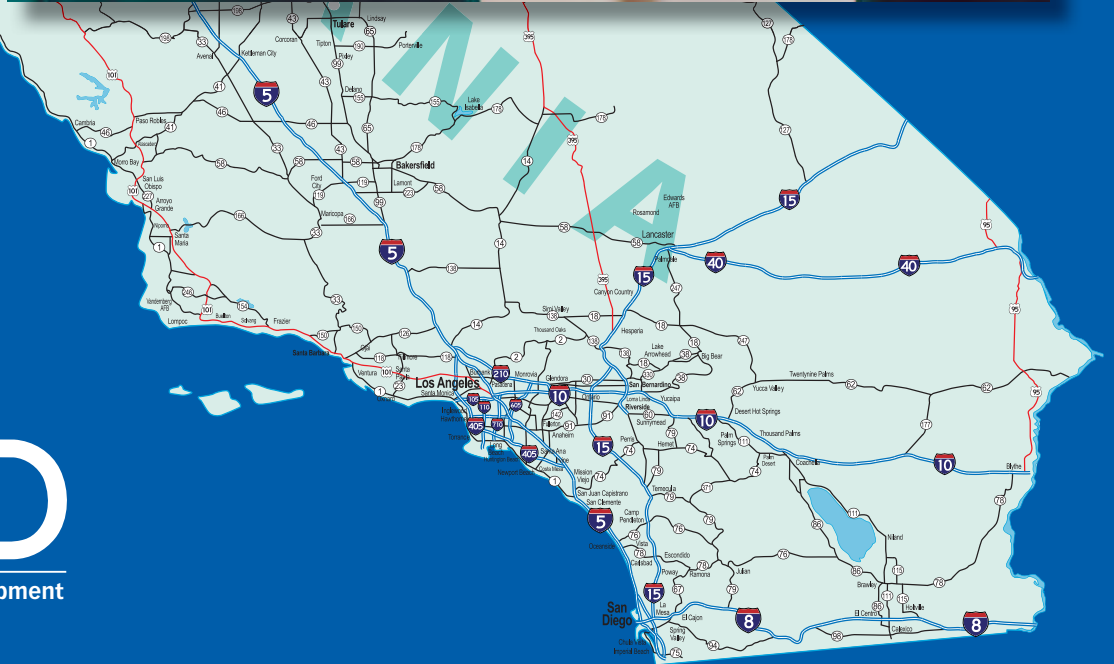


Health Care in California and National Health Reform

Research Report

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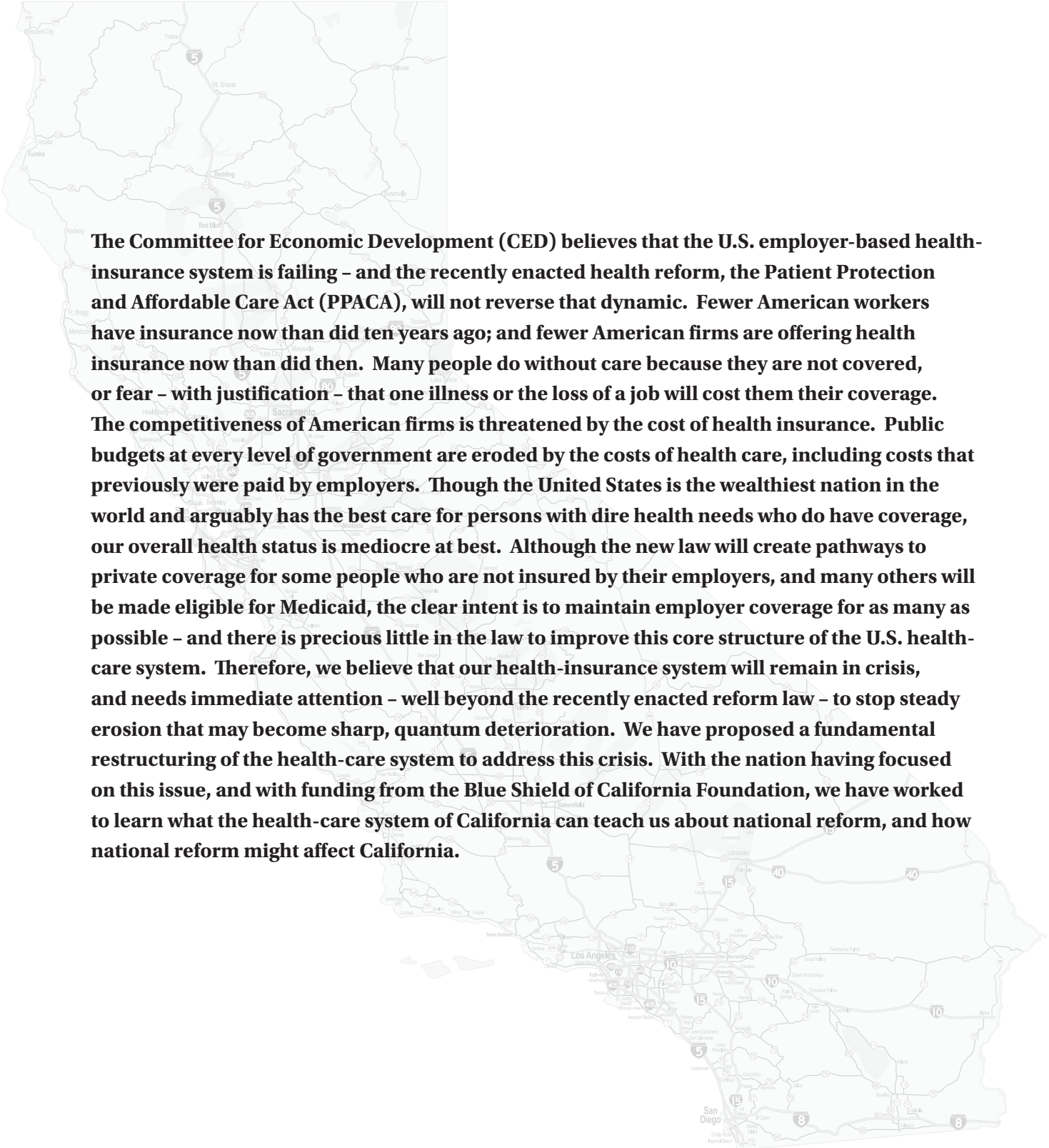
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Introduction



The Committee for Economic Development (CED) believes that the U.S. employer-based health-insurance system is failing – and the recently enacted health reform, the Patient Protection and Affordable Care Act (PPACA), will not reverse that dynamic. Fewer American workers have insurance now than did ten years ago; and fewer American firms are offering health insurance now than did then. Many people do without care because they are not covered, or fear – with justification – that one illness or the loss of a job will cost them their coverage. The competitiveness of American firms is threatened by the cost of health insurance. Public budgets at every level of government are eroded by the costs of health care, including costs that previously were paid by employers. Though the United States is the wealthiest nation in the world and arguably has the best care for persons with dire health needs who do have coverage, our overall health status is mediocre at best. Although the new law will create pathways to private coverage for some people who are not insured by their employers, and many others will be made eligible for Medicaid, the clear intent is to maintain employer coverage for as many as possible – and there is precious little in the law to improve this core structure of the U.S. health-care system. Therefore, we believe that our health-insurance system will remain in crisis, and needs immediate attention – well beyond the recently enacted reform law – to stop steady erosion that may become sharp, quantum deterioration. We have proposed a fundamental restructuring of the health-care system to address this crisis. With the nation having focused on this issue, and with funding from the Blue Shield of California Foundation, we have worked to learn what the health-care system of California can teach us about national reform, and how national reform might affect California.

CED's Diagnosis of the Health-care System

Is the U.S. Health-Care System Failing? Performance Standards for a Nation's Health-Care System

The standards by which to judge the overall performance of a health-care system are cost, quality, and access.

“Cost” is the usual shorthand term for the amount a society spends on health care. Do health insurance and health care remain within reach for families of moderate means? Can health-insurance premiums fit within the total compensation that is affordable by the employers of most or all people?

“Quality” has many meanings. Are Americans likely to receive *recommended* care – that is, those interventions that are well supported by clinical evidence and are known to benefit patients? How likely are patients with serious chronic conditions to get the care they need? How likely are they to get *appropriate* care – that is, care of the kind and in just the amount that confers maximum benefit, but no more?

“Access” is shorthand for people’s ability to obtain appropriate care, including having health insurance that makes care reasonably affordable to people who need it, and whose provisions, like coinsurance and deductibles, do not deter people from obtaining care that is important for their health. It also means having geographic and transportation access to a facility and to professionals who will provide appropriate care.

For all of our country’s wealth and power, our healthcare system demonstrably fails to meet these basic criteria – and the recent reform shows little promise of improvement.

On cost, the price of an average family insurance policy – \$11,500 per year for a family of four in 2006¹ – is almost 20

percent of the earning power of the median household,² and health expenditures are growing about 2.7 percentage points per year faster than the non-healthcare gross domestic product (GDP).³ Thus, health insurance is pricing itself out of reach.

On quality, authoritative studies document numerous errors of prescription and treatment, and inappropriate and unnecessary surgery and hospitalization, which cause unnecessary suffering, illness, injury and cost.⁴ There are wide variations in medical practices from one community to another, and even among doctors in the same community.⁵ Moreover, a 2003 study by RAND found that consumers are receiving only about 55 percent of the care called for under generally accepted standards of medical practice.⁶

1 National Coalition on Health Care, “Health Insurance Cost: Facts on the Cost of Health Care,” <http://www.nchc.org/facts/cost.shtml> (accessed June 12, 2007).

2 U.S. Bureau of the Census, Historical Income Tables, “Table F-6. Regions--Families (All Races) by Median and Mean Income: 1953 to 2008,” <http://www.census.gov/hhes/www/income/histinc/f06AR.xls> (accessed May 26, 2010). In 2006, median income for families (that is, two or more persons related by blood, marriage or adoption living together – not including one-person households or unrelated groups) was \$58,407.

3 National Coalition on Health Care, “Health Insurance Cost: Facts on the Cost of Health Care,” <http://www.nchc.org/facts/cost.shtml> (accessed June 12, 2007).

4 Linda T. Kohn, Janet M. Corrigan, and Molla S. Donaldson, eds., *To Err is Human: Building a Safer Health System* (Washington, DC: National Academy Press, 2000). See also: Philip Aspden, and the Committee on Identifying and Preventing Medication Errors, Board on Health Care Services, eds., *Preventing Medication Errors* (Washington DC: National Academy Press, 2006).

5 John Wennberg, M.D., Professor of Medicine at Dartmouth Medical School and director of Dartmouth’s Center for the Clinical Evaluative Sciences, documented variations of ten-fold and more. See: J. Wennberg and A. Gittelsohn, “Variations in Medical Care Among Small Areas,” *Scientific American* 246, no. 4 (1982): pp. 120-134; John E. Wennberg et al., “Changes in Tonsillectomy Rates Associated with Feedback and Review,” *Pediatrics* 59, no. 6, (1977): pp. 821-826.

6 Elizabeth A. McGlynn et al., “The Quality of Health Care Delivered to Adults in the United States,” *The New England Journal of Medicine* 384, no. 26 (2003): pp. 2635-2645.



But perhaps most seriously, on access, 46.3 million Americans were without health insurance in 2008, up from 38.7 million in 2000.⁷

Employer-Based Health Insurance Is Declining

Most insured Americans get their coverage through employment, either theirs or a family member's. But the number and percentage of Americans covered by employer-based health insurance (EBI) is declining. From 2000 to 2008, the absolute number of people under age 65 covered by EBI fell from 167.9 million to 163.1 million; and the covered percentage of the population under age 65 fell from 68.3 percent to 61.9 percent.⁸ From 2000 to 2007, the percentage of firms offering health benefits fell from 69 percent to 60 percent, reflecting mainly small employers dropping EBI.⁹ There are underlying forces, especially the rapidly increasing cost of health insurance and small employers locked out by pre-existing conditions, that make this trend likely to continue.¹⁰

Why Is This Happening? The entire health-care financing system rests on inflationary foundations. The incentives and the organization of health care work against affordable care.

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- 7 U.S. Bureau of the Census, "Income, Poverty, and Health Insurance Coverage in the United States: 2008," September 2009; U.S. Bureau of the Census, "More People Have Health Insurance, Census Bureau Reports," press release, September 28, 2001.
 - 8 U.S. Bureau of the Census, Table HIA-2. Health Insurance Coverage Status and Type of Coverage All Persons by Age and Sex: 1999 to 2008, <http://www.census.gov/hhes/www/hlthins/data/historical/files/hihist2.xls> (accessed May 25, 2010).
 - 9 Henry J. Kaiser Family Foundation and the Health Research and Educational Trust, *Employer Health Benefits 2007 Annual Survey* (Menlo Park, CA: Henry J. Kaiser Family Foundation; Chicago: Health Research and Educational Trust, 2007).
 - 10 Henry J. Kaiser Family Foundation and the Health Research and Educational Trust, *Employer Health Benefits, 2006 Summary of Findings* (Menlo Park, CA: Henry J. Kaiser Family Foundation; Chicago: Health Research and Educational Trust, 2005), p. 1. Premiums in 2006 are estimated to be higher than those of 2000 by 87 percent.

The causes are several. However, the heart of the problem is that the vast majority of employers offer their employees no choice; they offer either no insurance at all, or one insurance company.¹¹ For firms that offer coverage, having just one carrier is administratively simpler. Insurers also prefer to cover all of a firm's employees, because that minimizes per-worker administrative cost, and obviates the risk of enrolling only the sickest employees. Because employees, understandably, want to choose their own doctors, employers tend to offer one insurance plan that offers access to as many doctors as possible; and the only way to reimburse doctors under such wide access is fee-for-service payment.

Therefore, the vast majority of employees have no opportunity or incentive to choose a cost-effective high-quality health *plan*, and health-care insurers and providers have no inducement to provide the quality, affordable care that *consumers* want. Employers, not patients and consumers, make the decisions that shape the U.S. health-care system, from financing to delivery of care. And multiplied over tens of thousands of employers, those decisions dictate a dominant system of fee-for-service medicine for the entire population.

Fee-for-service medicine presents the worst incentives: the more services, the more fees. Patients want all the services that might deliver any benefit, however small; doctors and hospitals are predisposed to provide those services, at least in part because they are paid for each service they provide. Providers actually make more money when they are slow to diagnose and treat a problem: They are paid for more "services" that way. There is little or no incentive to utilize cost-saving technological advances such as health information technology and electronic patient records.¹² Indeed, in this "cost-unconscious" environment, there is little incentive to find a less-costly way to solve *any* health problem. On the contrary, costly new discoveries, though often highly

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- 11 M. Susan Marquis and Stephen H. Long, "Trends in Managed Care and Managed Competition, 1993-97," *Health Affairs* 18, no. 6 (1999): pp. 75-88.
 - 12 J.D. Kleinke, "Dot-Gov: Market Failure and the Creation of a National Health Information Technology System," *Health Affairs* 24, no. 5 (2005): pp. 1246-1262.



beneficial, can be deployed at great expense and considerable risk even before they are fully evaluated.

Alternative health plans might offer lower cost by choosing providers who wish to practice in integrated networks, taking advantage of technology and other efficiencies.¹³ However, such integrated systems would, in effect, dictate the choice of providers to employees. Employees would not want such an absence of choice, especially if they had no sense that they would share in the financial savings.

Compounding these structural problems, there has been a large increase in the prevalence of chronic disease and our ability to treat it – and the cost of doing so. Twenty medical conditions accounted for 67 percent of the per capita growth in private health-insurance costs between 1987 and 2002.¹⁴ The health-care system is not oriented to early detection and treatment or to chronic disease management, but rather to a visit to the doctor and the collection of a fee for a service to treat symptoms when they arise.

Expenditures are increased by the extensive deployment of new medical technologies that benefit people's lives, in some cases greatly, in other cases not at all. People want them, and their doctors want to provide them, and society does not want to deny them. Consumption of these technologies has been increasing, often at double digit rates.¹⁵ Examples include joint replacements and invasive cardiology procedures. There are costly new biologics that correct inherited enzyme deficiencies. Cerezyme, a biologic to treat Gaucher's disease, now costs some \$200,000 to \$600,000 per patient per year de-

pending on weight-related dosage.¹⁶ New drugs for some blood-clotting disorders can exceed \$1 million per year, and some cancer drugs are also very costly.

Other countries with much lower health costs as shares of GDP perform explicit evaluations of costs vs. benefits for costly new technologies, and do not include technologies in their insurance coverage whose benefits are not, in the judgment of officials, worth their extra costs. Some politicians call this "rationing," while other people see this as sensible pursuit of value for money and priority setting. The issue is what technologies patients can reasonably expect taxpayers and other premium payers to support.

Also, largely because of the fee-for-service method of payment to doctors in which millions of individual acts must be billed and paid for, improper billing because of fraud, carelessness, or error is a huge problem. The Office of the Inspector General of the Department of Health and Human Services estimated that in 1996, the Medicare Program made about \$23.2 billion in improper payments.¹⁷ As the Inspector General's Report said, "The Medicare program is inherently vulnerable to incorrect provider billing practices."¹⁸ The same could be said of all insurance under fee-for-service medicine.

EBI Costs Cause Employers Major Problems. Employers, the primary purchasers of health insurance, must deal with the insurance market as it exists; they cannot themselves change the structure of the entire system. EBI costs give employers a powerful incentive to try to avoid this growing burden – which employers do, in part, by tightening restrictions on who is eligible for EBI, and by increasing required employee contributions so that

13 Joseph P. Newhouse and the Insurance Experiment Group, *Free for All? – Lessons from the RAND Health Insurance Experiment* (Cambridge, MA: Harvard University Press, 1993).

14 Kenneth E. Thorpe et al., "The Rising Prevalence of Treated Disease: Effects on Private Health Insurance Spending," *Health Affairs*, Web Exclusive, June 27, 2005.

15 Measured on an age-specific per-capita basis. Victor R. Fuchs, "Health Care for the Elderly: How Much? Who Will Pay for It?" *Health Affairs* 18, no. 1 (1999): pp. 11-21.

16 Greg Anand, "How Drugs for Rare Diseases Became Lifeline for Companies," *Wall Street Journal*, November 15, 2005, p. A1.

17 U.S. Department of Health and Human Services, *Report on the Financial Statement Audit of the Health Care Financing Administration for Fiscal Year 1996*, by June Gibbs Brown, Inspector General, A-17-95-00096 (Washington, DC, 1997). See also: Carrie Johnson, "Medicare's \$869 Air Mattress Bill; Government Arrests 38 as It Cracks Down on Health-Care Fraud," *Washington Post*, May 10, 2007, p. D1.

18 Ibid.



low-paid workers do not choose to pay their share and participate. Or, employers can simply close the plant or office and obtain the services from lower-cost labor overseas, or from low-cost employers in this country who do not provide health insurance. These policies may mitigate employer problems, but they cause serious human problems, and they do not help forestall the decline in EBI.

Employer Responses to Date Have Not Solved the Problem.¹⁹ Because merely shifting costs to employees is a clearly visible dead end, firms also have experimented with wellness programs, preventive care, and management of chronic conditions, backed up with financial incentives or even penalties.²⁰ Firms have tried bargaining with providers, using health records to promote “evidence-based medicine” to choose the best treatments, and creating “high-performance networks” of physicians with strong records of cost-efficient care.²¹ However, none of these efforts would change in any fundamental way the practice of medicine, or the arguably cost-inefficient adoption of new and ever-more-expensive health technologies.

In sum, the entire U.S. health-care system is built on inflationary foundations – worse still, with limited incentives to keep people healthy.

Proposed Solutions – Past and Present – Do Not Work

“Band-Aids.” For at least 35 years, there has been a slowly building realization that our health-care system is not sustainable. Public policymakers and private actors

have tried to respond, yielding a discouraging history of espousing and adopting simplistic and partial “solutions” ranging from utilization reviews, or attacks on “waste, fraud and abuse,” to “managed care” – veritable “Band-Aids” on top of a fundamentally flawed system. Some of these contained germs of good ideas, and some could be part of a rational comprehensive solution; but none came close to addressing our fundamental problems. Likewise, new ideas such as health information technology and electronic health records would help, but would not solve the fundamental, systemic weakness in health-care delivery.

Consumer-Directed Health Plans (CDHPs). CDHPs are claimed to be something close to a complete answer for the problems of the nation’s healthcare system. CDHPs are insurance plans with high deductibles, which the consumer must pay before insurance coverage begins. Consumers may have health savings accounts (HSAs), funded either by themselves or by their employers, to pay for care under the deductible. Because of the high deductible, the premium can be lower. Also because of the high deductible, consumers would be expected to engage in preventive care, and then, when illness or injury strikes, to use the latest information technology to find the most economical and efficient therapies and treatments, to minimize their out-of-pocket spending under the CDHP deductible, and to protect the balance in their HSAs. In this way, it is claimed, total health-care costs would be brought under control.

Though CDHPs are better than no coverage at all, they are not a complete solution. Health expenditures are very concentrated on relatively few people.²² In any given year, well over 80 percent of health expenditure dollars will be spent on people who have exceeded their deductibles or can safely expect to do so, for any level

19 CED issued its own recommendations for action by employers, but saw few results. Research and Policy Committee of the Committee for Economic Development, *A New Vision for Health Care: A Leadership Role for Business*, (New York and Washington, D.C.: Committee for Economic Development, 2002).

20 Michelle Conlin, “Get Healthy – Or Else,” *Business Week*, February 26, 2007, http://www.businessweek.com/magazine/content/07_09/b4023001.htm?campaign_id=msnbc, (accessed May 27, 2010).

21 Marilyn Werber Serafini, “Taking Matters into Their Own Hands,” *National Journal*, September 30, 2006, pp. 36-40.

22 M. L. Berk and A. C. Monheit, “The Concentration of Health Care Expenditures, Revisited,” *Health Affairs* 20, no. 2 (2001): pp. 9-18.



of deductibles that is reasonable.²³ Many people with chronic conditions can expect to reach their deductibles, as can anyone who has been an inpatient in a hospital, or is likely to enter a hospital.²⁴ Once CDHP enrollees have reached their deductibles, they will in effect be in cost-unconscious fee-for-service medicine. CDHPs will be advantageous to those who are both healthy and wealthy, because they can both afford the higher deductibles and take the most advantage of the health savings account tax shelter (which benefits most those in the highest tax-rate brackets, but is worth next to nothing to the worst-off taxpayers who face a very low or even zero-percent tax rate).²⁵ The loser may be the fairness of our private health-care financing system – not to mention the viability of health insurance for those who are not fortunate enough to benefit from CDHPs.

Single Payer, or “Medicare for All.” Another “big idea” for health-system reform is a “single-payer” system, like Canada’s. Probably at the federal level, government would serve as the single health insurer, cover everybody, and pay all the bills according to a government-determined or negotiated fee schedule. Another name could be “Medicare for all;” every American would be covered by the Medicare program or something very similar. In the United States today, this model has features with great appeal, like universal coverage and one billing system.

However, the U.S. single-payer system, Medicare, is locked into uncoordinated, fragmented fee-for-service medicine with the law allowing patient access to any willing physician; it has proven practically impossible for Medicare to break out of that constraint. Medicare

fee-for-service has built-in incentives for delivering volume, not quality. It motivates, or is compatible with, a great deal of over-use, under-use, and misuse of services.²⁶ Studies show that Medicare patients in the last six months of life in Florida get several times as many doctor visits as similar patients in Minnesota, while reporting less satisfaction with their care.²⁷

Thus, a single-payer system might provide universal coverage for a time, but costs would surely continue spiraling out of control – as they are in Medicare today – threatening everyone’s coverage.

What Might an Equitable, Efficient, Universal Health-Care Financing and Delivery System Look Like?

The heart of the solution for health care is competition to serve cost-conscious buyers, and incentives for providers to create and run high-quality, but affordable, health-care systems. Competition motivates innovation and efficiency improvement. For virtually the entire non-health-care economy over the history of the nation, competitive pressures have increased quality and tempered prices. The improvements could not be predicted in advance. Consumer choices signaled price standards and preferred product and service attributes to the marketplace, and suppliers improved their processes and methods to meet and then to surpass those standards, thereby setting new ones. Even given the unique nature of health care, competition provides the best hope for affordable, quality health care.

23 In 2002, 80 percent of total health-care expenses were spent on the top 20 percent of spenders with spending exceeding \$3,219. Mark W. Stanton and the Agency for Healthcare Research and Quality, “The High Concentration of U.S. Health Care Expenditures,” *Research in Action*, no. 19 (2006).

24 Ibid.

25 Henry J. Aaron, Patrick Healy, and Surachai Khitatrakun, “What’s In a Name? Are Health Savings Accounts Really Health Savings Accounts?” http://www.american taxpolicyinstitute.org/pdf/health_conference/Aaron-Healy-Khitatrakun.pdf (accessed May 25, 2010).

26 John E. Wennberg and the Dartmouth Atlas Working Group, “The Dartmouth Atlas Project,” Center for Evaluative Clinical Sciences at Dartmouth Medical School, www.dartmouthatlas.org (accessed January 11, 2007). For under-use, see: McGlynn et al., “The Quality of Health Care,” pp. 2635-2645. For misuse, see: Kohn, Corrigan, and Donaldson, *To Err is Human*.

27 J. Wennberg and A. Gittelsohn, “Variations in Medical Care Among Small Areas,” *Scientific American* 246, no. 4 (1982): pp. 120-134; John E. Wennberg et al., “Changes in Tonsillectomy Rates Associated with Feedback and Review,” *Pediatrics* 59, no. 6, (1977): pp. 821-826.



Our goal should be adaptive delivery systems that move toward the attributes of the modern firm in virtually every other industry: from unaccountable to accountable; from uncoordinated to coordinated; from wasteful and inflationary to efficient (seeking maximum value for money for patients), with incentives for value-enhancing innovation; from provider-centric to patient-centric; a system focused on keeping people well, at work, and out of the hospital; in short, a system committed to improving health outcomes and reducing health system expenditures, bringing expenditure growth into line with income growth.²⁸ Delivery systems that approximate most of these attributes do exist. True competition among insurers and providers will encourage the entire industry to improve in all of these dimensions.

Also, to correct the problems created because many people lack health insurance, everyone should have informed, responsible (that is, cost-conscious) choices of health insurance programs that are financially sustainable. To have efficient delivery systems, there must be a market for them – that is, a demand for efficiency. Today, there is virtually no demand for efficiency. If all or most people had a reason to choose efficient systems, care providers would find it necessary to create and offer them. Thus, engaging both patients and providers to align incentives is a necessary condition for an efficient delivery system. Once the incentives truly are aligned, we can expect improvements along the following fronts.

Health-care providers who need to satisfy cost-conscious consumers must organize their systems for **chronic-care management**. As of September 2004, 133 million people, almost half of all Americans, live with a chronic condition.²⁹ Almost half of these people have multiple chronic conditions.³⁰ In 2001, the care given to people with

chronic conditions accounted for 83 percent of health-care spending.³¹ Today's health-care and payment systems are designed to manage and pay for acute episodes, not chronic conditions. Fee-for-service generally pays for episodes such as doctor visits or procedures, not for on-going preventive and chronic care such as counseling sessions.

Chronic disease often arises from the failure to engage in good health behaviors – such as obesity prevention, exercise, diabetes control, smoking cessation, and prevention methods such as cancer screening.³² Resources could be saved in the long run by systems that emphasize **primary care, disease prevention and early detection and treatment**. Fee-for-service generates unusual income opportunities for doctors in specialties such as oncology and radiology, and poor pay for primary care – leading progressively fewer graduates of American medical schools to seek careers in primary care. The other stages of the continuum of health-care delivery, **procedures, catastrophic care, and end-of-life care**, also could be improved in quality and cost in the same way – through system coordination across teams and error avoidance.

Although the share of health spending on patients in their last year of life has often been exaggerated, it remains significant: it is about 30 percent of Medicare, and Medicare is about 17 percent of national health expenditures. There is substantial regional variation. The high-spending regions spend 60 percent more per patient and provide more services than the low-spending regions, but Medicare enrollees in higher-spending regions do not experience better health outcomes or satisfaction with care.³³ Providers in a cost-conscious system will need to develop more-humane alternatives for **end-of-life care**

28 Committee on Quality of Health Care in America, Institute of Medicine of the National Academies, *Crossing the Quality Chasm: A New Health System for the 21st Century* (Washington, D.C.: National Academy Press, 2001).

29 Johns Hopkins University and the Robert Wood Johnson Foundation, "Chronic Conditions: Making the Case for Ongoing Care, September 2004 Update," Partnership for Solutions, www.partnershipforsolutions.org (accessed August 17, 2006).

30 Ibid.

31 Ibid.

32 Denise Grady, "Second Drop in Cancer Deaths Could Point to a Trend, Researchers Say," *New York Times*, January 18, 2007, p. A14.

33 Elliott S. Fisher et al., "The Implications of Regional Variations in Medicare Spending," pts. 1 and 2, *Annals of Internal Medicine* 138, no. 4 (2003): pp. 273-298.



that are less specialist- and ICU-intensive than the acute inpatient setting.³⁴

The huge flow of medical information (over 10,000 randomized trials are published each year) is beyond the grasp of solo or small group practitioners. A successful system must translate this information into up-to-date science-based **best-practice guidelines** and conveniently integrate them into actual care delivery. Health information technology can include caregiver support tools – such as shared comprehensive electronic health records, guidelines, prompts, and reminders – to monitor performance and take corrective actions. Care should be delivered in the least-costly appropriate settings, considering total system costs, not just costs and revenues associated with one setting – with smooth transitions and hand-offs between care settings, so that, for example, outpatient providers are well-informed on inpatient care (and vice versa).

Although this restructuring would radically change America's health-care delivery system, each of these expectations is nonetheless reasonable on its face – no more than what one would reasonably expect from a well-run world-class competitive company that adapts to technology and market challenges and opportunities in any other sector of the economy. It is highly questionable whether the recently enacted reform law will move the U.S. health-care system measurably in this direction – at least, without the most informed implementation of the key provisions that are most similar to the ideas discussed in the following section of this report.

34 RAND Health, "Redefining and Reforming Health Care for the Last Years of Life," RAND Corporation, 2006, http://www.rand.org/pubs/research_briefs/2006/RAND_RB9178.pdf (accessed May 5, 2009).



Summary of the CED Position on Health-Care Policy

Essentials of Market-Based Universal Health Insurance with Consumer Choice of Health Plan

CED has proposed a system of *market-based universal health insurance* – which eliminates the current system’s distortions by giving each consumer a choice of different plans and a fixed-dollar credit to purchase the plan of his or her choice. With this system, consumers have an incentive to be cost-conscious. ***We believe that competition among private insurance plans, to attract informed, cost- and quality-conscious consumers, is the only way to achieve sustainable, affordable, quality health care for all Americans.*** By reforming the *financing* system for health coverage, we can create the incentives that will drive insurers and providers to reform the health *delivery* system.

The nation can achieve such a market for quality, affordable health care through two key steps:

In the first step, the federal government should establish independent regional “exchanges” that would provide a single point of entry for each individual to choose among competing private health plans. The markets for health insurance and health-care delivery are unique. Competition is possible, but the nature of these markets does mean that the competitive process needs rules – much as do the markets for other insurance products or for securities, for example – to be efficient and fair. To provide those rules, we propose a health-insurance “exchange,” which would improve on the current Federal Employees Health Benefits Plan (FEHBP) – the system that also covers members of Congress – and also on the less-robust exchanges called for in the new law. Every individual would be guaranteed the right to choose one from a range of private insurance plans. Every plan would be required to meet the comprehensive standards set by the exchange; only quality plans with broad coverage may compete. Health insurers and providers would be free to use alternative delivery system models.

It would be essential that wide-access PPO plans be available, so that everyone who wanted to continue with such coverage and with his or her own physician could do so; every consumer could “keep what he (or she) has.” Plans could charge no difference in premium for age or preexisting conditions (unlike the

current individual insurance market). These exchanges would set standards for plans to ensure quality, comprehensive coverage, and consumer protection through standardized “fine print.” Each exchange would provide side-by-side plan comparisons, and would organize an annual open season at which individuals could change plans – introducing competition into the marketplace for health insurance and care. Each exchange would “risk-adjust” premium revenue to insurers – that is, pay more to insurers that cover relatively more people with expensive conditions. Risk adjustment is already undertaken by insurers in some private systems that resemble what we propose and has just been adopted for the private Medicare insurers.

The exchanges would be supervised by a “Health Fed,” modeled on the independence and structure of the Federal Reserve, which would be established at the outset to guide and facilitate the creation of the exchanges.

The Health Fed would be funded independently (as is the Federal Reserve), by a small surcharge on insurance premiums; its independent funding is essential, to ensure that it is insulated from politics, and that it can react quickly to market challenges and opportunities and to technological change. The Health Fed would collect initial data to evaluate proposed insurance plans and to establish and improve risk adjustment. It would set standards for performance disclosure by plans and providers. The Health Fed would create an Institute for Medical Outcomes and Technology Assessment to evaluate the comparative costs and benefits of technologies and care practices, and report to health providers and the public. There would be an option of national (not just state) regulation of health insurance plans to facilitate competition and innovation. In sum, the exchange system would perform a role very similar to, but we believe improving upon, that now performed by the Office of Personnel Management for the Federal Employees Health Benefits Plan.

Second, subject to progress of the exchanges and the willingness of the public to provide the financing, every household would receive a fixed-dollar credit sufficient to purchase the low-priced quality health plan offered in its region. Every individual, therefore, would be able to buy quality health insurance at no out-of-pocket cost, and coverage would be universal.



As an alternative to the low-price plan, an individual or household could choose to purchase a more-expensive plan by paying the additional cost above the low-priced plan, using after-tax dollars. Such fixed-dollar contributions have been used with success in the employer context by Hewlett Packard, Wells Fargo, the University of California, and Stanford University, and the states of Washington, Wisconsin, and California. The fixed-dollar credit would be financed by eliminating the current exclusion for employer-provided insurance, and by broadly based tax revenues – for example a payroll, value-added or environmental tax. In effect, every individual in the nation would contribute toward the health-insurance program, and every individual would be entitled to insurance – without costly “mandates” or means-testing.

With every individual assured access to a quality insurance plan, and able to pocket the full savings from choosing a low-priced plan, insurers would for the first time have an incentive to organize with health providers to offer quality, affordable care that people – not their employers – want. Together, the health-insurance exchange and the fixed-dollar contributions to individuals would lead naturally to a competitive marketplace among health-care providers and insurance plans. Every consumer would have insurance and an incentive to choose the plan that provides what he or she believes to be the best combination of quality and value for money, because he or she would be responsible for costs beyond the fixed-dollar contribution. Consumers could change plans freely at annual open seasons if they were dissatisfied. Therefore, to attract and to keep customers, plans would need to be adaptive to pursue efficiency and quality, which would create meaningful competition in the health-care marketplace, driven by fair rules to reward quality and cost-effectiveness, rather than denying care and selecting risks. Rules-based competition has driven progress in every other industry in our economy and around the world, and competition shows the greatest promise of turning health care from its current path of unsustainable cost growth, mediocre quality, deteriorating health, and declining coverage.

With health plans competing to attract cost-conscious consumers, we can expect our health-care system to change for the better. Health providers would be accountable for quality and cost. To remain affordable

while maintaining quality for their customers, providers would move away from fee-for-service episodic treatment to emphasizing primary care, health promotion, disease prevention, early detection and treatment, chronic disease management, and cost-reducing innovation and process improvement – which would include efficient use of technology, such as electronic medical records, knowledge management, and computerized caregiver support tools; better use of physicians’ time, in part through team practice with non-M.D. professionals; matching resources to the needs of the populations served; and regional concentration of complex care, to achieve expertise and economies of scale. To control costs, providers would need to avoid conflicts of interest, and use the best possible evaluation of the efficacy of treatments and therapies.

This design would focus competition on value for money in the informed best judgment of consumers, and not in any way pick winners and losers in advance. The competitive market would do that, over time. The system should encourage differing delivery modes to foster competition and innovation. In the end, some existing models might be winners in the competitive marketplace, or the winners might be entirely new, as-yet-unimagined models. One thing would be certain: the outcome would be better than what has gone before because the incentives and opportunities for consumers to make economizing choices, and the need for insurers and providers to seek improvement to satisfy consumers, would be enormously increased.

The Cost of a Reformed Health-Insurance System.

Universal coverage would increase the number of people seeking services, but cost-conscious consumers would gradually migrate toward less-expensive plans; and all plans would seek efficiencies to reduce their premiums. Thus, it is not certain whether market-based universal health insurance would cost the nation more or less than government, businesses and individuals now collectively pay.

Without a full actuarial assessment, we can draw inferences from basically similar legislation proposed by Senators Ron Wyden (D-OR) and Robert F. Bennett



(R-UT) (which does differ in some significant details).³⁵ Their bill is estimated to reduce total national health-care spending by a small percentage in the first year, rising to 7.7 percent in the tenth year, compared to continuing with the existing system. The savings would be the net of costs for additional services for the newly insured, more than offset by savings from the incentives of price competition for consumers and insurers, and additional savings in administration. In other words, according to this analysis of a system of responsible, cost-conscious consumer choice, the issue is not *how much* the nation spends on health care, but *who* pays a *smaller* total; if the nation can use the resources that are now devoted to health care – by employers, households, and governments – then it can afford coverage for all, with money left over, and the savings would grow over time. However, mobilizing all of the resources now used for health care would be a non-trivial task. We believe that such a financing solution is attainable.

Effects on the Health-Care Industry. The health-care industry is now about one-sixth of the U.S. economy. Any marked change in the structure of that industry would have correspondingly large impacts. In the broadest sense, improvements in the efficiency of delivering health care, like those for any other good or service, would make the economy and the nation as a whole better off. Process improvement in healthcare delivery likely would reduce (or reduce the rate of growth of) the 16 percent of the GDP that is now devoted to health care. However, every dollar of that 16 percent of the GDP is income to those who work in the industry today. If that share declines, some people's incomes will decline, and some people may lose their jobs altogether. Society should be sensitive to these effects, but concern about those dislocations should not prevent progress for all. The deteriorating current system has left growing millions of people without insurance coverage, to the detriment of their health and of the health-care system. Inaction would merely extend that deterioration.

In fact, many segments of the health-care sector would benefit from reform. Physicians and other providers of health care would be better off having more people covered as users (and reliable payers) for their products and services. At the same time, of course, those firms and individuals would face greater competition, and more scrutiny of the efficacy of treatments and procedures. But in sum, the outlook for stable growth would be much improved under a system of sustainable and universal coverage. Those individuals and firms willing to compete should welcome such reform.

Other sectors of the economy – insurers, employers, and state and local governments – would be affected in varying ways, but in the end benefited by a sound health-care system.

How Might We Get There? A Path to Consumer-Choice-Driven Universal Health Insurance in Feasible Incremental Steps

Our political process much prefers incremental movement to sudden, large, discontinuous changes whose consequences cannot be foreseen. Still, the problems of cost, quality and access have become so serious that the needed changes to our health-care financing and delivery system are fundamental and far-reaching. Such restructuring through a political process that values stability would require bold but feasible incremental steps that could produce steady progress, and in the end get us to Market-Based Universal Health Insurance. We recommend a three-step process.

Phase I: Building the Foundations for Responsible Choice. To create an administrative structure, *modernize and adapt the FEHBP* into a framework for a national system of health-insurance exchanges. Use fixed-dollar contributions to encourage responsible choice; introduce risk adjustment; establish a minimum benefit standard for all plans; and allow premiums to vary by region. To ease market entry in many locations across the country, to make the system more competitive and less costly, and to eliminate conflicts between state and federal health-insurance regulation, *modernize and simplify health insurance regulation* by creating an alternative federal regulatory system that participating multi-state health plans can choose instead of being

35 John Sheils, Randall Haught, and Evelyn Murphy, "Cost and Coverage Estimates for the 'Healthy Americans Act,'" (working paper, Lewin Group, Falls Church, VA, December 12, 2006), http://wyden.senate.gov/Healthy_Americans_Act/HAA_Cost_Coverage_Report.pdf.



regulated by states. **To perform such regulation, build a new independent agency – a “Health Fed” – patterned on the Federal Reserve Board and the Securities and Exchange Commission.** To provide authoritative scientific information about the value and costs of clinical interventions, **create a national institute for medical outcomes and technology assessment.** And to reverse the recent growth in the number of the uninsured, **expand existing safety-net programs,** especially the State Children’s Health Insurance Program (SCHIP), pending the availability of true universal coverage.

Phase II: Progressively Expand the Availability of Coverage. To begin transforming the employment-based insurance system into a wide range of responsible choices of carrier and delivery system, **include all small employers (up to 50 or 100 employees) in a new exchange system,** building on the FEHBP. Small employers need the most help to provide coverage to their workers, and will benefit from participation in the exchange. To maintain a large, sound risk pool, require that those small firms purchase their insurance through the exchange to keep the tax exclusion for employer premiums. Include the self-employed, and even entire states that choose to opt in. **Progressively expand the employment group size ceiling for the new system until all employers are included.** To create cost-consciousness, and to save billions of tax dollars to help low-income people buy insurance, **cap the tax exclusion** for employer health benefits at the level of an efficient health plan in each region. Further, to maintain cost-consciousness, prohibit employers from selectively subsidizing the purchase of more-expensive health plans by their employees. Employers must give any such subsidy to all of their employees, not only those who choose more-expensive insurance; and employers must allow their employees to take the subsidy in cash, rather than insurance premiums, if they so choose. Finally, expand the functions of the “Health Fed” to include setting standards for performance disclosure and risk adjustment.

Phase III: Achieve Market-Based Universal Health Insurance. To complete the transition to universal health insurance, **replace all employer contributions with universal fixed-dollar contributions** paid for with broad-based

tax revenues. To help finance this, eliminate any tax break for employer-paid health insurance.

In sum, the program outlined here has, we believe, the greatest prospect of reaching the three goals of restraining health-care expenditures, achieving universal insurance coverage, and improving quality – thus completing the task that was attempted in the recent effort at reform. It relies on incentives for individuals to choose both plans and providers that offer what those individuals judge to be the best combination of quality and price. In response, insurers and care providers will have the strongest incentive to increase quality and restrain prices, creating a new dynamic toward improvement. Those consumers who prefer today’s model of care would be able to keep it, if they were willing to pay any difference in price. However, by current indications, most people would be happy to consider new, evolving, and improving delivery modes that emphasize maintaining health through preventive care and healthy behavior, early intervention against and sustained control of chronic diseases, and use of contemporary digital technology and communications.

Merely extending coverage – even to universal coverage – under the current system would not solve the core problem, because with the cost of coverage growing faster than the economy’s capacity to pay it, **no** coverage is secure. Command-and-control systems have a poor track record in modern economies; and medical care is too complex to devolve all authority to the individual patient. Market-based universal health insurance, with individuals choosing the health plans and delivery systems that they deem best, shows great promise – much greater than any alternative.

The health-reform debate is not over. For the simplest and clearest indication, the Congressional Budget Office estimates that the recently enacted health-care law will reduce federal budget deficits by about 0.5 percent of the GDP in its second decade.³⁶ However, it is also projected that ten years from now, under current policy, the budget deficit will be nearly 7 percent of the GDP –

³⁶ Congressional Budget Office, letter to the Honorable Nancy Pelosi, March 20, 2010, page 12, <http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf>.



well beyond what is sustainable – and the public debt will have approached 100 percent of the GDP – a clear danger sign.³⁷ The 0.5 percent of GDP saved by health reform is only a small fraction of the 7 percent of GDP deficit – and experts have said for years that health care is the biggest part of the deficit and debt problem, and must be the biggest part of the solution. Nor is the new law designed to change the dominance of employer coverage, or the efficiency of health care delivered through employer-provided insurance. The CBO estimates that the number of persons with employer-provided insurance will be little affected, decreasing after 10 years by only about 2 percent.³⁸ Also, the new law would have no significant direct effect of inducing greater efficiency in private, employer-provided health insurance in the foreseeable future.³⁹ Rather, the enacted reform is intended to induce process improvements in Medicare through the development and ultimate enforcement of pilot projects, and later to have those improvements filter through to the private practice of medicine by example.⁴⁰ This process relies on a series of uncertain developments, and even if it succeeds, will take years.

For these reasons, CED believes that health reform must be revisited, and that the issues we have studied in California are important for the ultimate sustainability of health care for the entire country.

37 Committee for Economic Development, “The Debt Clock Is Ticking,” <http://www.ced.org/images/library/presentations/minarik/webinarfeb10.pdf>.

38 Congressional Budget Office, letter to the Honorable Nancy Pelosi, *op. cit.*, Table 4, page 21.

39 The major provision that might be so characterized, the so-called “Cadillac Tax” on high-cost plans, will not take effect until 2018. The legislation would also create a private, non-profit organization for patient-centered health research, which as a totally new entity would take some time to bear fruit.

40 For example, all of the major initiatives cited by OMB Director Peter R. Orszag (“Following Doctor’s Orders,” April 1, 2010, <http://www.whitehouse.gov/omb/blog/10/04/01/Following-DoctorOrders/>), apart from the two mentioned in the previous footnote, could affect private health care only indirectly, through their impact on Medicare.



California And Health-Care Reform

Reasons for CED Interest in California

California is highly pertinent to CED's vision of health reform for several important reasons.

Presence of systems similar to the CED model. As noted earlier, most of the employer systems that are similar to the health-system model envisioned by CED are located in California - including the University of California and Stanford University, Wells Fargo, and Hewlett-Packard. Each of these employers offers its employees fixed-dollar contributions, with which the employees can choose from a menu of alternative health-insurance plans.

In addition to these employer systems, the CalPERS system, which generally shares these major attributes, is also similar in important ways to the kind of state-based insurance exchange that is contemplated in the legislation now before the Congress, as well as to the regional exchanges advocated by CED. CalPERS' experience could shed light on the problems and potential of a state-level exchange, which could be useful whether the current debate moves toward a CED-type system or not.

A big market. California is large enough that there would be no peculiarities of small size that would raise problems in extrapolating from its experience to the likely environment facing a national health reform.

A diverse employer base. California is home to businesses in every industry, from agriculture to finance to technology, in urban and rural environments. The state exports and imports. It can shed light on many of the pitfalls and opportunities that would face a national reform.

Diverse providers and plans. The employers that follow the CED model of consumer-responsible choice of insurance plans can offer their employees a wide range of choices. In addition to conventional fee-for-service-type plans, California also has varieties of competing integrated delivery systems, described below. Conversations with those plans and their associated providers can yield insights into how the national market might react to introduction of a more market-driven health-care system.

National problems of costs and apparent (limited) progress in California. A major motivating factor in the current national health-reform debate is the unsustainable growth of costs. Although Californians would certainly describe their cost growth as excessive, in fact it has been less rapid than in the rest of the country. That may be as a result of the diverse market, with different types of plans that compete against each other in at least some of the systems (including the ones enumerated above that follow the general lines of the CED model). Conversations about the results of competition could be enlightening.

Efforts at reform in California. Because California has made its own attempt to reform the health-care system within its borders, its employers and providers may have thought more closely about the issues that will be pertinent to national reform. This could yield some possible clues as to employer concerns and attitudes toward reform in the rest of the country, as well as possible clues as to good practices for a reformed system for the country at large.

The California Health-Care Market

Several large employment groups (the state of California with about 700,000 lives, the University of California with about 180,000 lives, Stanford University with 23,000 lives, and Wells Fargo and Hewlett Packard), use a managed competition model, following the broad lines of the CED vision, for employee health care. In all of these cases, the management is satisfied with the model, happy they adopted it, and is not even thinking of going back to the industrial "single-payer" model, or to the employer offering choices but paying more for fee-for-service coverage. These groups save money because a very high percentage of employees, usually around 80 percent, find the best value for money is in the comparatively low-priced HMOs. Only the minority of 20 percent who choose fee-for-service must see value for money there, because they are willing to bear the cost difference.

Although these systems seem large, they are not large enough to have "bent the cost curve" or slowed its growth to sustainable rates on a national scale. However, they have made some progress at the state level. Although it is a large, costly, industrialized state, California health



spending per person is 12 percent below the national average and about 30 percent below Massachusetts and New York. The annual growth of cost in California from 1991 to 2004 was about 4.4 percent, compared with 5.7 percent and 5.8 percent in Massachusetts and New York, respectively.

California HMOs include Kaiser Permanente, a “delivery system HMO” with 5.3 million California “commercial” (i.e., non-Medicare, non-Medicaid) members in 2007. There are also seven “carrier HMOs,” with a total of nearly five million California commercial members.⁴¹ This latter group is characterized as the “California delegated model,” because in their coverage, medical decisions are delegated to physician organizations that are at risk at least for professional services. (For more detail, see “Problems of Incomplete Incentives Alignment in California Delegated Model HMOs,” attached as an Appendix.)

Despite this competition, the overall market remains dominated by one or another form of “cost-unconscious demand” – in the form of either a single fee-for-service plan for the employment group, or a choice of plans with the employer paying 80 to 100 percent of the premium of the plan of the employee’s choice. The latter approach is predominant in biotech companies, and unionized public-sector employees other than state employees. This cost-unconscious demand helps to drive up the cost of labor, physician services, hospital services, and so on.

Beyond the prevalence of the cost-unconscious demand sector, which is the most important, several other factors contribute to the failure of HMO competition to produce the desired result of expenditure growth at sustainable rates:

The importance of provider market power. The Sutter Health System has expanded to 26 hospitals in Northern California strategically placed so that none of the carrier HMOs can have a viable product without contracting with Sutter. And Sutter will not allow them to contract with one or a few without contracting with them all.

⁴¹ There are conflicting enrollment data. These figures are from the California Office of the Patient Advocate; IHA data are somewhat different. We believe that the differences are not large enough to affect the broad conclusions.

Sutter is well known as a very-high-cost hospital system. A few years ago, CalPERS publicly battled them and demanded more reasonable rates. When CalPERS was unsuccessful, they directed the Blue Shield HMO to drop 24 California hospitals from its network for CalPERS members. “CalPERS board president Sean Harrigan said hospitalization rates sought by Sutter were too high and eliminating the most expensive facilities would result in CalPERS members paying lower monthly premiums. ‘Premium increases exceeding 50 percent in the past three years are simply unsustainable,’ Harrigan said. ‘Almost half our cost increases are driven by hospital charges.’ ... CalPERS took the unusual action to exclude certain hospitals after an audit showed higher prices in general at Sutter facilities, in some cases 80 percent higher than average costs at hospitals statewide. CalPERS also complained that Sutter required that insurers include all 26 Sutter facilities rather than separating them by region.”⁴² Clearly, such instances of market power can make cost control infinitely more difficult, both in-state and nationally.

The importance of transparency. A related problem in California is that hospitals make it very difficult for health plans and consumers to compare their costs. Thus, it can be very difficult to isolate them in the marketplace and to make these hospitals bear the market consequences of their costs. For example, Sutter demands contract provisions with HMOs that prevent them from placing Sutter in a higher-cost tier.

The importance of incentives and the organization of markets. There are significant imperfections in the alignment of incentives between health plans and medical groups in the California delegated model. For example, the choice of capitation rate paid by the health plan to the medical group is a zero sum game. They have no mutual interest in raising or lowering it. This is in contrast to, for example, Kaiser Permanente, whose Health Plan has an interest in a well-paid successful medical group, and whose medical group has an interest in the health plan charging an affordable premium that will attract members. In the delegated model, usually the medical groups have little or no financial interest in the economi-

⁴² Bleys W. Rose, “CalPERS Shuns Sutter Hospitals,” *The Press Democrat*, August 10, 2004, page 1.



cal use of resources such as hospital and pharmacy. And because the medical groups in the delegated model lack mutual exclusivity, investments made by one health plan in one group, such as in information systems, create benefits that accrue to the six other health plans that are the health plan's competitors. (Again, see the Appendix, "Problems of Incomplete Incentives Alignment in California Delegated Model HMOs.")

California Attitudes Toward Health Care

According to the most recent Field Poll, popular attitudes toward health care in California track closely those in the nation at large.⁴³ Forty-eight percent of Californians, a plurality, are dissatisfied with the current health-care system, slightly larger than the share (45 percent) reporting that they are satisfied. Those who are dissatisfied are more intense in their feelings (24 percent are very dissatisfied, and 25 percent somewhat dissatisfied; only 14 percent are very satisfied, with 31 percent somewhat satisfied). A majority (54 percent) of California voters report that they are very concerned that they or someone close to them will lose (or have already lost) their coverage.

In assessing the urgency, 32 percent of Californians believe that the health-care system needs to be completely rebuilt; 39 percent are just short of that, asking for fundamental changes. Another 23 percent say that minor changes are needed. U.S. opinion is only slightly stronger, according to a March national survey, with a total of 76 percent asking for at least fundamental changes. In terms of timing, 67 percent of Californians say that it is more important than ever to take on health reform now – more than the percentage (62 percent) so responding among the population of the nation as a whole. Fifty-seven percent of Californians say that the country would be better off with health reform.

In terms of simple questions about the policy choices, Californians do tend to favor options that would entail costs; few polls, of course, attempt to tie the policy steps needed to pay such costs. Eighty-nine percent favor tax

breaks or other incentives for businesses who offer plans; 76 percent approve of tax credits to moderate income individuals who buy insurance. Eighty-five percent agree with choices among competing public and private health plans. Eighty-three percent approve of savings on insurance for individuals who follow healthy lifestyles. Eighty-one percent would require insurers to offer coverage without regard to pre-existing health conditions, but 70 percent *dis*approve of requiring individuals to purchase coverage. Sixty-four percent *dis*approve of giving people fixed amounts of money to purchase insurance on their own instead of having employer coverage. (CED is sensitive to the distinction, probably not appreciated by all, between purchasing insurance in the individual market and purchasing it from an exchange, such as in the Federal Employees Health Benefits Plan.)

Precisely half of Californians (and 49 percent of all Americans) poll as willing to pay higher taxes to provide coverage to all Americans; very nearly equal percentages are opposed. Seventy percent oppose increasing the deficit to finance health reform. But when it comes to specific ideas to pay the bill, few policies meet with approval. Only tax increases on families with incomes of over \$250,000 per year – either limits on tax deductions or repeal of the Bush tax cuts – achieve majority approval. A cap on the deduction for health insurance premiums by employers reached plurality support, but other ideas, including a value-added tax or reducing the employer-premium exclusion for employees – are opposed by majorities.

Thirty-eight percent of Californians prefer to receive their insurance from their employers, as opposed to 28 percent favoring government, and 26 percent preferring personal responsibility. Thirty-four percent would replace the current system with a government-run program, whereas 43 percent prefer reforms within the framework of the current system, and 18 percent would rely on free-market competition.

In sum, Californians are less than satisfied with the current health-insurance system, but seem far from settled on an alternative. Learning more about the workings of the system and its alternatives is essential.

43 Field Research Corporation, "Large Majorities of Californians Believe the Nation's Health Care System Needs Fundamental changes or Should Be Completely Rebuilt," Release #2308, June 18, 2009.



California Small Business Attitudes Toward Health Care

A 2009 survey undertaken by the advocacy group Small Business Majority assessed the attitudes of entrepreneurs toward health care.⁴⁴ The survey shed light on the problems that the small business community has in addressing the health-care needs of its owners and employees.

In California, more than half (55 percent) of small businesses do not pay for health-care coverage for their employees. The smaller the business, in terms of number of employees (one to three) or revenue (less than \$250,000 annually), the greater the probability of not contributing (65 percent and 75 percent, respectively). Greater than average percentages of Latino, rural, and young (aged under 55 years) business owners (66 percent, 59 percent, and 58 percent respectively) do not contribute. This is so even though 62 percent (31 percent strongly, 31 percent somewhat) agree that companies have a responsibility to provide coverage. Cost is clearly the major reason why small businesses find it hard to contribute toward coverage. Eighty-six percent of firms that do not contribute say that they cannot afford to do so; 70 percent of those that do contribute say that they struggle to find the money. Small business owners in general, and Latino, rural, and young entrepreneurs in particular, say that they have difficulties in getting affordable coverage and quality care.

Small business owners see health care as an important economic issue. Forty-two percent strongly agree, and 19 percent somewhat agree, that health-care reform is important for getting the economy back on track. Women and young business owners are the most likely to hold this view.

Small-business entrepreneurs see a government role in a solution, although there are characteristic differences in the perceived nature of that role. Forty-three percent see a shared responsibility of employers, consumers and government in make health care more affordable; 18 percent want government to provide health-insurance coverage directly. Again, women and young business owners feel

most strongly that government action is called for (68 percent and 64 percent, respectively).

In terms of policy solutions, a substantial majority (63 percent strongly, 24 percent somewhat) agree that pre-existing conditions should not affect eligibility for coverage. Equally substantial majorities agree that restrictions of coverage for pre-existing conditions inhibit entrepreneurship. The largest positive response (50 percent) among alternative criteria held that the top priority of health reform is controlling costs. Eighty-three percent (63 percent strongly, and 20 percent somewhat) want preventive medicine to be used to control costs. A large majority (58 percent strongly, 23 percent somewhat) support a marketplace where small businesses and individuals could choose their coverage. Two-thirds (66 percent) believe that marketplace should offer both private and public plans; 24 percent want private plans only, and 7 percent want only public plans. A majority (35 percent strongly, 33 percent somewhat) support shared responsibility among individuals, employers, insurance companies, providers, and government to make coverage more affordable.

Clearly, California small-business owners, like the public at large, believe that our health-care system must be improved.

Employer Attitudes Toward National Reform

Of course, most larger firms have multi-state operations, and so identifying a large business solely with California is problematic. This report includes interviews with a smaller group of California-based executives, but this effort is not intended to construct a scientific sample. Rather, it includes in-depth interviews that provide insights into firm policies and their likely interaction with public-policy reform in health care.

However, the Committee for Economic Development conducted its own survey of the attitudes of 300 business

44 Small Business Majority, "Report: California Small Business Healthcare Survey," August 27, 2009.



executives at large toward the health-insurance system.⁴⁵ The respondents clearly are concerned about health care. Fifty-four percent of those business leaders said that it is more difficult than five years ago to provide health-insurance coverage for their employees, while 39 percent that that it is about the same as five years ago. Fifty-eight percent expect that providing coverage will be more difficult five years from now; 30 percent expect it to be about the same. Fifty-six percent believe that providing health insurance helps them to compete for talent in the labor market, but only 14 percent believe that it helps them to sell their output; 37 percent believe that providing health insurance makes them less competitive. Seventy-four percent say that their firms have been forced to take action to address rising health-care costs.

This level of concern leads to one of the most striking findings of the poll, especially given the tendency of business to support the employer-based insurance system. Thirty-six percent of respondents strongly agree, and 26 percent somewhat agree, that “the current employer-based healthcare system in the United States is not sustainable in the long term.”

Questions about preferences for public policy and health-care reform showed that the views of business leaders are as divided as those of the public at large. However, when presented with a range of options, extending from a “single-payer” public insurance system to sending all consumers into the individual market, the strongest support (18 percent very supportive, and 42 percent somewhat supportive) came for a system, like CED’s, following the general outlines of the Federal Employees Health Benefits Plan, which serves Members of Congress. And 81 percent (42 percent strongly, 39 percent somewhat) agreed with a more-specific statement of the CED plan: “Every American with good healthcare should be able to keep the coverage that he or she has, but every American also should have more choices among private insurance plans. Those plans should be portable when people change jobs. And every American

should be able to save money if he or she makes a wise choice among those alternative health-care plans.”

Clearly, health insurance is complex, and people’s preferences differ in many ways. However, the level of popular dissatisfaction with the current system is high, just as fears are widespread among experts that costs are out of control. This project has sought the guidance of experts and practitioners in California to address people’s perceived needs in a higher-quality, more-affordable system.

45 Committee for Economic Development, “Poll Shows Business Leaders Want a Bold New Direction in Health-Care Reform,” June 24, 2009, <http://www.ced.org/news-events/health-care/351-poll-shows-business-leaders-want-a-bold-new-direction-in-health-care-reform>.



Interviews With California Employers And CalPERS, The Large Exchange For Public Employees

CalPERS

This review is based on an interview with CalPERS staff on April 13, 2009, and on information provided by personnel of the Health Benefits Branch, Office of Health Plan Administration. We gratefully acknowledge their kind and capable assistance, and accept responsibility for any errors of fact or interpretation.

Introduction. CalPERS runs a large exchange that manages (brokers) health benefits for nearly 1.3 million state employees, dependents and retirees, and also for employees, retirees and dependents of more than 1000 local Public Agencies (PAs). From the point of view of the CED's interest in public policy, CalPERS Health Benefits Program is the closest living approximation to, or model for, the large Regional Exchanges recommended by CED as the foundation for market-based universal health insurance. Through CalPERS, eligible employees can choose from among three HMOs and three statewide PPOs, as well as three employee association plans specifically for Highway Patrol personnel, prison guards, and peace officers. In 2009, about 82,000 people get their coverage through these employee association plans. In what follows, we treat this population as a separate market. In times past, such as in the late 1980s, CalPERS offered more than 20 different plans. In fact, this exchange contributed greatly to the development of the California health-care economy by offering new plans access to a large market with the signing of a single contract. The number of HMOs diminished over the years by a Darwinian process. But Blue Shield Access Plus, a network HMO, offers the services of generally the same non-Permanente physician groups as those that contracted with the other HMOs serving CalPERS members.

Employer Contributions. In this model, it is the employers (state and local government agencies) that determine the contributions made to employee health care, as a part of their respective labor-management relationships. In the case of the state, each bargaining unit has its own contribution. However, these are all in fixed dollar amounts that, for the most part, fall below the lowest prices in PERS, so it can be said that State employees are fully cost conscious in their choices. (It was not always this way. Back in the 1970s, the State contributed 100% of the average premium for the

employee and 90% of the average for dependents. This was, of course, inflationary, because plans charging less than the average were "leaving money on the table" or getting no marketplace reward for charging less than average. If every employer did that, the pressures for every plan to raise its premiums to the average would be strong, thus raising the average, and an unending inflationary spiral would ensue.) Around 1990-91, in the context of a recession and budgetary crisis, Governor Wilson agreed to some tax increases to help balance the budget in exchange for abolition of automatic spending increase formulas, including this one. Employer contributions were turned into fixed dollar amounts, independent of the actual prices of health plans. In the early 1990s, premium growth decreased sharply, as did some actual premiums, because of the introduction of and competition among managed care plans, and some of the state employee contributions were above the actual prices. But in the later 1990s, as premiums economy-wide began to rise, the premiums of the state's plans rose above the contribution amounts. The contribution amounts became an object of collective bargaining, but have generally increased no faster than the premiums, retaining cost-conscious choice for all employees. The PAs are different, however. There are no reliable data, but the PAs are free to negotiate employer contributions with their unions, and apparently many of them have agreed to contribution formulae in which the employer contributes more on behalf of more costly plans, such as 80-100 percent of the premium of the plan of the employee's choice, thus weakening or depriving the employees of the incentive to make an economical choice, and weakening the incentive of plans to offer low premiums.

THE PLANS OFFERED. The plans offered to the general employee population in 2009 are as follows:

Blue Shield Access + HMO offers typical comprehensive HMO benefits, with no deductibles and \$15 copayments for office visits, for the services of some 200+ physician organizations generally contracting on the basis of per capita prepayment for professional services (but usually not institutional services and pharmacy). The monthly premium for a single adult is about \$392 in Los Angeles, the most populous county. (For prices in other areas, see the discussion of regional pricing below.) This plan



serves residents of 35 of California's 58 counties, generally not including thinly populated rural counties. (All the prices can be found on the website www.calpers.ca.gov.) Blue Shield shares some risk with PERS.

Blue Shield Net Value HMO is a fairly recent innovation, requested by CalPERS, in which Blue Shield offers a subset of its Access + network, chosen for superior value for money, serving residents of 17 counties not including such relatively costly areas as San Francisco, San Mateo, Santa Clara and Santa Cruz counties in the North. The monthly premium for a single adult in Los Angeles is about \$352. The deductibles and copayments are the same as Blue Shield Access+.

Kaiser Permanente HMO, the largest fully integrated prepaid group practice, is offered with the same cost-sharing provisions as the other HMOs, in 31 counties, generally excluding the most rural thinly populated areas. Its monthly premium in Los Angeles is about \$359 for a single individual. Kaiser Permanente is fully at risk for all services.

Three self-funded PPOs – **PERS Care**, **PERS Choice**, and **PERS Select** – are all administered by Anthem Blue Cross, which pays providers the fees it can negotiate in the private market. The three plans offer similar deductibles, such as \$500 per year for an individual, \$1000 per year for a family, \$3000 out of pocket maximum for an individual and \$6000 for a family. (The PERS Care maximums are \$2000 and \$4000.) PERS Care and PERS Choice are offered in every county. PERS Select is not offered in four mainly high-cost Northern California counties. Some people stay with PERS Care despite its considerably higher cost, because of attachment to providers who are not in the more selective networks, or because of preference for its somewhat more generous coverage.

HISTORY OF THE PPOs. The history is interesting. Back in the 1970s and before, indemnity insurance was offered by a private insurance company, CalWest Occidental. With the growth of HMOs in the urban areas, CalWest went into a “death spiral” and left the market. CalPERS did not then, and still does not, practice “risk equalization,” a practice in which all plans are presented to the market on a risk-neutral basis so that risk selection is

taken out of the competition. (The new Dutch model of universal health insurance based on competition in the private sector does use risk equalization.) Moreover, operating in many rural counties with provider monopolies, it was and is difficult for an insurer to operate with providers who are unwilling to negotiate prices and accept utilization management. But CalPERS must offer insurance to employees everywhere in the state; that is a given. So CalPERS decided to create and offer their own self-funded fee-for-service PPO to be available everywhere. By self-funding, they could keep close control of the benefit design and not have to rely on insured plans with more state insurance regulation. However, PERS needs to charge premiums that would allow its PPO to break even over the cycle. That is, this plan does not have an open-ended call on the State General Fund. PERS Care has gradually gone into a death spiral. Its single premium in Los Angeles is now about \$698 per month. So, wishing to preserve the same covered benefits but with a less costly plan, PERS created a second self-funded PPO, PERS Choice, focused on a narrower network of more efficient providers. Its monthly premium for a single adult in Los Angeles is about \$459. This was still undesirably high. And PERS stood up to and fought the high prices charged by the Sutter system of non-profit hospitals that enjoys considerable market power in Northern California.⁴⁶ So PERS has recently introduced a still more selective network of high-value providers, PERS Select, which does not include Sutter and other high-cost providers. Its single premium in Los Angeles is about \$435 a month. It is offered in all but four counties.

A Government Insurance Company? These CalPERS PPOs have attracted some attention in the context of the discussion of national health reform, and whether there should be a government insurance company. Single-payer advocates, failing to achieve their actual goal, appear to be very enthusiastic about a government chartered and run insurance company “to compete with the private companies and make them charge less.” Others are wary that this government insurance company could charge Medicare’s administered prices (which are generally significantly below prices paid in the private market), shift costs to the private companies (as Medicare does now), and thereby accomplish the

46 Bley W. Rose, “CalPERS Shuns Sutter Hospitals,” op.cit.



ultimate goal of the single-payer advocates: to drive the private companies out of business. And, if that did not do the job, the government could tilt the playing field further by subsidizing the government insurance company, and/or by regulation. Are the CalPERS PPOs such a government insurance company? Probably not. For one thing, the CalPERS PPOs rely on a private company to administer them, and Blue Cross pays that company's commercial prices. For another, the PERS plans were invented to solve a particular problem in the market, i.e., the need for a wide access PPO to be available in all parts of the State. They take on a more difficult task that, apparently, private companies are unable or unwilling to perform. They were not invented to compete with the private sector across the board. (If they were, their 28 percent market share of the non-employee association market would not suggest much success.) And finally, with its chronic and apparently incurable budget deficits, the state of California does not appear to be in a position to fund any deficits. And, unlike the federal government, the state cannot just print money. If people are concerned that private companies may not cover all of the geography of the country, however, it could make sense for the regional exchange to fill the gap with a self-funded but unsubsidized (that is, required to break even) private-company-administered PPO.

Market Shares. Of the 1,285,983 total covered lives, about 86,430 are in the Association Plans. Of the remaining 1.2 million, the market shares are as follows:

Plan	Market Share (Percent)
Blue Shield Access +	24
Blue Shield Net Value	9
Kaiser Permanente	39
PERS Care	6
PERS Choice	21
PERS Select	1

Recall that Blue Shield Net Value and PERS Select are fairly recent entrants, so these market shares may not reflect their long-run equilibrium levels. In any case, the HMO market share in this population is 72 percent, despite the fact that about 500,000 lives come from the

PAs whose employees have less incentive to be cost conscious than state employees.

Regional Pricing. Twenty years ago, perhaps less, the prices charged the members were uniform across the State. Then cost trends in the different regions diverged increasingly. PAs that were in PERS and in particular regions of the state began to notice that they could get significantly lower rates locally, outside PERS. Some left PERS. The attrition became significant. The PERS Board tried various measures to make it more difficult or less attractive for PAs to withdraw from PERS and go on their own. Now, by contractual agreement, participating plans in PERS cannot undercut PERS prices to attract PAs to leave PERS. But the main response was to bow to economic reality and to introduce separate prices by distinct regions to reflect local market conditions. The following are the regions for pricing purposes, and for illustration, the Blue Shield Access + single monthly premiums in each:

Region	Blue Shield Access + Monthly Premium
SF Bay Area/Sacramento	\$533
Los Angeles Area	\$392
Other Southern California	\$448
Other Northern California	\$541

Innovative Use Of Size And A Market Of Cost Conscious Customers To Develop Economical Alternatives. It was observed above that historically, CalPERS eased the market entry of many new HMOs in California by offering them one standard contract that would let them reach 1.3 million potential members. This was far less costly than entering the employer-based market otherwise, where plans would need to seek entry into thousands of employment groups, each of which would require its own non-standard benefits package, its own sales efforts, underwriting, employee materials, etc., all perhaps to be able to enroll a few hundred members at best from each employer. From the point of view of developing a competitive market, the employer-based system is usually a huge barrier. CalPERS is a much more promising model, indeed a real "market opener."



But in recent years, possibly under pressure from State employees on fixed-dollar contributions, CalPERS has gone even further, and taken the initiative and advantage of its size to demand actively the development of new competitors within its system. No single employer would be able to initiate such market innovation, nor has the Pacific Business Group on Health had such success. One such new plan was the development of PERS Select, a narrower network of more economical providers that could be offered for a 3 percent lower premium than PERS Choice. The next was Blue Shield Net Value HMO, again a narrower network of more economical providers, that could be offered for 10 percent less than Blue Shield Access +. Each of these begins to offer some marketplace reward to providers for being more economical, something that is generally lacking in America's health care system.

The newest, and by far the most ground-breaking initiative, is a new pilot project for the Sacramento market among Blue Shield of CA (BSC), Hill Physicians Group (Hill), a large IPA, and Catholic Healthcare West (CHW), a large nonprofit hospital organization. The provider partners have committed to a new joint project in which they are at risk to hold flat or reduce costs for their enrollment of the 220,000 CalPERS members who choose to enroll in Blue Shield Net Value in a three-county area (Sacramento, Placer and El Dorado counties) through better, more-coordinated care. This project addresses the problem that even in the typical "carrier HMO," incentives of doctors and hospitals are not aligned the way they are in a center-based HMO such as Kaiser Permanente. There are many things that doctors can do to keep people from needing hospital admission. Typically, hospitals' incentives are to keep their beds filled, and they have little incentive to work with the doctors on such initiatives. The possibilities for collaborative efforts include choice of medical devices, joint discharge planning, disease management, palliative care, end of life care, chronic complex case management, management of Acute Coronary Syndrome patients, and more. As one example, inpatient readmissions within 30 days have received a great deal of attention lately. It is a major problem for Medicare. Mitigating this problem requires the collaborative efforts of doctors and hospitals. Medicare does not reimburse doctors adequately for extra


efforts to keep people from returning to the hospital.⁴⁷ In this model, the doctors will be rewarded for their efforts in preventing the need for readmissions. To facilitate achievement of this goal, CalPERS will establish a new pricing region for public agencies within Sacramento, Placer and El Dorado counties. This will sharpen competition in the three-county area and increase the ability of this pilot to gain market share by focusing price competition on its service area.

This has not happened, and would be most unlikely to happen, in the traditional employer market – because no single employer or even coalition of employers could offer insurers a market of price-conscious employees large enough to enable the pilot to achieve economies of scale and to pay for itself. In fact, other value networks by other carriers have not done well in the employer market because employers generally want one or a very few plans to satisfy most employees and are not interested in narrow networks.

This is highly provocative in relation to the CED proposal, because the regional exchanges proposed by CED would be able to undertake similar initiatives. It also helps explain why **regional** exchanges, as opposed to a single national market like the FEHBP, are important. Regional strategies based on local market conditions can innovate in ways that a national exchange could not. Also, this pilot is important from a national point of view, because it is almost the only initiative, outside of the large multi-specialty group practices that have their own affiliated hospitals, that offers to align incentives of doctors and hospitals.

From a broader efficiency standpoint, it is noteworthy that CalPERS has been able to innovate in plan design within geographic sub-areas of its jurisdiction, while continuing to capture economies of scale in administration and organization over its entire jurisdiction. For example, it can process paperwork for all of the state's employees, and it can offer insurers

47 Reed Ableson, "Hospitals Pay for Cutting Costly Readmissions," *New York Times*, May 9, 2009, p. B1, <http://www.nytimes.com/2009/05/09/business/09relapse.html?r=1&sq=reed%20abelson%20may%202009&st=cse&scp=1&pagewanted=print>.



the economy of contracting state-wide, while creating a high-value network in only part of the state. This advantage suggests that the design of an exchange system for a national health reform should pursue such opportunities, in the interest of both innovation and administrative savings.

Risk Equalization. CalPERS does not now do risk equalization of premiums. They do have the DxCG technology which enables them to do risk assessment, i.e. to look at what is going on in terms of risks enrolling in the different plans. They are using that technology now. They use Mercer, which is capable of such analysis. The purpose of risk equalization is to focus competition more sharply on cost and quality, by eliminating risk selection as a tool that plans can use to earn profits. If CalPERS were to use risk equalization, that might have a large impact on the rest of the State. And it might mitigate the death spiral that is driving PERS Care out of the market.

Western Health Advantage. Last year, CalPERS dropped Western Health Advantage even though it was the lowest priced HMO in their portfolio. Reasons included that WHA was getting favorable risk selection, it was not planning to expand, and it was not doing enough disease management. However, the WHA providers are represented in BSC Net Value. If it works, the BSC HILL CHW pilot could replace WHA as the lowest-priced HMO in the system, and should have considerable potential for expansion, because Hill and CHW have a much larger reach than just the three county area. In fact, the BSC HILL CHW pilot has statewide and national significance because, perhaps for the first time, it integrates traditional non-profit community hospitals with traditional fee-for-service solo practice doctors, and aligns their incentives. It could serve as a model to create Accountable Care Organizations, a concept gaining increasing attention nationally. Such integration is a significant contributor to the superior efficiency of Kaiser Permanente.

Catholic Healthcare West

The following is based on a September 3, 2009 interview with personnel at Catholic Healthcare West.

Generally speaking, the thinking and views of CHW are very similar to the views and conclusions of CED. Both

organizations believe that health care costs too much now, there is a great deal of waste, and improved access to care is very important but would not be sustainable without serious cost savings that require delivery system change. As the written materials of both organizations state, delivery system change means integration and incentives alignment so that all participants are rewarded for providing high-quality *affordable* care.

The enacted national health reform bill refers to moving to payment by episodes, accountable care organizations, bundled payments, reducing unnecessary readmissions, quality incentives, and changing from fee-for-service delivery. But these ideas are pilot projects, not policy changes that would drive actual fundamental change. Congress is focusing on access now, as if in the fear that the nation will never get there if not now. But delivery system change is essential to achieve the savings that are needed to pay for and sustain that broadened access.

A key issue and barrier to efficiency through integration of services in California is the prohibition against the corporate practice of medicine, something established by the medical profession to block competition by organized systems. If this were changed or circumvented, CHW could at least in theory hire physicians for such purposes as primary care in underserved areas, hospitalists, and other services requiring physicians. The CMA strongly opposes the corporate practice of medicine. (Apparently other states do not ban the corporate practice of medicine.) This policy should be changed, if necessary through a federal override. Similarly, the new reform law creates only a pilot program for bundled payments. (Although such reform is very much in the spirit of CED's policy recommendations, it was not explicitly discussed in the CED statement.)

Regarding the AHA's agreement with the White House in the national health reform debate to offer Medicare savings of \$155 billion over 10 years, with five years to adjust with Market Basket minus 1 percent annual update, CHW recognizes that there is a lot of inefficiency in the system now, a function of incentives, from which such savings could be achieved. CHW intends to manage to that target. However, beyond this "conceptual" statement, there were no specifics, and this does not amount to a large volume discount when one considers



the additional \$175 billion of revenue that would result from universal coverage.

CHW reported that achievement of the CHW/Hill/Blue Shield/PERS Sacramento pilot project (discussed in detail in the report on the interview with PERS officials) was not easy. The CHA opposed it. What are the prospects for success? “We’ll see. The devil is in the details.” It is structured so that it is in the doctors’ interest to save on hospital costs. It will be a “virtual ACO.” It will be a model that is more nimble and flexible than Kaiser Permanente with the latter’s large fixed costs. Recognizing that some 85 percent of health care is in fee-for-service solo practice in community hospitals, this is a prototype that could transform the largest segment of the delivery system and give traditional providers a vehicle for participating in fundamental restructuring of the delivery system.

CHW/Hill is an example of what CHW would like to do. CHW officials fundamentally believe that integration and efficiency enhancement are essential to their mission. They are not fighting for the status quo. They want to innovate. But the Sacramento pilot is a first, and no one knows whether it will work. They take a cautious stance.

The immediate goal of CHW is to make the Sacramento pilot work. If it does, they would want to expand it. But to do so, there would have to be market conditions similar to what PERS has created in Sacramento, including consumers with choices and the opportunity to save money by choosing a less costly health plan. The Sacramento area is a “system-based market” with Kaiser Permanent, UC Davis, and Sutter (which has affiliated medical groups). It would be hard to rival Kaiser Permanent because Kaiser’s structure gives it built-in advantages of incentives alignment.

The Service Employees International Union agrees with and supports the pilot. They are very interested. They understand the implications for members (wage pressures and possible job losses), but their members have an interest in lower health-care costs. SEIU wants to be in the front of the movement to lower costs. All of the CHW-SEIU contracts have retraining clauses, so there would be retraining as the nature of the work changes. CHW’s dialogue with Andy Stern of the SEIU has pro-

duced a different labor-management arrangement with recognition that workplace rules would need to change to lower costs.

What about CHW as employer? They offer employees multiple health plan options and a fixed dollar payment so that the employee can save money by choosing the low priced plan. They are not self-insured. Also, like Safeway, they offer tools and ideas for healthier lives. CHW has 53,000 employees and spends \$380 million a year on employee health care. They do offer a CHW PPO with incentives to use their facilities. They offer dependent care for all employees. Their belief that everyone should have access to health care has trumped concerns about same-sex partners’ lifestyles, so they cover them.

How would CHW adapt to the CED model? (They reported to the CED by a separate channel that they were acquainted with CED and its work.) This is just the model they would like to see. We also discussed the similar Wyden-Bennett bill that was introduced in the Congress, and they said they thought that it was a great idea and expressed regret and surprise that it “didn’t have legs.”

Cisco Systems

This interview was held on September 8, 2009, with health-care personnel at Cisco Systems. Cisco personnel reported familiarity with the managed competition model and had read some of Alain Enthoven’s writings about it.

Cisco’s own model of employee health care, however, is quite different. Cisco is mostly self-insured with 90% of employees in the self-insured plans, while 10% are in HMOs (KP in Northern California and Harvard Pilgrim in Massachusetts). Other than the HMOs, they offer a PPO and an EPO, the latter using the CIGNA and United networks. They have just introduced a high-deductible plan.

Like much of the high-tech industry, Cisco is “very paternalistic” with rich health-care benefits (but not much in the way of retirement benefits, with the expectation that employee profit sharing or stock options will build personal wealth). They are moving to more employee cost sharing in health care. For 2009,



the PPO and EPO both have coinsurance for out-of-network services, 100 percent coverage in network, with copayments of \$10 and \$15 per visit. The PPO has a \$250 deductible, the EPO \$100. Both have a \$1000 out of pocket maximum. Also, they offer up to \$300 in bonuses for participation in health incentives and improvement programs. For 2010, they will introduce 90/10 coinsurance in network, raise the deductible to \$400/800 for employee and family, and make the PPO and EPO similar. Later, the interview revealed that Cisco is actually eliminating the EPO because it is not very efficient. They took the gatekeepers out of the system. They are also moving to a more robust health incentive account, \$800 for fitness, disease management, health appraisal, and so on. They are trying to have employees and families think about healthy lifestyles and disease prevention.

Cisco personnel did not discuss whether the company engaged in self insurance to escape benefit mandates under insurance regulation.

Cisco does not do “strict Managed Competition.” The HMO costs the company much less than the PPO or EPO and the employees pay less, but they do not get to keep the full savings. In the course of its upcoming program changes, Cisco will not pass on the full difference, but they will move closer to that.

What are Cisco’s thoughts about the problem of costs continuing to rise? Their average employee age is 39-40. They hope to stave off chronic conditions by engaging employees in healthy lifestyle activities. In November 2008, they opened a large onsite health center in San Jose, which is available to families of employees. It is staffed by four family practitioners, two internists, a chiropractor, a physical therapist, and a pharmacy, with behavioral health and full service primary care. Cisco is also developing a referral network with negotiated prices. They get better drug prices for their center than their PPO gets. One half of their U.S. employee population is in San Jose. The center is now only nine months old, and so it is too soon to tell what impact it will have on costs.

Cisco’s corporate goal for health care is to be a bit richer than the competition, as it is one of the differentiators, and they want their people to be proactive and partici-

pate in prevention activities. High users should have to pay more, so they are raising their out-of-pocket maximum to \$2000.

Can employers “bend the curve?” Not alone. Cisco believes that they need to work with the health plans and look for efficiencies. They need to get patients to be more involved in their health. They need behavioral therapies. But there is nothing radically new or different in their practices thus far.

What would CISCO think about an employer mandate? Cisco is going to cover its own employees regardless. Still, an employer mandate is not a bad idea, but there needs to be a balance between what large employers can provide and what small employers can afford.

What would Cisco think about a tax cap? Cisco likes to use health care generously to minimize health-related absenteeism or disability. It is worth a lot to keep healthy employees on the job. Cisco does not believe that the nation should cap the benefit. Cisco personnel include a member of the American College of Occupational Medicine and they are cognizant of the costs of disability. Cisco wants the costs of absence factored into decisions. Employers are willing to pay more for total efficiency including the costs of work loss. Cisco partners with Kaiser on IT, but they are concerned about inefficiencies from delays. Kaiser members get prompt access to primary care, but if someone needs an MRI, there is likely to be a two week wait. The Palo Alto Medical Foundation is a lot more expensive for CISCO, but it is easier there for the patient to be seen.

Integrated delivery systems are not a large part of Cisco’s thinking, mainly on this issue of delay. Employees come back to Cisco, and Cisco has to intervene to get them health care.

Cisco does not have a position on national health reform. Cisco personnel expressed a view that Cisco would like to stay in the employee health insurance business, to keep employees healthy and productive. Still, the sentiment was that, in the long run, employer-based health insurance is not sustainable.



What about Wyden-Bennett or the CED vision of “beyond employer-based health insurance?” Cisco thinks of health insurance as a differentiator and would like to stay with it. General Motors has a huge retiree burden, so it is understandable how GM would like to get out. But most companies do not. Still, Cisco personnel could imagine the day when employers agreed on a common standard plan design for the sake of simplification and cost savings from standardization.

Genentech

Alain Enthoven met with employee benefits personnel at Genentech, on May 5, 2009. Opinions were expressed as personal rather than as official Genentech views.

Genentech, as a health-care provider, would not seem to have a compelling reason to lead America in health-cost containment. They are focused on advanced bio tech products.

The most important idea guiding Genentech’s policies is that they have earned and received ratings in national publications as one of the best places to work, or “an employer of choice,” and that they work hard and systematically to keep that rating. “We work to make the benefit package compelling,” so that employees do not have to spend time over it. They cover very broad benefits, including unusual procedures if desired. They benchmark with Amgen, Genzyme, Merck, and Pfizer, the large pharma companies. Now that it is a part of Roche, Genentech itself is a large Pharma company. The company’s job is to help “win the war for talent.” All of those companies have very generous health benefits, partly for the war to win talent, and partly because they are part of health care.

Genentech offers Aetna PPOs and Kaiser Permanente. About 10 percent of employees choose Kaiser. Five percent waive coverage. They have a cafeteria plan which includes more credits for lower-paid employees. The company pays 90 percent of the cost of whatever plan the employee chooses. They are self insured. They have \$5 copayments. They do not offer Consumer Directed/

Health Savings Account plans because very few would choose them if they could.

On questions about public policy:

On an employer mandate, they meet it by most definitions. They cover anything that anyone can think of, so mandated benefits would not be an issue for them.

On the tax cap, they do gross up pay for some employee expenses, so they would be likely to go on doing what they are doing, possibly grossing up pay to compensate for tax losses. If the tax break was taken away, the expectation is that large employers would figure out how to provide health insurance, customizing their program to meet their requirements. If the government covered some benefits, they would probably provide a wrap-around.

What should government do? Cover the uninsured and cover preventive services.

Whatever the question on public policy, Genentech would be determined to keep winning the war for talent.

One thing they are looking at now is an on-site medical clinic. They are doing a feasibility study. Google has a clinic for convenience. Roche has one in its U.S. headquarters (likely to move to San Francisco). As explained in the previous interview, Cisco has an onsite clinic as part of their Life Connections Health Center which also includes a fitness center and child care. Genentech has considered these examples as it makes its choices about its own on-site clinic.

Intel

Alain Enthoven met with health benefits personnel for Intel on May 19, 2009.

Intel is primarily a self-insured employer with 87 percent of employees in their self-insured plans. (The other 13 percent are in Kaiser or GHC.)



They prefer the self-insured approach for several reasons:

- They like to be able to control their own plan design. Federal regulation now constrains self-insured plans with respect to Mental Health and Substance Abuse, but at least that is uniform across the United States.
- Administration is easier that way because they are the same in every location. Intel's employees are mobile, and different benefits in different locations would cause complexity.
- State mandates add cost and complexity.
- State mandates add cost which can add up when there are many such mandates, even if each one adds only 1 percent to the cost.
- Employees can be made to understand that health expenditures are out of the company's money, not an insurance company's. The whole complex matter of experience rating is not a part of most employees' thinking. Intel wants the employees to know that the real payer is Intel. Intel devotes a lot of effort to education about costs, wellness, and the employer's cost.

Intel offers several choices including a high-deductible plan that is free to the employee (with a \$1200 individual deductible, \$2400 for a family, and a \$4200 annual out of pocket maximum). They have eight tiers of coverage (including tiers for employee only, employee plus spouse, and plus one, two or three or more children). They also have a first-dollar, \$20 copayment plan, for which the additional premium can be as high as \$6000 per year in the most expensive tier. They do have some HMOs, though that does not appear to be a significant part of their thinking. They have a coinsurance plan with a \$250/500 deductible that pays 90 percent in network and 70 percent out of network. They also have a "legacy" plan, a CDHP with HRA model which they no longer offer to new employees. Altogether they have seven plans to choose from, managed by two networks (Anthem and Cigna). They pay for the low-priced plan and the employee pays the rest. The market share of the coinsurance plan has fallen from 60 percent to 34 percent

as people figured out that it is tax-advantageous to take the higher deductible and fund their own HSAs.

Intel is trying to get the employees to be conscious of total cost, as noted above. Their strategy on total costs is:

- The right level of coverage for each employee including protection against catastrophe;
- Employee engagement;
- Health and wellness, including a health-risk appraisal and a free once-a-year wellness checkup;
- Management of chronic conditions; and
- Engagement with providers: conversations with doctors, report cards for doctors, annual reviews, and an executive review meeting.

Costs are rising too fast. Intel does not believe that it knows the right solution. There appears to be a gulf between the CED economists' way of thinking which includes markets, incentives, and delivery systems, and the Intel view which is still rooted more in the traditional model. As to who are addressing cost and quality, Intel cites Minnesota broadly, General Mills and General Electric, who are innovating in payment models (Prometheus), coalitions who are trying to change payment. Intel participates in the Pacific Business Group on Health.

On the CED approach and Wyden-Bennett, the reaction was, "Why do we believe we need to take employers out of the picture?" Enthoven explained the main problem: No choices of systems, and the employer model as a barrier to entry for innovative health plans. Another Intel concern was "too many choices." Enthoven did relate that Stanford employees seemed to find six choices burdensome. The discussion led to plan-chooser software as potentially a good way to narrow the field.

Intel supports accountability in care delivery, but the discussion did not reveal concrete mechanisms to accomplish that objective.



Intel operates in 12 countries and in most of them they offer a supplemental plan in addition to the national plan.

Employees choosing HMOs pay lower premiums than they do for the coinsurance plan. Their prices are very competitive. “We are an anomaly,” as most of Intel’s peer companies have larger market penetration by HMOs.

Intel personnel visited the Kaiser Permanente innovation center and thought it was phenomenal and that there was a lot to learn from their system. But people come with pro- and anti-HMO prejudices, and Intel personnel personally were negative about HMOs.

On public policies, there was a fear that an employer mandate could cause Intel to be stuck with federal standards that would not fit them, such as a proposal that there be no lifetime maximum. Pay or Play could be very costly if the law is that an employer must pay 8 percent of payroll. That means no reward for good cost management. Who knows that 8 percent is right? At some point, employers would decide to just “pay,” but Intel does not want to walk away from employee health. Intel employees in San Francisco are well covered in Intel’s view, but what they have does not satisfy the new city mandate, presumably because the employees all have chosen the high-deductible plan.

The conversation with Intel was a striking indication that reasonable, informed people can see the whole world of health care quite differently. Intel personnel are acquainted with Hill Physicians and with Kaiser. Follow-ups to the formal interview included the description of the Blue Shield/Hill/CHW pilot, and discussions of how incentives were needed to support disease management infrastructure to facilitate doctors working to keep hospital discharges from being readmitted.

Nektar Therapeutics

Alain Enthoven interviewed human resources personnel at Nektar Therapeutics on March 11, 2009.

The main message was that in biotech, health benefits are considered to be very important because they are in the health-care business, and employees are likely to be

particularly health-conscious or aware of the high costs of medical care. Employees want choices. And to attract highly educated and skilled employees, biotech companies want to be seen as generous in health benefits.

Nektar offers employees a choice that includes Anthem Blue Cross (HMO and PPO) and Kaiser Permanente. The employee pays 10 percent of the premium for the HMOs and 15 percent of the premium for the PPO. Market shares are:


Plan	Market Share (Percent)
Kaiser	21
Blue Cross HMO	31
Blue Cross PPO	43

Five percent opt out, probably relying on the spouse’s employer.

So a substantial percent (52 percent) do choose HMOs, even without getting the full savings from doing so. Younger people are more likely to choose an HMO while older people are more likely to choose the PPO. The older employees have more health issues and more pay.

Nektar does not do cafeteria benefits (meaning a fixed dollar budget). The Nektar human resources personnel had prior experience in other high tech firms (computers, electronics etc.) where cafeteria benefits were more prevalent, before moving to Nektar.

According to Nektar, Genentech is the pace-setter in biotech; apparently, more companies in electronic high tech follow Hewlett Packard as a model. These companies are seen as the industry leaders in their sectors. Genentech is the poster child for very generous benefits. Also, having mainly highly educated and skilled people, biotech can afford more generous health benefits. The approximately 250 biotech companies in California with about 85,000 employees generally do about the same as Nektar. This is a volatile industry with low job security. If a clinical trial fails, the company needs to cut back its work force. People fear the loss of jobs. They are interested in their COBRA rights. Companies generally have severance pay and pay the health benefits for as long as the severance lasts. (Under



the recent stimulus bill, companies pay 65 percent of the cost and the government reimburses this through tax offsets.)

In the early days, Nektar paid 100 percent of the premiums. Then they decided to encourage HMOs because they cost less. So now employees pay 10 percent of the premium for the HMOs, 15 percent for the PPO.

In biotech, “Health care is our business, so rich health benefits are the norm.”

Even biotech’s health-specialist workforce is fairly ignorant about what health insurance costs. The company talks about total compensation, tells employees what the company is spending on their health insurance, and “people are stunned by that.”

Right now, Nektar HR personnel see no reason for Nektar to do things differently from what they are doing. A “consumer directed health plan with an HSA” does not look attractive. It would cost the company the same, assuming they funded the HSA.

When asked about the CED proposal for universal market-based health insurance, they note that in other countries with universal health insurance, health benefits are seen as a key attraction. In New Zealand, companies compete for skilled employees by offering supplemental health insurance, even though employer contributions to it are taxable income. In Germany, anybody who can afford it buys private health insurance.⁴⁸ Employers seeking to hire highly educated skilled employees want to offer health insurance. So in their view it is likely, even with universal health insurance, that many companies like Nektar would want to offer supplemental health insurance.⁴⁹

48 In Holland, 93% of people buy supplemental insurance at their own expense.

49 The CED proposal would not prevent companies from providing supplemental insurance with after tax dollars.

University of California

Alain Enthoven interviewed University of California officials about their employee/retiree health insurance program. The interview took place Thursday, March 26, 2009.

In the early 1990s, UC adopted a model of employee health care that offered each employee a multiple choice of health plan and a fixed-dollar employer contribution to help them buy it. The contribution was set at the level of the lowest-priced plan serving all campuses. (It was not Kaiser Permanente, which was often the low-priced plan at the campuses it served, but it did not serve all campuses.) The main motivation for instituting this competition model was to change a fixed-percentage-of-premium contribution to a fixed-dollar contribution, regardless of the plan chosen.

UC has maintained the general outlines of this plan, but with a number of modifications to adapt to the University’s changing environment. Broadly speaking, UC management remains satisfied with the managed competition idea. However, they are concerned that the low-priced plan’s premiums continue to grow faster than employee compensation in general. Thus, the health-care share of total compensation continues to grow. The trend to higher costs seems inexorable. With this reservation, UC management is satisfied with the competition approach and sees no practical alternative.

The UC workforce is quite unionized, and the faculty is organized and functions, in some respects, like a union. So change is not easy and does not happen frequently.

One development of the plan, taken several years ago in response to budgetary needs, was to adopt a tiered employer contribution depending on salary. Employer contributions range from 72 percent of the low-priced plan serving all campuses (Health Net HMO) for the highest-paid employees, to 96 percent for the lowest-paid (\$40,000 or less). These contributions remain fixed-dollar amounts. Employees may pay their shares with pre-tax dollars. This structure generally leaves employees fully cost-conscious in their plan choices.



The plans offered to active employees now are:

Health Net, a network-model HMO marketing the services of many medical groups and IPAs throughout the state, contractors paid on a per-capita prepayment amount for professional services, in some cases with incentives to manage other costs. Market share 37.6 percent. Premium per family per year \$15,030.

Kaiser Permanente, a prepaid group-practice model HMO which bears full risk for all services and which serves many parts of California, but not Santa Barbara or Santa Cruz (though in the latter case, some Santa Cruz employees make the trip to Kaiser facilities). Market share 27.9 percent. Premium per family per year \$13,935.

Western Health Advantage HMO, a small provider-based non-profit HMO serving mainly the Sacramento area, but with some presence at UC Davis. Market share 2.7 percent (but 20.4 percent at the Davis campus, where offered.) Premium \$13,579.

HMOs offer first dollar coverage.

Anthem Blue Cross PPO, with \$250/750 individual/family deductibles, mainly 20 percent coinsurance for in-network providers, a tiered formulary, and out-of-pocket maxima of \$3000/9000 for individuals/families in network. Market share 9.4 percent. Annual family premium \$15,364.

Anthem Blue Cross PLUS, a point-of-service product with an HMO for the first tier, and a PPO for patients who want to get covered care outside the HMO. Market share 12.1 percent. Annual family premium \$15,495.

The combined market share for the whole system for HMOs, including Western Health Advantage and the point of service plan as an HMO, is 80.3 percent. Without the POS plan, the HMO market share is 68.3 percent.

CIGNA Choice Fund, a high-deductible plan with a University-funded HRA of \$1000/2000 individual/family per year, and deductibles of \$1500/3000 for individuals/families. Eligible preventive care is paid 100 percent without a deductible. It does not cover behavioral health. Members pay 20 percent coinsurance in network. The

out-of-pocket maxima, including the deductibles, are \$3000/6000 for individual/families. Market share 1.3 percent. Annual Family premium \$15,425.

The market share for HMOs has slipped some as their cost advantage has diminished over time. This is a trend noted more generally in California. One factor is that the 200 or so medical groups that serve as HMO providers are also PPO providers, and it is expected that they will treat both sets of patients the same. The HMO product is regulated more tightly by DMHC, with requirements that are not placed on PPOs by DOI. Moreover, the medical groups have little or no reason, in general, to favor HMOs.

The University used to offer PacifiCare HMO as well. However, there was disappointment and concern, after it was acquired by United HealthCare, of a growing national corporate presence with direction coming from out of state, and a loss of focus and commitment to California. PacifiCare and Health Net have similar provider networks. The university at one time piloted a Definity plan, but its market proved to be quite narrow.

There are some campuses whose environs have little provider competition, and this can be a problem.

The University is assisted by Deloitte. Deloitte “has earned their fees” with savings generated by their work. They do risk adjustment using the DxCG Drugs model. They use a North-South adjuster of 1.2 to reflect the higher costs in the North. Employees are charged “risk neutral” rates and, 12-18 months after each year, there is a financial reconciliation to compensate plans for unfavorable risk selection. Plans are less likely to price conservatively because they know they will be compensated for bad risks.

The University, like Stanford and CalPERS, is a member of Pacific Business Group on Health.

University management seeks continuing engagement with its health plans, and holds “Blue Sky or Horizon” meetings to consider possible developments and be informed and engaged on likely changes.



Wells Fargo Bank

Alain Enthoven interviewed Wells Fargo Bank human resources personnel on April 6, 2009.

In California, Wells Fargo still offers competing alternatives: Kaiser, Health Net, more- and less-rich CDHPs, an HSA-eligible high-deductible plan, and still a broad-access PPO. The PPO costs a lot more. It is preserved by inertia (people reluctant to change, arguably not practicing economic rationality). “Competition at the retail level just doesn’t happen.” The attempt at introducing competition among health plans is not producing the expected effects. There is some competition at the carrier level, but too little competition. There are decisions that are not rational from an economic point of view based on non-quantifiable factors or qualitative perceptions. Wells Fargo’s experience is not encouraging from the point of view of the power of price competition – though personnel acknowledged that an important part of the problem is that providers face so few employers like Wells Fargo and Stanford whose employees are cost-conscious.

The CDHP has produced a little more value, but at the lower end of the cost spectrum – for generic drugs and the like. The result has been perhaps a 4-6 percent real reduction in cost, risk adjusted. People are making rational decisions at the lower end, but not yet asking “who is the best doctor,” because there is no information on the quality of individual doctors, especially at the specialist level. Medicare does collect information on individual doctors, but it is not being made public. Doctors are afraid of transparency. There is a web site, YELP, that lets people comment on anything, including doctors and hairdressers. A doctor in San Francisco brought suit to stop it.

Kaiser appears to shadow-price the other plans, running generally about 2 percentage points less expensive than Aetna. (Kaiser Permanente makes its own unilateral investment decisions with no transparency to employers, so employers do not know the ROI resulting from those decisions.)

Health Net has a Value Net, but only in the South. Because of Sutter, there is no point in trying it for the North. The Pacific Business Group on Health tried to

look into anti-trust action regarding Sutter, but Wells Fargo personnel do not know what came of it. Wells Fargo found that the Health Net Value Net costs are no lower than their broad network when risk adjusted. Health Net and Kaiser Permanente have converged to almost the same cost. Kaiser does a lot of the right things in care management, but that doesn’t show up in lower dues rates. Thus, the differences between low- and high-cost groups have narrowed.

What should the government do? The expressed personal opinion was to support HIT to use the information for quality transparency – though the doctors resist transparency. The most important potential accomplishment of national health “reform” would be having quality-related information. Likewise, the potential great value of Health Information Technology would be if it could lead to a large increase in quality-related information. Then people could make evidence-based decisions. Following that, there needs to be payment reform: pay doctors for outcomes.

There should be individual mandates, but what we learned in Massachusetts was that the definition of the meaning of “covered” depends on “weird standards” so they have had to tell their well-insured employees that they may not be insured in the eyes of the state. Also, employers need to be more open about mandates. Individual mandates appear to be a good idea, but are not affordable.



Lessons from the California Health-Care System

Provider Market Power

The battle between CalPERS and a large and important chain of hospitals, described above, yields one of the powerful lessons from the experience of California. It is not enough for an insurer or market organizer to seek to provide quality, affordable health care; that entity must have choices from a truly competitive marketplace. Competition may come from conventional antitrust action, although this path is always complex. Even if it is clear that there is excessive market power, it is almost never clear what remedy could prove appropriate. A merger or acquisition that would accumulate excessive market power can be blocked in a generally simple fashion, but excessive existing market power is difficult to excise. Owners of existing firms will argue that weakening their competitive positions, though potentially in the public interest, devalues investments that they made in good faith. In some markets, the owners and monopolizers of capital may even be not-for-profit entities, which could seem to the non-expert electorate to be inappropriate targets of antitrust enforcement.

CED advocates optional alternative federal regulation of health plans, which would allow efficient plans to expand across state borders and introduce competition where there is market power and an excessive return on investment. That competition would drive prices down and benefit consumers. However, expanding investment may not be a sound remedy in markets that already have adequate or excessive capacity, even if that capacity is controlled by too few owners and thus provides market power.

Creative and painstaking antitrust enforcement may well be needed in some markets. New and innovative remedies may be needed. There will be no textbook, one-size-fits-all answer to the kinds of bottlenecks to competition that can occur in complex corners of the medical-care marketplace.

Transparency

In an exercise of market power, as noted above, health providers can use the complexity of their services to conceal true costs from consumers – including even

health-insurance plans. Those providers can demand complicated contract terms that prevent consumers and insurers from accessing choices and alternatives. Public policy will need to be just as creative to prevent abuses of market power through manipulation or withholding of information.

Incentives And The Organization Of The Market

A premise of CED's approach is that providers, insurers and consumers can be driven toward responsible behavior only if their incentives are aligned. As explained above, we believe that employer-provided insurance generally has led to dysfunctional, non-competitive markets in health care. However, in California, several major employers – including the state itself – have organized markets constructively, and improved outcomes as a result. Cost growth in California has been less than in other metropolitan states, which is difficult to achieve in an increasingly national market for health care. However, cost growth in California still is unsustainable, and even the differentials achieved to date will be difficult to maintain over extended periods of time.

For all of the difficulty of holding growth below a comparable national average, and though most employers in California do not organize markets in approximation to CED's ideal, the experience in California is instructive. The interviews in this project do reveal that employers that provide cost-responsible choices to their employees are broadly satisfied with the results, and have not considered reverting to more-typical approaches of offering more limited choices with simpler contribution systems for their employees. The discussion of these experiences helps to explain why the “managed competition” model, as it sometimes is called, has been attractive to employers that have used it.

Still, the experience observed by CED nationwide is that firms find it hard to change from long-standing practices. In general, any change in human-resource policy that angers even a small minority of the work force can be painful. In particular instances of collective bargaining, change may be conceivable only at infrequent time intervals, and may be difficult to achieve even if it promises long-term benefit greater than any short-term perceived cost. Thus, lessons from existing successes



in California may provide the strongest arguments in a very difficult process of improving health care – certainly necessary even if not sufficient by themselves to motivate reform.

The Geographic Scope Of Exchanges

Under the CED proposal, or any market-based system that uses the exchange model, a potentially critical choice is the geographic scope of the exchange or exchanges. Many different opinions have been heard; some have advocated one national exchange, and some have argued for an exchange in each individual state. CED's own plan specified regional exchanges, with boundaries following coherent health-care markets – perhaps embracing several states, or perhaps only parts of individual large states.

However, an important insight arising from the interviews in this project is that the ideal borders for an exchange might or might not be the same with respect to pricing as they would be with respect to administration or regulation. In the case of California, one exchange might cover all of the state to capture economies of scale in administering the program, but the experience of CalPERS suggests that premium rating ought to be done by economic zones that reflect the geographic differences in costs and prices in different parts of the state.

CalPERS found that when they used uniform prices across the state, some local public agencies that belonged to CalPERS, and that operated in low-cost parts of the state, could get much lower premium rates outside the exchange than in it. So those agencies started dropping out. CalPERS then divided the state into five economic zones for premium rating – from high-cost Northern California outside of the San Francisco Bay Area and Sacramento (where the Blue Shield Access + HMO premium is \$1,524 per family per month), to Los Angeles (where it is \$1,104, or 28 percent less), to forestall this adverse development.

But on the other hand, as the interview revealed, having CalPERS manage the exchange for the whole State creates some important economies of scale in such things as contracting, including benefit design. Thus,

under an ideal exchange system, a single exchange carrying out administration and regulation might encompass several pricing zones. In the context of the recent policy debate in Washington, which centered on state-based exchanges, it is clear that states will be the ideal boundaries for exchanges with respect to pricing only by pure accident – and state exchanges might very well forfeit potential administrative and regulatory economies of scale.

Economies Of Scale In Risk Pools, And Benefits For Innovation

A large exchange that can afford to offer multiple health plans is in a much better position to foster desirable innovation than are individual large employers, by reason of important but insufficiently recognized economies of scale.

Individual employers generally would not be interested in offering a plan that appealed to only five or 10 percent of their population, because such a plan would entail high per-employee administrative costs. Yet such a plan might embody a very desirable innovation that could put competitive pressure on other plans.

For CalPERS with its 1.3 million covered lives, five to 10 percent of its population is 65,000-130,000 lives, a number large enough to make it worthwhile for the exchange to offer it and for a plan to design and offer the model. If available nationwide or even statewide, a plan of that size could create true competitive pressure and drive the entire market toward increased efficiency. However, if forced to win subscribers employer by employer, even a highly efficient and innovative plan of that nature would be unlikely ever to gain a foothold.

As described in the interview above, CalPERS fostered a significant and desirable innovation along these lines. First, they asked Blue Shield to offer “Blue Shield Net Value,” a very selective network of the highest-value physician organizations. In Los Angeles, this could be offered for a 13 percent lower price than Blue Shield Access +. This same kind of product has been developed by Health Net and Pacificare, but they have not found much receptivity in the employer market, because many employers prefer to offer only one or very few plans,



including at most one flavor of carrier HMO, for reasons of administrative cost. Therefore, the plan or plans they choose must appeal to a wide cross-section of employees. (Recall that for the great majority of private employers, the preferred number of plan offerings is one.) Yet in the CalPERS population, this plan could attract about 110,000 lives in 2009, and thus be more than commercially viable. And that offering can put competitive pressure on medical groups that lose membership to groups included in Net Value.

CalPERS went on to encourage Blue Shield, in the context of the Net Value product, to develop an innovative program in Sacramento in which Hill Physicians and Catholic Healthcare West teamed up to commit to holding 2009 per-member per-month cost constant into 2010, and to do it by improved integration and cooperation between the physician organization and the hospitals. (Again, see the above interview on CalPERS.)

Conclusion

Health care in California as a whole is unsustainable, just as it is for the entire nation. However, experiments within California have shown a path that could lead toward an improved health-care system.

The slower growth of health-care cost state-wide, compared with growth across the nation as a whole, shows the potential of the innovations in California. The satisfactory results in the individual innovating systems indicate a possible cause of the above-average performance of the state.

However, the current unsatisfactory state of the California market, coupled with the unsustainable growth of cost in the national market, provides a final lesson. Even though some employer systems are performing well in California, we have not seen the result typical of competitive markets, where superior performers expand market share and force efficiency laggards to improve, driving up overall performance and benefiting consumers. In fact, even some of the California companies that we interviewed – successful, progressive firms on the cutting edge of their fields – do not employ the competitive model espoused by CED, and show no interest in adopting it. They are

satisfied with their own current performance, see some compelling reasons to continue their approach, and are unwilling to accept the inevitable risks of change. This is true even of companies whose representatives expressed a belief that the current employer-based system is not sustainable in the long term. For all of these reasons, the practices of the efficient California performers have not spread nationwide, just as they have not spread within California.

These are strong indications that the health-insurance and health-care markets are not competitive, and good performers do not have the leverage to drive out bad. This is so for several reasons. As noted above, individual employers are driven by insurers and by their employees to offer only one plan, which leads to inflation-laden fee-for-service medicine. An efficient insurer that might be attractive to a sustainable share of the overall market, but would not appeal to all consumers, cannot induce an employer – which is compelled to offer only one plan – to strong-arm all of his employees to accept *that* one plan. Because the employer will not offer that niche-market efficient plan as an alternative, it cannot enter the market at all. The experience of CalPERS in nurturing such a niche plan has demonstrated the potential for such disruptive innovations in the health-care marketplace. But the failure of that innovation to propagate on its own indicates strongly that it may take public-policy intervention to allow even such existing, successful models to improve the health-care marketplace in ways that in other industries are the natural achievement of the “invisible hand.”

CED will continue to pursue the improvements in public policy that are needed to provide quality, affordable health care for all, with these lessons from California experience as an important guide.

Appendix I

Problems of Incomplete Incentives Alignment In California Delegated Model HMOs

Alain Enthoven

I. Introduction

The “California Delegated Model HMO” refers to a type of health plan/delivery system that is made up of partnerships among: one of seven insurance carriers; roughly 200 medical groups and other physician organizations; and contracting hospitals. The physician organizations contract with the carriers to care for enrolled members on the basis of per-capita prepayment for professional services plus, in some cases, limited risk sharing for institutional services or pharmacy costs. The name “delegated model” refers to the fact that the insurance carriers delegate medical decisions to the physicians, rather than trying to do the job of utilization management with their own medical staff.

The seven carriers participate in the Integrated Healthcare Association (IHA). IHA is a statewide non-profit leadership group that includes major health plans, physician groups, and hospital systems, plus academic, consumer, purchaser, pharmaceutical and technology representatives. The IHA promotes integration and value improvement in California health care, and has created and operates the nation’s largest pay for performance (P4P) program in which physician organizations receive incentive payments for superior performance in a suite of quality metrics. (The IHA contribution was to convene representatives of all the participants and obtain agreement on a common set of metrics for purposes of reporting and bonus payments, as well as to establish agreement on bonus methodologies, so that all medical groups would be working to the same reward system.)

The enrolled commercial (i.e. non-Medicare, non-Medicaid) membership covered by the California delegated model has been declining steadily from, for example, 6,278,188 lives at the end of 2004 to 5,219,952 at the end of 2008.⁵⁰

About two years ago, David Joyner, Senior Vice President for Network Management at Blue Shield of California, reported to the IHA board that a thorough analysis of their data, operating in both the HMO and PPO markets,

with adjustment for comparative risks, showed that by and large the California Delegated HMOs have lost their cost advantage. In some markets, HMOs cost less, in others PPOs cost the same or less. (Kaiser Permanente maintains its cost advantage in most market segments.)

These developments are a cause for concern among those who would like to see more vibrant competition among health plans in California. This memorandum is a discussion of some of the issues contributing to this trend.

II. Incomplete Incentives Alignment in the California Delegated Model

1. On Capitation and Dues or Premium Rates

If a health plan seeks agreement on a lower capitation payment to a medical group, there is nothing in the reduction of the capitation rate that is of any benefit to the medical group. The loss to the group is gain for the plan. It is a zero sum game. So plan-group incentives are actually opposed on this important point. This can be contrasted with the situation in a fully integrated program with mutual exclusivity as between the group and the plan (e.g., integrated delivery systems such as Kaiser Permanente). In that case, the group and the plan have common interests. The health plan knows that without well paid, satisfied doctors in adequate numbers, it would not have a good business. Its success depends on the success of the group. And the group knows that if the plan’s premium is not competitive, if it cannot offer good value for money, it will lose members and patients. So their shared interests point them in the same direction - that is, a competitive premium and good value for money.

Two ideas for how to improve incentives alignment have been proposed and tried. One is a **tiered network** in which the plan charges lower copayments for patients in groups accepting lower capitation rates. Apparently, this has run into opposition from the high-cost groups and hospitals who do not want their costliness to be exposed to cost-conscious consumer choice. Also, employers often must want to control the copayments, and possibly standardize them across plans (as is done at Stanford and CalPERS). That is, the copayments are an

⁵⁰ As reported in the health plans’ financial filings to the Department of Managed Health Care, available at <http://wpsc.dmhc.ca.gov/fe/search/#top>.



employee-relations issue. It would be interesting to gather data on the extent of tiered networks among IHA health plans.

Another idea for how to improve incentives alignment is for plans to offer “**value networks**” made up of lower-priced groups to employers at lower premiums. For example, in CalPERS in the San Francisco Bay Area, the Blue Shield Net Value plan, a narrower network of higher-value groups, charges \$478.22 per single member per month compared to \$532.93 for Blue Shield Access Plus, which offers most or all groups. And in fact, Blue Shield Net Value is priced below Kaiser in Los Angeles. So this approach is meant to reward groups accepting lower prices with being a part of a more economical and hopefully more popular product. Blue Shield Net Value has enrolled over 108,000 covered lives in 2009.

The popularity of this product is limited by the fact that some of the most famous groups are not included. Also, large employers may not want to offer it because they want to offer only a few products that satisfy many employees. For example, Health Net and Pacificare HMOs received recognition for their innovation in creating value networks, but apparently this was not a major success in the employer market.

A major advantage of large PERS-like exchanges is that they can offer “niche” network products, such as these value networks, that appeal to a relatively low percentage of people. Such a large insurance “exchange” knows that the niche products do not need to attract or satisfy most people to achieve sufficient enrollment to survive. With that opportunity, innovative products can prove themselves and potentially move the entire market. In contrast, such niche plans would not appeal to individual employers, who almost always want only plans that will appeal to large percentages of their workforces, and so those plans would not have the opportunity to drive innovation.

A similar point applies as between plans and hospitals. The delegated model involves zero sum, opposed interests. Also, unfortunately from the cost point of view, many hospitals are full or are in monopoly positions, so they do not have much reason to accept lower prices.

2. On Resource Use Other Than Professional Services

Though there is variation, apparently most HMO/group contracts do not put the groups at risk for institutional services or for pharmacy. (Some groups do bear some hospital risk.) Thus, groups have no strong incentives to hold down resource use in these categories. It may even be easier for them to prescribe more hospitalizations or drugs to reduce physician work load. In some cases, incentives may be worse, such as in the case of doctors receiving payments from manufacturers of devices (such as joint replacement prostheses, stents and pacemakers) and making decisions on use of their products, shifting costs to hospitals that pay for the devices or pass the costs through to insurers. At the request of plans, IHA is building a list of measures of Appropriate Resource Use (ARU) to reward appropriate group resource use decisions in, for example:

- Use of Ambulatory Surgery Centers;
- Use of generic prescribing;
- Readmissions within 30 days;
- Hospital Days per 1000 lives per year;
- Hospital Admissions per 1000 lives per year; or
- Emergency room visit rates.

These indicators will be built into contracts between groups and plans with significant gain sharing. It would make sense for plans to pay on the basis of each group’s aggregate performance across plans to get a better statistical base. This could significantly reduce misalignment of incentives.

3. Measuring Total Resource Use

IHA is now working to develop measures of total resource use per capita (risk-adjusted) per medical group. This could set the stage for gain sharing among the contracting parties if resource use is more efficient. An early stage of this kind of process is described in the section on CalPERS in the body of this report. Blue Shield Net



Value has teamed up with Hill Physicians Medical Group and Catholic Healthcare West to offer a less costly joint product in the PERS Sacramento market.

4. Misaligned Incentives for Investment

Because of lack of mutual exclusivity between health plans and medical groups, the benefits of investments that a plan otherwise might make in a group (such as in information technology or consulting help to improve care processes) will be spread over six other health plans, and not captured by the investing plan. Worse yet, the other six plans are competitors. This clearly inhibits potentially valuable investment in process improvement.

5. Incentives for Unnecessary Hospitalization

Hospitals need and want to fill their beds and also have their high-cost equipment fully utilized. So they have little or no incentive to cooperate in projects intended to reduce hospital use, including reducing use of the ER. The coming inclusion of readmissions costs within 30 days into the costs of the hospitalization by Medicare will give hospitals some incentives to work with patients and their doctors to reduce the need for re-hospitalization. Could plans follow Medicare and get hospital agreement to include readmissions in the payment for the initial hospitalization? Could IHA encourage that and make it a standard?

6. Distorted Treatment Decisions for HMO versus PPO Patients

Groups are supplying services to both HMOs and PPOs. Presumably they practice medicine the same way for both groups of patients. However, at least at first look, it would appear that HMO patients would represent more work for groups because their care must be managed, while PPO patients would be less work and PPOs would pay per visit or service. So it is not clear that medical groups have much incentive to sacrifice to make the HMOs do better if the customers are just as satisfied with fee for service. Some might be just as happy to see the HMO business continue to decline. The same analysis applies to hospitals and health plans, all of whom work in both HMO and PPO markets.

III. The Destructive Role Of Employers And Unions

To understand these dynamics, it is necessary to look upstream in the money flow to examine the role of employers. If all employers offered cost-conscious choices the way the States of California and Wisconsin, Stanford and the University of California, Wells Fargo and Hewlett Packard do for their employees, then it is reasonable to suppose that some 80 percent of employees would choose HMOs – provided that the HMOs could achieve and maintain a significant cost advantage. If the market is moving toward cost-conscious choice, it is reasonable to suppose that medical groups and hospitals would be motivated to serve that market. The market share of cost-conscious choice could increase as HMO facilities proliferated, because some consumers now do not choose HMOs – whose facilities are not as numerous and hence might not be conveniently located.

But most employers do not offer cost-conscious choice. We lack a good survey of such employer behavior in California, but the available national evidence indicates that a preponderance of employers drive health care almost solely toward the fee-for-service model.

The reason for this is clear from the CED policy statement. All but the largest employers are subject to heavy pressure to cover all of their employees through one insurer (because insurers want to avoid a risk of adverse selection, and the employers themselves save on administrative cost by dealing with only one insurer). Smaller employers see themselves as too small to offer choices of plan, and so choose a “free choice” fee-for-service plan that includes most or all local doctors and hospitals. Such a plan will satisfy everyone, with respect to choices of providers. But the cost of this non-choice of plan with wide choice of providers is high, both now and in the future, because of static fee-for-service delivery and stifled innovation.

Large employers prefer to self insure for well known reasons, including avoidance of state benefit mandates and premium taxes. Self insurance means fee-for-service medicine in most cases, leading to the same stagnant practice patterns as for smaller employers. Some large employers offer self-insured fee-for-service coverage



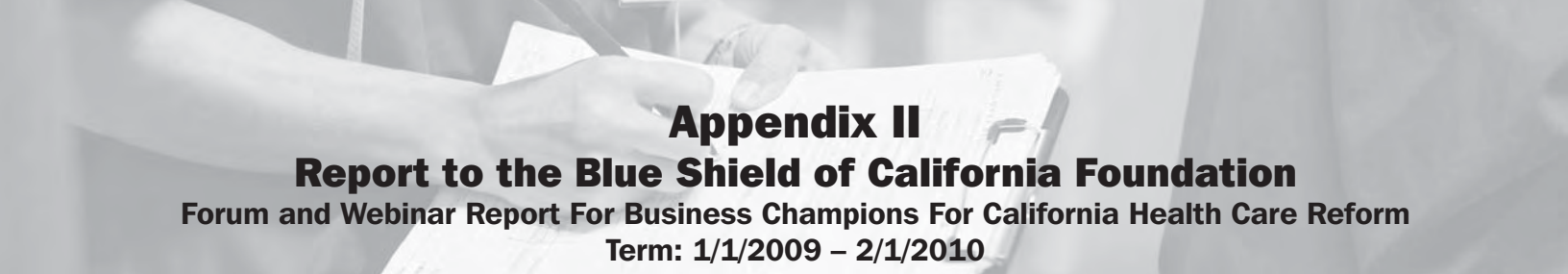
and also choices of integrated delivery systems such as HMOs. But in most instances, their employees are not offered a cost-conscious choice, under which they would save money by choosing a more-efficient, less-costly plan. Thus, few of their employees choose HMOs. Some other large employers, like Stanford, buy insurance from HMOs and also offer self-funded PPOs, but with the proviso that employees are fully responsible for premium differences. CalPERS does this also for California state employees. In those comparatively rare instances, market forces do push competing modes of coverage and practice. But with the market dominated by incentives driving fee-for-service medicine, progress toward more-efficient, more-economical practice patterns has been slow to nil.

Unions play a role in this incentive-free industry pattern as well. As noted in the CED statement, unions quite commonly bargain for no-out-of-pocket-cost health insurance for their members. Because unionized employers tend to be large, some such employers can offer choices to their employees. But because a condition of the contract is that the employer pays 100 percent of the premium no matter which plan an employee may choose, employees have no incentive to consider cost.⁵¹ Changing contract terms to provide employees with meaningful cost-conscious choices can seem like a “give-back” to employees who see the high costs and insecurities endured by their non-union neighbors. The clear message for unions and unionized employees is to pursue what appears to be in their own interest – apparently cost-free health coverage – but at the end of the day the result is higher-cost health care for the entire society, including themselves.

IV. Conclusion

The newly enacted health-reform law will expand coverage to many currently underserved Americans – a worthy goal. However, fee-for-service medicine will continue to dominate the market unless employers find a way to offer competing plans through cost-conscious choices, which would be aided if unions could be convinced to accept responsible, fixed-dollar premium contributions in exchange for higher cash compensation. Today the trend does not appear to be in that direction; and without more-efficient delivery of health care, expanded coverage will prove an empty promise. What could reverse the decline in California delegated model HMO membership would be a shift by employers to competition and cost-conscious employee choice. It is possible that the new excise tax on high-cost health plans could motivate such a shift. If that proves insufficient, then further changes in public policy will be necessary.

⁵¹ In fact, in many instances the incentive may be perverse. Some national-employer human resource professionals have told CED in interviews that employees who receive 100 percent employer contributions regardless of the employee’s choice of plan, confused by the multiplicity of claims in competing health-insurance promotional materials, eventually choose the *most* expensive plan on the presumption that it must be the best. Those of the same employers who have different premium-contribution policies for management as opposed to unionized employees find that the plan choices of the two groups are totally different.



Appendix II

Report to the Blue Shield of California Foundation

Forum and Webinar Report For Business Champions For California Health Care Reform

Term: 1/1/2009 – 2/1/2010

With the support of the Blue Shield of California Foundation, the Committee for Economic Development (CED) reports on our program to learn more about the feasibility and application of a market-based universal health insurance system from several large California-based employers, and to provide opportunities for current and emerging business leaders in California to discuss health-reform financing options.

To leverage our convening power to move business toward an understanding of the need for meaningful, comprehensive reform of the health-care system, CED coordinated two forums in the Bay Area to engage key California stakeholders on the issue of health-care reform. These targeted regional forums made the case for system-wide change directly to business leaders. Each meeting included a presentation of the national challenges in addressing comprehensive reforms by recognized experts from CED and other policy organizations. The forums stimulated discussions and media reports about which policy choices would lead to the best outcomes for health care, business competitiveness, and long-term economic growth.

Below is a brief summary of the forums, the media generated, and the key concerns expressed by business leaders:

April 23, 2009

On April 23rd, CED and the Stanford Graduate School of Business Health Care Club hosted the *Stanford GSB Health Care Summit: Is Health Care Getting Personal?* at Stanford University. More than 120 students attended the event, which featured two keynote speakers: Randy Scott, Founder of Genomic Health; and Mary Hall Gregg, Vice President, Global Clinical Trials and International Business at Quest Diagnostics, Inc. Both Scott and Hall Gregg touched on the future of health care, and offered predictions for how new technology, in both genomics and diagnostic testing, heralds a new era of personalized medicine.

The event also included two roundtable discussion sessions, where fifteen health-care industry and business leaders discussed key health-care, economic, business and policy issues with small groups of students. Among

the roundtable discussion leaders was Charles Kolb, President of CED, who spoke about the importance of corporate statesmanship, and why it is never too soon for business students to become involved in public-policy reform.

CED is proud to have continued its tradition of engaging graduate business students in economic issues of national concern. CED is committed to opening up the dialogue on health-care reform to include emerging business leaders, and is pleased to have had the opportunity to provide a forum for students at Stanford to debate such a critical issue.

In addition to the generous support from the Blue Shield of California Foundation, CED was proud to have partnered with graduate students from the Stanford Health Care Club, McKinsey Corporation and Yahoo! to host this event. This event description and pictures can be found on www.ced.org at <http://www.ced.org/news-events/health-care/310-healthcare-summit-2009-is-healthcare-getting-personal>.



Small Group Leaders and their discussion topics included:

Small Group Dave Dickey, Co-Founder

Co-Founder, RedBrick Health

Topic: "Earning the change we seek in health care through the alignment of health care financing, personalization and independence."

Dr. Alain Enthoven

Marriner S. Eccles Professor of Public and Private Management, Emeritus and HP/PCOR Core Faculty Member, Stanford University

Topic: "No Easy Solutions: An Advocate's Response to Critics of Managed Competition."

Jim Greffet

Finance Director, Lilly Research Laboratories, Eli Lilly & Co

Topic: "Eli Lilly Strategy on Personalized medicine - 5 Words - Improved Outcomes for Individual Patients."

Ron Gutman

Founder and CEO, Wellsphere

Topic: "Health information 2.0: Online and mobile models for personalized information, engagement and support."

Susannah Kirsch

Venture Capital Professional, Physic Ventures

Topic: "Personalized health in a consumer-directed world."

Charlie Kolb

President, Committee for Economic Development (CED)

Topic: "The Importance of Corporate Statesmanship: Why American Business Voices Matter in the Fight for Health Care and Public Policy Reform"

David Levison

CEO, CardioDx

David G. Lowe Ph.D.

Managing Director, Skyline Ventures

Topic: "Hope versus reality in personalized medicine: obstacles and opportunities to commercial success."

Paul Maloney

Principal, ZS Associates

Topic: "Biopharma Self-imposed Disruptive Innovation: How Drug Companies Can Reinvent Their Approach to Marketing and Sales"

Samuel R. Nussbaum, M.D.

Executive Vice President, Clinical Health Policy and Chief Medical Officer, WellPoint, Inc.

Topic: "Health Plan Strategies to Improve Patient Health. How WellPoint uses comprehensive health information and data to identify gaps in care, promote evidence-based medicine, and improve health outcomes."

Alain T. Rappaport, MD, Ph.D.

General Manager, Health Search, Health Solutions Group, Microsoft Corporation

Topic: "The Internet and Personalized Health Care."

Jeff Tangney

President, Chief Operating Officer and Co-Founder, ePocrates

Topic: "HC IT on Steroids: What will \$30 bil in Recovery Act stimulus do to the market?"

David Woodhouse, Ph.D.

Vice President, Goldman, Sachs & Co. Investment Banking Division, Healthcare Group

Topic: "After the Dust Settles: Impact of the Capital Markets and M&A trends on the Direction of the Healthcare Industry"

Grant Wood

Senior IT Strategist, Intermountain Healthcare Clinical Genetics Institute

Topic: "Opportunities Created as We Store and Use Personalized Medicine Data in Electronic Health Record Systems."

Chris Young

Vice President, Ascension Health

Topic: "Corporate America: The Need for full Engagement in the Transformation of the Health Care Delivery system."



November 10, 2009

On Tuesday, November 10th, 2009 CED, in partnership with the Bay Area Council, hosted a forum entitled *The Business Case for National Health Care Reform* in San Francisco. The audience of 80 consisted primarily of business and civic leaders.

The forum featured keynote speaker Ken Shachmut, Executive Vice President of Safeway Health, who delivered a dynamic presentation on Safeway's health care findings and policies. His presentation outlined the economic pressure of the current health care system on employers and employees alike. Shachmut shared with the audience the cost-saving methods adopted by Safeway to incentivize healthy lifestyle choices by its employees.

The co-chairs of the CED health-care report, Robert Chess, Chairman, Nektar Therapeutics, and Alain Enthoven, Marriner S. Eccles Professor of Public and Private Management, Emeritus, Stanford University Graduate School of Business, presented CED's case for health-care reform. In his remarks, Enthoven informed the audience of the issues in the current health-care reform debate on Capitol Hill, and discussed the policy areas on which business should focus.

Following the presentations, Lynn Jimenez, Anchor of KGO's Morning News, moderated an expert panel. Panelists answered a series of questions from the moderator and audience members about the cost of different types of health-care-reform models, the efficacy of cost savings through an expansion of integrated health-care systems, and why it is important for business to play a role in the health-care-reform debate. The panel consisted of Lloyd Dean, President & CEO, Catholic Healthcare West and Chairman of the Bay Area Council; Charles Kolb, President, CED; Lenny Mendonca, Chairman, McKinsey Global Institute; Wade Rose, VP Public Policy & Advocacy, Catholic Healthcare West; and Jim Wunderman, President & CEO, Bay Area Council.

The timing of the event was ideal, as the Speaker of the U.S. House of Representatives, Nancy Pelosi, was in San Francisco to discuss health-care reform. This resulted in media coverage of CED's event on the radio and in the San Francisco Chronicle as an additional and somewhat

differing view of that of Speaker Pelosi. The media report is attached.

CED Health Care Webinar – June 26, 2009

On June 26th, 2009 CED hosted a webinar on health care reform. The presentation and discussion was led by Joe Minarik, CED Senior Vice President and Director of Research, and Alain Enthoven, Marriner S. Eccles Professor of Public & Private Management, Emeritus, at the Stanford University Graduate School of Business.

The webinar documented that America's employer-based health-insurance system is failing. Coverage under employer insurance is flat in a growing eligible population, while national health expenditures rise 2.7% per year faster than the rest of the GDP. CED believes that we need to move beyond the current employer-based system and realign incentives in the health-care market. Meaningful reform can only be achieved by introducing greater choice for individuals and healthier competition among insurers.

CED's approach to health-care reform includes the creation of exchanges with a menu of competing private insurance plans from which each individual may choose. It would create the greatest incentives to improve quality, cost, and service. Under the CED plan, every American would have access to high-quality, affordable health care. The event description can be found on the CED web site at <http://www.ced.org/news-events/health-care/364-health-care-webinar>.



Media Coverage related to the CED November 10, 2009 Event:

Bottom Line: Chinese IT firm opening in S.F.
San Francisco Chronicle, Andrew Ross
November 10, 2009

<http://www.sfgate.com/cgi-bin/article.cgi?f=/c/a/2009/11/09/BUD51AGAB0.DTL>

A fast-growing Chinese IT consulting and outsourcing company is set to open in San Francisco, reflecting the country's increasing competitiveness in a market space long dominated by India.

Isoftstone Inc. of Beijing is expected to pitch tent in San Francisco early next year and begin extending its U.S. client base, which already includes **Microsoft**, **IBM**, **Citigroup** and **Boeing**, to the rich pickings in the Bay Area.

"We'll grow as quickly as the market will bear," said **Anders Brown**, the company's senior VP. While the Bay Area staff will be small initially, "We expect to double or triple the size of our San Francisco office over the next couple of quarters," Brown said.

Isoftstone employs 7,000 people worldwide and is looking to go public on the NYSE in the next year, I'm told.

The move represents another notch in the belt for **ChinaSF**, the city agency with an office in Shanghai that has worked to bring Isoftstone here since December. It joins several Chinese solar and biotech companies whose San Francisco presence has been assisted by ChinaSF in the past year. On the runway, I'm told, are two more Chinese solar companies, a bank and a digital media firm.

"China is our largest international trading partner," said **Ginny Fang**, director of ChinaSF (links.sfgate.com/ZIPW). "We must continue to work closely with fast-rising companies there."

Job seekers, look east: From across the Formosa Strait, a Taiwan "recruitment mission" is winging its way to Silicon Valley later this week, looking to fill more than 1,500 IT slots in the island nation.

Recruiters from high-tech companies will be on hand at the **Hyatt Regency Santa Clara** Friday and Saturday, talking to those who might be interested from various fields, including semiconductors, telecommunications, biotech and clean energy.

Taiwan's government promises to smooth the way, with a one-stop "employment pass," tax incentives and Taiwanese residency. The kind of bennies, btw, Asian and European countries are offering U.S. companies to set up shop overseas aren't being matched by the United States, critics say.

In addition to the job fair, a senior government minister, **Chang Jin-fu**, will hold an investment seminar Friday afternoon titled "Taiwan as an Asian Hub: Outlook & Opportunities." More details on the job fair, and Taiwan's high-tech recruitment program, at links.sfgate.com/ZIPV.

Code blue: A number of prominent Bay Area executives and health care experts will present the "business case" for health care reform at a free, open-to-the-public con-fab in San Francisco today.

It's not the kind of case the Obama administration or the legislation's water carriers might particularly care for.

Among the conference's bullet points:

- The system requires "a change far more sweeping than any advancing in the Congress today."
- "Legislative efforts to date point in the wrong direction, and the savings that are claimed to pay their costs are doubtful at best."
- Ditch the current fee-for-service system, which remains the keystone of the legislation, and replace it with a "market-incentive-based system," some of which is contained in an amendment offered by Sen. **Ron Wyden**, D-Ore.

These, at least, are the positions of the Washington, D.C., **Committee for Economic Development**, which is sponsoring today's conference at the **Bank of America Center**, 555 California St., 12-2 p.m.



One panelist, **Alain Enthoven** of **Stanford University's Center for Health Policy**, is a known backer of Wyden's amendment. **Safeway Inc.**, represented at the conference by the company's executive VP, **Ken Shachmut**, ejected fee-for-service as part of its employee insurance program, and **Lenny Mendonca**, chairman of San Francisco's **McKinsey Global Institute**, has long favored different payment and incentive models.

It will be interesting to hear from **Lloyd Dean**, CEO of **Catholic Healthcare West** and FOB (Friend of Barack), who has heretofore sworn fealty to the White House approach.

In the end, though, as thought-provoking as the conference's bullet points may be, isn't it a little late to turn the ship around?

"I don't think so," **Mendonca** says. "There's lots of heavy lifting still in the Senate."

Conference proceedings should be posted on the CED Web site (www.ced.org) next week.

Pelosi Answers Tough Questions at Home

Abclocal.com (KGO-TV San Francisco), Mark Matthews
November 10, 2009
<http://abclocal.go.com/kgo/story?section=news/politics&id=7111827>

House Speaker Nancy Pelosi faced tough questions in the Bay Area over the battle for health care reform. She met with reporters in San Francisco's federal building.

On the heels of Saturday's vote, Pelosi is back home pushing the legislation forward, even as questions arise about whether the entire package will pass and how much it will accomplish.

It was a very friendly crowd at the federal building and when asked about a provision in the bill that has split in her party over the provision to ban abortion coverage, Nancy Pelosi called it a temporary distraction.

"Beware of any of these kinds of issues because the fact is they want to take your attention away," said Pelosi.

Pelosi said heated protests focusing on inflammatory issues are keeping Americans from hearing what the legislation will do for them.

However, on KGO Radio Tuesday morning, the president of the Committee for Economic Development -- an independent, non-profit, non-partisan, public policy organization -- told Ron Owens that the bills in the House and the Senate would bankrupt the country.

"The system right now rewards volume it rewards people for doing more services more tests more medication," says **Charles Kolb**, the president of **Committee for Economic Development**.

That said Kolb is a recipe for rising costs.

"We want a system in this country that rewards value and actually focuses on the health of the patient," said **Kolb**.

Pelosi's answer was "I completely agree. The fee for service is an obstacle to getting everything that we want." But she added there are provisions in the bill that will move towards rewarding quality instead of quantity. "Well, community health centers are a big example of not having fee for service."

Pelosi pointed to Dr. Ricardo Alvarez, M.D., medical director of San Francisco's Mission Neighborhood Health Center, who says his health center does focus on outcomes.

"I'd like to tell you that we do it purely because we have absolute clarity in the rationality of our interventions," said Alvarez.

Still, the truth is community health centers have fewer resources which has forced limits on what they can offer, but he says in other countries' doctors order fewer tests, health care costs less, and yet the patients aren't less healthy.



“You know we don’t need to do, we don’t need to be that aggressive the evidence isn’t that compelling,” said Alvarez.

Pelosi says there are provisions in the bill that will bend the system towards quality of care rather than quantity and it is also not the end all for healthcare reform.

“Don’t get the idea that in passing this bill, we’re taking a key and locking the capitol, and never passing another bill,” said Pelosi.

At the free market advocacy group, the Pacific Research Center, the director of health care studies told ABC7 Americans don’t want government deciding on what tests and what procedures will be available.

Supporters of the bill say it will be doctors, not the government bureaucrats making those decisions and letting the insurance companies decide what we’ve got now.

Pelosi Pushes Health Care Reform

KCBS.com

November 10, 2009

<http://www.kcbs.com/pages/5645459.php?>

House Speaker Nancy Pelosi was back in her home district of San Francisco pushing for health care reform.

She received a standing ovation Tuesday and chants of thank you as she called last weekend’s house passage of the health care reform bill historic.

But Pelosi said she knows it still has to get the nod from the Senate.

“I’m hopeful that we will have a bill as a Christmas present for the American people. But we will have a bill and it will be soon.” Pelosi said.

Pelosi said she plans to see the senate leaders at the conference table.

“Now, we will go up to the table fighting for a public option because we believe that’s the best way to keep the insurance companies honest and to increase competition,” said Pelosi.

But **Charles Kolb**, the President of the **Committee for Economic Development** said he has issues with the public option.

“The **Committee for Economic Development** is very much in favor of health care reform, but we’d like to see reform that actually bends the cost curve as well as provide universal coverage, but does so in a way that really offers important structural reform that’s market-oriented and incentive-based,” Kolb said.

Representatives from the AARP, local health centers, labor and the small business majority were out to lend their support to the house version of the bill.



Broadcast Coverage Links:

KCBS News

KCBS-AM - San Francisco, CA

November 10, 2009 (9:00 - 10:00 PM Duration: 1:24)

Audio link: http://www.vmsdigital.com/download/newsdigital/ingestedfile/mp3/TSF114802_01.mp3

KCBS News

KCBS-AM - San Francisco, CA

November 10, 2009 (6:00 - 7:00 PM Duration: 1:22)

Audio link: http://www.vmsdigital.com/download/newsdigital/ingestedfile/mp3/TSF114802_04.mp3

Evening Drive Time

KCBS-AM - San Francisco, CA

November 10, 2009 (5:00 PM Duration: 1:25)

Audio link: http://www.vmsdigital.com/download/newsdigital/ingestedfile/mp3/TSF114802_06.mp3

ABC 7 News At 9

KOFY-TV - San Francisco, CA

November 10, 2009 (9:00 - 10:00 PM Duration: 2:54)

Video link unavailable

ABC 7 News At 6:00

KGO-TV - San Francisco, CA

November 10, 2009 (6:00 - 7:00 PM Duration: 3:05)

Video link unavailable

KTVU Channel 2 News At 5

KTVU-TV - San Francisco, CA

November 10, 2009 (6:00 PM Duration: 1:17)

Video link unavailable

The Ronn Owens Show

KGO-AM - San Francisco

November 10, 2009 (10:00 - 11:00 AM Duration: 1:00:00)

Audio Link: http://www.vmsdigital.com/download/newsdigital/ingestedfile/mp3/TSF114802_06.mp3

For more information please contact, Meredith Hanley, Director of Foundation Relations at Meredith.hanley@ced.org or 202-296-5860 ext. 31.



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