are good either, but I think it is important that if we are going to have alliances they should be set up with big business at the core, with small businesses benefitting by buying into these alliances.

Regarding quality, there is something more important than “centers of excellence.” There are also “doctors of excellence” who are not attached to such centers. I participated in a Donahue Show, called “Finding your Medical Miracle,” in which four families said they literally had to go out and find the doctor who could solve their children’s problems. Not one of the doctors they found was at any major center of excellence. In fact, these people had all gone to renowned centers of excellence, all of which threw up their hands and said, “We cannot do anything.” One person found a doctor because the Reader’s Digest mentioned the person’s name. Another person found one because a friend said that they knew someone who had somebody at such and such a place in South Dakota.

We cannot have a system that does not allow people to find such practitioners. More importantly, we need to have a system that identifies them—a registry of doctors who are doing cutting edge procedures. Business can go on line and find information about business. We do not have that capability with health care.

Finally, we must think about our ability as consumers to take the information
that we have and form a real partnership with the health care system. The consumers ultimately make the decisions. We cannot let the system manipulate us to be what the doctor wants. This is why we have 9 out of 10 hysterectomies that are unnecessary. The highest rate of hysterectomies is among physicians’ wives. The studies still show it. Suburban areas, affluence: if you carry an insurance card, you get a hysterectomy.

Before Honeywell went into the HMO system, the rate of caesarean sections among their employees who gave birth was 34 percent. With the HMO it dropped to 11 percent–12 percent because they were managing the system with information. They distributed information both at the company level and at the HMO level about the pros and cons of medical procedures.

There are numerous ways to get that partnership going, but the most important is to train employees/consumers. Companies spend money to train their employees how to work on an assembly line. However, most of them do not spend a penny telling a pregnant woman in their plan about obstetrics, caesarean sections, birthing classes, and other issues that would enable them to improve their health and also save money because they would be buying quality health care.

This is what I think should be the next step. A consumer report card, which I have always advocated, requires backup information. People need to know what to do with that report card, what it means, if the system is to effectively change buyer behavior to the point of quality.

The bottom line is: if you get good health care, it is cheap. It is the lousy stuff we are paying too much for. When we can identify the best health care and can lead people to it and show them how to use it appropriately, we will have a system that, whether it is 14 percent of the gross national product or 7 percent, will be on target with what we really want as a nation.
VI. Perspective of Consumers

By John Rother,
American Association of Retired Persons

Introduction

Trying to speak for consumers is always difficult because we are all consumers and we all have our own values, but I do think there are several needs and preferences that stand out when looking at health care delivery from a consumer point of view:

- a user-friendly system that through the use of a card allows you to access it and handle billing with a minimum of paperwork;
- choice;
- a strong quality assurance system that gives you information about performance on which you can base your choice;
- comprehensive benefits, because if you do need the care and it is not covered, then the health care system is not a very responsive or adequate;
- limits on financial risk; and
- continuity, which is tied to portability, so that even if you change jobs you can still retain the relationships that you have with your health providers.

There is something else that is harder to articulate—the doctor-patient relationship. This is not an economic transaction alone. This is something much deeper, more emotional, and in a way more important than a normal economic transaction. To most consumers in their daily lives, this aspect can be the dominant part of the transaction, and it has gone through an evolution. In the lifetimes of most people alive today, we have gone from a delivery system characterized by a family doctor and a community hospital to a very fragmented system with many specialists and outpatient sites and lots of choice but nothing that ties it all together. Many people are on their own and lost in the maze that has evolved, with no good information to make many of these choices.

Proposals for Reform

Certainly the plan that we have before us from the Clinton administration and some other plans would move us back in the direction of more integrated organization and delivery systems over the continuum of acute care delivery. While I think that is welcome, I would say that it does not really complete the job at all from the delivery system point of view. If we are really concerned about improving health status and public health, then we need to think about integrated systems that look at chronic care, that take into account the role of prevention in public health as much as, or even more than, the need to integrate the acute care parts of the delivery system. I think that is the next step beyond the current phase.

If we are going to actually look at outcomes and health measures, then that is going to move us into areas that we have not thought about very much in terms of the delivery system but that can be very powerful in terms of actual outcome, including public education, guns, seat belts, and similar items.

The consumer’s role in the administration’s proposal is basically three-fold, which I find laudable. First, the consumer is viewed as a person who can choose in a structured environment a plan in which he or she want to enroll. Today that choice is available to fewer and fewer consumers. The employer is making these choices, and under the proposed plan it will be the individual or the family making the choice. That is a very important change in terms of how the choice is structured.

Second, and even more important, it is hoped that the consumer will have decent information on which to base that choice. That is the real power here. Third, the role of consumers and business jointly as the board
members of the alliances is something that we ought to prepare for. I want consumers involved directly; however, they are not very well prepared in communities across the country to make some of these key system management decisions, while many businesses are.

If we let businesses go their own way and let everybody opt out and do their own thing, then where is the managerial talent that is going to run the health care system for the rest of us? Business has to be a partner in this undertaking, and we need to have it involved in the structuring of the new system through the health alliances. As we move to greater and greater vertical integration, the challenge will be to retain the quality of the doctor-patient relationship.

Conclusion

In closing, I would say that the test of any new delivery systems should be, beyond what we have just mentioned, how well they serve the needs of the most vulnerable populations. How well is the new delivery system going to serve the needs of the disabled or those who have multiple conditions? How well will it serve the needs of those who live in geographically remote areas? How well will it serve the needs of the illiterate, the people who cannot interpret data on their own, who do need some help in navigating the system? And how well will it serve children?
VI. Perspective of Consumers

**Policy Forum Discussion**

**MS. HOSAY:** One issue we barely touched upon as we talked about health care delivery is the question of medical education. In this newly restructured health care delivery system, physicians may not play quite the powerful role that they have in the past, but there seems to be a consensus here that they will play an important role. Medical education will have to change in order to train the new primary care providers how to use the new technology appropriately and medical education should change in order to train physicians how to be gatekeepers. Not fiscal agents, but gatekeepers who are guides into a very complicated and intimidating health care delivery system, since we've heard nothing today to suggest the system is going to be less complicated or much less intimidating.

So, I would hope that if we could continue this discussion in the future, we could talk more about the important role of medical education in the changing delivery system.

**MR. LEACH:** The system is not patient focused. The system is provider focused. I think a significant role for primary care physicians is to, in fact, educate patients so they can make better decisions about their own health. Still there is this bias built in that health care is going to do something to patients because the providers know better. That does have to stop and that gets to the issue of personal accountability.

There’s only so much we can do to change the system by making businesses or organizations or systems accountable. We’ve got to drive more personal accountability into the system on the part of individuals interacting with the health care delivery system and that is a broad issue of education in the school systems and something that is far broader than what just the health care delivery system can address, and we do have to make that change.

**DR. CAPER:** Just an observation on the process of policy development we’re all witnessing here from the perspective of somebody who’s watched it a long time. Winston Churchill once described Americans as a people who would always do the right thing, once all other alternatives had been exhausted. I think we’re in the process of exhausting the other alternatives.
VII. Policy Forum Participants

Moderators
Laura K. Bos
Employee Benefit Research Institute
William S. Custer, Ph.D.
Employee Benefit Research Institute

Speakers
Kevin Anderson
The White House
Harry P. Cain, II, Ph.D.
Blue Cross/Blue Shield Association
William S. Custer, Ph.D.
Employee Benefit Research Institute
Helen Darling
Xerox Corporation
William J. Dennis, Jr.
National Federation of Independent Business
G. David Hurd
The Principal Financial Group
Charles B. Inlander
People's Medical Society
Clark E. Kerr
Bank of America
James A. Lane
Kaiser Permanente
John Rother
American Association of Retired Persons
Dallas L. Salisbury
Employee Benefit Research Institute
Jerald R. Schenken, M.D.
American Medical Association
Peter A. Wilson, Ph.D.
American Hospital Association
Doug Guerdat
Office of Senator John Chafee
Cynthia Hosay, Ph.D.
The Segal Company
John Iglehart
Health Affairs
Anthony J. Knettel
The ERISA Industry Committee
Sophie M. Korczyk, Ph.D.
Analytical Services
Dan Leach
Lutheran Medical Center
William Link
Prudential Insurance Company of America
William C. Mohlenbrock, M.D.
Iameter, Inc.
Richard F. O'Brien
General Motors Corporation
Kenneth I. Shine
Institute of Medicine

Participants
Joseph Antos
Health Care Financing Administration
Patricia Bancroft
National Rural Electric Cooperative Association
Paul Berger
Arnold & Porter
Francis Bonsignore
Marsh & McLennan Companies
Jon Breyfogle
Groom & Nordberg
Richard Burke
Automatic Data Processing, Inc.
Michael Calhoun
Stanford University
Sharon Canner
National Association of Manufacturers

Discussants
Ronald K. Dewsnup
W.F. Corroon/Great Lakes Div. (for Willis Corroon)
Willis Gradison, Ph.D.
Health Insurance Association of America
Debra Lipson
The Alpha Center

Peter Long
The Kaiser Commission on the Future of Medicaid

Juanita Mast-Faeth
Bristol-Meyers Squibb Company

Roland McDevitt
The Wyatt Company

Tom McMahon
Pacific Maritime

Curt Mikkelsen
Morgan Guaranty Trust Company of New York

Mimi Yumiko Nishimura
Stanford University

Kelly O'Brien
Office of Representative Gerald Kleczka

Robin Osborn
Association for Health Services Research

Robert Paul
The Segal Company

Brian Radin
Automatic Data Processing, Inc.

John Rafaeili
Solomon Brothers

Ken Reifert
Merrill Lynch

Melvyn Rodrigues
Atlantic Richfield Company

Syl Schieber
The Wyatt Company

John Seiter
Capital Guardian Trust Company

Audrey Smolkin
The Rand Corporation

Thomas Sommers
Pennsylvania Blue Shield

Scott Spencer
Equitable Life Assurance Society

Richard Tomlinson
The Upjohn Company

Anne Welton
BellSouth Corporation

Jane White
Project HOPE/Health Affairs

John Winebarger
Otsuka America Pharmaceutical, Inc.

Bob Witcoff
McDonald's Corporation

Dale Wolf
The Travelers

Sandra Wright
Marsh & McLennan Companies

Aki Yoshikawa
Stanford University

EBRI Staff
Althea Alexander
Malaika Barnes
Leah Blaugrund
Sarah Boyce
Patsy D'Amelio
Paul Fronstin
Massaru Hiraiwa
Nora Super Jones
Ken McDonnell
Kathy Stokes Murray
Carolyn Pemberton
Celia Silverman
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