



**Prepared For CED Research And Policy Committee**

**November 7, 2006**

**The Employer-Based Health-Insurance System  
(EBI) Is At Risk  
What We Must Do About It**



## Part One

### Why Another CED Statement On Health Care?

Four years ago, the Committee for Economic Development issued a statement entitled *A New Vision For Health Care: A Leadership Role for Business*. That statement presented four major recommendations for large businesses and another four for large businesses in conjunction with government (along with others addressed directly to government). The statement decried “...the closely entangled problems of escalating costs, uneven and poor quality, and inadequate access,” and stated that the “recommendations..., taken together, would address these problems and improve the system’s efficiency and equity... This report is a call to action. We challenge our own members, the business community at large, public policymakers, and other sectors of society to join us in taking the difficult steps necessary to create an efficient system that will provide access to high-quality health care for all Americans.”<sup>†</sup>

Although we continue to believe that the recommendations in that statement are sound, and though data on developments in the succeeding four years are scarce, we fear that little progress has been made since we released that report. The number of Americans with employer-sponsored health insurance, and the number of employers who offer health coverage, have continued to decline.<sup>†</sup>

The nation’s health-care problems are becoming critical, if they are not so already. Rising health costs are straining both public and private budgets, and are making many American businesses less competitive. Moreover, the public is ill-served by the failure to deliver the care needed by rich and poor alike.

We have concluded that even more-aggressive public-policy action is needed before the damage to our health-care system becomes even more costly to repair. This statement will explain why.

### Performance Standards For A Nation’s Health-care System

What are the reasonable standards by which to judge the overall performance of a health-care system? The usual answer in health policy circles is “cost, quality and access.”

“Cost” is the usual shorthand term for health-care expenditures – that is, the amount a society spends on health care, measured either per capita or as a percent of GDP. Why should we care what percent of our GDP we spend on health care? First, we care about affordability. It makes sense that an affluent society, as it grows still more affluent, would choose to devote some (or even much) of its extra income toward its health.<sup>2</sup> But beyond the question of whether cost growth represents improved care, or rather is merely a rear-guard action against the ill effects of unhealthy lifestyles, does 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? In these terms, the cost as a percentage of the GDP correlates with the share of people’s earning power. Second, national health expenditures (NHE) as a percent of GDP matter because now more than 60 percent of NHE passes through public-sector budgets (including the tax exclusions for employer-paid health benefits, and insurance costs for public employees) and is therefore a drain on public-sector finances, leading to higher deficits or taxes, and crowding out other vital public services. If health insurance is not affordable to people with low incomes, is there room in public-sector budgets for subsidies for their purchases of health insurance? Third, is the trajectory of health expenditures sustainable – that is, growing no faster than the GDP, or not much faster than affordable total compensation of employees?

“Quality” has many meanings. Americans like to think that we have the highest quality health care in the world. That may be true in the sense of the most advanced medical technologies for well-insured people. However, other concepts of quality have been gaining attention lately. How likely are Americans 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? *Inappropriate care* is the medical term for what is often called “unneces-

<sup>†</sup> A more detailed evaluation of the evidence is included later in this statement.

sary care.” How many are in the hospital unnecessarily, or for a condition that could have been prevented by less costly and less invasive outpatient care? How many operations do people have that are not the best for their health? Is American medical care safe? How often is the wrong limb amputated? How likely are Americans to die or suffer from errors in hospitals or in medications? Finally, is quality, so defined, *improving* as a consequence of better organization of care, or is it suffering due to the increasing fragmentation of care delivery?

“Access” is shorthand for people’s ability to obtain appropriate care. This has a financial component and a delivery system component. The financial component generally refers to having health insurance whose coverage 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. The delivery system component refers to having geographic and transportation access to a facility and to professionals who will provide appropriate care.

Financial access is usually evaluated in terms of the number of people who do not have health insurance – which is arguably the most important single criterion of success. It is in everyone’s interest that everyone has health insurance. The uninsured go without needed care. What care they get is often in emergency rooms, which is very costly and lacking in the continuity of care that is important for patients with chronic conditions. Some uninsured adults with chronic conditions become disabled and end up on public programs, which could have been avoided if they had had proper care. The lack of health insurance causes financial hardship and loss of savings, leading in the extreme to medical bankruptcies.<sup>3</sup> Uninsured people place financial burdens on hospitals that are required by law to treat people in urgent need of care and without insurance. This burden is shifted to those who do have health insurance, raising the cost of insurance for them. In addition, the whole problem of determination of eligibility for public programs, credit and collection leads to large administrative costs. Finally, doctors and hospitals do provide substantial amounts of charity or free or “uncompensated” care, and they argue that they must be protected from competition because they are disadvantaged by the burden of uninsured patients. Without this burden, which could be lifted by universal coverage, unleashed competitive market forces could drive greater efficiency without the unintended side effect of further denying uninsured people access to care.

## Does The American Health-care System Meet These Standards?

For all of this nation’s wealth and power, our health-care system demonstrably fails to meet these basic criteria.

On the question of cost, the price of an average family insurance policy, \$13,382 per year for a family of four in 2006, can be weighed against typical family earning power.<sup>4</sup> The median household income in the United States in 2006, with employer costs of health insurance included, is roughly \$48,250.<sup>5</sup> A family health-insurance premium in 2006 costs more than a quarter of the earning power of the median household. NHE in 2006 are about 16 percent of the GDP.<sup>6</sup> This means that government health outlays (and the revenue cost of tax exclusions) at all levels come to about 10 percent of GDP. In 2004, all government receipts at federal, state and local levels came to about 30 percent of GDP. Thus, the cost of health care looms large in public finances, even before the postwar baby boom starts retiring into Medicare eligibility. Once the baby-boom generation begins to retire, public health-care costs will grow even faster. For the past 25 years, NHE have been growing about 2.5 percentage points a year faster than GDP. If these rates continue to 2030, NHE will reach about 28 percent of GDP. If health outlays are not unbearable today, they soon will be. Health-insurance purchasers, public and private, have been unable to hold their shares of NHE to sustainable growth rates.

On the matter of quality, the Institute of Medicine of the National Academy of Sciences (IOM) finds that our health-care quality leaves much to be desired. The IOM accepted estimates that between 44,000 and 98,000 Americans die each year in hospitals from medical errors.<sup>7</sup> A recent IOM report estimated that at least 1.5 million Americans are sickened, injured or killed each year by errors in prescribing, dispensing and taking medications.<sup>8</sup> Drug errors cause at least 400,000 preventable injuries and deaths in hospitals each year, more than 800,000 in nursing homes and facilities for the elderly, and 530,000 among Medicare recipients treated in outpatient clinics. A 2003 study by RAND asked how much of the care called for under generally accepted standards of medical practice people are actually receiving, and found the answer was about 55 percent.<sup>9</sup> Adoption of technologies to improve this situation has been very slow.<sup>10</sup> RAND studies also have documented a great deal of overuse. Dartmouth studies have shown wide geographic variations in medical practices such as frequency of hospitalizations and surgery per capita (adjusted for differences in the characteristics of the different popula-

tions), suggesting some people are getting too much (that is, unnecessary or unhelpful) care, and others too little (or some combination).

Still, it is on the score of access that the failure of our health-care system may be most serious. In 2005, according to the August 2006 Census Bureau report, 46.6 million Americans were without health insurance, up from 39.6 million in 2000.<sup>11</sup> The IOM estimates that the uninsured have a 25 percent higher risk of dying than similar people with health insurance.<sup>12</sup> This situation is clearly contrary to our nation's values. Nobody says that people should suffer and die for lack of ability to pay. We have created, in this country, numerous public programs that are patches on the system to compensate for lack of health insurance: EMTALA, the law requiring hospitals to care for uninsured people; disproportionate share payments by the federal government to hospitals in areas that have a disproportionate share of uninsured; Medicaid; the State Children's Health Insurance Program; Ryan White for AIDS; Maternal and Child Health; and so on. It would be a lot simpler – and if all costs were considered, including those from disability and suffering, a lot cheaper – simply to make sure everybody had at least financial access to appropriate care. As just one indication of the potential savings from having coverage and receiving sound primary care, the *New York Times* recently reported that a hospital in Texas found that it could actually save money by providing *free* outpatient care to diabetics, thus obviating their need for more expensive emergency hospitalization which the hospital was obligated to provide without reimbursement.<sup>13</sup>

Is universal coverage a utopian, unrealistic or socialistic dream, or is it a practical, economically and morally compelling goal for our society? Most of the other advanced democracies have achieved it, and we could do so too – with a system that is built on our own history, and accords with our own values. “Universal coverage” is not likely to achieve 100 percent enrollment of the population in health plans. There will always be people whose lifestyle does not fit with enrolling in a health plan, and there must always be public provider systems of last resort to care for them. But we can do much better than the status quo.

## Employer-based Health Insurance Is In Decline

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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. Based on the Current Population Survey (households), the Employee Benefits Research Institute (EBRI) found that the percent of *all* workers with EBI fell by 2.8 percentage points between 1987 and 1999.<sup>14</sup> Another survey showed a decline from 1999 to 2004 of 3.5 percentage points.<sup>15</sup> Linking the two series implies a decline of about 6.3 percentage points from 1987 to 2004. Data from the Bureau of Labor Statistics, derived from establishment surveys, suggest a greater decline. For full-time workers in the *private* sector, the BLS reports a decrease in medical care coverage of 15 percentage points from 1989-90 to 2003. From 2000 to 2005, the absolute number of people covered by EBI fell from 177.8 million to 174.2 million.<sup>16</sup> Moreover, the covered percentage of the population under age 65 fell from 63.6 percent to 59.8 percent. From 2000 to 2005, the percentage of firms offering health benefits fell from 69 percent to 60 percent, reflecting mainly small employers dropping EBI.<sup>17</sup> Put alternatively, the percentage of workers in all firms who were covered by EBI fell from 63 percent in 2000 to 60 percent in 2005. There are underlying forces that make this trend likely to continue, especially the rapidly increasing cost of health insurance. The falling EBI trend shifts the costs of the health-care system onto those employers that do provide insurance and onto government.

## Why Is This Happening?

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National Health Expenditures (NHE) reached 16 percent of GDP in 2004. As noted earlier, they are rising faster than the GDP, in fact by a margin of 2.5 percentage points per year over the past 25 years. This translates into health-insurance premiums rising faster than the affordable increases in total compensation, and therefore, faster than incomes. Family premiums reached \$13,382 in 2006<sup>18</sup> compared to \$6,740 in 2000. In 2006, the average family health-insurance premium reached 28 percent of the earning power of the median household. Health insurance is pricing itself out of reach. Of course, the real problem is not the insurance policies themselves. It is the underlying costs of health-care services.

## Causes Of High And Rising National Health Expenditures

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The causes of the high level of health expenditures and their relentless rate of increase transcend the reach of the business community and are national in scope. Indeed, though all other



advanced industrialized nations have lower levels of health-care spending as a share of GDP, their expenditures also are rising at rates in excess of their GDPs (though somewhat slower than in the United States). So health expenditure increases are a global phenomenon. The same forces have the same effects in government health programs such as Medicare and the Federal Employees Health Benefits Program. The following causes interact with each other.

First, there is cost-unconscious demand (unconstrained by the global budgets that are used, arguably inefficiently, in other countries). We in the United States have created a system in which most people, patients and providers alike, have little direct personal interest in making the most cost-efficient choices in health care, and often little opportunity to do so. American health-care financing and delivery are dominated by fee-for-service medicine (FFS), which leaves insured patients cost-unconscious, especially at the margin, and which reduces the incomes of providers who innovate to reduce the need for services. Indeed, providing patients with more services, even if they have little or no medical value, results directly in greater incomes and revenues for providers.

All this is exacerbated by tax policy, in particular the exclusion of employer contributions to employee health care and insurance, without limit, from the taxable incomes of employees. Depending on the tax rates of the different states, this tax break means that an extra \$100 in health benefits may cost many employees only \$60-70 in after-tax income. This too biases choices in favor of more costly health care.

Second, expenditures are increased by the extensive deployment of new technologies that enhance the power of medicine to benefit people's lives, in some cases greatly. People want to have them, their doctors want to provide them, and society does not want to deny them. Thus, the age-specific rate of per capita consumption of these technologies has been increasing, often at double-digit rates.<sup>19</sup> 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 depending on weight-related dosage.<sup>20</sup> New drugs for some blood clotting disorders can exceed \$1 million per year. Some cancer drugs are also very costly.

Cost-unconscious demand gives an extra impetus to the development and deployment of many costly new technologies. Providers are often rewarded with prestige, patients and revenue for using the most costly new technologies. Converse-

ly, under FFS, there is little demand for expenditure-reducing technologies. Technology developers know that patients and their doctors will not go through a careful weighing of costs versus benefits. Indeed, the Medicare program is prohibited by law from considering costs in coverage decisions. Doctors are essentially reimbursed for cost, and so save nothing for themselves (or their patients) by rejecting new and more expensive technologies. Many of the new technologies have been evaluated and are valuable for health outcomes. Others go into widespread use without a thorough evaluation, and may not be more beneficial than existing, less costly technologies.<sup>21</sup>

In the United States, we have a culture that places a very high value on advanced medical technology and has great faith in it. (Recall John Edwards in 2004 saying: "If we do the work that we can do in this country [with stem cell research]... people like Christopher Reeve are going to walk, get up out of that wheelchair and walk again."<sup>22</sup>) A culture with this enthusiasm can regard cost reduction as unworthy. One young physician reported: "In training, we were taught that if you really care about cost, you are not a good doctor." Who wants to be (or to go to) the "low-priced doctor"?

Third, there has been a large increase in the prevalence of chronic disease and our ability to treat it.<sup>23</sup> An analysis by K.E. Thorpe observes that "among adults ages 20-74, obesity prevalence increased from 14.5 percent (1976-80) to 30.4 percent 20 years later (1999-2000). During the same period, total diabetes prevalence, which is clinically linked to obesity, increased 53 percent, and diagnosed (treated) diabetes prevalence increased 43 percent." He examined 20 medical conditions accounting for the largest portion of the rise in private health-care spending between 1987 and 2002, and found that these conditions accounted for 67 percent of the per capita growth in private health-insurance costs during this period. This problem is exacerbated by a health-care system that is not oriented to early detection and treatment or to chronic disease management, but rather to the treatment of symptoms when they arise.

The prevalence of chronic conditions and the cost of their treatment are of fundamental importance to the appropriate structure and focus of the health-care financing and delivery system. Johns Hopkins University has a center called Partnership for Solutions, which studies the prevalence and cost of chronic conditions.<sup>24</sup> They find that in 2005, 133 million Americans had a chronic condition, with such conditions defined as those that "last a year or longer and limit what one can do and/or require ongoing medical care." The number is growing faster than the population in general, in part be-

cause the population is aging, and because medical advances have transformed former deadly diseases into costly chronic conditions, as in the case of HIV/AIDS. (The anti-retroviral therapy for HIV/AIDS costs roughly \$18,000 per year in the United States.) The most prevalent chronic conditions are hypertension, arthritis, respiratory diseases, cholesterol disorders, chronic mental conditions, heart disease, eye disorders, asthma and diabetes. In addition, there are some cancers, congestive heart failure, and end-stage renal disease. In 2001, care given to people with chronic conditions accounted for 83 percent of total health-care spending. (This does not necessarily mean that that much of the care was for chronic conditions – only that it was for people having chronic conditions.) In fact, 62 percent of all health-care spending was on behalf of people with two or more chronic conditions. As the Johns Hopkins report concludes, “...the care provided in the current acute, episodic model is not cost-effective and often leads to poor outcomes for patients with chronic conditions.” This has led the IOM to recommend “[c]are based on continuous healing relationships,” which is particularly difficult to achieve when workers so frequently change jobs, and as a result, change (or even lose) health insurance and health caregivers.<sup>25</sup>

Fourth, in the United States, health-care delivery is dominated by fragmented, uncoordinated, small-practice fee-for-service (FFS), the traditional model in this country and others. This system can be extremely wasteful. It is filled with cost-increasing incentives. It in effect rewards and encourages such things as wasteful duplication of tests. It is poorly organized for systematic improvement in system coordination, overall economy and safety, or even measurement of performance. It lacks incentives for such innovations as health information technology,<sup>26</sup> which is not in the economic interest of individual providers. Unfortunately, FFS sets the standard for economic performance in the non-FFS sector. For example, Medicare payments to the other common delivery mode, health maintenance organizations (HMOs), are tied to FFS costs in the same geographic areas and on a risk-adjusted basis. Prepaid group practices have been able to raise their prices in step with FFS-based insurance. In other countries, specialists are salaried, in hospital-based practices, usually under global budgets.

We will never get an economically efficient health-care system without the right incentives. The present dominant system is very far from that.

And fifth, because most health-care delivery is local, there are insurer, hospital or system monopolies at that level. Anti-trust policy at the local level is weak and unfocused or does not exist at all.

## EBI Costs Cause Major Problems For Employers

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EBI costs give employers a powerful incentive to try to avoid this growing burden, while continuing to pay attractive cash wages. This can be done, in part, by tightening restrictions on who is eligible for EBI, and by increasing required employee contributions so that low-paid workers do not choose to pay their share and participate. Thus, about 80 percent of employees in firms offering EBI are actually eligible, and only about 83 percent of the eligible actually participate.<sup>27</sup> These policies mitigate employer problems, but they cause serious human problems and they do not help forestall the decline in EBI.

Rising EBI costs force employers to face some unpleasant choices. When general inflation is high, employers can mask the increased costs by giving wage increases that are less than the inflation rate. However, when the inflation rate is low, as is now the case, employers must seek to reduce benefits, e.g. by raising deductibles and shifting costs to employees, or to reduce cash pay – either of which (particularly the latter) evokes employee dissatisfaction. Alternatively, employers can simply close the plant or office and obtain the services from lower-cost labor overseas. Or they can selectively outsource services overseas, or to low-cost employers in this country who do not provide health insurance.

Employers are constrained by the forms of insurance that are offered; they must deal with the market as it exists. One or a small group of employers cannot revamp the entire system. In today’s market for health insurance, there is little demand for economical care. One or a small group of employers acting alone to create competition in a market that is largely cost-unconscious is not rewarded with the competitive health-care delivery system that would result if all did. Unfortunately, the great diversity of interests, circumstances and views about health insurance among employers has precluded collective action to create a market open to competition from efficient delivery systems.

## Employer Responses To Date Have Not Solved The Problem

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Employers have tried to control their costs, by innovating in the delivery of insurance, and health care generally, to their employees. The incentive to innovate can be strong, because individual U.S. firms can become less competitive relative to each other, and producers of tradable goods and services can

lose market share relative to foreign firms. Because merely shifting costs to employees is a clearly visible dead end, firms have experimented in wellness programs, preventive care, and management of chronic conditions, backed up with financial incentives, and with on-site exercise and basic-care facilities. 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.<sup>28</sup> On the other side of the transaction, employers have created quick-access low-cost health facilities in retail stores, and cut-priced strategies for dozens of basic prescription drugs.

All of these approaches are helpful. However, it is not clear that any one, or even a carefully selected combination among them, would do more than achieve (admittedly welcome) one-time savings in costs. The reason is that none would change in any fundamental way the practice of medicine, or the flow and arguably cost-inefficient adoption of new and ever-more-expensive technologies into the health-care marketplace.

One approach toward changing insurance and health care more fundamentally, Consumer-Directed Health Plans (CDHP) (sometimes called High-Deductible Health Plans (HDHP)), involves some elements that would be valuable for the health-care system, such as greater transparency in health-care quality and prices (which are included in other ideas as well, including CED’s own 2002 statement), and greater responsibility on the part of consumers.<sup>†</sup> However, CDHPs are not, over the long run, a complete answer to the cost problem.

Some firms are using CDHPs to try to find insurance that is affordable to their lower-wage workers (the CDHP premium can be lower because the cost of care below the high deductible is paid by the employee if and when care is needed). In the extreme, in the short run, CDHPs are one way for firms hard-pressed to continue existing insurance to shift the burden of EBI to employees (or “rebalance the compensation portfolio”). However, in the long run, that will not mitigate the problem of expenditures growing faster than affordable total compensation. This is because health-care expenditures, in any year, are very concentrated on few people – the most-costly 10 per cent use 70 per cent of the resources – so most spending will be on people who have exceeded their deductibles, or can reasonably expect to do so, in which case the marginal cost to them of more care will be at or near zero. (In 2002, 80 percent of health spending was on people who incurred at least \$3,219.)<sup>29</sup>

There are other problems with the high-deductible approach. Many people do not have much money in the bank, if they even have bank accounts. They may lack the funds to pay the deductible expenses. This may create incentives to forgo necessary care, leading to more costly medical needs later on. (Some HDHP plans attempt to mitigate this by exempting preventive care services from the deductible. The success of this strategy in the long run is uncertain. Another tool to pay for large deductibles is the health savings account (HSA). However, persons with low incomes, facing low (or zero) marginal tax rates, have correspondingly low incentives (and limited means) to contribute to the accounts, and the employers of low-wage workers may not contribute. Those accounts may then be filled with public grants. However, if the deductibles are in effect paid with public grants, it is questionable whether the beneficiaries have any remaining incentive to economize on discretionary health care.)

In an alternative approach, some large employers have offered employees responsible choices (in which the employees are responsible for the additional cost of more-expensive plans) across a wide range of health-care delivery systems, but such employers are usually not large enough in any area to impact appreciably the whole delivery system. In addition, many employers that do offer choices also contribute some high percentage (80-100 percent) of the premium of any plan of the employee’s choice. Though apparently generous, this subsidizes the inefficient systems against the efficient, biasing choices toward more-costly plans. Many of the employers who do this are constrained by collective bargaining agreements and the demands of unions to make the employer pay the whole premium. The struggles of the Detroit car companies illustrate how difficult it can be to change this.

To illustrate, consider a health plan that is competing in a group where the employer pays 80 percent of the premium. The health plan management asks: “Should we make the effort to cut costs and premiums by \$1.00 in order to attract more customers?” The answer is: “Probably not; the customers considering choosing us will get to keep only 20 cents pretax, and maybe about 12-14 cents after tax. Perhaps it would be better to spend the dollar on other things that would attract customers more.” Thus, the strong incentive is to *increase*, not *decrease*, costs. Economists call this “price-inelastic demand.” Markets cannot discipline prices when demand is inelastic.

<sup>†</sup> CED will discuss CDHP and HDHP in greater detail in a subsequent statement.



## Buyers Have Been Unable To Achieve Sustainable Growth Rates In Health Expenditure

The biggest problem with EBI is that employers, acting individually, collectively, or in concert with government, have been unable to conceive and execute any strategy to address effectively the problem of unsustainable expenditure growth.

Employers in general have not been able to create competition in the market so that more-efficient delivery systems can emerge and compete and take market share from the dominant fragmented, uncoordinated fee-for-service small-practice model that still accounts for most health-care delivery. Alternative delivery systems cannot market their superior efficiency in the form of lower premiums; remarkably, there is no market in which such efficient systems compete with each other to serve premium-price-sensitive consumers.

As one possible example of greater efficiency, the RAND Health Insurance Experiment, a randomized comparison study, found that Group Health Cooperative of Puget Sound, a leading prepaid group practice, delivered high-quality care for 28 percent fewer resources than did the FFS sector in Seattle.<sup>30</sup> Yet neither they nor imitators have been very successful in that market. Group Health Cooperative has not been able to force the rest of the market to meet its efficiency performance. Employer policies forced it to create a network of FFS solo doctors as a combined offering so that they could compete in the market demanding “full replacement” – that is, one plan serving a whole employment group. In this way, employer policies actually destroyed value by forcing a delivery system to revert to a less-efficient delivery model.

Upon reflection, it should be clear why greater efficiency has not been rewarded in the health-care marketplace. The dominant FFS system contains incentives for over-use, under-use and misuse of medical technology.<sup>31</sup> It contains no built-in system of performance measurement (other than revenues), no monitoring and no feedback into quality improvement. It pays for the volume of services, not for quality, not for actually curing the patient promptly. It pays more to providers who cause complications or are slow to make a diagnosis. This applies to hospitals as well as to physicians. (For more detail and sources for these assertions, see Appendix A.)

It is most unusual to see a “market” in which producers of-fering more value for money cannot translate this advantage into a larger and growing market share. To create a market in

which the efficient can drive the others to greater efficiency, the great majority of employers would have to offer their employees responsible choices of delivery systems (and their affiliated health-insurance plans) so that the insurance plans could pass on their efficiencies to customers in the form of lower premiums. (“Responsible” here means with fixed-dollar employer contributions, or some other method that allows employees who choose the efficient alternative to pay less and keep the savings.) And they would have to offer plans that select providers for quality and efficiency, not only wide-access PPOs that include virtually all physicians. Most employers do not offer such choices. One employer changing to this model would not get the benefit of a fully competitive health-care system as long as most other employers did not.

Traditional FFS, in which providers set their own fees, has largely been replaced by wide-access “preferred provider organizations” (PPOs), nearly all-inclusive networks of FFS providers who accept the network’s negotiated fees as payment in full. But this is a change more in form than substance. Because most providers know that these networks must include them to satisfy customer demand, the networks are not in a position to drive hard bargains. PPOs cannot really trade volume for price because they exclude few, if any, providers. The wide-access PPO that permits people to get their care from anywhere, even including efficient delivery systems, is not a “choice” in the sense of the preceding paragraph – because the premium of the PPO reflects the efficiency of all the participating providers in the community, not just the efficient ones.

In addition, most employers do not offer meaningful choices of health plans. This problem extends across firms of different sizes.

Small businesses can be locked out of insurance altogether because of a pre-existing health risk, or because of high prices; and small-employer work forces are not large enough to be attractive risk pools for insurers. Only 41 per cent of workers in firms with 3-24 employees are covered by their employer’s health benefits, and only 59 per cent for firms with 50-199 workers.<sup>32</sup>

Medium-sized firms, and small businesses that do manage to offer coverage, are usually constrained to the services of one insurance carrier because of insurers’ dislike of “slice business” – that is, understandable concern over high administrative costs per insured worker, and the instability that can be caused by adverse selection, when different carriers compete for business within a comparatively small employee pool. Some firms in this category give all their business to one insurance carrier,

which offers two or three “plan designs” (e.g. HMO, PPO, HDHP). However, most often all of these plans market the services of the same unaffiliated FFS doctors. For this reason, this choice of “plans,” meaning “plan designs,” is not competition either among carriers or among delivery systems. Thus, they are not efficient delivery systems, and they display most of the flaws of uncontrolled FFS. For example, these “carrier HMOs” put themselves in the difficult position of standing between FFS doctors who want to do more services, and patients who want to receive more services, and trying to create restraints. Their insurance costs rise with industry costs. Usually, employees are locked into a wide-access PPO so that every employee can have insured access to his/her favorite doctors. The PPO is really uncoordinated FFS, not an organized delivery system.

Even large firms sometimes offer employees only one plan, or one carrier. Sometimes this is due to past collective bargaining agreements. In addition, even large firms that do offer distinct choices, as was noted earlier, sometimes cover a high fixed percentage – 80 per cent, or even 100 per cent – of the premium of whatever plan the employee chooses. This situation also can be driven by collective bargaining. (Ironically, it is not unheard of for employees who are confused by alternative complex insurance agreements, and who will pay little or nothing whichever they choose, to pick the most expensive, on the assumption that the costliest must be the best.)

So most employers offer a single carrier, and their insurance companies give them incentives to do so or even require it – with minimum participation requirements or offers of better prices if the insurers can cover the whole group. As a result, there is no reward to insurers to provide good coverage at low prices – and little or no consumer pressure for them to do so. With limited incentives for better performance, it is not surprising that the health-care sector has seen rising prices with little or no indication of better health outcomes. If employees

had choices, and if they bore the cost of a choice of a more expensive plan, it is more likely that insurers and health-care providers would try to find more efficient ways of providing better health-care results.

Employers that do offer their employees fully cost-conscious choices among delivery systems, like the University of California, Wells Fargo and Hewlett-Packard, often find that very high percentages, like 75-80 percent, choose among the least expensive plans which, in these cases, are group practice-based HMOs. This is in stark contrast to most other employer arrangements in which employees have no choice of carrier or little or no incentive to choose a lower-priced plan. This difference reflects the effect of price-sensitive choice, and the fact that many people choose an alternative mode of organization if they would otherwise have to pay the extra cost of a more expensive one.

The Federal Government buys health-care services in at least three ways. In the case of Medicare, FFS predominates and it has not so far been possible politically to subject it to effective competition from more efficient alternatives. In the case of the Federal Government as employer, that is, the Federal Employees Health Benefits Program (FEHBP), the government offers employees multiple choices of health plans and also a semi-fixed-dollar contribution.<sup>†</sup> Where they exist geographically, other modes of organization, including HMOs, often do well in the FEHBP.<sup>††</sup> In the case of the Veterans Administration Health System and DOD TriCare, the government has had an integrated delivery system for some time – and there has been great innovation, especially in the Veterans Administration, in such areas as chronic disease management and adoption of electronic health records. In the latter case, the VAH clearly leads the private sector.

In theory, large employers could try to go into the health-care management business and organize their own delivery

† There is an important deficiency and inflationary bias in the structure of the FEHBP. The government, as employer, contributes an amount set at 70 percent of the average price of the largest plans in the system. If a plan were to come in with a premium below the contribution level, the employee would get to keep 25 percent of the difference while the government would keep 75 percent. After tax, the employee would keep less, perhaps 15 percent. So there is not much incentive for a plan to offer prices below the average and attempt to drive down the prices.

†† There is an artifact in the pricing scheme that works to the disadvantage of HMOs in the FEHBP. The program contains several nationwide fee-for-service plans whose premiums reflect costs averaged over the whole nation, including many low-cost areas. HMOs, on the other hand, are local entities, and those in high cost metropolitan areas must bear the costs associated with doing business in those areas. HMOs tend to be in metropolitan areas. The program would do a better job of promoting competition if it used regional pricing.

systems. That is how Kaiser Permanente started. However, that would be very difficult today. Henry Kaiser had a lot to learn about doctors and health care, and the lessons did not come quickly. Only the largest employers, or very cohesive coalitions, could consider it. Generally, employer work forces in any one geographic area are small compared to the size that efficient delivery systems need to achieve economies of scale, that is, several hundred thousand members. Few, if any, employers have enough employees in any given area to support one integrated delivery system, much less the two or three that would be needed to create competition. Since Henry Kaiser, few employers have attempted this so far, usually with poor results. Health care is a complex business. Organizing efficient health-care delivery is not part of the core competence of most employers.

Alternatively, several employers could try to collaborate to create an efficient health-care system of sufficient size. The Minnesota Buyers' Health Care Action Group (BHCAG), originally formed in 1991 by 14 large, self-insured employers in the Twin Cities, is a rare example.<sup>33</sup> In 1997, BHCAG offered employees of participating employers a broad choice of "care systems" built around groups of primary care physicians and affiliated specialists and hospitals. Each care system set its own price for covering an employee of standard risk. Care-system-specific provider fees were developed. If actual expenditures exceeded the bid amount, adjusted for enrollee risk, the fees actually paid could be reduced to bring the expenditures back into line with the care system's bid, creating a kind of "virtual capitation." There was risk adjustment (that is, transfer of premium revenues to the insurers or care systems that enrolled costly risks from those that did not), employee cost-conscious choice, and quality measurement and reporting. This was the best private-sector implementation of economically rational incentives. Its enrollment reached about 150,000 employees and dependents. In the face of comings and goings of key personnel and company ownership (i.e. acquisitions), it proved difficult to sustain employer commitment, and attempts to export this model to other cities were not successful. Some of the success in the Twin Cities could be ascribed to special features of the Twin Cities market, such as the presence of multi-specialty group practices and national firms headquartered there.

In sum, the current employer-based health-insurance system is poorly structured for competition and incentives to improve efficiency. In light of these fundamental problems, it is not surprising that costs have risen faster than quality, and it is not likely that this outcome will change on its own.

## The CED Statement Of 2002—Has It Made A Difference For Health-Care Reform?

As was mentioned at the outset, CED issued a statement on health care in 2002.<sup>34</sup> It contained numerous sensible and important recommendations for business and government. For example, for employers:

1. Demand transparent quality information and adherence to best medical practices; use comparative performance information to select plans and providers; incorporate accountability for cost and quality into contract specifications.
2. Offer wide, responsible health plan choices to employees in exchange for their greater financial responsibility. Such plans would incorporate contribution policies that encourage workers to choose efficient, high-quality plans...help to establish, operate, and manage regional purchasing cooperatives that offer affordable plans to small firms.

For government:

1. Restructure Medicare on the model of the Federal Employee Health Benefit Program [that is, wide, responsible choices].
2. Cap the currently open-ended federal tax exclusion of employer contributions to promote cost discipline and equity; this could also provide some funding for policies to expand access.
3. Provide vehicles, funding, and technical assistance to establish purchasing cooperatives for small employers.

Substantial progress towards these policies since the release of the statement is difficult to discern. Transparent quality information based on results or outcomes is difficult to come by, though ongoing efforts to develop it ought to continue. Many opportunities, such as to extend to the whole nation the work being done by the State of New York, and a few other states, on risk-adjusted outcomes for cardiology procedures have been missed.<sup>35</sup> A great deal of useful work that might have been done has not. Measurement of adherence to best medical practices requires development of guidelines, and then information systems to make the measurements. Leading integrated delivery systems like Health Partners in Minnesota and its cooperating medical group practices had created the Institute for Clinical Systems Improvement; businesses have worked to-



gether in the Leapfrog Group; Kaiser Permanente had created their Care Management Institute to define practice guidelines before 2002; the Veterans Health Administration had created a similar Quality Enhancement Research Initiative. And they have continued this work. But there has not been a great deal of similar progress elsewhere.

The trend in the offering of wide, responsible health plan choices to employees is difficult to judge because it is not measured in regular surveys. The two most important surveys were done in 1997 and 2000. The former surveyed a representative sample of U.S. employers and found that the employers of 77 per cent of employed insured Americans did not offer a choice of carriers, and 28 percent of establishments offering a choice contributed a fixed-dollar amount for single coverage to all health-insurance plans (and therefore gave employees an incentive to make a cost-effective choice), thus leaving only 6.4 percent (.23 times .28) with both a choice and a fixed-dollar contribution.<sup>36</sup> The latter survey found that fewer than 10 per cent of Fortune 500 employees combined a choice of carrier and a fixed-dollar contribution.<sup>37</sup>

Similar surveys have not been done since, possibly indicating a lack of interest in the issue. However, there is little evidence that this situation has improved. On the positive side, both Wells Fargo and Hewlett-Packard, which previously offered choices, have recently adopted the defined contribution approach. However, this is the only indication of progress. The Henry J. Kaiser Family Foundation and Health Research and Educational Trust publish an annual Survey of Employer Health Benefits which touches on the subject of employee choices. Unfortunately, they survey and report on “choice of plan,” meaning “plan designs.” Their survey would report that an employment group offering one carrier, with three plan designs (e.g. HMO, PPO, POS (Point of Service) or High Deductible Health Plan) all providing insured access to the same networks of FFS providers, would be offering three plans. But this is neither competition at the insurance carrier level nor at the delivery-system level, so this is not choice from the point of view of bringing about delivery-system competition. Regrettably, even by that defective measure, the survey shows little change in the frequency of offering a “choice of plan.”

As noted earlier, employers considering offering choices are inhibited by concern over administrative costs, the possibility of adverse selection, and insurance company preferences to be the sole carrier for the group. The 2002 CED report called for large multi-employer exchanges, like CalPERS, that pool the purchasing of large numbers of employers and therefore create

a market in which many carriers will be willing to participate. That would take sustained collective action among employers. Unfortunately, employers find it difficult if not impossible to organize collective action because their interests and priorities are so diverse: some are large, some small; some have foreign competition, some do not have much competition; some are unionized (and most, but not all, unions demand that employers subsidize more costly choices), some not; some have mainly high-paid employees, while some have mostly low-paid workers (for whom health-insurance costs are a larger percentage of total compensation). Multiply this diversity by the myriad views and understandings of what health care is all about, and the difficulty of collective action is clear.

In the summer of 2006, the Pacific Business Group on Health announced that PacAdvantage, a voluntary pooled purchasing arrangement for small employers of 2-50 workers, was closing because one of the carriers was persistently losing money in that business. If pooled purchasing arrangements are wholly voluntary, a spiral of adverse selection against the pool is almost inevitable unless there is a strong incentive for a large representative sample of employers to participate. There need to be strong incentives, such as access to tax exclusions, to hold such pools together. (The problem may be mitigated, and possibly solved, by the use of a risk adjustment procedure under which groups with predictably higher costs pay proportionately more, relieving employers of comparatively healthy employees of the burden of sharing in the costs of the more costly groups. Technology exists to do this. However, this would work against the ideal of broadening the risk pool even more substantially and evening out costs and risks so that everyone could afford insurance.) Also, a system of reinsurance of very high-cost cases could help a great deal. Employers apparently did not put a high value on being able to offer competing choices to their employees. Creating competition is a collective action problem. That is, one employer offering responsible choices will not get the benefit of a reformed competitive delivery system. That takes concerted action by many employers. However, if employers are unable to collaborate to create an effective competitive market, there may well be a need for some public-policy response to the problem of soaring costs of insurance.

As to the recommendations for government action, the idea of restructuring Medicare to work like the FEHBP has attracted some rhetorical support, but progress toward making Medicare into a defined-contribution competitive model has been only incremental. The Congress did take an important step forward in the Medicare Prescription Drug, Improvement and

Modernization Act of 2003 (MMA) in providing that Part D of Medicare would be organized through price-sensitive individual choice of prescription-drug insurance plans from among many alternatives. The addition of new, at-risk competitors in the Medicare Advantage program, such as regional PPOs and private fee-for-service plans, has added a new competitive dynamic, but only so long as underlying payment levels are attractive. The shift in the program from an administered-pricing model to one in which plans engage in a quasi-competitive bid process has the potential to create a new competitive force – although this is limited by the retention of statutory pricing as the yardstick that determines government payments, notwithstanding the competitive basis of the bid. Whether these changes will have a lasting impact is not clear, particularly if competition among providers – both in Medicare Advantage and traditional Medicare – does not flow from these changes. More important will be the nascent move toward quality-based payment for providers and health-care organizations, which rewards both efficiency and good outcomes.

## Conclusion

In short, in 2002 CED mapped out a private, voluntary path toward creation of an effective market for competing health plans and delivery systems. We remain confident that such ideas, if adopted widely and vigorously, could work. However, there is little or no evidence that these ideas are being taken up and acted upon in a timely manner. It is now not at all clear that constructive change to create an effective market model will happen before NHE reaches 20 per cent of GDP, family premiums reach 40 per cent of the earning power of the median household, and the number of uninsured reaches 60-80 million. At that point, desperation could break out, creating a fertile ground for simplistic “solutions” that do not work, or indeed do more harm than good.

And yet there is the potential for a better health-care system at the same or lower cost. As was noted at the outset, patients today are treated at considerable cost, but receive only about

Capping the exclusion of employer contributions from employee taxable incomes to induce cost-consciousness was recommended by the President’s Advisory Panel on Tax Reform, but apparently rejected out of hand. Purchasing cooperatives for small employers have, for the most part, gone in the wrong direction, closing rather than proliferating.<sup>†</sup> The Congress has not considered serious proposals to condition continued access to the tax exclusion on the offering of choices and defined contributions, but something like that might provide the incentive for small employers to form or join such pooled arrangements to achieve economies of scale.

Some changes have been in the wrong direction. For example, the emphasis on high deductibles, despite the best of intentions, could weaken primary care, disease prevention and disease management, with the side effect of lessening the already insufficient market forces of competition for the now privileged FFS model.<sup>††</sup>

half of what best practice would define as appropriate care. This suggests strongly that following better practice would result in better health and lower costs down the line. In the same vein, reputable studies have identified excessive and inappropriate treatment and expense. This suggests opportunities for savings that would have no cost in terms of health. Thus, our health-care system could deliver better care at low or even negative additional cost – without the feared necessity of withholding beneficial care in the interest of cost. The nation should pursue greater efficiency in the existing system first.

The next part of this statement will explain why the most widely discussed large-scale “solutions” would not work. In a later statement, CED will explore steps to restructure the health-care market to achieve greater cost effectiveness and coverage for all.

<sup>†</sup> There is a successful broker-created multiple choice arrangement for small employers that offers, in Southern California, a choice of 6 or 8 delivery systems to employees of participating employers, called California Choice. It covers 170,000 lives and is growing. It is not entirely clear how this survives and prospers when PacAdvantage could not.

<sup>††</sup> The next CED Statement will address the merits of the high-deductible approach in greater detail.



## APPENDIX: Economic Aspects And Consequences Of The Traditional Fee-for-service Small Practice Model (FFS)

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Medical practice in the United States is dominated by the fragmented, uncoordinated, fee-for-service (“FFS”) solo (or small single-specialty group) practice model of health-care organization and finance. This appendix explains this model, its origins, and its consequences for health expenditure in this country. It is important to understand that the dominance of this model is not the natural consequence of market forces. Rather, it has been sustained by inertia, unchallenged because of the absence of normal competitive forces in the health-care market. It needs to be subjected to competition from informed, financially responsible consumer choice. In those limited instances when competition is at work, alternative modes of organization of health-care delivery do much better.

### I. The Traditional Fee-for-service Indemnity Model Of Health-care Finance Is Fundamentally Flawed

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#### A. The Fee-For-Service Model Explained

The traditional fee-for-service, solo-practice model of medical organization and finance is as old as medical science itself. In the early days of this country, when there was only one doctor for wide swaths of the frontier, solo practice was inevitable. For years thereafter, the body of medical knowledge was sufficiently narrow that there was no such thing as a “specialist;” apart from differences in individual skill, one physician was interchangeable with any other. Again, solo practice was the inevitable result. Health insurance did not exist, and so people paid for each service when they needed the doctor. Fees and costs were restrained by the limits of patients’ willingness and ability to pay. The patients were using their own money and went without care they could not afford unless they were poor enough to be considered charity cases.

Similarly, in those days, retailing began with the “general store.” There was not a sufficient range of goods to justify more than one store for many, or even most, of the geographic regions of the country. Competition between stores was unheard of.

Now, of course, the general store is a vague memory for all but the most rural parts of the United States. It has been overtaken by technology in goods themselves, in organization, in transportation and distribution, in financing, and in countless other areas. Although this quaint and warmly remembered institution is gone, the vast majority of the population surely believes that they are better off today with the fruits of competition and the resulting innovation: greater efficiency, lower prices (relative to typical incomes), and a wider array of up-to-date choices.

But even though the general store and most other economic institutions of that era are gone, rendered obsolete by organizational and technological improvements, fee-for-service solo-practice medicine goes on – even though the nation’s health-care system is widely regarded to be in crisis. Why? The answer is largely inertia – because the existing institution was never challenged, as the general store was, by meaningful competition from alternative forms of organization.

No one can know what the results of greater competition in health-care delivery would be. (And of course, one can speak only of the results of competition at any one moment, because further innovation and change would go on endlessly.) It is even possible that innovations would arise that would breathe new life into the FFS solo-practice model. The one thing that we do know with certainty is that the cost of health care under the status quo is rising unsustainably, threatening access and quality for every American. We cannot continue on this path.

FFS solo-practice medicine came to be based on the following principles:

- “Free choice of doctor” at all times. That means that the insurer that pays the bills has no bargaining power with the doctor because it cannot influence whether or not the patient goes to any particular doctor.
- “Free choice of treatment,” i.e. nobody “interferes” with the doctor’s treatment decisions and recommendations. This means no monitoring of compliance with established practice guidelines, no utilization management, no quality management and no peer review. Process, organization and management innovations such as these have been the life blood of progress in virtually every other industry in the developed economic world.

- “Fee-for-service payment,” which means that the doctor can always earn more by doing and prescribing more treatments (and more-costly treatments) whether or not they would benefit the health of the patient. This creates a conflict of interest for the doctor.
- “Direct doctor-patient negotiation of fees.” The patient is in a very weak position to bargain or shop because he depends on the good will of the doctor and lacks information about what other doctors charge, or how capable they are, or how many visits or procedures they would take to solve a given problem. Insurers, on the other hand, have a great deal of such information and could use it in the patient’s interest. But they are not allowed to do so in the FFS model. (This aspect of the model has been superseded by Medicare fees and by the wide-access PPO in the private sector.)
- “Solo (or small single-specialty group) practice.” Doctors depend on other doctors for referrals. Within a multi-specialty group practice, primary-care doctors can refer patients to their own specialist partners, thus eliminating potential pressure from outside doctors who would want referrals. This puts multi-specialty group practices in business conflict with solo practitioners.

Especially because of this last point, and because of the lack of competition and innovation in health care in general, physicians in solo-practice FFS medicine are put in an impossible position. Because they are trained in the context of the FFS model and are fully invested in it in all aspects of their careers, they naturally tend to see the future of health care in those terms, and to oppose departures from that model. But precisely because costs under the status quo are growing at unsustainable rates, openness to new options is essential and inevitable.

The traditional FFS model for the organization of and payment for medical care maximizes autonomy and economic benefits for physicians. There is reason to believe that it is not the best model, and possibly not even a sustainable model for our society. Arguably, it does not consider the important and legitimate need of patients for affordable care and insurance. It has survived and its performance has been taken as the standard for the health-care system in large part because that system is not compatible with effective competition to test FFS (and the practice of medicine generally) and force it to improve.

After years during which patients were using their own money and going without care they could not afford, employment-based health insurance grew rapidly and became widespread during and after World War II. Most health insurance was FFS, or “service benefit” insurance, by Blue Cross and Blue Shield (“the Blues”). Hospital and physician associations created the Blues to assure payment on terms acceptable to them. (In that case, there were agreed-upon fees, but providers sat on both sides of the bargaining table where the fees were determined.)<sup>38</sup>

In the case of FFS, insurers set indemnity payments for each particular service or group of services that they would provide to insured patients. Because of FFS principles, there was no contract between doctors and insurers. Doctors often charged more than the indemnity payments; under pressure from employees who did not want to have to pay the difference, employers instructed insurers to raise indemnity payments, and the indemnity payments chased the fees. Under the community rating that was dominant in the early years of mass insurance, higher claims costs were distributed across all participants, and so no one increased payment seemed to have any meaningful consequences. Employers often backed up indemnity insurance with “major medical insurance” that paid most of the patient’s out-of-pocket cost not paid by indemnity insurance. Insurance left patients with little or no reason to care what services cost. The old restraint of the patient’s ability and willingness to pay was removed or greatly attenuated by insurance. The FFS model has been strained to the breaking point as costs have soared.

In the FFS model, the idea is that the doctor decides what he or she wants to do and what he or she wants to charge, and the patient’s role is merely to pay and then seek reimbursement from his health plan or employer. This is a model that leaves employers and employees with minimal control over the costs of health care – and the employees with minimal concern about the costs in the first place.

## **B. Inappropriate care and variation in practice patterns**

Under FFS, providers of care are not held responsible for the cost of care. There is little economic restraint on fees. PPOs are negotiated fee arrangements, but because the popular version offers wide access – that is, practically every provider in town is in the network – the PPO has little bargaining power. It cannot trade volume for price. Insured consumers are not price sensitive. A doc-

tor who keeps his/her patients in the hospital longer than other doctors, for the same condition and case severity, is rewarded with more money and the regard of the hospital administration because s/he brought in more revenue.

Studies by the UCLA Medical School-RAND Corporation team and by others documented large amounts of inappropriate surgery and hospitalization (“inappropriate” means the patient would have been better off without it, cost not considered). Other studies found a great deal of “unnecessary surgery.”<sup>39</sup>

There were and are very wide variations in medical practices from one community to another and even among doctors in the same community. 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.<sup>40</sup> Doctors in some parts of Vermont did ten or more times the per child rate of tonsillectomy as in others. This suggests doctors were following their own patterns of practice, perhaps doing what they were told in their training programs years ago, rather than being guided by up-to-date science. Wennberg’s findings bear quotation at length.

Most people view the medical care they receive as a necessity provided by doctors who adhere to scientific norms based on previously tested and proven treatments. When the contents of the medical care “black box” are examined more closely, however, the type of medical service provided is often found to be as strongly influenced by subjective factors related to the attitudes of individual physicians as by science. These subjective considerations, which I call collectively the “practice style factor,” can play a decisive role in determining what specific services are provided a given patient as well as whether treatment occurs in the ambulatory or the inpatient setting. As a consequence, this style factor has profound implications for the patient and the payer of care.

For example, the practice style factor affects whether patients with menopausal symptoms, with hypertrophy of the tonsil, with hyperplasia of the prostate, with mild angina, or with a host of other ailments receive conservative treatments in an ambulatory setting or undergo a surgical operation in a hospital. It also affects whether patients with relatively minor medical conditions such as bronchitis or gastroenteritis, or who need minor surgical procedures such as cystoscopy, teeth extractions, sterilization, or breast biopsy receive their care in a hospital or elsewhere.

The practice style that favors inpatient treatment greatly affects the demand for hospital care and has serious implications for efforts to constrain costs.

Some of the differences in opinion arise because the necessary scientific information on outcomes is missing. For other conditions, the practice style factor appears unrelated to scientific controversies. Physicians in some hospital markets practice medicine in ways that have extremely adverse implications for the cost of care, motivated perhaps by reasons of their own or their patients’ convenience, or because of individualistic interpretations of the requirements for “defensive medicine.” Whatever the reason, it certainly is not because of adherence to medical standards based on clinical outcome criteria or even on statistical norms based on average performance. In some markets, a substantial proportion of hospitalizations are for cases that in other markets are usually treated outside the hospital. If more conservative, ambulatory-oriented practice styles were substituted – then substantial cost savings and improvements in quality could be realized without fear that needed services were being withheld.<sup>41</sup>

This variation undercuts the notion of “medical necessity” as judged by the individual doctor. It also undercuts the notion that there is a “standard of care.” It suggested some people were getting more therapies or procedures than was beneficial while others might be getting too few. This pointed to the need for scientific evidence-based practice guidelines, which would be more conducive to control of costs. Dr. Wennberg has continued this line of research and from time to time publishes the *Dartmouth Atlas of Health Care*.<sup>42</sup> In the *Dartmouth Atlas 1999*, the Dartmouth team reports that in 1996, the age-sex adjusted per capita rate of radical prostatectomy for Medicare beneficiaries in the hospital referral area with the most was 9.4 times that in the referral area with the least, while for carotid endarterectomy the ratio was 7.7. (The procedure counts are based on area of residence of the beneficiaries, not where the procedure was performed.)

There is a need for scientific, evidence-based practice guidelines, produced as a collective effort of teams of doctors and others. In view of the massive amounts of medical literature appearing every week, the individual doctor – unaided by some organized effort – cannot possibly keep up and also have time to see patients. Some organization is needed to develop such guidelines, and to monitor compliance with them. The individual physician needs to make judgments informed by up-to-date science.

It is arguable that many doctors' decisions and behavior are, understandably, at least influenced by the financial incentives in FFS, as well as by the traditions and training of the system, and by loyalty to the physician's particular specialty. The *Wall Street Journal* recently reported an example in an article entitled "Hysterectomy Alternative Goes Unmentioned to Many Women."<sup>43</sup>

Hundreds of thousands of women go to gynecologists each year with a common condition known as uterine fibroid tumors. When it's severe, a majority of them get the same recommendation: a hysterectomy, or removal of the uterus. In recent years, a less invasive procedure, known as uterine artery embolization or UAE, has been growing in popularity. Yet some patients, and even some gynecologists, say many gynecologists aren't telling their patients about the alternative.

A study presented at a medical conference in 2002 found that of 100 UAE patients at Chicago's Northwestern Memorial Hospital, 79 had learned about the procedure from a source other than a gynecologist. A survey by Yale University School of Medicine in 2003 found that 13 of 21 UAE patients had learned about the procedure from the Internet.

"It's sad," says Juergen Eisermann, a gynecologist who is medical director of the South Florida Institute for Reproductive Medicine. "We do a disservice not to mention all the options."

Some gynecologists blame the failure to inform patients about UAE on the fact that gynecologists generally don't perform the procedure. Instead, members of a specialty known as interventional radiology do UAE. When gynecologists lose the chance to perform a hysterectomy, they also lose the roughly \$2000 fee the gynecologist might have earned.

For the many women for whom the UAE produces a better and more desired medical outcome, the more costly hysterectomy is not "medically necessary."

A good example of a proliferation of unevaluated technology in FFS is the case of arthroscopic surgery for osteoarthritis of the knee. A recent *New England Journal of Medicine* article reporting a clinical trial that compared arthroscopic surgery with a pretend or sham or "placebo" operation dramatically illustrated this point.<sup>44</sup> Patients with osteoarthritis of the knee were randomly assigned to and received "arthroscopic debridement" or "arthroscopic lavage" (two frequent operations), or placebo (i.e. pretend

or sham) surgery. The authors concluded that: "At no point did either of the intervention groups [i.e. those who got a real operation] report less pain or better function than the placebo group." In other words, *this operation conferred no medical value*. On the other hand, other research has shown that "Postoperative thromboembolic events [blood clots] are serious complications, and retrospective studies have reported an incidence of 0.2% to 7% for clinically apparent deep venous thrombosis (DVT) and pulmonary embolism (PE)."<sup>45</sup> DVTs and pulmonary embolisms can lead to strokes, death, and heart damage, and to long and costly treatments in and out of hospital with anti-coagulation drugs. According to a report from the Baylor College of Medicine: "In the United States, it is estimated that more than 650,000 arthroscopic debridement or lavage procedures are performed each year, many of these for arthritis, at a cost of about \$5000 each."<sup>46</sup> That amounts to \$3.25 billion per year. Moreover, this does not include the costs of treatment of the complications. Practice according to the best current science would curb such waste. (UnitedHealthcare reported that in 2002, they sent copies of this *New England Journal of Medicine* article to physicians who were doing arthroscopy for osteoarthritis).<sup>47</sup>

The FFS model of insurance gives patients no guidance as to who are less costly doctors, and little reason to care. All the incentives point to doing too much care, or care of little or no marginal value.

Another important driver of cost inflation in the FFS model is that hospitals compete for doctors – because doctors bring in paying patients – by offering amenities such as low-cost convenient office buildings next to hospitals, and by buying the latest and best high-tech equipment. This leads to a "medical arms race" of proliferation of high-tech equipment, much of which is not used to full capacity. Underused specialists and facilities can mean lack of proficiency. This leads to the proliferation of hospitals doing costly, complex and dangerous procedures such as open-heart surgery in volumes that are so low as to be both dangerous and uneconomic.<sup>48</sup>

### C. FFS is inadequate for the treatment of chronic conditions

There is now growing recognition of the importance and cost of chronic disease. Some estimate that more than half of medical resources are spent caring for people with chronic conditions.<sup>49</sup> However, the FFS model is



particularly poorly adapted to this kind of care. FFS is oriented to acute, episodic care. It pays for doctor visits and procedures. Chronic care needs what the Institute of Medicine of the National Academy of Sciences (IOM) calls “care based on continuous healing relationships” usually performed by allied health professionals.<sup>50</sup> FFS has a hard time paying for nurses to telephone patients to ask them about their weight, and recommend changes in their medications.

#### D. Error, fraud and abuse

Largely because of the FFS method of payment to doctors in which millions of individual acts must be billed and paid for, improper billing because of fraud, carelessness, or errors is a huge problem. Payers—governmental and private—have to sort through millions of claims and separate the appropriate and legitimate from the inappropriate and false. The insurance industry has had to innovate to do this job. Reasonable approximations must be used. Perfection is not possible. Getting the payments right overall, in the large majority of cases, must be accepted as an appropriate standard. Otherwise, transactions costs would soar even more than they have.

The *Report on the Financial Statement Audit of the Health Care Financing Administration for Fiscal Year 1996* by the Office of the Inspector General of the Department of Health and Human Services estimated that in that year, the Medicare Program made about \$23.2 billion in improper payments.<sup>51</sup> The main reasons the payments

were judged to be improper were insufficient documentation, no documentation, lack of medical necessity, incorrect coding, and non-covered or unallowable services. Examples of what the audit found are contained in the report.<sup>52</sup> As the Inspector General’s Report said: “The Medicare program is inherently vulnerable to incorrect provider billing practices.”<sup>53</sup> The same could be said of all insurance under FFS.

Malcolm Sparrow, who teaches at the Kennedy School of Government at Harvard and is an expert on fraud and the control of fraud, has written a book entitled *License to Steal: How Fraud Bleeds America’s Health Care System*.<sup>54</sup> Sparrow provides many examples of fraud. A kind of abuse that is particularly hard to detect is, for purely economic reasons, increasing the volume of services that confer no additional benefit to the patient.<sup>55 56 57</sup>

#### E. Lack of Performance Tracking

One of the important deficiencies of FFS is its very slow (often nonexistent) adoption of comprehensive longitudinal records. Doctors do not have a systematic way of following their patients and tracking the outcomes of different procedures and treatments. They follow those of their patients who want to come back and be seen, but have little knowledge of the others who should be part of the denominator for comparing success rates. Today, outside of prepaid group practice, registries of patients are the exception, not the rule.



## II. CONCLUSION

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Under the current health-care delivery system, dominated by FFS solo-practice medicine, costs are growing unsustainably, and quality and access are far from satisfactory – especially in light of how much the American people are paying for their care. Certainly, something must change. Arguably, the continuation of the FFS model, largely sheltered from competition and therefore lacking innovation in organization and process, has contributed to the increase in cost without improvement in access or in many dimensions of quality.

Many surely hope for the continuation of something very close to the traditional organizational model for U.S. health-care delivery. Innovation directed through fortuitous channels might make that possible. However, the unaltered status quo is not an option. Much as we might want the traditional model of a single doctor treating a single patient in blessed isolation, our society does not have enough doctors; and if we recruited and

trained them, we could not afford the medical establishment that would result. Our society has reached the point where ignoring the mounting costs will result in the loss of access – and hence severe harm – to an unfortunate segment of our population that is already too large, and is growing too rapidly.

In virtually every other sector of the U.S. economy, competition has led to enormous and unpredictable change, but in the end to greater value for the consumer. More-effective competition in the health-care sector could only be expected to do the same. No one can predict what the outcome would be – in five years, ten years, twenty years, or longer – for the organization of the health-care sector. A revitalized FFS model is well within the bounds of the possible. What we can predict is that consumers, empowered with choices and information about both cost and quality, can be expected to drive the health-care sector toward better outcomes – and perhaps to ward off the three-way collision of cost, access and quality that now appears to be just around the corner.

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## Part Two – The Options

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Part One of this statement explained that the heart of our problems with national health expenditures (NHE) can be summarized by the persistent gap of 2.5 percentage points per year between the growth in NHE and the growth in GDP. In addition, there are major problems of quality failures and of uninsured people lacking financial access to needed medical care. Part One reviewed the causes of the high level and rapid growth in NHE, including that our health care is dominated by the uncoordinated, fragmented traditional model of fee for service and small practice.

This part will review the following topics:

1. Why, for the past 35 years, the many “band aids” on a fundamentally flawed system of health-care financing and delivery didn’t work.
2. Why some of the current favorite ideas, though possibly useful in the context of comprehensive reform, will not work if seen as the solution in themselves.
3. Why “single payer” or “Medicare for All” or “Consumer-Driven Health Plans” (CDHPs) or “High-Deductible Health Plans” (HDHPs), are not complete solutions.
4. The attributes of a fundamentally reformed system that has a good chance of success.

The next part of this CED statement, forthcoming, will explain in greater detail the specifications of a reformed and improved health-care system, and how the nation might achieve the least disruptive transition from the current, deficient system.

### Why 35 Years Of “Band Aids” On A Fundamentally Flawed System Did Not Work

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For at least 35 years, there has been a slowly building realization that our health-care system is not sustainable. Costs are growing so rapidly that at some not-far-off date, our economy will no longer be able to bear them. Even those who are satisfied with their current health-insurance arrangements have become less secure that those arrangements can continue. Furthermore, even those who are most confident that their own health insurance is secure must see that more and more people

have no care at all, to the detriment of our society as a whole. Moreover, even practitioners doing their best under the current system must see that the system eventually must change.

Public policy and private actors have tried to respond. But today’s health-care system provides no incentive to individual doctors and patients to pursue cost-efficient medicine. Accordingly, the United States has a discouraging 30-35 year history of espousing and adopting simplistic and partial “solutions” on top of a fundamentally flawed system. We have had a long procession of “band aids” in health care, each of which was supposed to solve, or significantly mitigate, our problem of uncontrolled health-expenditure growth. Some of these contained germs of good ideas, and some of them would have figured prominently in a rational comprehensive solution; but none of them came close to addressing our fundamental problems.

The basic problem has been and remains that the whole health-care financing system rests on inflationary foundations. The incentives and the organization of health care work against affordable care. Medicare is predominantly fee for service. In the private employment sector, most employees have been locked into fee for service (formerly indemnity insurance, now PPOs) without a choice. Health expenditures are now dominated by the cost of caring for people with chronic conditions, but the traditional system does not provide the financial foundation on which the infrastructure of chronic disease management can be built. Our traditional health-care system is oriented toward acute episodes, not ongoing care for people with chronic conditions. Our current systems flaws are exacerbated when people change jobs (which is happening increasingly frequently) and must change both health insurers and providers as well. Few employers offer employees choices of delivery systems, and if they do offer a choice, they often systematically pay more on behalf of the more costly plans (often fee-for-service plans) than on behalf of the less costly plans (usually integrated-delivery systems). Both of these employer practices deny employees the opportunity to save money and pay lower premiums by choosing less-costly health-care systems. There was and is little understanding of the basic problems of incentives and organization. Indeed, in the 1970s, most people thought that financial incentives and organization were irrelevant to health care. Legislatures and citizens were reluctant to address the fundamental problems and eager to find painless incremental solutions – veritable “band aids.” Here is a list of some of them, in roughly chronological order:



*Waste, fraud, and abuse* (WFA) was the perceived villain of the year in 1972. Hence, the solution would be more lawyers, inspectors and penalties for fraud. WFA is still present on a large scale more than 30 years later. It received honorable mention in the Medicare Prescription Drug, Improvement and Modernization Act of 2003. The very structure of the traditional model invites WFA. Harvard's Malcolm Sparrow characterized fee-for-service as "a license to steal."<sup>1</sup> Action against WFA has had some successes; but rapid health-care cost growth continued. (If the problem of our health-care system truly were outright fraud and abuse, it would be relatively easy to solve, because it would require only the identification and apprehension of a comparative few practitioners whose motives were outright greed. Unfortunately, the problem is far more complex, involving well-intended behavior within a system that provides every incentive for over-utilization, and no incentive for cost-consciousness.)

Then the problem was identified as excess capacity, so the new "big thing" became *Certificate of Need* (CON) laws and health systems agencies to prevent building of unnecessary capacity. These measures failed because incentives to match capacity to need were not present. The regulators could not stop building in the teeth of the economic incentives to do more with the facilities that already existed. If a doctor believed that a marginal test or procedure might provide some benefit, however small, to a patient, and the facilities to provide that test or procedure were available, the facilities would be used – therefore demonstrating the "need" for those facilities, and the "need" to build more. Studies showed CON had no effect on overall spending.<sup>2</sup>

President Nixon then imposed *price controls*. But experience showed that the doctors made up for lost income by increasing volume. The system imploded in complexity over the requirement that regulators use due process and just compensation. "Just compensation" becomes a fair rate of return, which becomes cost reimbursement; and providers have the ultimate power to increase costs by providing more services.

President Carter wanted price controls on hospitals but could not get them enacted. Hospital and medical associations opposed these measures vigorously. One of their proposed alternative weapons against cost growth was "*the voluntary effort*" ("the VE"). Providers of health care would solve the problem by voluntary action. The voluntary effort had no lasting effect.

Next the problem was identified as an excess utilization of services, and the answer became *Utilization Review and Professional Standards Review Organizations* (PSROs). These were

local non-profit physician cooperatives that were supposed to detect overuse and admonish over-users. That failed, because there was no incentive for local doctor groups to curtail local spending when so much of the money came from elsewhere. A dollar saved in Palo Alto was a dollar returned to Washington.<sup>3</sup> Why would anyone in Palo Alto want to do that? Moreover, and probably more importantly, meaningful standards of appropriate utilization, based on medical evidence and persuasive to doctors, simply did not exist.

Then the Congress created *Peer Review Organizations* (PROs) – contract police forces to challenge utilization. They failed, partly for the same reasons as PSROs. It is hard to second-guess the doctor's care for the patient, especially after the fact, and especially if one is not a doctor caring for similar patients. Cost-efficient medicine requires a system that involves the doctor prospectively – not merely a set of rules, or worse still a single reviewer, imposed upon him or her after the fact.

Then came what could have been an important part of a genuine solution, the *Health Maintenance Organization Act* of 1973. A key point is that it was focused on refinement of delivery systems in search of greater cost-efficiency. At the time, the leading alternative modes of organization were group practice HMOs and individual practice HMOs. In those days, "HMO" referred to a delivery system, not just to an insurance contract. The fatal flaw of the legislation was that it failed to create the market conditions of widespread cost-conscious individual consumer choice so that there would be a market for cost-effective care. That is, the vast majority of individual health-care consumers either did not have a choice of a more-efficient, less-expensive health-insurance plan, or, if they had the choice, did not themselves save any money by choosing the more-efficient system. The reason was that many employers fulfilled the HMO Act's legal requirement not to discriminate against HMOs by paying the same 80 to 100 percent of the premium of the plan of the employee's choice, whether it was fee for service or HMO. This deprived HMOs of the opportunity to market cost-effectiveness, because the employee would save either nothing (if the employer paid 100 percent of any premium) or only 20 percent (if the employer paid 80 percent) of the difference by choosing a lower-priced HMO. Thus, HMOs helped, but they failed to achieve their potential because employers and government failed to create a market for them. Policymakers simply assumed that there would be a market for economical health care without careful examination of employer practices. The HMO Act should have been accompanied by more-fundamental and far-reaching reform of the EBI system, but there was neither the vision nor the felt need at that time.

The *Prospective Payment System* (PPS) for Medicare for hospitals was a logical and significant step toward a more economical health-care system, improving incentives for hospitals by requiring them to accept responsibility for managing at least a significant piece of the cost. It was a big success for a while. However, it was limited to inpatient care, and much care escapes the limits on inpatient services; and it did not include physician inpatient services (which Holland has included for some years). In addition, it did not reward prevention of inappropriate care, or prevention of the need for hospitalization in the first place. The latter point is especially important. Over half of all Medicare patients are now treated for five or more chronic conditions. This problem is growing rapidly (in 1987, 31.0 percent of beneficiaries were treated for five or more chronic conditions; in 2002, it was 50.2 percent), and is responsible for virtually all of the Medicare spending growth (in 1987, beneficiaries with five or more chronic conditions accounted for 52.2 percent of all Medicare spending; in 2002, it was 76.3 percent).<sup>4</sup> Persons with (or at risk of acquiring) several chronic conditions need far-more-coordinated treatment and counseling than is provided by the traditional medical model, under which the patient chooses to see the doctor only when symptoms arise.<sup>5</sup> Although PPS was successful on its own terms, the problem of unsustainable growth of Medicare is very much still with us.

In the early 1980s, “*competition*” became the “Magic Bullet,” but the government and employers did not make the changes in the market to assure cost-conscious consumer choice of delivery system, and so competition did not happen. President Reagan advocated “free markets,” and dismantled ineffective regulation, but did not take the steps necessary to create a functioning market of competing delivery systems. His administration even let expire the provision in the HMO Act that employers must offer choices of HMOs, which had at least encouraged some competition among different modes of organizing care. In addition, the administration turned down strong recommendations to cap the exclusion of employer contributions for health insurance from employee taxable income. Somehow, the notion of “competition” was based on the unrealistic belief that what happened in the health-care sector was actually the product of the free market.

Then Congress adopted the *resource-based relative value scale* (RBRVS) governing Medicare fees for doctors, in a sense

expanding PPS from the hospital segment of the program to apply more broadly. Like PPS, this was a good idea as far as it went. It was an attempt to create a rational basis for Medicare fees, to take excess profit out of some services, especially procedures, and to assure adequate payment for evaluation and management services. However, Medicare is still fee-for-service, and doctors increase volume to protect themselves from loss of income when fees are cut. (In fact, Medicare has an office whose mission is to estimate the volume response to fee cuts.) In any case, government simply cannot set all of the hundreds, or even thousands, of prices at efficient levels; and government controls can turn such prices into political prizes.

In the 1990s, many had great hopes for “*managed care*,” which promised an improved mode of organization of medical care. However, much of what was offered was essentially insurance companies or “carrier HMOs” marketing the services of fragmented, uncoordinated, fee-for-service doctors, without reorganizing the delivery system, and doing so under a comprehensive care contract characteristic of HMOs.<sup>†</sup> As under traditional fee-for-service medicine, the doctors wanted to do everything they could for their patients, and the patients wanted anything that might help them; so the insurance companies found themselves in the uncomfortable position of standing between wanting patients and willing doctors. A backlash followed because employers forced many people into “managed care” without a choice, without visible sharing of the savings, and without much explanation of what was happening or why.

People, understandably, want to be able to choose their doctors. They do not understand why their employers should make that choice for them. HMOs select doctors. Therefore, people must be allowed to choose their HMOs, or any other plan that limits their choices of providers, or whether to be in and HMO at all. Research showed that the dissatisfaction with managed care was concentrated among people who were assigned to it without a choice.<sup>6</sup> To assign people to HMOs without giving them a choice is to invite a backlash. Many HMOs were forced to have a very wide all-inclusive network. Managed care was reduced to FFS in states with “any-willing-provider” laws. Managed care was not allowed to “interfere” with the way medicine was practiced and it was not allowed to select providers. If managed care is forced to mimic FFS, there is no way for it to innovate and develop systems different from

† Some of the “carrier HMOs” were mostly only about restraint, not about reorganizing care, though some, like Prudential, actually built a delivery system of group practices, and others like Health Net, PacifiCare, Blue Shield and Blue Cross of California contracted on a per capita prepayment basis with existing Multi Specialty Group Practices that were willing to accept responsibility to manage care and costs.

FFS. There is also no reason to expect that it can sustain any significant cost reduction.

## Why One Current Big Idea – The Consumer-directed Health Plan – Will Not Work

President Bush and some in the Congress have favored **High-Deductible Health Plans**, also known as **Consumer Directed Health Plans** (CDHP). In some presentations, this approach is billed as something close to a complete answer for the problems of the nation's health-care system. Some firms have introduced plans along these lines. Will these plans help to close the gap between NHE growth and GDP growth?

It is good that firms have used the CDHP model to obtain coverage for their employees who hitherto have had none. CDHP coverage clearly has value. However, we are skeptical that CDHP will prove to be the solution to the deterioration of employer-based insurance, and to the unsustainable growth of health-care costs.

Fundamentally, CDHP is not one variation on existing mainstream health insurance, but a combination of two. It is helpful to analyze those two parts separately, and then to consider the implications of putting them together.

**Consumer Direction.** Many experts have argued for some time that consumers must accept more responsibility for their health, including both managing their habits (diet, smoking, alcohol, exercise) and choosing their providers and treatments. Consumer-directed health plans generally assume an increased measure of such responsibility relative to conventional insurance. The assumed increased consumer involvement in medical-care choices is probably the more critical element.

To some degree, this assumption probably is based on the computer revolution. CDHP anticipates that, as in other phases of life, consumers will use the Internet and other information resources to make more-cost-efficient choices in health care: in this instance, shopping for the cheapest provider, learning about the implications of alternative treatments and therapies, and so on. CDHP calls for providers to release comprehensive information on their quality and prices. That would be incontrovertibly desirable, but it would require a major change from current practice. The availability of a computer-based health record would facilitate the heightened consumer responsibility. First recommended in the Institute of Medicine report, "Crossing the Quality Chasm," this advance

gives the consumer access to and control over his or her entire life-long medical record. Such records generally do not now exist. The coming evolution of consumer choice of treatments and therapies, and the opportunities surrounding personal computerized health records, are both uncertain.

This kind of information could be used to plan health care under any kind of insurance policy. Would it work to control costs in a CDHP? Consider the other element in this model.

**High-Deductible Health Insurance.** CDHPs require the insured to pay the first dollars (usually \$1,000 to \$2,500) of health-care expense (that is, the "deductible") before the insurer begins to pay the bills. Some CDHPs are associated with health savings accounts (HSAs), which are tax-deferred, and which can be used to pay for the care below the high deductibles associated with the policy. In some instances, the employer makes deposits into the HSA for the employee, either independently or as a match; in other instances, the employee alone is responsible for funding the HSA. Unspent balances in HSAs can be rolled over from year to year without tax, and can be withdrawn without tax to pay medical expenses. (If withdrawn for non-medical purposes, the withdrawals are subject to income tax plus a 10 percent penalty. If the balances are not used until the owner becomes eligible for Medicare, the 10 percent penalty is waived. If the owner passes away, the balances can be bequeathed to the individual's heirs, and the 10 percent penalty is waived.)

The rationale for CDHPs is that the incentive of the high deductible will induce the consumer to economize on health care; after all, it is the consumer's money. Having the HSA is expected to mitigate any cost problems in meeting the deductible for consumers of modest means. Many CDHPs waive the deductible for preventive care, which is supposed to encourage consumers to keep close tabs on their health.

Thus, putting the two elements together, the result is somewhat analogous to the shift from a defined-benefit pension plan to a defined-contribution plan. Under conventional health insurance, individuals undertake less risk (and can choose to have less responsibility for their treatment choices), and pay higher premiums so that others take on those responsibilities. Under CDHP, individuals are at risk for the deductible, and might be expected to be more involved in treatment choices for that reason, while paying a lower premium in exchange for taking those responsibilities on themselves.

In other words, 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 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.

Is this outcome likely? There are several reasons to be skeptical. First, it is unlikely that health-insurance deductibles in the realistic \$1,000 to \$2,500 per year range (any higher amount would likely force many families without employer contributions to HSAs, with modest incomes, and with health problems to go without care) would exert any meaningful leverage to reduce total health-care costs. It certainly would be desirable for people to know the quality of medical services and what they cost, and to have some personal reason to care. This would probably be the case to the degree that they had to shop and pay for the first \$1,000 to \$2,500 of annual expenditure. However, health expenditures are very concentrated on relatively few people.<sup>7</sup> In 2002, as noted in CED's previous statement, 80 percent of health expenses were incurred by people with costs exceeding \$3,219. Thus, 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 of deductibles that is reasonable). Recalling that 83 percent of health expenditures are on people with one or more chronic conditions, many people with chronic conditions will expect to reach their deductibles. Certainly, anyone who has been an inpatient in a hospital, or is likely to enter a hospital, will have reason to believe that he or she will exceed any insurance deductible.<sup>8</sup> For those who expect they will exceed their annual deductibles, the marginal cost of more care will be small, probably zero – depending on whether their plans involved co-payments, which are usually relatively small percentages, for spending above their deductibles. In any event, the marginal cost will certainly not be enough to affect their decisions once they are hospitalized. The RAND experiment to test coinsurance found that once people were hospitalized, coinsurance had no effect on spending.<sup>9</sup>

Second, once CDHP enrollees have reached their deductibles, they will be in effect in fee-for-service medicine – to be precise, usually in wide-access PPOs, which are fragmented uncoordinated FFS arrangements. There is no expenditure restraint in such systems, only incentives to give and receive more care. Some have argued that once consumers had built the habit of shopping for price within the amounts of their deductibles, they would continue to try to cut costs even when their insurance kicked in at 100 percent reimbursement. Although it is impossible to rule out such behavior, it is clear that there would be no economic incentive for consumers to do so – especially given that high health expenditures can indicate

serious health problems, for which consumers likely would want all of the best possible care.

Third, CDHPs appeal most to consumers who have reason to believe that they will remain healthy, and thus will be able to bank their HSAs. To the extent that this is true, the risk pool for non-CDHP plans will be depleted, shifting costs mainly to people with chronic conditions who will not choose CDHPs because they would expect to exhaust their deductibles.

CDHPs will be especially 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, a new tax break in the Medicare Modernization Act of 2003 intended to encourage the choice of high deductibles by equalizing the tax treatment of out-of-pocket spending and spending through tax-favored insurance. Employer contributions to HSAs are free of income tax and employee contributions are deductible above the line. The limit on tax-sheltered savings is the deductible in the health-insurance plan, up to \$5,400 (for married couples) in 2006. For a high-bracket taxpayer, the tax savings on this will be worth over \$1,900 a year, plus possibly additional savings from state income taxes, plus tax free accumulations. This has created a very attractive opportunity to shelter income from taxes.

Because the HSA is an exclusion from taxable income, the tax benefit is most valuable to the best-off taxpayers who are in the highest tax-rate brackets (and is worth nothing to the worst-off taxpayers who face a zero-percent tax rate). These same well-off persons benefit from the lower premiums and, through this device, can escape the pooling of risk with their less-fortunate fellow employees. Favorable selection of risks will help CDHP to grow rapidly, while leaving the higher risks behind in the standard low-deductible plans. However, 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. It is not clear that this approach is based on a realistic concept of the problems of health care.

Fourth, about 83% of health-care spending is associated with the 133 million Americans who suffer from chronic conditions: hypertension, arthritis, asthma, cancer, heart disease, diabetes and its consequences (including renal failure), AIDS, etc.<sup>10</sup> These persons need to be, in the words of the Institute of Medicine (IOM), in “continuous healing relationships” with their health-care system.<sup>11</sup> We also are now suffering an epidemic of obesity, which will lead to many occurrences of heart disease, diabetes, etc.<sup>12</sup> These costs will ultimately be borne by

all of us through Medicare, Medicaid, and disability insurance. The emphasis in our health-care delivery system needs to be on teaching and motivating these patients to change their life styles and adopt healthier patterns of behavior, supporting them in their efforts, and monitoring their medications appropriately. Health-care organization and finance should create the foundation for disease-management infrastructure. However, CDHP is based on the idea that a key to economy is keeping people away from the doctor. That might be true for acute care in uncoordinated fee for service; but it will not be true in our society with so many people having and heading toward chronic diseases. CDHP moves in the wrong direction—attempting to keep people away from health care rather than reaching out to support them in improving their lifestyles and managing their conditions to keep them out of the hospital and away from more costly complications.

To be fair, many advocates of CDHP would exempt preventive care from deductibles and co-pays. However, to continue in fairness, it is by no means clear that such exemptions would work in a system whose entire philosophy is to keep people away from their physicians. For example, it is far from certain that those who enroll in CDHPs because they cannot afford higher premiums, and therefore cannot afford the deductibles, will go to the doctor for exempt preventive care when they know that they cannot afford any non-exempt treatments or therapies that the doctor might recommend. This could lead to under-funding of primary care and prevention, and could reinforce the present trend of young American doctors not going into primary care. Primary-care physicians could have increased difficulty collecting their bills, because those costs would be the ones to which deductibles would most likely apply. Interestingly enough, 22 per cent of large employers now offer in-house clinics to their employees to make access to the doctor more convenient.<sup>13</sup> (Alternatively, advocates of CDHPs have expressed concern that common low-deductible policies have led to overutilization, and yet Americans still have underconsumed preventive care. Should we expect that CDHPs will yield more use of preventive care, when their coverage of that care is no more generous than that under current low-deductible policies?)

Fifth, CDHP emphasizes the decisions of informed consumers, a model that may seem to fit well with a population of professors of management in universities that have medi-

cal schools who have enough free time to keep up with the medical literature, but that makes less sense for others. These consumers are supposed to shop confidently for doctors, and negotiate with them over prices and treatments. Medical care is very complex and uncertain. Wennberg's research has documented remarkably wide variations in physician practice patterns, reflecting the fact that most doctors do not have a very well-informed idea of what is the best thing to do.<sup>14</sup> Considering that only 27 percent of Americans age 25 and over are college graduates, it seems unlikely that even much better consumer information than we have will drive better decision making at the micro level.<sup>15</sup> Only recently, the most famous bypass graft (CABG) patient in America, William Jefferson Clinton, living in the state with the best outcomes-related information, chose a hospital with higher than average risk-adjusted mortality. His choice arguably did not fit well with the CDHP model. More broadly, the experience in New York has been that the publication of such quality-related information did not drive changes in market share. The changes in performance apparently came from extra-market forces such as state regulation, or the threat of it, and from the professional aspirations of doctors and hospital managements and boards, most of whom wanted to be among the best. Arguably, the information requirements at the micro-decision level of individual providers and treatments are much greater than the information needed to make an informed choice of a care system. This suggests that it makes more sense to ask consumers to shop in a routine open season for a cost-efficient health-care plan, rather than to require them to shop perhaps in a time of crisis when they need an expensive and potentially life-saving treatment or therapy.<sup>†</sup>

### **Why “Single Payer” Like Canada Or “Medicare For All” Will Not Solve Our Problems With Health Care**

Beyond Consumer-Driven Health Plans, another “big idea” for health-system reform is a “single-payer” system, of which Canada's is a prominent example. Many people think that the logical replacement for the employment-based system would be a Canadian-style system. That is, at either the federal or the state level, government would serve as the single health insurer, cover everybody, and pay all the bills according to a govern-

† Physicians in prepaid group practices take part in systems that accept responsibility to manage total per capita expenditure of their enrolled members. There is a great deal of evidence that they do the best job. They do not appear to be eager to add to patient cost sharing. They do not believe that unnecessary primary care visits are driving expenditure growth. They do want patients with medical problems to come in early and be seen, or at least to call an advice nurse.



ment-determined or negotiated fee schedule. (In Canada, hospitals are paid prospective “global budgets.”) Another way of expressing this type of approach is “Medicare for all;” in other words, every American would be covered by the Medicare program or something very similar.<sup>†</sup> The California Legislature recently passed a single-payer bill. Single-payer proposals have also appeared as ballot initiatives in California, but they usually have not fared very well. That could change, and probably will as the consequences of soaring insurance costs play out.

As an alternative in the United States today, this model has features with great appeal. For one thing, *everyone* is covered in the most familiar models. The complexities of determining who is covered, and by which program, are eliminated. There would be a huge simplification of administration. All providers would bill the government, or its agent, on a uniform claim form and be paid a uniform fee. In Canada, doctors bill the province on a claim form that looks like a credit-card charge slip. Canadians and Medicare beneficiaries have access to practically every doctor in the jurisdiction. (That is changing now as doctors decline to take new Medicare patients in response to Medicare fee reductions.) There would be no network restrictions. There would be no marketing and underwriting expenses of insurance companies dealing with many individual employers, because there would be no more insurance companies (other than as claims processors or vendors of supplemental insurance). Health insurance would be removed as a factor in the labor market. Employers could eliminate their bureaucracies for dealing with health insurance, and CFOs could forget about health care (except when they paid their taxes). Altogether, it would be reasonable to expect that some 15 to 20 percent of the costs associated with health insurance would be eliminated. This includes the costs of brokers and agents and the large costs to employers of retaining staffs and consultants to help them manage their health coverage purchasing.

Single-payer models are generally based on fee-for-service payment because that is the way most doctors are paid. Depending on one’s point of view, that would be an advantage or a major disadvantage. It would be an advantage because it would be familiar, and administrative processes exist. Most doctors and medical groups are paid that way today and prefer it.

However, from the point of view of concerns about the organization of medical care, or lack thereof, and its impact on economy and quality, locking in uncoordinated fragmented

fee-for-service would be a major disadvantage. It would leave in place existing medical organization, with all the deficiencies for quality and economy discussed in CED’s earlier reports. It would continue to be oriented to acute episodes – rather than chronic disease management, where most of the money is. It would deny us the benefits of any potential new and better-organized delivery systems. In sum, all of the organizational flaws that have rendered the current system inflationary and unsustainable would remain in place.

Fee-for-service solo practice is the most costly form of medical organization and finance. As noted above, 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. As Wennberg’s studies comparing Medicare in Florida and Minnesota show, fee-for-service allows very wide variations in medical practice and apparent overuse in Florida. Patients in the last six months of life in Florida get several times as many doctor visits as similar patients do in Minnesota, while reporting less satisfaction with their care. Because single-payer systems encourage fee-for-service medicine, Wennberg’s work shows that government would be forced to support the most costly providers in their preferred practice style.

The single-payer model is rigid and extremely hard to change. It has proven practically impossible for Medicare to break out of fee-for-service, even though Congressional leaders have long said that they want to offer choice to beneficiaries. Medicare does offer HMOs, called “Medicare Advantage” plans, but the amount Medicare pays to those plans is tied to the prevailing risk-adjusted fee-for-service per capita costs in each geographic area. Canada’s Medicare system destroyed their prepaid group practices because the dominant payment system left no opportunity for Canadians to save money by joining more-efficient delivery systems.

There are other problems with single-payer systems. Perhaps the next most important one is the entanglement of provider payment with politics. The medical-industrial complex already is a huge source of political money. Medical device companies and drug companies employ persons in many Congressional districts, either directly or through contractors. Every Congressional district has doctors and hospitals. If all of their revenues depended on the government, it would be hard to imagine that attempts to influence the allocation of funds in the program through lobbying and political contribu-

<sup>†</sup> There are many alternative ways for government to play a role in health insurance that might be characterized as “single payer.” The Canadian-style or “Medicare for all” approach is the most prominent, and the most widely understood.

tions would not grow substantially. Payment by government would become, literally, a matter of life and death to health-care providers.

Some think that a single payer would be able to control health expenditures. However, government today is having a very difficult time controlling the costs of its existing health commitments to Medicare (as well as Medicaid and public-employee health care). Health expenditures cannot be controlled effectively merely by regulating prices. Expenditures are the product of prices and quantities. Squeezing down on prices arguably motivates a “volume response” – that is, doctors react to a reduction of prices by increasing the volume of services they provide. Experience with the current Medicare program bears this out.<sup>16</sup> Congress has created a countermeasure to that in the “sustainable growth rate” formula: what the doctors take in utilization will be recaptured through lower fees. Obviously, that is hardly an optimal system. It punishes the frugal along with the prodigal. It remains to be seen whether or not it will be sustained.

Government appears unable to discriminate among providers. It is very unlikely that government could refuse to deal with providers who appear to be more costly for the results they produce, as long as some beneficiaries – that is, voters – demand them. Already, under the current system, Medicare’s attempts to offer a better deal for patients going to regional centers of excellence for complex care have foundered. Non-discrimination by any payer is a principle the provider organizations fight for.

Government cannot “just say no” to costly new technologies. In fact, Congress will not even allow the administrators of Medicare to consider costs in relation to benefits in decisions of whether or not to cover new technologies for Medicare payment. There is strong evidence that competing private health-care delivery systems can do a much better job of cost-effective deployment of new technologies, and targeting them to where they will really be effective.<sup>17</sup>

Government simply cannot know how to set so many and such complex prices, taking account of local market conditions. Congress must and does use across-the-board rules for setting prices, which are very hard to change. For example, Medicare has created a boom in cardiology procedures by overpaying for them and making them more profitable than other kinds

of care.<sup>18</sup> This in turn is leading to a boom in heart hospitals, which the Congress is now seeking to inhibit.

Canada is suffering from long waiting times from primary care referrals to specialist treatment. Global budgets do not create incentives for efficiency. The proper incentives could lead to the amelioration of the problem. It is interesting that the British are moving in the direction of market models and incentives reform.

In short, for all of its appeal, the single-payer model suffers from serious, probably fatal, weaknesses. Although other nations with single-payer systems spend smaller shares of their GDP on health care than the United States does, those shares are rising just as inexorably. Measures of dissatisfaction with single-payer systems abroad are growing, just as they are with our system. Moreover, our own single-payer systems – Medicare and Medicaid – already have their own problems (which are not solely assignable to their responsibility for the elderly and other groups with disproportionately ill health). CED concludes that a single-payer system would not solve our health-care problems – and in fact may make them even worse.

## Many Other Current Favorite Ideas Are Being Oversold As Solutions In Themselves; Others Would Not Work

Consumer-Driven Health Plans and single-payer health systems are probably the two biggest “big new things” in the dialog on health reform. However, there are many other popular ideas that are smaller in scope. Some would have positive effects, but are often oversold as total answers to the health-care cost problem – which they are not. Other ideas would have no favorable effect, or even would be retrograde. These ideas are the successors to the “band aids” of the 1970s, 1980s, and 1990s.

One idea that has generated much excitement is **Information Technology**. This seems like a safe course for politicians to favor. It has glitter and does not apparently threaten any important interests. In fact, information technology will surely be an indispensable component of any reformed, modern, high-quality delivery system, which is why the major integrated-delivery systems are spending billions to roll it out in their practices.<sup>†</sup>

† Veterans Administration Health System, Kaiser Permanente, the Mayo Clinic, and the Palo Alto Clinic, among others, are leaders in the development and application of health IT.

However, merely superimposing a veneer of IT on top of the current mal-constructed health-care system will not solve the underlying problems. IT will not do much good if the delivery system is not reorganized by redesigning care processes to take advantage of it. In a fundamentally dysfunctional and disorganized delivery system, IT may end up just giving an inefficient system an electronic means of communication to automate inefficient practices. IT is being ascribed magical powers; but one perceptive analysis pointed out that the deployment of IT is not in the interest of the doctors, hospitals, and laboratories in the uncoordinated FFS sector. This probably explains why it is being adapted so slowly there.<sup>19</sup> To illustrate, consider that a well organized solo primary-care practice has no particular need for IT for itself, though it could be a valuable tool for the doctor to use in managing chronic disease patients. The real benefit from IT adoption in that office would accrue to the health-care system as a whole, through better informed specialists to whom the patient is referred (fewer wasted visits, more productive visits, less time lost on history taking or tracking down lost information), better coordination between the specialists and the primary care physician, and fewer lost and/or duplicated test results. However, these “benefits” to “the system” would not be benefits to individual FFS physicians who would experience less revenue from fewer visits and tests. In addition, the primary-care practice itself would bear all of the costs. Given the circumstances, it is no wonder that there is slow or no adoption of IT in the solo-practice FFS sector. (Some might mandate the adoption of IT. This would raise the same questions as all other government mandates; and adoption would surely be halfhearted, if there were only compulsion and no positive incentive to make the system truly work.)

Comprehensive **Electronic Health Records (EHR)** would be an important output of health IT, and a foundation of efficient integrated-delivery systems. Prepaid group practices kept longitudinal comprehensive records from the outset, and are now converting them to electronic form. They are potentially very important, and they could be very helpful for quality and efficiency, but they will not make fragmented fee-for-service affordable. They may be defeated by the unwillingness of FFS doctors to expose their work to competitors who might criticize it. It is not clear that EHR will do much good in the uncoordinated fee-for-service small-practice sector.

**Pay for Performance (P4P)** was started in California by the Integrated Healthcare Association as a way of getting all the carriers participating in the California Delegated Model, and contracting with physician organizations that were willing to bear risk for resource use, to use the same quality metrics

for preventive services and patient satisfaction as the basis for bonus payments. Among other things, P4P could establish a single measure of practice quality, and get away from the confusing “dueling report cards.” Its main limitation is that it is based largely on process measures and not on medical outcomes. (It would be difficult to execute P4P on a risk-adjusted basis using health outcomes.) P4P makes sense in its original context because the physicians are already willing to accept responsibility for managing resource use. But now, P4P is being interpreted as something that might help limit expenditures in the uncoordinated fee-for-service context. In fact, it might even increase costs. There needs to be a fundamental shift to a market that is based on responsible consumer choice and competition among physician organizations to produce value for money. In that context, performance information can be helpful to consumers.

With the prominence of costly chronic conditions, **Disease Management (DM)** could be an important contributor to health care. It is, of course, an integral part of prepaid group practices, whose financing provides both the incentive and the financial platform (through the capitated prepayment) for successful disease management. In contrast to the close fit with prepaid group practice, disease management must be tacked on to fee-for-service, which lacks both the incentive and the financial platform. Now, with DM being promoted as another effort to overcome the fragmentation of fee-for-service, it is being offered as an optional program to consumers and has a low uptake and low follow through. Recent data suggest savings are low.<sup>20</sup> Disease management is potentially very important. It should be integral to the health-care system, not patched on from the outside.

**Evidence-Based Medicine (EBM)** is an attempt to synthesize the scientific literature and to combine it with analysis of detailed health records to determine which treatments work under which circumstances, and to steer the practice of medicine toward those treatments. It is important because it could improve care, reduce medical uncertainty and unwanted variations, and might save money. However, the success of EBM is not guaranteed. There need to be incentives to practice it, monitoring systems to make it happen, and incentives to choose economical guidelines. Research showed that mere publication of guidelines had no effect on physician behavior.

**Tort Reform** could help reduce expenditures and is surely well worth doing on its own merits.<sup>21</sup> Research by Kessler and McClellan suggests that, at least in the case of fresh heart attacks, reform could save five to ten percent if there were any incentive to reduce expenditures.<sup>22</sup> And five to ten percent is surely



significant. However, this may prove to be a one-time change in the level of expenditures, with no long-term reduction in their growth rate.

**Tiered High Performance Networks (THPN)** are an interesting idea: use claims data on all services associated with each episode of care (usually acute care) to ascribe the management of the episode to a physician (usually a specialist), and then to sort out high-cost and low-cost physicians. The ideal would then be to route all patients to high-quality low-cost physicians. This approach is promising, but has some distinct limitations. THPN obviously is designed as a cost-saving device for individual employers or insurers; it has much less relevance to attaining system-wide savings. (Some might suggest superimposing THPN on a single-payer system. However, that would be totally contrary to the experience of Medicare, under which policymakers have zealously guarded the right of every patient to choose any physician.) There are data analysis issues, such as the accuracy of assigning every episode to one physician, and of correcting for innate differences among the patients and the episodes. In addition, THPN will do little good if employers are unwilling to create sufficient financial incentives to induce patients to switch to economical doctors. Perhaps most importantly, because it is focused on specialists and acute-care episodes, the methodology ignores the important roles of primary care and prevention. Tiered high performance networks could end up with high volumes of preventable inappropriate episodes; even if they were handled efficiently, this would not solve the cost problem. THPN could do more good if plan designs gave people real incentives to choose economical doctors; and still more good if plan designs were connected with a strong system for primary care and prevention, in which motivated primary-care physicians used the data to guide their patients to quality cost-effective specialists and to oversee the appropriateness of procedures.

**Transparency** is also cited as a potential solution. Transparency is an attribute of all well functioning markets. The current health-care manifestation of transparency is the idea that consumers, not just insurance company or medical group managers, who have some reason to act on the information, should know what hospitals charge. Of course, purchasers who are using their own money or their company's money need to know the cost of the things they are buying. Contracting between insurance companies and providers is now a well developed, if imperfect, art. However, one wonders what the ordinary insured consumer with a \$2,000 deductible is going to do with that information. The doctor says, "I must admit you to the hospital." The consumer thinks, "There

goes my \$2,000! Now bring on the technology: More scans. More tests. Do anything that might conceivably help me." Mere \$2,000 deductibles are not going to make patients price sensitive about hospital costs. If people have reason to believe they are likely to reach their annual deductibles, as would be the case with pregnancy, a costly chronic condition, or any hospitalization, there will be no cost-reducing incentive from deductibles. Moreover, much higher deductibles are likely to make care unaffordable for average-wage people.<sup>23</sup>

This history of "band-aids," and the latest successors, should make it clear that there are no easy, simple reforms, things that sound good and have popular appeal, that would solve the health-care problem. All of these examples are attempts, sometimes useful, sometimes not, to bring spending under control without doing the "heavy lifting" of reforming the market. Excess expenditure growth is too fundamental, too pervasive, and is driven by forces that are too powerful for any superficial changes to make a meaningful difference.

In contrast, in an efficient health-care market, all consumers would have informed cost-conscious choices of delivery systems (so that cost-effective delivery systems would prosper and have serious incentives to improve efficiency, quality and service). This informed cost-conscious consumer choice would drive the market toward economical delivery systems that could address issues such as alignment of the incentives of providers with the interests of patients in high-quality affordable care.

## **Characteristics Of A Health-care Financing And Delivery System That Could Respond To America's Needs: What Should We Demand And Expect?**

If the single-payer or consumer-directed approaches will not solve the problems of high levels of expenditure and growth (not to mention poor quality and poor disease management), what will? As we have seen, there are no easy or simple solutions. Unfortunately there are no guarantees. The nation cannot simply decree a reduction in reimbursements for health-care providers. That would discourage the supply of health care, and as has been the case in stop-gap reimbursement cuts in the federal Medicare program, doctors and hospitals would respond by performing more individual services to maintain their total billing amounts. The nation cannot decree that there will be some arbitrary limit to the volume of medical



services provided; that could prevent the delivery of needed services. An arbitrary halt to the development of medical technology would prevent the discovery of cost-reducing, as well as cost-increasing, treatments and therapies, and would inhibit innovations that would benefit people enormously. And there are no clear models from overseas; recall that all the industrialized countries are facing similar unsustainable expenditure growth rates, though from much lower levels of spending than ours (measured as percentages of GDP). Thus, there likely is no strategy that would yield a precisely measurable, accurately predictable amount of savings to limit the growth of health-care costs.

However, there are some serious possible changes that might make a large difference and, in the long run, move the system in a desirable direction. The heart of the issue 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 and even before, competitive pressures have increased quality and tempered prices. The improvements have occurred in ways that could not be predicted in advance. Consumer choices have signaled price standards and preferred product and service attributes to the marketplace, and suppliers have 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, some elements of competition provide the best hope for a more cost-efficient health-care system.

What would a competitive system do? Clearly, we need a very fundamental change that would give almost everybody a serious personal interest in seeking and choosing an economical health-care delivery system. The earlier discussion of CDHPs expressed doubt that consumers could drive health-care efficiency by shopping for lower prices for individual treatments and therapies for serious illnesses. However, consumers could have meaningful influence on the health-care market by shopping in a more deliberate fashion for cost-efficient health-care financing and delivery plans.

This is not unheard of in this country. The University of California offers employees a range of choices including both FFS and group practices, with a fixed-dollar contribution set at the premium (risk-adjusted) of the low-priced plan. In this arrangement, every consumer can benefit financially from

choosing a lower-priced plan, and the low-priced plan can protect its market share by maintaining or widening the gap between its premium and those of its competitors. Employees make their choices at an annual enrollment at which the prices are displayed side by side, and switching plans is made easy. Under these conditions, 81 percent of the employees have chosen the lower-cost group-practice-based HMOs. At Wells Fargo Bank in California, with a similar model, the enrollment in low-cost group-practice-based HMOs is 78 percent. (These are not cheap or bare-bones “plan designs,” but rather comprehensive coverage associated with large multi-specialty physician organizations that are committed to economical use of resources.) The Federal Government does something similar for its employees (though the federal design has some technical deficiencies that impart an inflationary bias, and premiums are not risk-adjusted). Fifty-eight percent of Federal employees in California have chosen the same HMOs.

Under these systems, employee cost-conscious choice raises the market share of the most-efficient providers, and motivates the others to try to reduce costs to maintain their competitive positions. Unfortunately, only a small percentage of employees are in such models now. As explained earlier, most employers do not offer choices, and many of those that do offer choices systematically subsidize the more costly plans (by contributing a fixed percentage of the total cost for whatever plan the employee chooses). This leaves a large cost-unconscious sector in which generally cost-inefficient FFS providers can survive. What modicum of competition there are in the current system have motivated many doctors who prefer the FFS practice style to form Independent Practice Associations (IPAs) that include management controls and enable them to compete. What is needed is for essentially everyone (possibly excepting the very elderly, the disabled and a few other groups) to receive a defined contribution and some choices.

What would the successful delivery systems under such an approach look like? The brief and definitive answer is, no one knows. Just as competition has produced unpredictable results in every other industry, so it would in health care. In fact, the answer would change constantly, because the process of innovation and improvement would never stop. Thus, the object of health-system change is not to anoint any one delivery model from today's landscape as the definitive answer, but rather to unleash the forces of competition to work their unpredictable will. Because the outcomes of competition are unpredictable, in time, the apparently successful systems might even be significant improvements of models that today appear outdated,

or alternatively might be models that do not yet exist. The one thing that is certain is that the systems that succeed in a fair competitive environment will be those that best meet the needs of the population at large.

Despite the uncertainty, there are some reasonable general statements that can be made on the basis of delivery systems that appear more efficient within today's health-care sector. These are based on the apparent requirements for a system that would respond to America's needs, and also some attributes that seem likely to be favored by the competitive process at this time. These characteristics would amount to a major innovation, and a fundamental transformation of the health-care delivery system:

- ✦ **Health Promotion and Disease Prevention:** Emphasize primary care, disease prevention and early detection and treatment, to address the current epidemics of chronic diseases. It will take a great deal more than the health-care delivery system to reverse these epidemics; public-health measures, school-based programs, work-site programs and more are needed. Nevertheless, it certainly could help a great deal if the health-care delivery system, with all its resources in intelligent well-educated personnel, technology and money, were clearly oriented in the direction of improving the health of the population.<sup>24</sup>
- ✦ **Management of Chronic Disease:** Create the infrastructure for chronic disease management and support it financially. Improve care management for chronic diseases. This includes monitoring patients, adjusting their medications in a timely and appropriate manner, educating them on their conditions, and how to do their part in managing their diseases. Appropriately trained non-physician personnel can do much of this work.
- ✦ Develop more humane alternatives than the acute inpatient setting for end-of life care.
- ✦ **Efficiency:** Align the incentives of providers with the needs and wants of the American people for high-quality affordable health care. That could mean salaried physicians with significant bonus payments for quality, patient satisfaction, efficiency and teamwork in at least some of the competitors. Select and train physicians and other health professionals for quality and willingness to work in teams, with programs to be sure they are proficient, well informed and up to date. Train non-physician personnel to maximize the services they can perform appropriately, reserving physicians for where they are needed. Deploy health professionals in the appropriate numbers and specialties needed to care efficiently for enrolled populations. Correct specialty imbalances.
- ✦ Continually evaluate and redesign work processes to improve efficiency and take full advantage of IT. (The integrated-delivery systems are far ahead of the traditional FFS sector in deploying HIT. It is apparent that the benefits of HIT—reducing the need for hospital days, doctor visits and diagnostic tests—are not in the interest of individual providers in the FFS sector.<sup>25</sup>) Keep continuous, comprehensive, longitudinal medical records, analyze them and feed the results back into practice improvement. Follow patients over time and learn what works and what does not. Deploy and use health information technology to create caregiver support tools such as shared comprehensive electronic health records, guidelines, prompts, and reminders, to monitor performance and to take corrective action, where appropriate, to assure optimal care. McGlynn et.al. recently documented that Americans are receiving just over half of recommended care.<sup>26</sup> Errors of omission are widespread. Caregiver support tools, combined with organization and incentives, could ameliorate this greatly.<sup>27</sup> Make Continuous Quality Improvement a way of life.
- ✦ Match all resources used to the needs of the population served. Select equipment that has been properly evaluated for safety and effectiveness, and deploy it in appropriate numbers for proficiency and economies of scale. Create training programs to be sure personnel are expert in its use.
- ✦ Integrate and coordinate services through the continuum of care, at home, the doctor's office, and the hospital inpatient and outpatient settings. Deliver care in the least-costly appropriate settings, considering total system costs, not just costs and revenues associated with one setting. (Integrated-delivery systems can engage in such planning in a way that is impossible for disaggregated providers.) Create smooth transitions and hand-offs so that patients leaving one setting are not lost when they transfer to another, so that their outpatient providers are well informed on their inpatient care, and vice versa.
- ✦ Concentrate complex care in regional centers of excellence. Delivery systems may create their own centers, or subcontract the work to centers outside their systems, based on rational "make-buy" calculations.

- ✦ Enact a rigorous policy to prevent conflicts of interest in treatment and procurement decisions.
- ✦ ***Innovation and Technology for Efficiency:*** Manage the huge flow of medical information. (Over 10,000 randomized trials are published each year.) This is beyond the reach of solo or small group practitioners. A system must translate this information into up-to-date science-based best-practice guidelines and make them conveniently available to doctors. Physicians with a serious interest in economical practice should develop these guidelines. This would speed the transition from scientific discovery to medical practice. This is being attempted by a consortium of medical groups in Minnesota called the Institute for Clinical Systems Improvement, and also by the Kaiser Permanente Care Management Institute. The Veterans Health Administration has a similar program called the Quality Enhancement Research Initiative. Such programs, combined with monitoring and feedback, should be able to help greatly in reducing the medical uncertainty underlying the very wide variations in medical practice.
- ✦ Back off of “flat-of-the-curve” medicine (that is, practices in which the marginal benefit in health outcomes is very small and uncertain relative to the cost). Evaluate new technologies and use them selectively only where evidence supports that they are beneficial to patients.
- ✦ Tackle the problem of technology assessment, including cost-effectiveness or value for money in actual practice over time, and not just in controlled trials. Create a legal framework that can permit health insurers to offer policies that do not cover some technologies because of cost, to help make their programs more affordable. This will be an exceedingly difficult problem, but there may be no long-term success without addressing it. At the same time, we must be careful not to shut down valuable life-saving innovation. We will also need legislative changes to facilitate market entry by companies that want to create and market generic substitutes of very costly biologics once the patents held by the original developers have expired.
- ✦ Genomics offers exciting opportunities for better care and also large challenges to the health-care system. There are hundreds of genetic tests now available, some quite costly.

Genomics offers opportunities to diagnose people at high risk of disease and to develop targeted therapies. To use these resources wisely and effectively, there will be a need for organized systematic approaches, including evaluation of who should be tested, and what prevention strategies and therapies they should be offered. A satisfactory system must be structured to organize this effort effectively.

In its important report, *Crossing the Quality Chasm*, the IOM put forward a shorter list that is well worth considering carefully.<sup>†</sup>

If all this were to happen, we would have a radically different health-care delivery system from the one we have today. Yet each of these expectations is reasonable on its face. Reflection on the difference between these reasonable requirements and where we are in health care today tells us how far we have to go. Yet none of this is more than what one would reasonably expect from a well-run world-class competitive company in any other industrial sector in the economy.

We also need very broad risk pools, because some treatments that society seems unwilling to deny to those who need them have become extremely costly. Risk-spreading among competing delivery systems can be accomplished by risk adjustment and reinsurance for very-high-cost cases.

This transformation of health-care practices cannot be imposed by the government, top down, or even by employers. It would be very difficult to define such a system in legislation. Nobody knows exactly what the best system for health-care delivery is, or what it will become as health technology continues to evolve. Nevertheless, the market forces of informed cost-conscious consumer choice can drive the transformation. Within these specifications, there is a lot of room for adaptation for different cultures, geographic circumstances, and the like. The best delivery systems are those that can survive in a competitive market.

We also need humane coverage: coverage that is comprehensive (protecting everyone from severe financial hardship related to medical expenses); and coverage that is secure, so that people do not lose their coverage when they lose their spouses or change their jobs, divorce, become sick, or retire before age

<sup>†</sup> Washington, DC 2001. The paragraph headings of their list were: 1. Care based on continuous healing relationships. 2. Customization based on patient needs and values. 3. The patient as the source of control. 4. Shared knowledge and the free flow of information. 5. Evidence-based decision making. 6. Safety as a system property. 7. The need for transparency. 8. Anticipation of patient needs. 9. Continuous decrease in waste. 10. Cooperation among clinicians. The ideas are completely compatible with the CED report.

65. We need the right of people to stay with their preferred delivery system as long as they do not move out of its service area. Insecurity of coverage is a major problem in our health-care economy today. So is churning. Many people are just a layoff away from economic insecurity because of uncovered health-care costs. Financing today is fragmented with each payer seeking to shift costs onto other payers. This is a costly and unproductive effort.

Radical as all this is, it may not be enough to solve our problem. We also need a more vigorous and effective anti-trust policy including breaking up any regional provider monopolies created by mergers whose only purpose was to achieve market power.

Could all this solve the problem of the unsustainable growth rate? There is no guarantee, just as there is no guarantee with any other system; and the underlying rapid growth rate of the elderly population, who are disproportionately in need of health care, without a doubt will increase the rate of growth of costs. But it is reasonable to suppose that the system reforms outlined here could reduce the *level* of health expenditures. Given the range of premium costs among different modes of delivery at this time, it is not out of bounds to imagine that the level of costs could be cut by as much as half. The motivation of a continuous program of cost-reducing innovation would appear to be our best chance for an acceptable way of counterbalancing the expenditure-increasing effects of expanding technology, and thereby reducing the *rate of growth* of costs. Furthermore, a delivery system seriously focused on disease prevention and management might be able to mitigate significantly the cost consequences of the proliferation of chronic conditions.

## How Might We Get There?

As was noted above, there is an existing model of what the whole market for health-care financing and delivery could look like in the choices presented to a University of California employee: a reasonable set of good-quality competitors, with available information on quality and patient satisfaction, and a responsible financial choice (i.e. the University pays the price of the low-priced plan, and the employees who want a plan that costs more pay the difference).

A similar suggestion that has been made by some prominent elected officials from both parties is to use the Federal Employees Health Benefits Program (FEHBP) as a model for everyone. The FEHBP offers employees and retirees a wide range of choices and a semi-fixed-dollar employer contribution. The FEHBP is a large and nationwide system and serves as a good metaphor, although it has several significant design deficiencies that ought to be corrected, either for serving its existing population, or for a national model.<sup>†</sup>

The result might be called “market-based universal health insurance” (M-B UHI). It includes two essential elements: First, individuals must have choices of alternative health insurers and providers, who are free to use alternative delivery system models. Individuals should be provided with fixed-dollar defined contributions, which should equal the cost of the low-priced plan that meets comprehensive standards (such as in the case under the University of California and the Federal Employees Benefits plans; only quality plans with broad coverage may compete). If an individual chooses to buy a more-expensive option, he or she must pay the difference. Thus, individuals save if they choose more-economical plans.

<sup>†</sup> Specifically: (1) The employer contribution amount is not a fixed-dollar defined contribution. It is set at 70% of the average premium of some of the largest plans. But if a plan were to come in with a premium lower than the contribution amount, the employee choosing the plan would get to keep only 25% of the savings. That amounts to a 75% tax on efficiency and a strong disincentive for any plan to come in with a premium below that average. Of course, that tends to drive up the average. The Congress should provide that if any plan offers a premium below the average (subject to a limitation mentioned next), the employee choosing it gets to keep 100% of the savings. (2) The program ought to specify a standard uniform minimum package that all plans must cover, but let competitors come down to that standard if they want to. Establishing a standard minimum package would help to prevent problems of adverse selection (if, for example, one plan were to offer coverage for fertility treatments while another did not, the former systematically would attract some very expensive risks). (3) There ought to be risk adjustment of premiums using state-of-the-art risk-adjustment methods, analogous to what is done in Medicare Advantage. (4) Instead of national uniform pricing that does not take account of regional differences in the cost of doing business, there ought to be regional pricing.



Second, those choices should be made available through health-insurance exchanges, which pool large numbers of individual risks and spread administrative overhead so that small-business workforces can participate. Issuance must be guaranteed, so that everyone can obtain insurance. The exchanges should require standardized policy “fine print;” distribute information about plans, including their quality and performance; and facilitate individual choices and switching among plans during periodic open-enrollment periods. They should risk-adjust premiums – so that costs are spread equitably over the whole population, to maintain incentives for plans to enroll and care for sick people, not to avoid them; and to avoid the instability caused by spirals of adverse selection. As a part of this process, exchanges could create regional reinsurance pools for very-high-cost cases or conditions.

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 encourage competition and innovation. It should include plans with fee-for-service organization and wide choices of physicians, so that those who currently use such systems and want to continue to do so can stay with what they know and like. 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 for sure: The outcome would be different from what has gone before because the incentives and opportunities for consumers to make economizing choices would be radically increased.

These broad outlines, even with two real-world examples, leave important questions of implementation. One of the examples is public, and one is private. Which mode should be chosen? If it is the private (University of California) model, why is it that this successful model has not spread on its own? What changes in public policy would be needed to scale such a model to national implementation? The private model is based on employment. How could that approach be implemented to achieve broader or even universal coverage, to attack the problem of the uninsured? And if the public model should be chosen, what would be the cost, and how would it be financed?† A forthcoming CED statement will examine these choices.

## Potential Alternative Delivery Systems

Many people find it hard to imagine health-care financing and delivery systems other than the dominant uncoordinated, “free choice” fee-for-service small-practice system. This system is hard to change, and its adherents fairly successfully fought off the “managed care” revolution of the 1990s. To imagine how different insurance might be, it is important first to imagine a world in which every individual or household has an annual, cost-conscious choice among alternative financing and delivery systems in a model structured to make sure their choices are informed and easy to make. (This is a state of affairs that exists, for example, for employees at the University of California and Stanford University, Wells Fargo Bank and Hewlett Packard, and Federal and California State Employees, but otherwise only in a small minority of employment groups.) How would things be different if health insurers had to compete for members, not employers?

Experience shows that people would migrate to what they perceive to be value for money. This might not be the cheapest plan; but it would be the plan that people decide to be the best combination of price and all other attributes that they value. For such a system to work, the number of choices must be manageable for typical consumers. (The experience of employers with 401(K) retirement plans is that some of their employees become overwhelmed when confronted with too many options.) On one key dimension, however, it is likely that consumers will have to trade off price against choice: plans that have constrained integrated networks of providers will probably be cheaper than those that allow unlimited selection. Thus, consumers would have a choice between delegating the management of their health care at a lower price, versus becoming responsible for that management in all of its detail – or some combination in between. It would be important that consumers be offered the option of a free-choice fee-for-service plan – so that every person who is satisfied with his or her health care could keep what he or she had. However, in the interest of value for money – and in particular financial savings – it is likely that some consumers would choose health plans with limitations on choice of provider that they would not have accepted if they could not *choose* the limited group of physicians – if it had been imposed by their employers, and especially if that imposition did not include visible receipt of the attendant financial savings.

† One plan along these lines has been introduced in Wisconsin by a bi-partisan pair of legislators and can be seen at [www.wisconsinhealthproject.org](http://www.wisconsinhealthproject.org).

One of the most important insights is that there is very wide variation in practice patterns among physicians, and the most cost-effective physicians often achieve the best outcomes by “doing it right the first time.” A key step toward a quality cost-effective health plan is *selection* of a limited set of providers.

It is impossible to forecast which systems would prosper in a reformed truly competitive market for health plans. The following are some of the likely candidates at the starting gate.

### 1. Tiered High-Performance Networks (THPN) combined with Capitated Primary Care Networks (CPCN)

The major health-insurance companies have been developing extensive analyses of databases to identify quality cost-effective doctors and to be able to separate them from doctors who are of high cost and poor quality. Insurers usually find quite a few who are in the favorable quadrant of the quality and efficiency space, using total cost per episode to measure efficiency. The general idea would then be to offer health plans, usually in a PPO format, that would require substantially higher customer cost sharing if the customer goes to other than the designated quality cost-effective doctors. As mentioned in the body of this statement, there are data analysis issues, such as the accuracy of assigning every episode to one physician, and of correcting for innate differences among the patients and the episodes. In addition, there are concerns that employers might be reluctant to use plan designs that include powerful incentives to make people change doctors. Also, because this methodology is focused on specialists, where most of the money goes, it ignores the important roles of primary care and prevention and appropriateness of care. THPNs could end up with high volumes of preventable inappropriate episodes; even if they were handled efficiently, costs per person might be high.

The weaknesses of THPNs might be addressed by pairing them with Capitated Primary Care Networks (CPCNs). Starting in the late 1970s, HMO of Pennsylvania, later U.S. Healthcare, developed a network of selected primary care physicians who were committed to the concept of cost-efficient medicine, who would be paid on a per capita payment basis for all primary care services, and who would accept extensive quality measurement. In addition, they would share in the savings, if any, in a budgeted pool of money for specialist services. This model grew rapidly and was very successful, enrolling more than one million members. It was eventually acquired by

Aetna, which apparently no longer uses it because it does not fit well with Aetna’s “single-source” business model. Nevertheless, such a Capitated Primary Care Network could build in the important functions of health education, early detection, disease management and management of referrals to cost-effective doctors. In addition, it could grow rapidly because it uses doctors already established in practice. The effectiveness of the HMO of Pennsylvania model was limited by the lack of the kind of data needed to identify the most efficient doctors.

It is not hard to imagine how such a model could evolve toward greater integration as the primary care doctors and the health plan could invite the specialists with the best records of performance and cooperation to join their system. Eventually these models could become more and more like multi-specialty group practices.

### 2. Individual Practice Associations

In the 1970s, doctors in traditional practice in counties that also had strong Prepaid Group Practices formed Individual Practice Associations (IPAs) through their county medical societies. The idea was to preserve the traditional model in a format that would allow the FFS doctors to offer the financial equivalent of Prepaid Group Practice while preserving their individual or small practice style. The IPA would be paid capitation, but the doctors would be paid fee-for-service. IPAs reconciled the difference by imposing management controls on their physician members, and usually withholding payment of some 20 percent of fees until the end of the year, and then paying out what was left if there was a financial surplus. Many IPAs failed financially in California in the 1990s, often because they lacked the commitment of their participating doctors and because the fee-for-service incentives were too strong. Many doctors considered IPAs to be “just another insurance company.” An important weakness of the IPA was its lack of selectivity. It could not trade volume for price or protect its surgeons from the surgeon surplus (or otherwise correct specialty imbalances) because all the doctors in the county not in prepaid group practices belonged to the IPA. Another significant weakness was anti-trust risk, as it was often not clear what distinguished an IPA from a price-fixing agreement among doctors.

However, the leading IPA in Northern California, Hill Physicians Medical Group, caring for nearly 400,000 members, has survived and prospered in an environment where there are strong multi-specialty medical group



kind from similar delivery systems and, for the most part, premium-price-sensitive customers.

#### 4. Large multi-specialty group practices evolving toward PGP

Should the market and consumer choices lean in that direction, the 175 multi-specialty group practices that have over 100 physicians now existing in the United States could evolve toward larger integrated systems by having a portion of the practice prepaid. In 2005, these practices included 81,600 physicians. While higher concentrations of these entities exist on the Pacific Coast, upper Midwest, Florida and New York, at least one exists in all but three states. Clinics from Boston, New Hampshire and Vermont could reach out to serve people in Maine, etc. Many of these are quite famous, including the Mayo Clinic; the Ochsner Clinic; the Leahy Clinic; the Fallon Clinic; Marshfield; Scott and White; Virginia Mason; Henry Ford Hospital, and many more. Many of these have their own affiliated health plans now, although that activity has been receding in the face of unfavorable market conditions. Others have had their own health plans in the past, and others, such as Leahy, have teamed up with a Blue Cross or Blue Shield carrier to produce a joint venture product when they thought market conditions were receptive. All could be marketed through network-model carrier HMOs like PacifiCare and Health Net – a move more plans could offer without major start-up costs.

If a model of universal health insurance based on competition to serve cost-conscious consumers were enacted, most or all of these group practices, and perhaps some smaller ones as well, would find it in their economic interest to create their own health plans again, or team up with established carriers to create joint-venture partnerships for “private-label products” (like the Blue Cross Leahy health plan). One main reason for this is that the per capita prepayment that comes with having their own health plan facilitates realization of many efficiencies not available in FFS, such as the smooth transfer of resources from the inpatient sector to outpatient disease management programs (because the disease management programs reduce the need for hospitalizations), as well as reduction in the need to engage in fee-for-service billing and collection. That is, cost reductions would not be accompanied by reductions in revenue as they usually are in FFS. In the market conditions hypothesized here, these entities could grow rapidly, and that growth could trigger innovation on the part of all other providers.

These innovations could move much more quickly if their access to customers were not filtered through employers. Numerous other promising ideas that surfaced and were tried in the late 1980s and early 1990s might be tried again in more favorable market conditions.

#### 5. Roles of Academic Health Centers

Leaders of academic health centers (AHCs) have often felt themselves to be threatened by the prospect of competition, and have expressed opposition to the creation of a truly competitive health-care economy. What would be their roles in a model of market-based universal health insurance? Here are some possibilities.

Of course, their unique roles would be teaching and research. The products of these services are public goods, which are and must be subsidized at their appropriate value, by government. AHCs also now often provide a great deal of care to the uninsured poor. To some extent, this is subsidized by Disproportionate Share payments. With universal health insurance, the need for this would be greatly reduced, but nevertheless present.

Some Academic Health Centers would find it in their interest to create comprehensive care programs based on per-capita prepayment to compete in the general market for health insurance. This usually would not be their core competence.

Probably all Academic Health Centers would compete for regional referrals for complex care from the region’s suppliers of comprehensive care. This happens today as many Academic Health Centers provide organ transplants, neonatology, and “quarternary care” in the grey zone between ordinary care and research. (Think of heart surgery in utero.) These logically would be financed by negotiated global condition-based payments per case. And finally, AHCs would compete in the market for “destination medicine” in which patients in need of their care will travel even great distances to receive it. The Mayo Clinic comes to mind. This might be on a fee-for-service basis, or negotiated global condition-based payments.

The next CED statement will describe a market-based system of universal health insurance in more detail, and will map out a practical transition from where we are to sustainable and more-efficient medical care.



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