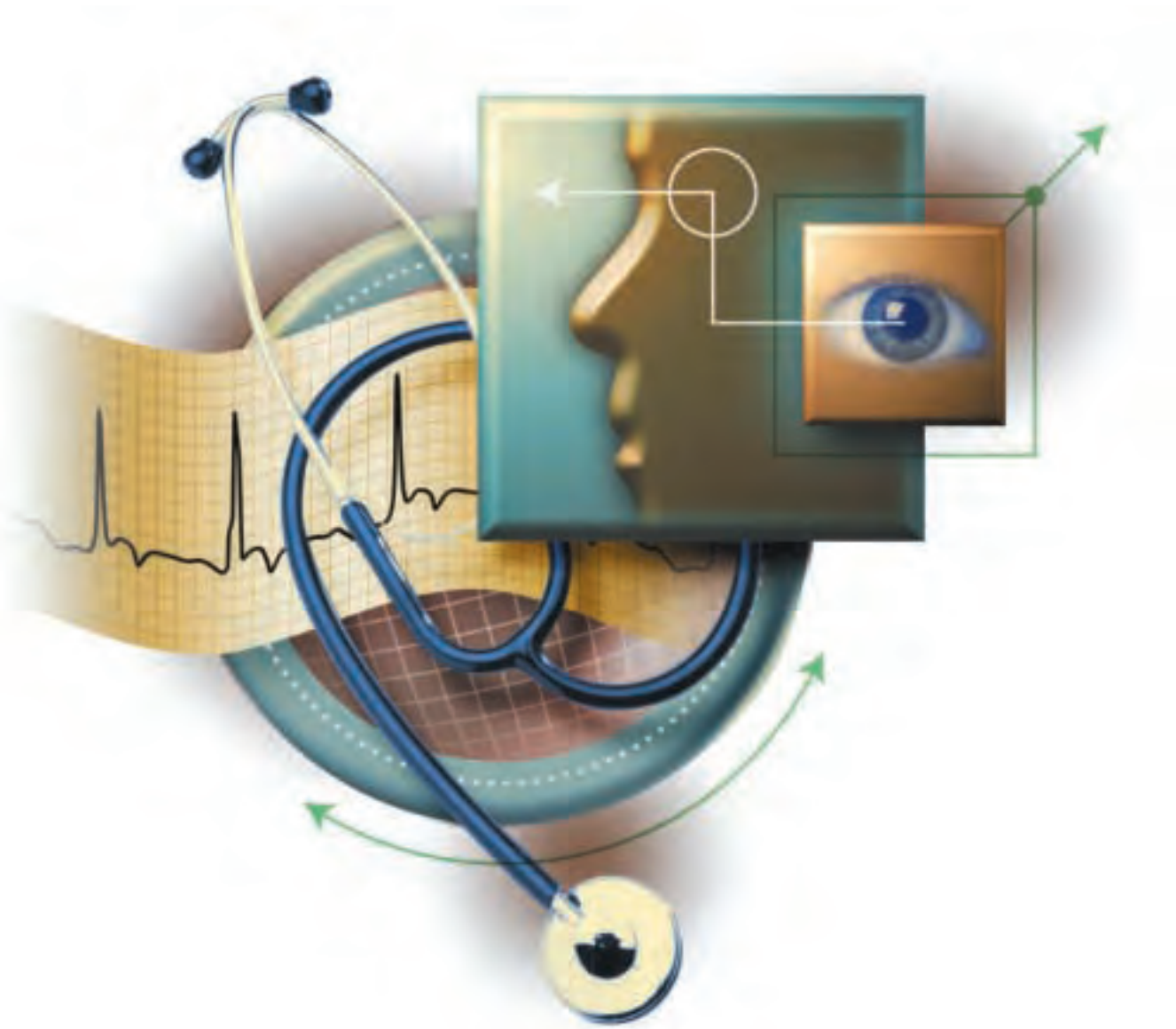
A NEW VISION FOR HEALTH CARE

A Leadership Role for Business



A Statement by the Research and Policy Committee of the Committee for Economic Development

A NEW VISION FOR HEALTH CARE

A LEADERSHIP ROLE FOR BUSINESS

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CED

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All CED policy recommendations must have the approval of trustees on the Research and Policy Committee. This committee is directed under the bylaws, which emphasize that "all research is to be thoroughly objective in character, and the approach in each instance is to be from the standpoint of the general welfare and not from that of any special political or economic group." The committee is aided by a Research Advisory Board of leading social scientists and by a small permanent professional staff.

The Research and Policy Committee does not attempt to pass judgment on any pending specific legislative proposals; its purpose is to urge careful consideration of the objectives set forth in this statement and of the best means of accomplishing those objectives.

Each statement is preceded by extensive discussions, meetings, and exchange of memoranda. The research is undertaken by a subcommittee, assisted by advisors chosen for their competence in the field under study.

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PURPOSE OF THIS STATEMENT

The United States' employer-based health care system is in serious trouble. Health care costs are again exploding at double-digit rates, the number of employees without health insurance continues to grow, and many health care services suffer from misuse, underuse, and overuse. We are concerned that employers, in discouragement and frustration, will seek to avoid further involvement by capping their health care contributions or discontinuing them altogether. In this statement we urge employers, along with government, not only to stay the course but to actively lead in implementing specific changes in private and public policies that could produce a health care system that works for all Americans. We set forth the reasons for this view more extensively in the Preamble to this statement.

A New Vision for Health Care: A Leadership Role for Business builds on a long history of CED research on workplace and labor market issues focused on the well being and effectiveness of employees and society more broadly. CED last examined health care policy in *Reforming Health Care: A Market Prescription* (1987), and more recently pension issues in *Who Will Pay for Your Retirement?* (1995), and the challenges posed by an aging workforce in *New Opportunities for Older Workers* (1999). A broader range of such issues was also examined in *American Workers and Economic Change* (1996) and *Growth With Opportunity* (1997).

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PREAMBLE

The employer-based health care system in the United States is facing serious challenges. Health care costs and insurance premiums are again rising sharply, and the number of employees without health insurance continues to grow. Moreover, there are signs that the willingness of large private employers to confront these challenges is diminishing. Many large firms are considering capping their contributions to health coverage, and some say they may discontinue funding health coverage under certain circumstances.

CED understands the frustration of employers in the face of a sharp re-acceleration of health care premiums and the threat of greater legal liability for services denied or delayed by the managed care review process. But a retreat by employers from active efforts to improve health care is likely to have negative consequences for their businesses, their employees, and the system as a whole. Such a retreat is not in the best interest of our nation. CED therefore believes that employers should take more initiative and responsibility to improve the health care system, not less.*

We are not suggesting that "doing more" means paying more, but rather that employers and their associations, where feasible, become smarter and more demanding purchasers on behalf of themselves and their employees. Business should bring its experience with quality improvement to the health care system in order to reduce widespread inappropriate care, medical errors, and billing mistakes.

The present tendency is to shift more responsibility to employees, but without ensuring that the employee is offered a choice of health plans with demonstrated quality standards and without providing the purchasing information and market clout needed to obtain value. Instead, we believe employers should cooperate and collaborate to transform health insurance into a market-oriented, user-friendly service industry with clear and effective accountability to purchasers and patients for cost and quality.

What will happen if large companies simply shift their costs to their workers, to smaller firms, or to the public sector by capping costs *without improving the quality and efficiency of the system?* In the short term employers may serve their business interests by reducing their costs, but over the long run they likely will continue to pay their share of the total bill, either directly or indirectly. They will pay more in wages and salaries if the compensation mix is changed to lower their contributions to health care, and they could suffer increased absenteeism and turnover, and diminished productivity, if workers respond to this form of cost-shifting by under-spending on their health. Employers (and their employees) will pay in the form of higher taxes if costs are shifted to government. And if employers' spending caps lead to underpaying those who deliver proper care, and to investing too little in new medical technology, the quality of care ultimately will be diminished for all. Finally, as the number of uninsured rises in response to reduced access and escalating costs, political pressures will build

*See memoranda by JAMES Q. RIORDAN (page 44).

for a mandated government-administered national plan with little private-sector participation.

We stress that the health care system is in serious trouble not because of bad people or bad organizations, but because it is perfectly aligned to yield the negative results we see—exploding costs, more uninsured, and inappropriate medical care (as evidenced by extreme variability in practice patterns and the lack of standards of care). Until the economic incentives driving these outcomes are changed, we will not get better results.

Recently, a strong backlash to managed care has developed, following a measure of success in controlling costs in the mid- to late-1990s. The business community has helped weaken managed care through its purchasing practices. Policymakers have contributed through statutory and regulatory restrictions. And the health plans themselves have invited some of the backlash by creating irritating roadblocks and "hassle" requirements for patients and physicians. Meanwhile, providers have rapidly consolidated, and the resulting increase in their market power, combined with exploding new technology and looser managed care rules, has led to a sharp rise in costs.

Resolving these problems will be enormously difficult. CED is not naïve about the obstacles to change, nor enamored of any "quick fix." But if the problems are neglected, the system will deteriorate further. Employers cannot fix these problems by themselves. But they can properly align their own incentives and practices and reach out to the other major stakeholders in the system—small business, labor, government, managed care organizations, physicians, and hospitals. Large companies can start building bridges by working closely with state and local government purchasers to enhance the strength of their efforts to control costs and improve quality. They can also reach out to small companies by developing purchasing pools to make health coverage more affordable and accessible. Working together, we can reshape this broken system to make it more efficient, effective, and equitable.

In this report, we set forth initiatives and recommendations on issues in which the business community has expertise and interest. These recommendations involve fundamental changes in the way that health care is purchased by both businesses and their employees and government. We also recommend policy reforms that would increase access to affordable insurance coverage. We believe that implementation of these recommendations would bring us significantly closer to our vision of a better health care system:

CED'S VISION

A well-functioning health care system would provide affordable health coverage to all Americans and promote improvements in the health of our population. Purchasers of health care would hold health plans and providers of health services accountable for both cost and quality. These purchasers would offer their employees (or other participants) a wide, responsible choice among reliable health plans, together with accurate, user-friendly information about the options. Purchasers would contribute to those plans in a manner that gives individuals financial incentives to select a plan wisely, with attention to value. A good health care system would offer small businesses opportunities and incentives to obtain affordable, quality health coverage for their workers, and it would provide assistance to low-income workers to enable them to participate in these health plans.

SUMMARY

The current U.S. health care system is unsustainable. It has major flaws that must be addressed. Problems of high cost, low quality, and limited access are interwoven and feed on each other:

- Health costs are exploding. Health care premiums rose by 11 percent in 2001, and larger future increases are projected. This is placing a financial strain on business, individuals, and government, making health care unaffordable for many and displacing other economic and social priorities. Small firms face particularly strong obstacles to obtaining affordable coverage.
- There is increasing evidence of inappropriate medical care; overuse, underuse, and misuse of health care services are leading to adverse outcomes and unnecessary costs. Employers frequently fail to hold medical providers and health plans accountable for poor quality and often underwrite an "open access, any willing provider" model.
- Patients frequently want unrestricted access to all providers at little or no cost. They have little stake in costs and insufficient awareness of wide differences in provider quality.
- Nearly 40 million Americans lack health coverage. Although the majority of the uninsured are either poor or near poor, most uninsured families have at least one member working. The lack of health coverage creates hardship; the uninsured frequently delay or forgo needed care, or hospitals and physicians must provide care without compensation.
- A small proportion of patients with serious chronic illness and disability account for a large proportion of health care spending. Yet, we have not widely implemented chronic disease management that provides effective preventive care for these patients, thereby reducing expensive hospital-based and long-term institutional care.
- The health care industry, while making dramatic technological advances in diagnosis and treatment, is extremely inefficient in delivering care. Data collection, analysis, and information sharing are primitive. Duplication and waste drive up administrative costs and impede the coordination and integration of services.

None of the key stakeholders in the system—managed care organizations, physicians, hospitals, business, labor, patients, insurers, government—are purposefully doing wrong. The problem is not a lack of good intentions, but a series of *systemic flaws*. As a recent report from the Institute of Medicine says, "Trying harder will not work. Changing systems of care will."

CED cannot address every aspect of the ailing health care system. We choose to focus on the areas in which private employers and government purchasers can play a central role. Employers have the opportunity to make staged changes in their purchasing practices

that will enhance cost discipline and quality. Large employers and government, working in collaboration, can:

1. **Demand transparent quality information and adherence to best medical practices**; **use comparative performance information to select plans and providers; and 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. Workers would receive user-friendly quality and cost information that explains how low-quality care adversely affects their health and how high costs can reduce their wages;*

3. **Work actively with physicians and hospitals to improve quality, building on the strengths of managed care**. This approach would emphasize prevention, early detection, and the reduction of inappropriate care, while avoiding managed care's worst features, such as unjustified delays in authorization and claims payment; and

4. **Work with public purchasers and labor to strengthen the drive for reform**. Government and labor should not be seen as adversaries to business, but as purchasing partners with whom a coordinated, complementary effort could be effective.

This report elaborates on these steps and highlights some promising, real-world examples. The emerging models are not yet widespread or fully tested, and we do not want to oversell them. But they point the way to more rational, aggressive purchasing. Clearly, the actions of one individual business, or even a few large companies, will not produce the needed systemic change. Concerted actions by large and small businesses and their associations or representatives, with support by labor, will be necessary.

CED acknowledges that small businesses have fewer options and less flexibility in purchasing health coverage. However, small employers should be shown how they could benefit from joining with other businesses in buying and managing health care. They could also be given access to public employee groups. Large employers should recognize that if the health insurance problems facing small companies are not resolved, they will continue to pay a portion of higher costs indirectly through some combination of higher premiums and higher taxes.

CED calls for action to lower the barriers to health coverage facing small firms. We also acknowledge that low-wage and part-time workers in medium-sized and large firms are frequently not eligible for employer-based health coverage, or cannot afford their share of the premium. Part-time, temporary, and contract workers change jobs frequently, as do many low-wage full-time workers. Because of this mobility, employers may focus more on meeting the short-term cash needs of these workers than investing in their health. Very mobile workers also raise the issue of which employer pays to cover pre-existing conditions.

Large businesses can play a direct role in improving access to affordable coverage for small firms and for lower-wage and "contingent" workers. We recognize that the *direct* incentives to expand access are limited and that partnership with the public sector will sometimes be required (as explained below). Nevertheless, where feasible, large firms can help in the following ways:

1. **Through business coalitions, help to establish, operate, and manage regional purchasing cooperatives that offer affordable plans to small firms;**

2. **Share provider networks and their discounted rates with small employers;**

*See memoranda by JOSH S. WESTON (page 44).

3. **Expand coverage eligibility, particularly to part-time workers and other employees currently ineligible for such benefits, where feasible;**

4. **Investigate reasons for employee rejection of work-based health insurance and provide incentives, such as premium assistance, to improve take-up rates of low-wage workers.**

CED also recognizes that government policies influence what the business sector can accomplish in reforming health care. *The government plays a critical role as the largest purchaser of health care.* The Federal Employee Health Benefit Program (FEHBP) provides a good model of contribution policies that encourage employees to enroll in cost-effective health plans. Many states have improved purchasing practices for their own workers and Medicaid enrollees. Large companies and business coalitions also can join forces with these government purchasers, for instance by developing joint requests for proposals for health plans that feature incentives to manage costs and improve quality. Yet Medicare, which accounts for about 17 percent of our national health expenditures, remains a fee-for-service arrangement for 34 million of its 40 million enrollees, where it is unable to limit or vary reimbursement to reflect a provider's performance or adherence to best medical practices. Government and business should coordinate strategies to improve the performance of Medicare.

Government as purchaser, law maker, and regulator can address the problems of high cost and uneven quality through the following public policies:

1. **Restructure Medicare on the model of the Federal Employee Health Benefit Program;**

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. **Preserve the ERISA preemption† that allows self-insured firms to control costs and provide uniform benefit packages across various states;**

4. **Enact responsible patients' rights legislation that protects patients against unwarranted delays or denials of care, without prohibiting payment mechanisms that reward appropriate and effective standards of care or exposing businesses to unlimited litigation costs;**

5. **Address the most pressing quality problems—lack of patient safety and widespread delivery of inappropriate care—by expanding research, serving as a clearinghouse for information on quality, and helping to establish national standards of care;**

6. **Establish oversight to promote competition in health insurance markets; and**

7. **Strengthen initiatives to reduce fraud and abuse in Medicare and Medicaid.**

Government also can address some of the problems facing small companies and lower-income workers. CED recommends the following public policy initiatives:

1. **Provide vehicles, funding, and technical assistance to establish purchasing cooperatives for small employers;**

2. **Provide tax credits or direct premium assistance to small businesses and low-income workers to help such workers purchase employer-sponsored or individual coverage; and**

3. **Expand efforts to enroll eligible low-income workers in programs such as**

*See memoranda by JAMES Q. RIORDAN (page 45).

† See Chapter 3 for a discussion of the ERISA preemption.

Medicaid and the State Children's Health Insurance Program (S-CHIP). In particular, encourage states to use mechanisms available within these programs to help workers pay their share of employer-sponsored coverage.

These initiatives would require public expenditures. Some public funds could be reallocated, for instance by using the savings from a cap on tax exclusions to finance targeted subsidies. We also believe that reducing inappropriate care and inefficiency would gradually decrease health care utilization and costs. But our ability to "capture" these savings for public purposes is uncertain and, in any case, will take time. As a result, the government would need to raise additional revenues, and/or tap specific sources, such as tobacco settlement funds or disproportionate share hospital (DSH) funds, to finance the recommended reforms.

Making CED's vision a reality will require fundamental changes in employer purchasing practices, public policies, labor demands, the legal system, and the incentives facing health care providers and insurers. These changes will not happen overnight. They will involve difficult tradeoffs that will face stiff opposition. CED believes that we must face up to these difficult choices. To do so, the major health care purchasers—business, labor, and government—should organize their efforts to improve efficiency, access, and quality.

Chapter 1

U.S. HEALTH CARE: FLAWS AND STRENGTHS IN A CHANGING MARKETPLACE

The U.S. employer-based health care system is plagued with flaws that increase costs, compromise quality, and limit access. However, the system also has many strengths. CED believes that employer-based health care is here to stay and that we must build upon those strengths in developing reforms to improve the system.

BACKGROUND: FORCES AND TRENDS IN HEALTH CARE COSTS

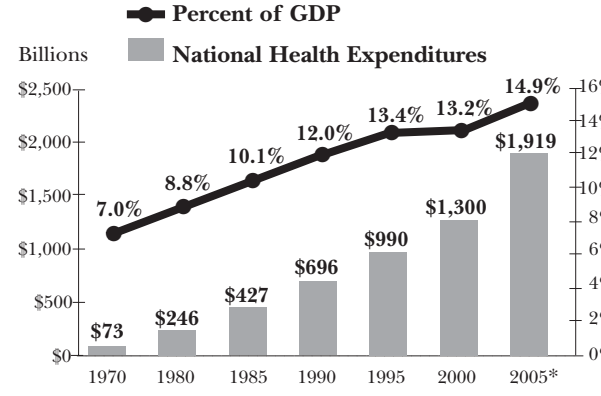
Health costs are being driven up by a lack of effective technology assessment, widespread inappropriate care, fear of malpractice suits, consolidation of health care plans and providers, and a dilution of the beneficial features of good managed care. These forces will soon be reinforced by an aging population.

The cost of health care per worker is projected to be approximately $5,500 in 2002, a 16 percent increase from 2001 and the fourth consecutive year in which many employers have experienced double-digit increases in their health care costs.[1] Furthermore, expenditures on health care are projected to resume their steady increase as a share of the U.S. economy. As Figure 1 shows, health care spending, which was 7.0 percent of GDP in 1970, now consumes 13.2 percent of our national output and is projected to take nearly 15 percent by 2005.

The high cost of health care is inexorably entwined with quality and access problems. Inappropriate and unnecessary medical care inflates health care costs. Higher health costs, in turn, help raise the large number of Americans who are uninsured.

Figure 1

Trends in Health Care Spending, 1970-2005

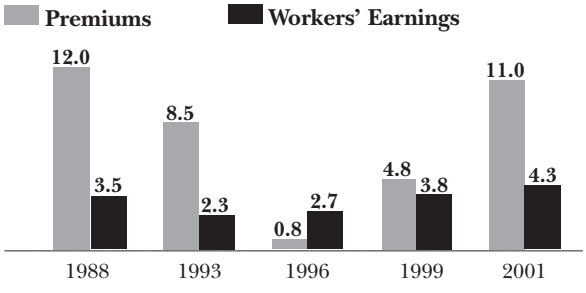


SOURCE: Centers for Medicare and Medicaid Services (CMS). *2005 is a CMS March 2001 projection based on somewhat earlier data than that used for 1970-2000.

Accelerating health care costs also have taken a toll on other economic and social priorities. For example, as health care spending has outpaced workers' earnings, wages have been squeezed as employers have restructured total compensation. In the late 1980s, health care premiums increased at double-digit rates. Partly as a result of strengthened managed care and the rapid movement of employees into HMOs, premium increases sharply decelerated in the mid- to late 1990s and, for a brief period, rose more slowly than earnings. But now premiums are again rising much more rapidly than earnings. (See Figure 2.)

Figure 2

Health Insurance Premiums and Workers' Earnings (annual percentage increase)



SOURCE: The Kaiser Family Foundation and Health Research and Education Trust, *Survey of Employer-Sponsored Health Benefits: 2001,* (Washington, D.C.: The Kaiser Family Foundation and Health Research and Education Trust, 2001). Earnings data are seasonally-adjusted total private hourly earnings from the Bureau of Labor Statistics and provided in the Kaiser Family Foundation survey.

Like employers, states have experienced rapidly rising health care costs: Medicaid outlays grew at 20 percent or more annually in the early 1990s, decelerated in the mid-1990s, and are now again rising sharply. Medicaid accounts for about 20 percent of state expenditures, so that rising health costs are reducing the capacity of states to meet needs in other vital areas such as education and transportation.

Accelerating cost increases, unchecked medical errors, and a substantial amount of uncompensated care point towards an emerging national crisis in health care. Palliatives are no solution—price controls, for example, would not address the underlying problems driving up costs and compromising quality. *What is needed is a fundamental overhaul of the incentives embedded in the system.*

MAJOR FLAWS IN THE HEALTH CARE SYSTEM

Medical care is underused, overused, and misused

There is mounting evidence of quality deficiencies in our medical care. A major report by the Institute of Medicine (IOM) finds that "the nation's health care industry has foundered in its ability to provide safe, high-quality care consistently to all Americans."[2] The industry lacks the basic information on quality and outcomes that is commonly available in most other sectors of the economy. The report further states that,

> A highly fragmented delivery system that largely lacks even rudimentary clinical information capabilities results in poorly designed care processes characterized by unnecessary duplication of services and long waiting times and delays.

Dr. Mark Chassin of the Mount Sinai School of Medicine has categorized health care quality problems into three groups: underuse, overuse, and misuse. *Underuse* is the "failure to provide health care service when it would have produced a favorable outcome for the patient." For example, among Medicare patients with diabetes, an estimated 54 percent did not receive an examination by an ophthalmologist during a year's time, while 84 percent did not receive a hemoglobin A1C test.[3] Among women over 50 years of age, 38 percent had not received a mammogram in the prior 18 months.[4] Children also experience underuse of care. For each type of clinical setting, such as physician offices, community health centers, and hospital outpatient departments, the average percentage of technical quality indicators for well-child care that were not met fell in the 35 percent to 65 percent range.[5]

Chassin found that a failure to use effective treatments for heart attacks for all patients who could benefit from these interventions may lead to as many as 18,000 preventable deaths each year in the U.S.[6] Underuse is found in both managed care and fee-for-service arrangements, but it is frequently more prevalent in the latter. One study found that 59 percent of patients with

hypertension enrolled in fee-for-service plans did not have controlled blood pressures, compared to 46 percent in managed care plans. Sixty-five percent of women in fee-for-service plans missed scheduled mammograms, whereas 45 percent in managed care plans did so.[7]

According to Chassin, *overuse* of health care occurs when "a health care service is provided under circumstances in which its potential for harm exceeds the possible benefit." Overuse is also very prevalent. Studies have revealed that antibiotics were prescribed in the office visits of 44 percent of children and 51 percent of adults diagnosed with the common cold.[8,9] In addition to being ineffective, these prescriptions may pose a risk of life-threatening adverse drug reactions and an increase in antibiotic resistance. Additional studies have shown that 16 percent of hysterectomies were inappropriate, 25 percent equivocal, and 58 percent appropriate,[10] and that 17 percent of coronary angiographies were inappropriate, 9 percent equivocal, and 74 percent appropriate.[11] Similar findings pertain to such procedures as coronary artery bypass surgery and pacemaker implants.

A summary of 48 published studies covering about one-half million people shows that on average 30 percent of patients did not get the treatment for acute care they should have received, and 30 percent in fact received care that they should *not* have received. Similar results were found for chronic care.[12]

Misuse occurs "when an appropriate service has been selected but a preventable complication occurs and the patient does not receive the full potential benefit of the service."[13] A notable example of misuse is medication error. An estimated 6 to 7 percent of hospital patients are exposed to serious medication errors, which account for more than 7,000 deaths annually.[14]

Studies of quality make three points abundantly clear.

***First**, the major quality problems documented above are systemic problems, not primarily the fault of careless or incompetent physicians, nurses, or other health care workers.* Instead, as quality expert Don Berwick suggests,

> The vast majority of these errors, something probably in the range of 95 to 98 percent, are what we call system errors attributable to characteristics of equipment, job designs, work circumstances, communications, and so on. Think of it this way. If we fired every health care worker who was involved in an error and substituted a new person, our future error rates would hardly change at all. Blame won't help.[15]

Berwick and other recognized quality experts argue that to reduce medical errors we must be able to talk about them. This, he suggests, will require a cultural change in which doctors and nurses are no longer frightened to report errors. In addition to requiring a cultural change, progress in reducing medical errors and other forms of inappropriate care may also require reforms in legal liability. Providers have cited concerns about litigation as a barrier to publicly reporting medical errors.

***Second**, the U.S. health care system remains geared to acute care, while the needs of the population have steadily shifted toward chronic care.* As the IOM report notes,

> …the current health care system is organized around acute care needs. It does not facilitate the flow of information over time; offers little recognition or reward for coordinating care; and pays mainly for face-to-face (office) visits, not for information and/or reassurance that may be needed at other times.[16]

The proportion of the population 85 years of age and older is expected to triple over the first half of this century. This demographic reality will require that we learn how to better manage chronic illness and disability.

Taking all ages together, patients affected by a few chronic illnesses account for a large share of total spending. A recent study showed that the annual medical costs of patients with one chronic condition were more than twice

those of people with acute conditions, and the costs of those with two or more chronic conditions were almost six times as high.[17] Indeed, the top one percent of patients in terms of medical outlays account for 30 percent of total health spending, while the lowest 50 percent of patients account for only three percent.[18] The IOM observes that four chronic conditions (cardiovascular disease, cancer, chronic obstructive pulmonary disease, and diabetes) account for almost three-quarters of deaths in the United States. These findings indicate that we must learn how to conduct effective disease management for several key chronic diseases. Such management requires the coordination and integration of health and social services and both physician and patient education.

***Third**, we must pay more attention to the clear relationship between volume of procedures and health outcomes.* A systematic review of 88 studies concerning eight conditions and procedures concluded that higher volume is associated with better health outcomes for both hospital and physician care. Statistically significant associations between a higher volume of medical procedures and better health outcomes were found in 79 percent of the studies of hospital volume and 77 percent of the studies of physician volume. None of the studies showed a negative effect on volume.[19] A study of California hospital admissions for 11 major types of surgical procedures revealed that about half of all admissions were in "low-volume" hospitals. The study attributed 602 deaths to this type of misuse.[20]

Both excess capacity and shortages abound

Most urban areas have substantial excess hospital capacity. This involves not only excess beds, but also a duplication of expensive diagnostic equipment, trauma care, and surgery capacity. Most urban areas have substantially more specialist physicians than required to serve the population. A surfeit of specialists with direct access to advanced medical technology creates considerable pressure to apply this technology in many cases where the expected medical benefits are marginal, at best.

At the same time, however, there are shortages of capacity in primary care. Many inner-city neighborhoods and rural areas are straining to attract and retain physicians, nurses, and allied personnel in such fields as pediatrics, family practice, and obstetrics/gynecology. In two counties of New Mexico there are no physicians (other than a few in the Public Health Service), while in three others there is only one physician. In California, rural hospitals are disappearing because they are unprofitable, overburdened with uncompensated care as emergency centers, or cannot afford to upgrade their facilities to meet new state requirements for earthquake standards.

Managed care is essential, but needs improvement

*The evidence cited above clearly shows that **unmanaged** care is not a viable option.* High-quality, cost-effective care requires careful management. Yet our recent national experience with managed care has been problematic. An effective health system should incorporate the health-enhancing features of managed care—even though they are not always popular. But it should also discard some undesirable features, in particular such "hassle factors" as unjustified delays or denials of authorization for services and unwarranted delays in payments to physicians.

Effective managed care involves: (1) carefully integrated services delivered by a team of professionals who can guide patients with serious illnesses and chronic diseases to a well-coordinated set of health and social services; (2) early detection and intervention to prevent disease and the complications of chronic illness; and (3) a reduction in inappropriate services.

Managed care organizations have developed a number of effective disease manage-

ment programs, which involve a comprehensive, multi-disciplinary approach that seeks to manage and improve the health of a defined patient population over the entire course of a disease. Disease management is geared to patients with chronic or high-prevalence illnesses such as diabetes, asthma, hypertension, and osteoporosis.

Employers and public purchasers usually view these programs favorably. But when managed care plans try to make evidenced-based decisions about whether a particular medical test or procedure is appropriate, they are sometimes met with a firestorm of protest from physicians and patients. Denials of treatments and procedures have generated such a strong backlash that medical directors may approve requests for treatment even when there is little or no evidence of its medical effectiveness. Threats of litigation exacerbate this problem, leading to both more "defensive medicine" by providers and automatic approvals by payers, which inflate costs and diminish quality. In response to this backlash from patients, physicians, and the legal system, some leading health plans are abandoning medical practice guidelines and limiting the use of profiles of physician practice patterns and pre-authorizations for visits to specialist physicians and non-emergency hospitalizations.

In an effort to address workers' concerns, many employers have contributed to the removal of one of managed care's most powerful tools, the limited selection of providers. Instead of tight networks of physicians adhering to best practice guidelines and engaging in peer review, managed care plans have moved to wide-open networks, seeking cost-savings primarily from provider discounts rather than effective disease management. Preferred provider organizations—the "loosest" form of managed care relying mainly on provider price discounts—have gained 20 percentage points in market share between 1997 and 2001. Indeed, the "tighter" HMOs lost 6 percentage points of market share just from 2000 to 2001.[21]

In addition, some states have enacted "patient protection" laws that have had widespread, bipartisan support. Some patient protection provisions have clear benefits and relatively low costs, such as assuring patients reimbursement for emergency room care if a "prudent layperson" would believe this care were warranted; a right to an external review by an independent panel of a health plan's decision to deny payment for services; and direct access to ob-gyn physicians without a prior referral. However, other features of both existing and proposed state and federal statutes and regulations could hamstring managed care and drive up costs. For example, providing a right to sue for unlimited punitive damages or "pain and suffering" awards could have a chilling effect on efforts to avoid unnecessary and inappropriate care. Some of these initiatives could also drive employers to abandon their involvement in the health care system. Thus, a key question is how we can protect patients and assure their access to appropriate care without being stymied by unwarranted litigation or onerous regulations.

Employers' purchasing practices frequently do not promote good value and high quality

Both private and public employers' purchasing practices are underwriting and exacerbating many of the problems described above. Most employers have not incorporated the key ingredients of a market-based system into their health care purchasing. These ingredients include offering employees enough choices to make the market competitive, establishing contribution policies that create incentives for employees to select high-quality, cost-effective plans, and using information about the quality of health plans and providers when they select them. When employers contribute more to high-cost plans and health care systems and make insuf-

ficient use of data on provider quality, they fail to hold physicians, hospitals, and health plans accountable for poor quality or poor value.

The proportion of workers offered a choice of plans has grown, but is still too low. For example, the proportion of workers eligible for insurance who are given a choice of more than one plan grew from only 18 percent in 1977 to 53 percent in 1988 and 65 percent in 2000.[22] This shows progress, but nevertheless only 55 percent of wage and salary workers (including those whose employers do not offer health coverage) had a choice of health plans, taking into account choices available through the jobs of other family members.[23] Many others are offered only two plans. Further, the overall expansion of choice in the aggregate masks a substantial variation by firm size. In 2001, only 9 percent of firms with 3 to 199 workers that offered health coverage provided a choice of plans. In contrast, 63 percent of such firms with 1,000 to 5,000 workers, and 77 percent of those with 5,000 or more workers, offered a choice.[24]

Moreover, most of those employees given a choice were not given incentives to select a cost-effective plan. According to one study, 31 percent of employers paid the full cost of the premium regardless of the plan selected, and 34 percent paid a fixed *proportion* of the premium for all plans. Such policies insulate employees from all or most of the financial consequences of their choices, and health plans therefore are unlikely to gain enough new members by reducing premiums to offset their revenue losses. Only 28 percent of employers offering multiple plans made a fixed-dollar contribution toward single coverage, which would strongly encourage cost-conscious choices by workers. It is notable that 51 percent of employees who were given such a fixed-dollar contribution selected the lowest-price plan, whereas only 37 percent did so when their employers paid the full premium.[25]

Finally, many employers either do not use assessments of the quality of health plans or fail to impose consequences related to quality assessments. A survey of employers found that the National Committee for Quality Assurance (NCQA) accreditation and Health Plan Employer Data and Information Set (HEDIS) indicators (two objective, comprehensive measures of health plan performance) play only a small role in employers' health care purchasing decisions.[26] Another study found that employer purchasers were frequently unaware of information on the performance of health care providers and often did not use such data when it was available.[27]

It is often claimed that the "health care market does not work." The problem is not so simple, since the market approach has not yet been tested. Too few of those who preach the virtues of the market practice what they preach.

Government tax, regulatory, and purchasing policies exacerbate the problems

Federal tax law provides several subsidies that reduce the after-tax cost of health insurance and health care. By far the most important of these subsidies is the exclusion of employers' contributions to health coverage from employees' taxable income, which reduced federal revenues by about $102 billion in 1998, equivalent to the $101 billion federal contribution to Medicaid in that year. This open-ended tax exclusion insulates employees from the financial consequences of their decisions and distributes the tax benefits in rough proportion to income.

Because employer contributions are not included in taxable income, workers do not pay more taxes when they select more expensive health plans. They therefore have little incentive to select cost-effective health plans or to be prudent in their use of health services. This leads to the "overpurchase" of expensive insurance and health care services and raises costs.

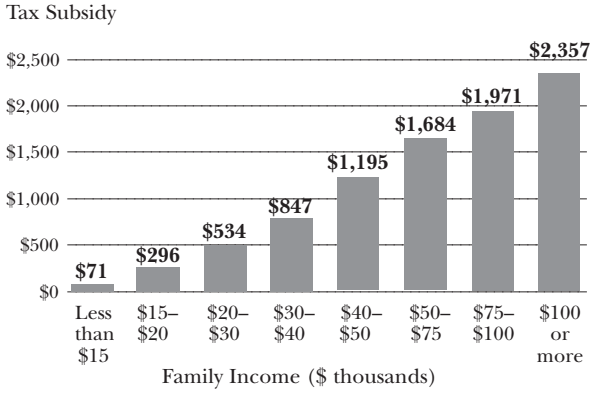
The open-ended exclusion also grants billions of dollars in government assistance to middle- and upper-income taxpayers while providing smaller subsides—or none at all—to lower-income workers, who face a lower tax rate, which reduces their tax benefit, or in many cases have no federal income tax liability against which to use the exclusion. Figure 3 shows the distribution of federal tax subsidies (including several smaller subsidies as well as the income exclusion) by family income in 1998.

The federal government also follows policies that drive up health care spending and costs as a purchaser of health care under Medicare. Although the federal government has opened Medicare to a variety of managed health care plans and provider-sponsored organizations, under its traditional fee-for-service arrangement (in which five of six enrollees still participate), Medicare is not allowed to select networks based on cost and quality. People in fee-for-service Medicare have open access to any and all providers, regardless of the cost and quality of their overall treatment plans and practices. This drives up the cost of the fee-for-service part of Medicare, with the result that Medicare is *overspending* in this area. Meanwhile, the managed care portion of Medicare is experiencing widespread withdrawals by health plans, leaving many seniors without coverage. Health plans contend that Medicare is *underspending* in this more economical portion of the program through cutbacks in government payments. Some of these cutbacks were restored in 2000.

State mandated health benefits are still another area of regulatory impact on costs. While well intentioned, these mandates may have the unintended side effect of pricing health coverage out of the reach of many small employers.

Figure 3

Average Federal Tax Subsidies by Family Income, 1998



SOURCE: John Sheils and Paul Hogan, "Cost of Tax-Exempt Health Benefits in 1998," *Health Affairs*, vol. 18, no. 2 (1999), p 180.

Many workers lack health coverage because small firms face obstacles to obtaining affordable health insurance

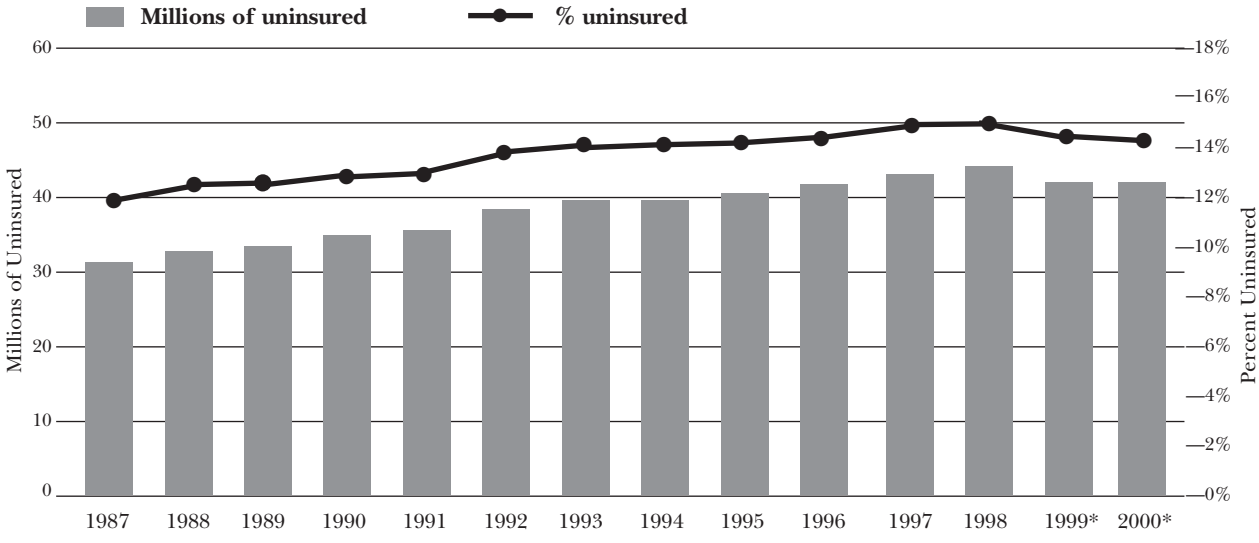
As shown in Figure 4, the number of uninsured people in the United States, and the proportion of the population without insurance, grew gradually but steadily from 1987 to 1998. The number of uninsured fell modestly in 1999 and 2000, but the upward trend is expected to resume, given the recent weakening of the economy and sharp rise in health care costs.

The majority of the uninsured are workers or their family members. About 24 million workers lack health insurance. Some two-thirds of this group work in firms that do not offer health coverage. The remaining third is comprised of workers who are ineligible for the coverage offered by their employer, and workers who turn down an employer's offer, generally because they cannot afford their share of the premium.

The small business community faces distinct and considerable difficulties obtaining affordable health coverage. Small businesses are generally charged higher premiums, in part because insurers' marketing and administrative costs cannot be spread over a large

Figure 4

Number and Percent of Total Population Without Health Coverage for 12 Months, 1987-2000



* NOTE: The 1999 and 2000 data are based on estimates comparable with that used for 1987-1998; under a new estimating methodology that adds additional verification questions to the survey, the numbers of uninsured are 39.3 and 38.7 million, respectively.

SOURCE: U.S. Bureau of the Census, *Health Insurance Coverage: 2000*, Current Population Reports, Series P60-215 (Washington, D.C.: U.S. Department of Commerce, September 2001).

enrollee base, and in part because of higher mark-ups to protect against adverse selection. Administrative, or "loading" costs, constitute 40 percent of premiums for firms with 1 to 4 employees, compared with 8 percent in firms with 2,500 or more employees.[28] Small-group premiums also tend to be more volatile, changing as the health risk profile of covered lives changes. The administrative burden on small employers themselves is another major obstacle to offering coverage. Recent and projected premium increases have been particularly high among small firms.

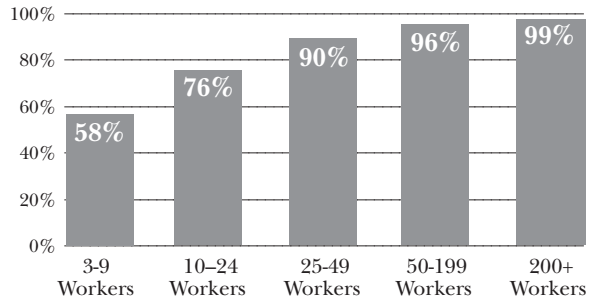
Because of these difficulties, the incidence of employers not offering coverage is much higher in very small firms than in larger companies; forty-two percent of firms with 3 to 9 workers did not offer health benefits in 2001, compared to only four percent of firms with 50 to 199 workers and one percent of firms with 200 or more workers (see Figure 5).[29] Lower-wage firms are also more likely not to offer health coverage than higher-wage firms.

High coverage rates in medium and large firms mask the fact that many employees of such firms are ineligible for health benefits or decline coverage. Among Fortune 500 companies, only 47 percent of part-time employees were eligible for some form of employer health insurance in 2000, compared with 99 percent of full-time employees.[30] Reasons for ineligibility include: insufficient hours worked per week or weeks per year; initial waiting periods for new employees; and their status as "contract" or "temporary" workers.

Insurance coverage has also declined because employee turndowns of coverage have risen over the past decade. The rising cost of the employee's share of the premium — at a time when real wages were generally stagnant and falling significantly for low-wage workers — was a contributing factor. The

Figure 5

Small Firms Are Less Likely to Offer Health Coverage



Firms offering health insurance in 2001, by firm size

SOURCE: Kaiser Family Foundation and Health Research and Education Trust, *Employer Health Benefits 2001 Annual Survey.*

average monthly employee contribution, in constant 2001 dollars, moved from $12 in 1988 to $30 for single person coverage in 2001, while for family coverage the increase was from $78 to $150.[31]

Analysis indicates that the decline in employer-based health coverage that occurred during the 1980s and early 1990s was explained almost entirely by the fact that per capita health care spending rose much faster than income.† In the late 1990s, many employers absorbed most or all of the cost increases in order to attract and retain workers in a very tight labor market. As labor markets slacken, however, firms are expected to shift more of the premium to workers, move to a defined contribution approach, or in some cases, drop coverage. Researchers point to the recent return of double-digit premium increases and note that, "If, as seems likely, health care spending continues to rise more rapidly than income over the next ten years, then more workers will lack insurance, not fewer."[32]

Retiree health coverage is also eroding. According to a survey conducted jointly by William M. Mercer, Inc. and Foster Higgins, the proportion of large employers (500 or more employees) contributing to retiree coverage for the 65 and over population fell from 40 percent in 1993 to 24 percent in 2000.[33] Many firms have also altered their retiree health coverage by capping their contributions, increasing retirees' share of the premiums, and making their contributions contingent upon retirees enrolling in Medicare's HMO program.

STRENGTHS OF THE EMPLOYER-BASED SYSTEM ON WHICH TO BUILD

Despite its many flaws, CED believes that the employer-based health care system has important strengths that can be built on through a series of reforms in both business practices and public policy.

Enrollment in employer-based coverage is relatively easy

Enrolling in employer-based coverage is relatively easy and straightforward. Workers may choose to participate, select a plan, and get coverage automatically unless they expressly decline it. Employees' contributions may be deducted from paychecks, with no complex application forms. As a result, take-up rates for employer-sponsored coverage approach 90 percent.

The business sector is bringing better cost management to the health care sector

While much more can be done in this area, the business sector is to some degree exerting pressure on health plans and care delivery systems to hold down premium increases and therefore costs. Business coali-

† Changes in job characteristics — firm size, part-time status, industry — and demographic trends had only a minor influence.

tions and individual large companies are building incentives for cost control into their contracting with health plans and health care delivery systems. The business sector is also developing new strategies for managing the cost of health care that build on e-commerce and other tools of emerging technology. Some employers have made investments in employee wellness programs and attempted to integrate health benefit cost management with disability, sickness and accident programs, and workers compensation. These investments are designed to lower turnover, reduce absenteeism, and increase productivity.

Many large employers have been driving quality improvement

Some large firms, acting on their own or through business coalitions, have been trying to improve the quality of health care. Business leaders have brought knowledge of quality control from their own industries into the health care arena, with appropriate adaptations for the special characteristics of the health care delivery system. They are working with physicians and hospitals to reduce unnecessary and inappropriate medical care. (The next chapter elaborates on some of these efforts.)

The United States continues to lead in medical innovation, research, and technology

The United States is a leader in many aspects of health care. We are among the leaders in basic medical research and applied medical technology. In cell restoration, the discovery of cures for diseases, and the alleviation of pain and suffering, research conducted in the United States is leading to exciting breakthroughs that benefit people worldwide. The mapping of the human genome will lead to further breakthroughs that can save lives and improve the quality of life. The United States is investing about $23 billion a year in research through the National Institutes of Health, and U.S. pharmaceutical manufacturers are devoting about $24 billion a year to research and development. Recent studies show that these investments yield a very positive return.[34]

THE IMPACT OF MORE CONCENTRATED MEDICAL MARKETS

The flaws and strengths of the health care system must be viewed in the context of a changing marketplace. First, there has been considerable "horizontal consolidation" in health care markets, involving mergers, acquisitions, and joint ventures within both the hospital and managed care industries. In fact, consolidation within these two markets has led to a situation in which hospital systems and managed care organizations are battling over the distribution of money put into the health care system by employers and government.

A recent report by the Center for Health System Change notes that in most of their 12 study sites, "hospital sectors were in the process of becoming largely concentrated in just two to four systems."[35] Some of these hospital systems have large numbers of community hospitals joined with a teaching hospital in a region-wide system. This is driven by a desire to position the system as indispensable to a managed care network and thus create leverage for hospitals in their rate battles with health plans. Many smaller communities are dominated by one major provider system. The health plans, in turn, have consolidated partly in response to employers' demands for broader geographic coverage. Other motives include regional expansion of local health plans to keep out national competitors and the desire of some local plans to expand into new geographic markets.[36]

All this consolidation, however, has had little if any positive impact on quality. The IOM report states that,

> Mergers, acquisitions, and affiliations have been commonplace within the health plan, hospital, and physician practice sectors. Yet, all this organizational turmoil has resulted in little change in the way health care is delivered.[37]

A study of hospital mergers found that the new entities are generally not consolidating clinical operations using criteria related to quality, such as volume/outcomes measures or risk-adjusted mortality rates. Rather, health plans are contracting only with hospital systems that cover broad geographic territory and offer a full range of services. Thus, hospital systems are being rewarded for maintaining multiple facilities and services, rather than for consolidating or eliminating them, and mergers are propping up the weaker facilities with lower quality records that might not survive on their own. The study concludes that:

> …if employers want a leaner and more efficient hospital industry, they will need to be less passive about the structure of that industry. If they actively try to reduce redundant capacity and channel their employees and their families to facilities with the best performance records, they will incur some opposition.…If employers are not willing to take such risks, however, they are unlikely to see much change in the near future and could find that they are buying hospital care from a more concentrated and less responsive industry as time goes on.[38]

Other industry trends include the consolidation of a number of large pharmaceutical manufacturers and the conversion of hospitals from non-profit to for-profit status or from public to private status.

Taken together, these trends point to a more concentrated health care industry with considerable market power. Employers will be challenged to ensure that competitive forces gain strength in the industry and that mergers are carefully scrutinized for their impact on both cost and quality.

In summary, the U.S. health care industry is a study in paradox. The nation has devoted large sums of money to medical research, frequently with very high returns in longer life expectancy and improved quality of life. Yet, we have skimped on funding for the science of "re-engineering" the health care delivery system to reduce medical errors and inappropriate care. Relatively little financial and intellectual resources have been devoted to asking how we can more efficiently and fairly run an industry that accounts for one-seventh of the U.S. economy. If we allow these imbalances to continue, our ability to extend life may outpace our ability to pay for our accomplishments.

Chapter 2

THE ROLE OF BUSINESS IN IMPROVING COST EFFECTIVENESS AND QUALITY IN THE HEALTH CARE SYSTEM

Business has a large stake in resolving the major problems described in Chapter 1. Employers can actively address many of the flaws through changes in the way they purchase and manage health benefits. These changes include establishing new relationships with health care providers and health plans (with new demands and expectations), continuing a transfer of more responsibility to employees by providing a wider choice of plans and information on their performance, and designing contributions that encourage "value-based" selections. This chapter presents specific recommendations on how employers can play a leading role in containing costs and improving quality in the health care system.

While large employers have the most scope for following our recommendations, many important employer actions do not require a large human resources staff or tremendous market clout. The first step that most companies can take is to offer their workers a meaningful choice of health plans. While very small firms may have difficulty providing multiple choices of plans, many medium-size firms could offer their workers three health plans and structure their contributions so that workers' premiums are related to their choices. They can also educate workers about the important differences among the plans.

ADDRESSING COST AND QUALITY PROBLEMS

The business community has too much at stake to remain passive in the face of the nation's health care crisis. First, the rising costs of health eats into the total compensation package that employers are willing to provide workers; it limits employers' ability to increase wages and to contribute to pensions and other employee benefits. Combined with palpable dissatisfaction with some of the restrictions and delays imposed by managed care, this will translate into deterioration in relations with employees and their representatives. Second, when workers fail to get timely and appropriate medical care, their productivity is likely to be lower and their absenteeism higher. Third, business pays a portion of the cost of the uncompensated care delivered by health care providers to the uninsured through higher corporate taxes as well as higher premiums.

Both positive incentives to reward good medical practices and good value and clear consequences for sub-standard care and inefficiency are needed to improve quality and contain costs. Physicians, hospitals, and other providers of health services who adhere to medical protocols and practice evidence-based medicine should be rewarded with both adequate payments and a larger volume of patients. Those who do not follow these standards should be assisted to improve their practice patterns, and if they ignore this advice, should expect to see their volume decline or be dropped from

provider networks. The business community needs to work with health plans and providers to analyze practice patterns, assess good value in medical care, and design reimbursement strategies that encourage practices consistent with the latest scientific knowledge and efficient management.

Efforts of the following kind can help accomplish these goals:

Demand transparent information on medical practices and use it

The business community should insist upon transparent information on the quality of care from both providers of care and health plans. Employers should not accept the excuses frequently put forward to avoid making this information available—that "it costs too much," "it is not fair," or "providers who report errors will be sued." Steps can be taken to address each of these potential problems. For example, performance measures of quality can be adjusted for case mix or for "transfer patients" to account for the fact that some health care providers serve older and sicker patients.†

Employers should make contracts with health plans contingent upon an assurance that participating providers comply with safe and effective medical practice. The Leapfrog Group, for example, is requiring that hospitals with whom they do business employ computer-assisted physician order entry to reduce medication errors, follow evidence-based guidelines relating patient volume to outcomes, and staff critical care units with appropriately trained physicians. (See box, The Leapfrog Group.)

Since health plans have moved toward more open networks that contain many of the same physicians and hospitals, comparisons between them have become less useful. In response to this problem, some innovative business purchasers have begun to measure the performance of providers rather than only managed care plans.

Employers may use information on patient satisfaction with providers and plans, but they should pay special attention to clinical indicators of quality. The "user-friendliness" of the system as manifest in hours of operation, ease of getting an appointment, and other matters is important, but the critical issue is the likelihood of a patient getting well or having a chronic condition properly managed over time. These questions may literally decide life and death and are far more important than "bedside manner" or the number of telephone rings that occur before someone answers. It is important that the public understand that there are in fact large differences between plans and providers in these critical dimensions.

Transparent and timely information on quality of care will only be helpful if employers *use* that information in their purchasing, both in choosing which plans to offer employees and in providing employees with the information needed to make wise, health-promoting choices themselves. As noted in the previous chapter, employers frequently let such quality information gather dust.

Health care professionals and health plans need to know that if they are consistently receiving low marks for their performance, there will be consequences. **In using information on quality in their contract decisions, employers could withhold a small portion of premiums pending attainment of quality improvement targets. Beyond financial rewards and penalties, physicians and hospitals need to know that their continued participation in employers' health plans hinges on their compliance with practice protocols and demonstrable quality improvement.**

† Some teaching hospitals, for example, serve a substantial number of patients who are transferred from other hospitals. These tend to be the most serious cases requiring expensive advanced medical technology.

THE LEAPFROG GROUP

The Leapfrog Group is an organization of more than 90 public and private organizations that provide health care benefits. It represents more than 28 million health care consumers in all 50 states. Initially, the group is advancing three methods of improving patient safety. Research conducted by John D. Birkmeyer at Dartmouth University found that these three improvements could prevent 522,000 medication errors and save up to 58,300 lives.

COMPUTER PHYSICIAN ORDER ENTRY (CPOE) SYSTEMS

CPOE systems with intercept capability based on protocols specified by the Institute for Safe Medication Practices can reduce serious prescribing errors in hospitals by more than 50 percent—yet fewer than 5 percent of hospitals use them. CPOE systems can reduce errors caused by misreading or misinterpreting handwritten instructions. They can also intercept orders that might result in adverse drug reactions or that deviate from standard protocols.

To fulfill this Leapfrog Group safety standard, a hospital must require physicians to enter medication orders via a computer system that is linked to prescribing error software; demonstrate that their CPOE system can intercept at least 50 percent of common serious prescribing errors; require documented acknowledgement by the prescribing physician of the intercept prior to any override; and post the test case interception rate on a Leapfrog-designated web site.

EVIDENCE-BASED HOSPITAL REFERRAL (EHR)

Referrals to surgical teams and hospitals with a lot of experience treating certain conditions offer the best survival odds. To fulfill this standard, hospitals will comply with volume standards with established relationship to positive outcomes. If scientifically rigorous risk-adjusted hospital outcomes measures are available, those should be the preferred standard.

ICU PHYSICIAN STAFFING (ICU)

When ICUs are staffed with physicians with credentials in critical care, or when intensive care specialists are available to respond to 95 percent of pages within five minutes, the risk of patients dying in the ICU is reduced by more than 10 percent.

To fulfill this safety standard, hospitals must operate adult ICUs that are managed by a physician certified (or eligible for certification) in critical care medicine. The physician must be present during daytime hours and provide clinical care exclusively in the ICU. At other times he must be reachable by ICU pages within five minutes and can work with a qualified medical assistant in the hospital who can reach ICU patients within five minutes.

SOURCE: The Leapfrog Group.

Work actively with providers to improve quality

Employers can also work directly with hospitals and physicians to improve the quality of health care. A number of business health care coalitions, and some large employers, are taking up this challenge. For example, the Chicago Business Group on Health has formed a Quality Improvement Council comprised of corporate human resource directors, hospital CEOs and quality assurance directors, and practicing physicians. The Council established a cardiac care program under which Chicago area hospitals developed critical pathways for coronary artery bypass surgery patients. The treatment approach was incorporated into four hospitals' practices and resulted in lower cost and reduced length of stay without impairing the quality of care; one company

saved over $4,000 per case. The Council also participated in a C-section reduction collaborative with the Institute for Healthcare Improvement (a nonprofit organization based in Boston) and other business coalition member companies. The C-section project was to be the first of a number of "breakthrough series" focusing on clinical and behavioral areas with the potential for quality improvement.

The Pacific Business Group on Health (PBGH) is collaborating with the California Office of Statewide Planning and Development to operate the California CABG Mortality Reporting Program. This system is collecting and reporting risk-adjusted, hospital-level mortality data for all hospitals in the state that perform coronary artery bypass surgery. The goal is to produce information to allow hospitals and physicians to compare their performance and to stimulate quality improvement.[39]

Offer workers a meaningful choice and employ contracts that create genuine competition to provide value

Firms should promote competition among health plans by offering workers a range of responsible choices. Choices may include more traditional HMOs featuring restricted panels of physicians and hospitals along with wide-access products such as preferred provider organizations (PPOs) and Point of Service (POS) options in which employees pay more if they select providers outside the network. "Responsible choices" are those in which employers provide employees with financial incentives to select a health care system with high quality and reasonable premiums. (This is discussed further with reference to contribution policies, below.)

Choice among plans will be most effective if it is a *multiple* choice, with real differentiation among offerings that recognizes different preferences among people. Employees should be able to choose among plans that offer a wide network of providers and those that are more restrictive and feature more tightly managed care. But workers who choose a higher-cost plan should also pay the full extra premium cost associated with it, preferably on an after-tax basis. If workers prefer the broadest choice of providers and/or minimal utilization review or prior authorization requirements, they will pay for these features. In addition, firms should ensure that workers have information to make *informed* choices. This will help reduce consumer backlash to managed competition.[40]

It is important to distinguish between providing employees with choices between plans that are more or less restrictive (with attendant cost consequences) and providing unlimited freedom of choice *within* the different plans. In recent years, the business community has signaled health plans that they want few limits on choice of providers and very limited cost consequences for members of the plans when they select providers. The plans, in turn, have responded by creating wide-open networks that often include most of the providers in a community. This latter approach will produce *rivalry* among plans but no real *competition* to provide value for money. The business community may have to take an active role in helping to structure the market so that competing groups of providers are not insulated from competitive forces by undifferentiated networks. We should avoid today's tendency to create "a distinction without a difference."

In contracting with health plans, employers should develop requests for proposals with clear specifications about the services they are willing to cover, the premiums they are willing to pay, and the quality improvement targets they require. Employers should seek bids from integrated service networks and health plans that are willing to be held accountable for cost and quality and then allow them to compete with all-inclusive networks on the basis of their superior cost-effectiveness.

Purchasers should purchase and offer to their employees plans that provide the same package of benefits. This will encourage competition based on reducing inefficient and inappropriate care, rather than on risk selection. As noted by Professors Alain Enthoven and Sara Singer at Stanford University, standardization of benefits does not necessarily mean that there should be one national uniform benefit package—there could be a different package for different aggregations of people, such as employer groups and purchasing cooperatives.[41] Their vision of managed competition,

> ….would build on the successes of the present employment-based system, correct its defects in incremental steps, and extend it to people who are now outside of it. Everybody would be covered through one or another sponsored group, which offers price-conscious multiple choice of plans and cost savings through economies of scale: large employers, mid-size employers pooled in purchasing cooperatives or other coalitions, small employers pooled though cooperatives, free-standing individuals who are not members of employment groups (early retirees, unemployed, self-employed) pooled through purchasing cooperatives or permitted to buy through a public sponsor agency, Medicare beneficiaries through their own competitive system, and low-income persons subsidized through a public sponsor.[42]

Under this approach, the financing and delivery of health care would be integrated under some form of risk-adjusted pre-payments with reinsurance caps. This approach would allow resources to be transferred across the continuum of care, so that, for example, savings in hospitalization could be redeployed to improve outpatient care. It would enable providers to contract with the right resources to care for their defined enrollee groups and to practice "population medicine." Such integration also requires teamwork and collaboration among hospitals, doctors, nurses, and other health professionals to improve health outcomes and reduce cost. Relaxing traditional "scope-of-practice" limitations tied to overly restrictive credentialing, and instead emphasizing the outcomes for which integrated medical teams are responsible, would facilitate this.

Integration also may involve establishing a systematic relationship among hospitals so that there is appropriate regional concentration and a sharing of resources. Finally, there is a need for integrated patient information that would feature complete, accessible, and longitudinal medical records, while addressing privacy concerns. In this way, diagnostic tests would not have to be repeated every time a patient meets a new provider.[43]

Coalitions of employers in Minnesota and Iowa have worked to organize the market into competing, non-overlapping integrated delivery systems. In Minneapolis-St. Paul, for example, employers make their contributions directly to care systems rather than to HMOs, and each primary care physician who wants to be a part of this bidding process must align with just one care system. (See Boxes, Iowa's Community Health Purchasing Corporation and The Buyers Health Care Action Group.)

Set contribution policies to encourage the purchase of efficient and high-quality health plans

Employers too often underwrite the high cost and poor quality waste in our health care system with open-ended contribution policies. These policies insulate workers from the adverse effects of plans that are inefficient and lax in monitoring both patients' care and the qualifications of the providers who deliver it.

A number of contribution arrangements would improve on this traditional design. The essential feature of an effective contribution policy is that employers not automatically

IOWA'S COMMUNITY HEALTH PURCHASING CORPORATION

The Community Health Purchasing Corporation (CHPC) is a cooperative that offers health coverage to large employers in central Iowa. It currently enrolls 10,000 individuals and families. In the belief that direct relationships between purchasers and providers are more likely to lead to improvement in care delivery, CHPC offers direct access to provider networks (Care Systems) in addition to more traditional health plan options.

The Care Systems under contract with CHPC are required to provide identical benefits, enabling consumers to compare the care systems easily and thereby promoting competition based on price, quality, and performance rather than benefits. CHPC is currently beginning a transition toward a new value-based provider payment methodology. They are planning a phased-in approach including the following:

1. Each Care System will develop (with the assistance of outside consultants) a standard per member per month price.
2. The Care System fee schedules will be locked in for a twelve-month period based upon the above negotiated fee schedules.
3. Care Systems will be placed into cost groups based on the above.
4. Employers will pass on differences in these cost groups to their employees.
5. Consumers/employees will choose Care Systems based on price differences and quality information (consumer guides), during calendar year 2002.
6. Data will be accumulated during this time in order to develop and activate adjustments for case mix in 2003.
7. There will be no quarterly provider payment fee schedule adjustment or ability of members to change Care Systems back and forth within the calendar year during 2002 or 2003.
8. Data and education for Care Systems will be given on an ongoing basis.

SOURCE: Community Health Purchasing Corporation, "Care System Severity Adjusted Provider Payment Method," (draft, Community Health Purchasing Corporation, Des Moines, IA, January 2001); CHPC, private communication.

raise their contributions to reflect higher costs. **We urge employers to design their contributions in this manner to encourage cost discipline, while continuing their helpful roles in screening and negotiating with health plans, managing health benefits, and promoting quality care.**

Some employers are adopting one of several defined contribution models. Under the least radical departure from the current system, some purchasers have switched from paying all or a fixed proportion of the total health care premium to paying a fixed-dollar amount. Under this approach, employers offer a range of plans and anchor their contributions to a "benchmark" plan with a superior record of cost management and quality of care. Workers' contributions would then vary inversely with a combination of cost and quality "scores" that plans receive. General Motors follows this approach for its salaried workers.

There is evidence that the switch to contributions pegged to cost-efficient plans is paying off. For example, prior to 1994, the University of California health system set its health care contribution equal to the cost of the health plan with the largest membership. In 1994, the UC system switched to a fixed-dollar contribution pegged to the amount

THE BUYERS HEALTH CARE ACTION GROUP

The Buyers Health Care Action Group (BHCAG), representing 27 major employers in Minneapolis-St. Paul, contracts with a variety of *provider-based* health care systems. It has 115,000 enrollees. A unique feature of this model is that primary care physicians must align themselves with just one care system. This facilitates assessments of provider performance and requires patients to remain with a care system for at least a year if they want to see a particular primary care physician.

Care systems submit bids with "claims targets" for the coming year's total costs. Claims targets are risk-adjusted to reflect the varying case mixes of different care systems. Based on these bids, each system is placed into one of three "price tiers." Enrollment in the high-priced tier requires a consumer to make a greater premium contribution than enrollment in a medium-price system, which in turn is costlier than a lower-price system. This creates incentives for consumers to enroll in less costly systems. But since the 27 participating employers agree to a common benefit package, and risk-adjustment is used, the competition is based on quality and efficiency rather than on risk selection or "cheapening" the benefit package.

The BHCAG model is supported by information on quality of care produced by the Institute for Clinical Systems Integration. This institute has produced over 50 medical practice guidelines, and it also provides technical assistance to help medical groups implement the guidelines. Health outcomes studies and annual population health surveys also contribute to quality improvement. Each care system must establish a quality improvement oversight group including medical staff, set specific quality measurement goals, and develop a plan to implement and sustain improvements in quality. In addition, BHCAG uses Medicare's Consumer Assessment of Health Plans Survey (CAHPS) to compare consumer satisfaction with the care systems in each of the price tiers. This survey includes consumers' ratings of their clinic or personal physician, how well doctors communicate, and their ability to obtain timely referrals.

Enrollment shifts are encouraging. Consumers are moving away from higher-cost systems and those with relatively poor patient satisfaction scores, and toward those with lower costs and better performance records.

SOURCE: Glenna Crooks, Jack A. Meyer, and Nancy Bagby, *Quality Health Care for Children in S-CHIP*, (Washington, D.C.: New Directions for Policy, 1999); Milbank Memorial Fund, *Value Purchasers in Health Care: Seven Case Studies*, (New York: Milbank Memorial Fund, 2001); BHCAG, private communication.

charged by the least-costly plan available statewide. Among employees whose premiums did not increase, only five to six percent switched plans. But among those facing premium increases, 30 percent of the HMO enrollees switched plans, while 50 percent of the fee-for-service enrollees switched. Overall, a $10 per month increase in out-of-pocket premiums resulted in roughly a fivefold increase in plan switching. The vast majority of those switching plans chose plans that provided similar benefits and did not require out-of-pocket premium contributions. In the three years following the benefits change, real

spending per employee by the UC health benefits program fell by 24 percent.[44] As another example, a survey of over 500 employers offering a choice of plans found that employers that did not pay more for higher-priced plans experienced much smaller premium increases than employers that did so.[45]

Some employers are experimenting with other types of arrangements for their workers such as personal medical funds (PMFs), medical savings accounts, and flexible spending accounts. Under PMFs, for example, an employer annually places a fixed sum into an employee's personal medical fund to cover routine medical expenses, such as physician visits, eyeglasses, and prescription drugs. Workers have ready access to their account balances through the year, and unused funds can be carried over into the next year. For more serious expenses related to hospitalization or prolonged care, the employer may purchase a catastrophic illness "wraparound" insurance plan to supplement the PMF.

Other firms are exploring the possibility of treating health contributions like 401(k) pension accounts, with fixed contributions that workers control and have available to use as they move from job to job, as with a vested pension account. This approach would probably require tax law changes to assure that employer contributions did not become taxable income for workers who changed jobs. Finally, some small and medium-size firms contract out for the entire employee benefits package, including health, pensions, workers compensation, and disability, using professional employment organizations (PEOs) to "outsource" these benefits.

With respect to the movement towards defined contribution plans, we believe three caveats are in order:

First, if employers totally disengage from screening and selecting health plans and care systems for their employees, we would lose an important force for quality improvement. While employees would have a wider choice of plans and could make those plans portable from job to job, some oversight would be necessary to protect consumers from unstable, or even disreputable, organizations and to hold the newer systems accountable for cost and quality. Since employers would still have a stake in a healthy workforce, they should continue to have a role in improving workers' health care.

Second, some employers attempting to change contribution policies will face difficulties related to contractual labor agreements or to an inadequate number of health plans to provide genuine competition in some rural areas.

Third, employers should recognize an important difference between their contributions to employee pensions and to employee health care. Private pensions put aside money to be combined with private savings and Social Security to meet relatively predictable income needs after retirement. Health care is a very different matter. It is difficult to "save for" catastrophic illnesses or chronic medical conditions, which are largely unpredictable and often extremely costly to treat, and there is no "safety net" program that provides a floor for the health expenses of working adults like Social Security provides for the income of retirees. For this reason, defined-contribution plans may not fit workers' health care needs as well as their pension needs if they simply limit employer exposure without providing for catastrophic and chronic health contingencies. Some companies are using a mix of defined-benefit insurance to cover catastrophic care and defined contributions into tax-sheltered personalized funds that create incentives for workers to economize on their use of health care resources.

In sum, CED recommends that employers move carefully toward contribution policies that help control costs but still enable workers to afford their share of the health care bill. Employers should continue to be active in

quality-improvement activities and provide some oversight and guidance to workers under any form of a defined contribution model. If firms step back from selecting plans, negotiating premiums, and managing benefits, they should not completely abandon health reform. However, if employers play a less-active role in plan screening and selection, quasi-public organizations in various regions of the country may be necessary to perform some of the oversight previously conducted by business. This need not entail detailed regulation of the health care industry; a model of sensible oversight without excessive intervention is described in Chapter 3.

Provide workers with reliable information about the quality of health plans and care systems

Employers should foster accountability for cost and quality by providing workers with understandable and timely information on the performance of providers and plans. Such information must be user-friendly—clear, concise, and delivered to employees just before their "open-seasons" when they select a health plan. Consumers want information about their physicians and other providers, not just a comparison of plans. Because many health plans have heavily overlapping networks of doctors and hospitals, comparisons to date have shown few meaningful differences in quality. Consumers also indicate a strong desire for information from an unbiased and reliable source. Businesses should tailor the information they offer to these clearly expressed desires and obtain continuous employee responses to revise and refine the information. The Pacific Business Group on Health (PBGH) and the California Public Employees Retirement System (CalPERS) are working together to provide their members, which together number about four million, with this type of information. (See Box, PBGH's HealthScope.)

Consumers frequently choose providers on the advice of family and friends, with little knowledge of the providers' experience, qualifications, and performance. Employers can help workers and their families obtain and use such information on provider performance. However, this will require a very large change in habits and behavior, and it will not happen overnight. Nevertheless, we know that at least 70-80 million Americans now use the Internet to obtain some type of information about their health. Highly-publicized reports by the Institute of Medicine on widespread medical errors and inappropriate care have spread awareness and concern beyond the experts to both patients and those who help pay their bills.

PRINCIPLES FOR APPROPRIATELY-MANAGED CARE

Business leaders should help drive the transition to the next generation of health care management—one that incorporates managed care, patient responsibility, and incentives for providers to deliver higher quality, more efficient services.*

"Unmanaged care" is not a viable option. We should not use payment systems that treat all physicians and hospitals alike regardless of their adherence to established best medical practices. A good managed care model involves an emphasis on preventive care and early detection and a determined effort to reduce medical errors and inappropriate care.

However, some employers have effectively forced HMOs on their employees and used them as "single replacements" for their old-fashioned indemnity plans. Employees often received little explanation of the differences between the indemnity plans, preferred provider organizations, and HMOs. This, in turn, led to an understandable backlash among workers while still failing to control costs.[46]

*See memoranda by RICHARD W. HANSELMAN (page 45).

PBGH'S HEALTHSCOPE

The Pacific Business Group on Health (PBGH) represents 45 major purchasers accounting for 3 million employees, retirees, and their families, and $3 billion in annual expenditures. In addition, PBGH now oversees a small business purchasing group that includes approximately 10,000 small companies with 2 to 50 employees, representing about 140,000 covered lives.

PBGH has developed HealthScope, an Internet-based tool allowing employees to view pre-designed report cards or to create their own report cards simultaneously for their own medical group and two other groups. Users can enter their region in the state, and identify the group of physicians whose performance assessments they want to scan. The next step is to select the quality measures that they believe are important to their own health or the health of a family member. They next click on a "Create My Report Card" button and obtain a personalized report card with scores for the quality measures that matter most to them. They can view a side-by-side comparison of medical groups along the key quality indicators that interest them.

Thus, consumers interested in such areas as asthma care, diabetes, or high blood pressure can focus on these chronic illnesses and comparatively assess various medical groups as to their degree of compliance with best medical practices, such as the proportion of patients with diabetes who obtain annual retinal exams. They can also obtain an account of the performance of the medical group on various measures of patient satisfaction, including access to care, promptness of care, physician communication and courtesy, and an overall satisfaction indicator.

Accompanying this customized report card is a guide to appropriate preventive and primary care. This includes guides to the timing and frequency of various preventive tests. For example, for women 18 to 35, there are schedules for PAP smears, breast cancer screening, prenatal care, etc. There are also immunization schedules for children. In addition, consumers may obtain written counseling on lifestyle and behavioral patterns (e.g. tobacco avoidance, exercise, nutrition, dental health, injury prevention, hormone replacement therapy, sexually transmitted diseases).

SOURCE: www.pbgh.org

We believe that employers should design managed care contracts that stress the following components:

1. Developing disease management strategies customized to people with serious illnesses and disabilities. The 10 percent of patients who account for about 70 percent of health spending need team-based care, case management with individually customized care plans, patient education to comply with treatment plans, and disease management to guide them through severe episodes and serious flare-ups of long-term conditions. Such an approach can lower costs and improve health status at the same time;
2. Rewarding providers for helping people stay well instead of waiting to treat them, more expensively, when they are sick. This could also involve incentives for managed care organizations to provide health education, to encourage people to change harmful personal behavior, and to use preventive services;
3. Developing and using evidence-based standards for diagnosing conditions and treating illnesses, and work to see that physicians adhere to best medical practices;

4. Finding the best mix of medical, public health, and social services to manage care efficiently and effectively. This can involve using nurse practitioners, physicians' assistants, physical therapists, and social workers as front-line workers, in coordination with specialist physicians;
5. Integrating financing and delivery so that providers are responsible for managing resources; and
6. Targeting high-priority conditions and highly vulnerable patients for intense care management.

The business community can also take the lead in insisting that undesirable features of managed care are set aside. These adverse features include:

1. Creating bureaucratic barriers that lead to substantial and unjustified delays in authorizing appropriate care and in claims payment;
2. Substituting specialist physicians for subspecialists in cases where the latter are more qualified to identify and treat serious medical conditions; and
3. Asking primary care physicians to do the work of specialists that stretches the limits of their training.

Employers should work to change the debate over quality from a focus primarily on giving patients virtually unrestricted access to all types of care (often couched in terms of patient "protection"), to a broader discussion of promoting patient safety and reducing inappropriate medical care. *Patients need to be protected not only from arbitrary managed care rules, but also from poor-quality care. Managed care plans need the flexibility to steer patients away from such care.*

Chapter 3

RECOMMENDED GOVERNMENT ACTIONS TO PROMOTE COMPETITIVE MARKETS AND IMPROVE QUALITY

CED calls on government to make changes, both as a purchaser of health care for its employees and public coverage program enrollees, and as regulator and law maker that enacts and implements public policies.

GOVERNMENT AS PURCHASER

Government purchasing policies should reinforce and complement the business initiatives described in Chapter 2.

Many states already have developed for their public employees, and in some cases for Medicaid enrollees, the types of contribution models, care system choices, and quality assessments outlined above. The Federal Employee Health Benefit Plan (FEHBP), covering some nine million federal workers and their dependents, has adopted a defined contribution model that creates incentives for workers to select cost-effective health plans with affordable employee contributions. In this model, the federal government pays a fixed proportion of an average of the premiums of the participating health plans, which must offer a minimum set of covered services to avoid cost reductions from skimping on coverage. Federal employees have a wide choice of health plans, and those who select more expensive plans pay larger contributions while those who select less expensive plans pay less. As a result, FEHBP encourages health plans to form selective networks to compete for employee enrollment against plans with expansive networks that include virtually all providers.

CED believes that Medicare should be restructured along the lines of the FEHBP program. Medicare is the largest purchaser of health care, buying nearly half of all hospital care and a large proportion of other services. Yet, Medicare is required by law to be a passive payer of bills submitted by providers. As noted earlier, about five of six of Medicare's 40 million enrollees are in the traditional fee-for-service system. They self-refer to any provider, and Medicare pays its share of the bill, for instance 80 percent of allowable charges for physician visits.

Recently, the Center for Medicare and Medicaid Services (CMS, formerly The Health Care Financing Administration, HCFA) has begun to make information on quality of care available to Medicare enrollees, but the program lacks a set of financial incentives that encourage patients to select the best performing providers.

Medicare should be given the authority to contract selectively with physicians, hospitals, skilled nursing facilities, home health agencies, and other providers who offer the best combination of effective cost management and quality of care. CMS needs the authority to reward such providers and, ultimately, to exclude from the program providers who consistently fall short of best medical practices.

The groundwork has been set for a transition to better purchasing by Medicare through the Medicare Plus Choice program, under which Medicare beneficiaries may enroll in a variety of managed care options. But progress has been impeded by several fac-

tors. First, the government has not established a payment structure that adequately pays such health plans in higher-cost areas, even while it over-compensates other plans. This has recently led to widespread plan withdrawals. Second, the federal government runs the open-ended fee-for–service Medicare program alongside the newer options without creating any financial consequences for enrollees who remain in it.

GOVERNMENT AS REGULATOR AND LAW MAKER

Government policies should reinforce rather than retard initiatives by business to correct some of their practices that drive up costs and ignore quality. **CED calls on the business community to endorse public policies that promote a competitive health care market, quality improvement, and a reduced number of uninsured.** We recommend the following policy reforms:

Reform health-related tax laws

The federal government should cap the current open-ended federal income tax exclusion of employer contributions to health coverage. Employer contributions above the cap would be treated as taxable income to workers. (Employers would continue to treat the full value of their contributions to health care as a deductible business expense.) This change would encourage workers and employers to seek health plans that provide value and thereby add cost discipline to the system. It would also provide some of the financial resources that the government would need to augment its assistance to lower-income families for purchasing coverage. (See Chapter 4.)

Preserve the ERISA preemption, but recognize its implied responsibilities

The business community must make its case for preserving the "ERISA Preemption." The Employee Retirement Income Security Act enables employers who self-insure to disregard states' reserve requirements, mandated benefits, and certain other rules and regulations, thereby providing companies the flexibility to operate a uniform benefit plan across various states. It also allows them to move a lawsuit filed against a company in state courts to a federal court where compensatory, but not punitive, damages can be imposed. Nonetheless, in recent years, the flexibility that business needs has been eroded by new federal mandates and judicial decisions. Pending patient protection legislation, in certain forms, could expose corporations to enormous legal liability. This would occur if patients were given legal rights to recover unlimited punitive damages and uncapped awards for pain and suffering.

The ERISA preemption, however, has also shielded companies from requirements to contribute to states' indigent care funds, and many observers believe that it is unfair for state mandates to apply to smaller companies that cannot self-insure while larger companies escape the reach of regulation.

Employers should recognize that the advantages conveyed by ERISA entail some important responsibilities. For example, employers will need to comply with or even promote some basic patient protections under managed care, such as the right of employees to have an external review of claims turned down by a managed care plan. Employers also may need to make some contributions to statewide indigent care pools or find some other ways to address the problem of the uninsured. (See Chapter 4 for strategies to address this problem.)

Expand research on quality and establish nationwide standards of care

As noted in Chapter 1, the federal government now funds much research on quality of care; the National Institutes of Health receives about $23 billion a year to conduct

basic research on a wide range of diseases. The Agency for Healthcare Research on Quality (AHRQ) creates interdisciplinary research teams to develop numerous medical practice guidelines and also funds health services research that examines the effectiveness of medical practices and gaps and deficiencies in the quality of care. These activities should be continued and expanded.

Specifically, in light of all of the emerging evidence about medical errors and inappropriate care, the government should take action on the following IOM recommendations related to research on the quality of health care:

1. **AHRQ should identify at least 15 conditions as high priorities for quality improvement, taking into account frequency of occurrence, health burden, and resource use. In collaboration with the National Quality Forum, the agency should convene purchasers, consumers, health care organizations, professional groups, and other stakeholders to develop strategies, goals, and action plans for achieving substantial improvements in quality in the next five years for each priority condition.**

2. **Congress should establish a Health Care Quality Innovation Fund to support projects targeted at safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity. The Fund would also support activities designed to produce substantial improvements in quality for priority conditions.**[47]

Through this type of research, **the United States should set nationwide standards for health care treatment and encourage their use**. Subject to legitimate privacy constraints to assure that individuals' health information is not made public, the government can require providers and health plans to make data available on a timely basis to central repositories of information. With the funding recommended above, researchers should evaluate and analyze this data, formulate practice protocols and guidelines, and update them periodically. **To encourage compliance with these standards, health plans and providers that deliver care within the guidelines should be granted a safe harbor from litigation.**

Serve as a clearinghouse for information on quality and standards

The federal government should ensure **that information on quality and standards of care is translated and disseminated in a user-friendly way.** At present, the missing element in a quality improvement strategy is an effective process for transmitting information to physicians, hospitals, other medical personnel, and consumers to encourage the adoption of best practices. As noted in the IOM report, "Health care delivery has been relatively untouched by the revolution in information technology that has been transforming nearly every other aspect of society."[48]

The government could serve as a clearinghouse for the information on quality and national standards of care that emerges from the research discussed above. The results could then be converted for use by physicians, purchasers, and consumers of care. This would include Internet-based tools on effective disease management, particularly for chronic illnesses such as diabetes, hypertension, and asthma.

Establish oversight to limit risk selection, improve resource allocation, and promote competition

Some type of government oversight of the health care sector will be needed to limit risk selection, reduce barriers to entry, improve the allocation of resources, and promote competitive markets. This type of involvement is a constructive alternative to classic "rate and entry" regulation that would lock in inefficiency and block entry to health care markets.

The federal government should use its anti-trust authority to assure that health care

markets are not monopolized by a small set of dominant sellers. This would entail more vigorous monitoring and, where justified, intervention to block mergers and acquisitions that are anti-competitive. Government would review a variety of health care markets to assure that barriers to entry do not impede innovation in either quality of care or cost management design.

Government should also reconfigure its educational support to produce a better mix and distribution of health care providers. Government can design its grants, loans, and funding for residency positions to increase the number of primary care practitioners in shortage areas and discourage the growth of new specialists in disciplines where there is excess capacity.

Professor Alain Enthoven and his colleagues at Stanford University have proposed one promising model of reasonable government oversight. This model involves an independent agency governed by an appointed board of directors whose members would be selected for their professional qualifications, serve for fixed, staggered terms, and be appointed by the President and confirmed by the Senate.[49]

The agency that Professor Enthoven recommends would:

- establish minimum benefit standards;
- develop and test practical and effective approaches to the risk-adjustment of premiums in order to limit adverse risk selection;
- encourage the development of "insurance exchanges," that is, purchasing pools for people who are not in large groups such as those sponsored by larger companies or coalitions; and
- establish minimal quality and reporting standards for health plans participating in such exchanges and a back-up health plan for people who do not qualify for or enroll in any other group.

The task of overseeing the development of exchanges would include assuring their establishment in every geographic region of the country. It would also encompass monitoring market concentration and detecting abuses of either monopoly or monopsony power that an exchange might develop. Information on questionable competitive conditions would be provided to the Federal Trade Commission or the Justice Department.

The quality measurement function would include setting minimum quality and reporting standards for health plans. Insurance exchanges would be required to report disenrollment, complaints, and satisfaction rates. Such data would be protected so that individual patient confidentiality is not compromised.[50]

In summary, this agency would provide oversight and monitoring of the health care system to promote competition based on cost management and quality of care (instead of risk selection) and to help those unattached to a large public or private purchasing organization obtain affordable health coverage.

Reduce fraud and abuse

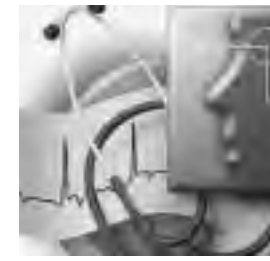
The federal government has recovered almost $9 billion in improperly paid funds from contractors accused of fraud since the enactment of the 1986 Amendments to the False Claims Act. This legislation protected "whistle-blowers" from retaliation and enabled them to bring suit against employers engaged in fraud. It also called for treble damages plus mandatory penalties of between $5,000 and $10,000 *per fraudulent claim* submitted to the government. In FY 2001 alone, $1.6 billion was recovered, and $1.2 billion of this amount involved health care fraud. States have also increased their efforts to detect and reduce fraud in the Medicaid program. Many health industry companies have developed

corporate compliance agreements and stepped up their internal vigilance in response to the more vigorous pursuit of fraud by the government.

Further work is needed in this area. CED supports the active pursuit of fraudulent government contractors in the health care industry. We therefore oppose efforts to weaken the False Claims Act. The government needs the authority to deter and prosecute fraud. It should use this authority responsibly, in a manner that protects the rights of providers to recover legitimate costs, but sends a clear message that bilking the taxpayers will not be tolerated.

Chapter 4

RECOMMENDATIONS FOR EXTENDING COVERAGE TO UNINSURED WORKERS



This chapter presents actions that employers can take to help reduce some obstacles to coverage, recognizing the unique problems facing small firms and firms with low-wage workers. We also delineate public policies that can make coverage more accessible and affordable to small businesses and uninsured workers.

THE ROLE OF EMPLOYERS IN EXPANDING COVERAGE

As described in Chapter 1, small businesses face serious obstacles in obtaining affordable coverage; they are generally charged higher premiums with more volatile rates, and they often do not have the resources or expertise to administer health benefits effectively.

CED calls for action to help small firms obtain affordable health coverage by helping to "level the playing field" for small businesses. We also note that there are ways to expand insurance eligibility for workers in firms that do offer health benefits and to increase the take-up rate by workers (particularly those with low wages) who would otherwise decline work-based insurance. Large businesses (with state and local governments) can play a leadership role in improving access for small firms and for their own lower-income workers in the following ways:

Establish and support purchasing cooperatives for small firms

Through business coalitions, large employers can help establish, operate, and manage regional purchasing cooperatives that offer affordable plans to small firms. The Pacific Business Group on Health, representing 45 large companies in California, oversees a small business purchasing group that includes more than 9,500 small companies with 2 to 50 employees that represent about 140,000 covered lives. Similarly, the New York Business Group on Health has been working with the city of New York to develop and manage a small business cooperative called HealthPass. (See Box, The New York Business Group on Health's HealthPass Program.)

We recognize that the direct incentives for large firms to participate in purchasing cooperatives are limited and that, as a recent study concluded, "private-sector sponsored health insurance initiatives are not the panacea that some proponents would like them to be." [51] As a result, if such initiatives sponsored by the private sector are to be successful, some actions by the public sector to make private insurance more accessible and affordable will be required. (See the following section on The Role of Government in Expanding Coverage.)

Large firms and business coalitions can work in partnership with government to help purchasing cooperatives gain necessary financial support and technical assistance. For example, larger companies and coalitions that have made progress in measuring quality and value of health plans or providers, producing materials that provide reliable, user-friendly comparative information for employees, or developing risk-adjustment tools that improve the distribution of premiums among health

plans, could share that expertise with new small-firm purchasing cooperatives. Larger companies and coalitions could also provide advertising and marketing expertise to help purchasing cooperatives attract a critical mass of small firms.

Share provider networks and their discounted rates with small employers

Large employer groups can also share their provider networks, along with the discounts they are able to negotiate, with small employers. Several large business coalitions are pursuing this strategy. For example, The Alliance, a group of large employers in Madison, Wisconsin, sponsors a Small Employer Initiative (SEI) in addition to managing its own purchasing cooperative (A-CHIP). The Alliance leases its A-CHIP network of local providers to two insurers that underwrite small groups. Operating since 1993, SEI provides the small companies (and

THE NEW YORK BUSINESS GROUP ON HEALTH'S HEALTHPASS PROGRAM

The New York Business Group on Health (NYBGH) is a coalition with a diverse membership composed of large employers and representatives of the health care industry in New York City. In 1998, the city government signed a two-year, $1 million contract with NYBGH to help develop and manage HealthPass, a new health insurance product for small businesses. The contract has since been extended; when the contract is complete, the city hopes that HealthPass will be able to function independently.

HealthPass represents an effort by a coalition of large businesses, in partnership with local government, to expand health coverage options to the small business community.

To create and launch HealthPass, the NYBGH formed a subsidiary called the New York Health Purchasing Alliance. HealthPass is based on a model where the employer sets the level of contribution but the employee chooses among several health plans and products. If a small employer purchases HealthPass, its employees have a choice of 20 different options: four health plans that offer five standard benefit options. Employers are not required to offer HealthPass exclusively, and in fact the majority of participating businesses offer other commercial plans as well. To help reduce the likelihood of enrolling only high-risk people, the Alliance requires that at least 75 percent of eligible employees enroll in a health plan, and at least two full-time employees enroll in HealthPass.

While HealthPass is not less expensive than other small group insurance plans (due to state rate regulations), it offers the following advantages to small employers:

- the ability to offer employees the same kind of plan choices that large employers can offer, but without a greater administrative burden;
- a vehicle for adopting a defined contribution strategy that could help employers manage and contain their health benefit costs; and
- access to a wide array of providers from which each employee can select the network that best suits his or her needs.

The Alliance now covers about 5,000 workers and dependents and represents more than 200 companies. While it is too early to judge its ultimate impact, HealthPass is generally regarded as a well-designed start-up with potential.

SOURCE: Jack A. Meyer and Lise S. Rybowski, *Business Initiatives to Expand Health Coverage for Workers in Small Firms,* (New York: The Commonwealth Fund, 2001).

the two insurers) with lower prices than they could obtain on their own. The Alliance benefits in two ways: it represents a larger number of covered lives, thereby giving it more influence in its negotiations with the providers in the network; and it receives a stream of income from the leasing arrangement with the insurers.

The Health Care Network of Wisconsin (HCN), a purchasing group of large, self-insured employers, located in Milwaukee, WI, created its own network of preferred providers (PPO) with which it has negotiated discounted rates. Concerned about the potential for providers to shift costs to the smaller employers as a consequence of HCN's negotiations, HCN arranged with local insurance companies that underwrite small groups (between 25 and 100 lives) to offer its network (with discounted rates) to smaller, insured employers. HCN also saw this initiative as a way to augment the PPO's membership; the insured businesses have now come to represent 40 percent of the PPO's covered lives.

We urge that initiatives of these kinds be undertaken more widely. In states that already have some organization and momentum in this area, business consortiums should coordinate with state governments to make available to smaller employers the networks, information, pricing terms, and quality control that already have been developed. Such initiatives could serve as pilots for subsequent expansion to other states.

Expand eligibility for coverage in businesses of all sizes

Firms of all sizes should consider ways to expand eligibility for health benefits to part-time workers and other employees currently ineligible for such benefits. This would not only ensure a healthier workforce, but would also strengthen their ability to attract and retain workers.

Employers should stop the practice of hiring workers for hours just below the "cut off" for health benefits and, where feasible, reduce the number of hours required for full eligibility. They should allow all workers with hours below that minimum to buy into the company coverage with a lower level of employer contributions. They should keep the waiting period for new workers to a maximum of one month. And contract workers who are under contract for a certain period of time (e.g., four months or more) should be given the option to buy into the company plan.

Provide incentives to improve take-up rates by employees

Employers of all size firms should investigate the reasons that employees turn down work-based health insurance and assess the extent to which their workers are turning down coverage because they cannot afford their share of the premium. Where premiums appear unaffordable, employers should consider scaling employee contributions to their ability to pay or offering low-wage workers other incentives to accept work-based coverage. Such incentives might include opportunities to work paid overtime to help pay for premiums, the ability to convert unused vacation days to premium contributions, and other creative methods.

THE ROLE OF GOVERNMENT IN EXPANDING COVERAGE

Larger businesses also can support government actions that address some of the problems facing small companies and lower-income workers. Specifically, CED recommends the following public policy reforms:

Promote purchasing cooperatives

Federal and state governments should provide vehicles, funding, and technical assistance for establishing purchasing cooperatives for small employers and individuals without access to group coverage. We recognize that the models used must be adapted to varying

circumstances. One possible approach, which establishes "insurance exchanges," a minimum benefit package, risk adjustment mechanisms, and quality standards, is described in Chapter 3. Regardless of the exact model selected, however, policymakers and administrators can learn from and build on the experiences of the more successful purchasing cooperatives, such as PacAdvantage and CalChoice in California, the Council of Smaller Enterprises in Cleveland, and the Connecticut Business and Industry Association. And they also can learn from and avoid the mistakes of several purchasing alliances that have collapsed. Those failures suggest several lessons: there must be a sufficient up-front investment in technical expertise, start-up capital, and a strong marketing program; gaining the cooperation of brokers and health plans is critical; and states must enact insurance market reforms that support these cooperatives.

As noted above, large-employer purchasing groups could coordinate with their state governments to make their networks, pricing, and other features available to small firms and individuals. Similarly, in the public sector, governments could open participation in FEHBP or state employee health plans to small groups and uninsured individuals. Some states have considered this approach but encountered political opposition based on concerns that new enrollees would have higher risk profiles and thereby raise the costs for all enrollees. These concerns would need to be addressed, perhaps by piloting the expansion and carefully monitoring utilization, and/or protecting existing enrollees from cost increases over a phase-in period.

Offer premium subsidies to small businesses

At the federal and/or state levels, governments should consider tax credits or subsidies for small businesses with lower-income workers to help them purchase coverage.

Employer subsidies can be designed to reach small employers who cannot obtain affordable insurance and/or employers with low-wage workers who are most likely to be uninsured. They are generally designed to give a "kick start" to employers who are inclined to offer coverage but need some financial assistance to make it possible.

A handful of states have experimented with such subsidies, but with mixed results. A few communities, such as Muskegon County, Michigan and San Diego, also have implemented subsidized insurance programs for small businesses, with considerable success to date. States should consider providing funding to expand these programs to wider geographic areas. The success of these employer subsidy programs appears to depend on such factors as the amount of the credit, the level of publicity and outreach, eligibility criteria, and other design features.[52]

Offer premium tax credits or subsidies to low-income workers

The federal or state governments should provide tax credits or subsidies to low-income workers to help purchase their share of employer-sponsored or individual coverage.

Several Congressional proposals and a plan outlined by President Bush are based on this strategy. States could take the initiative with premium subsidies, which could then lead the way toward national reform. Massachusetts is a leader in this area; its MassHealth Family Assistance Program couples a premium subsidy for small employers and self-employed individuals with a complementary subsidy for low-wage workers. (See Box, MassHealth Subsidy Programs for Small Employers and Low-Wage Workers.)

Expand Medicaid and S-CHIP enrollment and premium-assistance programs

CED calls for states to expand efforts to enroll lower-income workers eligible for

MASSHEALTH SUBSIDY PROGRAMS FOR SMALL EMPLOYERS AND LOW-WAGE WORKERS

The MassHealth Family Assistance Program, established by Massachusetts' Division of Medical Assistance, is designed to make employment-based coverage affordable to low-income employees and self-employed individuals and to small employers with low-wage workers. It has a dual subsidy approach:

PREMIUM ASSISTANCE PROGRAM

The Premium Assistance Program offers subsidies to help low-wage workers pay their share of health insurance premiums. A worker is eligible if: family income is no more than 200 percent of the federal poverty level; he/she is self-employed or works for a small firm OR has children and works for any size firm; and his/her employer pays at least half of the premium for work-based health insurance.

Typically, the subsidy covers the employee's share of the premium in excess of worker contributions of $10 per month per child up to a maximum of $30 per family or $25 per month per adult in families without children.

This subsidy is financed through a combination of state-only funds, state Medicaid funds, federal Medicaid matching funds, and S-CHIP funds. There were approximately 12,000 covered lives subsidized as of September 2000.

INSURANCE PARTNERSHIP

The Insurance Partnership offers subsidies to small businesses (up to 50 employees) to help pay insurance premiums for low-wage workers and to low-income, self-employed individuals.

A business is eligible if it employs 50 or fewer full-time workers, offers comprehensive health insurance, and pays at least half of the premium. The Insurance Partnership pays $400 (individual), $800 (couple or adult plus child), or $1,000 (family) per year toward the employer's health insurance costs for each qualified employee.

The program is financed through state funds. As of September 2000, more than 1,600 employers were enrolled, and more than 4,500 individuals were receiving the subsidized insurance.

SOURCE: Sharon Silow-Carroll, Emily K. Waldman, and Jack A. Meyer, *Expanding Employment-Based Health Coverage: Lessons from Six State and Local Programs,* (New York: The Commonwealth Fund, 2001).

programs such as Medicaid and the State Children's Health Insurance Program (S-CHIP). In particular, states should use the best practices emerging around the country to bolster enrollment. Such practices include:

- using simplified application and verification requirements, translators and multilingual forms;
- conducting Internet-based enrollment at sites where care is delivered, such as hospitals and community health centers;
- sending enrollment workers to churches, Head Start Centers, schools, clinics, and work sites;
- undertaking aggressive marketing campaigns; and

- using "presumptive eligibility," under which states may presume that a low-income person is eligible for Medicaid or S-CHIP, with verification done later.
- assuring eligible individuals with family members who are undocumented residents that it is "safe" to enroll and that relatives' residency status will not be questioned.

States should also make use of their current authority to use federal matching funds to assist workers with their share of premiums under employer-sponsored health coverage. The Medicaid Health Insurance Premium Payment (HIPP) program uses Medicaid funds to pay for the cost of health insurance premiums, coinsurance, and deductibles under employer-sponsored health plans for Medicaid-eligible people with access to employer-based coverage. States must show that this use of public funding is cost-effective. Six states currently operate HIPP programs; Iowa's HIPP is one of the largest, with more than 8,000 people subsidized. Iowa includes working parents who, while not eligible for Medicaid themselves, have children who are eligible. By subsidizing their participation in employer-based insurance, this approach leverages state dollars with federal contributions and actually provides savings to the state.

Similarly, under S-CHIP, states can obtain federal approval to operate an employer "buy-in" that provides premium subsidies to S-CHIP-eligible workers who have access to employer health plans that meet certain requirements regarding, for instance, benefits, cost-sharing limits, and minimum employer contributions. Like the HIPP program, S-CHIP premium subsidies must be less costly than enrolling the individual directly in public coverage. Wisconsin and Massachusetts have been using this mechanism recently, and Maryland and Virginia are planning to begin similar programs.

PAYING FOR HEALTH CARE REFORM

CED acknowledges that some reforms outlined in this report, particularly the public policies to expand coverage to uninsured workers, will require new expenditures. However, we note that other recommendations would produce cost savings for society and, in some cases, new revenues for the government:

- A cap on the tax exclusion of employer contributions would yield additional tax revenue to both the federal and state governments;
- Significant cost savings eventually would derive from new practices and policies that reduce inappropriate care and medical errors and from incentives to select more efficient health plans;
- The reforms in Medicare recommended above would reduce costs significantly for both society and the federal government.

In principle, both these added revenues and cost savings could be reallocated to finance additional expenditures such as targeted subsidies to small employers and low-wage workers and investments in information infrastructure. The *net* cost of reforming the health care system is therefore less than the *gross* cost of the new government outlays envisioned.

Furthermore, the real cost of providing health coverage to the uninsured is measured by the *additional* health care services they would consume *with* health insurance relative to what they now consume *without* it. This cost, although significant, is less than the gross cost of their new insurance. Some of the new consumption of health services would be on primary and preventive care, with a subsequent payback as the use of emergency room and hospital care declines.

Nevertheless, we realize that the ability to capture and reallocate some of these savings is uncertain, and will in any event take time. As a result, new funds would need to be committed at the front end of an effort to restructure the health care system and improve access to care. States and the federal government could use some general revenues, and/or tap specific sources such as tobacco settlement funds or "disproportionate share hospital funds" that are not flowing as intended to hospitals serving large poor populations. Given the projected fiscal constraints faced by governments, raising (or reallocating) the necessary funds will be a challenge that will require political will and support by business and other sectors of society. But it is essential to recognize that investments must be made in the short term in order to realize the longer-term gains of a more efficient health care system, a healthier population, and a more productive work force.

Chapter 5

CONCLUSION

This report has presented CED's strategies for moving to a better health care system. While we have not addressed all of the problems plaguing U.S. health care, we have outlined the key forces underlying the closely entangled problems of escalating costs, uneven and poor quality, and inadequate access. We have outlined a number of specific recommendations that, taken together, would address those problems and improve the system's efficiency and equity. Some recommendations could be implemented by the private sector alone. Others would require partnerships with federal or state governments. Many will take time.

As major purchasers of health care, large employers have a significant stake in improving the system, not only for themselves, but for their employees, small firms, low-wage workers, and those without access to insurance. The current system is clearly unsustainable. If the business community does not lead market-oriented reform, the problems of cost, quality, and access will become even more acute, and a "solution" may be dictated by the public sector. As employers, we prefer to step up, begin the dialogue, and develop the partnerships with other stakeholders that will be needed for systemic change.

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.

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MEMORANDA OF COMMENT, RESERVATION, OR DISSENT

Page 1, JAMES Q. RIORDAN with which HAROLD M. WILLIAMS has asked to be associated.

The report is correct that the U.S. health care system is in crisis and that the nation needs to address the crisis now. It is also correct that private employers should do their part. It is not likely, however, that private employers will assume the primary responsibility for correcting the system failures that are described in this report, nor that they would be successful if they were to. The efforts of private employers to address the cost and quality issues in recent years have brought them more hassles than approval and success. The report also calls for public employers to make a contribution but it does not make the point forcefully enough. If employers are to lead future health care reform efforts it will require primary leadership by public employers and unions as well as private employers. Without such a joint effort private employers are likely to continue to move to a defined contribution mode and will leave it to others to police health care providers.

Page 4, JOSH S. WESTON with which PATRICK W. GROSS and HAROLD M. WILLIAMS have asked to be associated.

The text sometimes confuses two different kinds of choice. The paper focuses on choice amongst third-party payers or administrators (TPAs), which is one category of shopping center or maketplace for employers and employees. Over any length of time, all insurers, PPOs, TPAs, and even HMOs are mostly time-consuming, bureaucratic, expensive, *pass-through* billing agents to employers, policy holders, and governments (i.e., taxpayers). They all are dealing with the same general pool of providers, and the various kinds of TPAs can seldom absorb premium decreases or increasing health costs. (Even the employer is a pass-through agent, unless he just passes out.) And, in the end, all health payments ultimately become a variation of fee for service, either directly or indirectly. Therefore, "control" of provider fees, not TPA fees, is the more urgent challenge.

In order to really "control" escalating fees and influence the quality and quantity of service, the most significant shopping center is at the *point of service* or prescription. This is where the two real decision-making parties (doctor and patient) set the transaction. Generally, neither doctor not patient (or family) has sufficient knowledge or economic incentive to effectively and jointly evaluate alternative cost/benefit decisions. Generally, they're the true independent variable in cost outcomes, even though they're not spending their own money; and their judgments are often influenced by various imbalanced externalities (including industry salesmen, consumer advertising, fear of lawyers, etc.). Therefore, where feasible, employers should always include an affordable co-pay on top of an affordable deductible, to encourage some degree of cost consciousness by the employee.

Furthermore, insured patients seldom know or ask about costs because they usually have a small economic stake, as they are allowed almost unlimited demand, mostly using "other people's money." Most patients

are not even asked to confirm to the TPA that the transactions are properly described (in reasonable English) and fairly billed. Many are not.

The patient *seldom* sees an itemized bill, even after the fact. With Medicare, Medicaid, most big TPAs, PPOs, and open networks, the itemized bill is initially sent *only* to the payer (who doesn't generally verify anything with the patient). If there is a balance due from the employee (co-pay, uncovered items, etc.), it is generally displayed to the employees as "previous balance still unpaid." Occasionally, it might be accompanied by a display of *numeric codes* that allude to procedures, all *without words*. It's unintelligible to the patient/employee.

If my comment above is accurate, and if the issue is significant and important, then experienced business people, should seek systems that require significant invoices be presented to a TPA with prior endorsement by the patient or family member (or *by the prescribing MD* in the case of big hospital, pathology, radiology, or pharmaceutical bills). What large company would pay a vendor bill without a receiving ticket from his receiving dock confirming the accuracy of the invoice?

Doctors seldom know or care about the alternative treatment cost/benefits involving drugs, devices, care protocols, or ancillary specialist charges (radiology, anesthesia, etc.), few of which are "regulated" by PPOs or TPAs. I've personally seen many cases where the (invisible) ancillary specialist has billed a lot more than the attending surgeon (who doesn't even know of this imbalance). This is an unresolved challenge.

Page 5, JAMES Q. RIORDAN

The report recommends a number of changes in the tax law in the hope that these changes will help to solve the problems of the health care system.This is an unfortunate approach. Our tax system is already overly complicated. Our tradition of voluntary assessment is on the verge of collapse. The administration of the tax law is too burdened with social engineering responsibilities. It is poor policy to impose additional duties on the Revenue Service at least until we have made significant progress in simplifying the current tax law. Some of the tax recommendations are evidently based on a view that the income tax should be made more progressive. The appropriate degree of progressivity in our tax system is a critical policy issue for debate. (It might be a good topic for a CED study.) Whatever we decide about progressivity, however, it should be implemented through the rate structure not through endless changes and adjustments in the definition of the tax base. This point is more fully developed in the recent Simplification Report by the Joint Committee on Taxation.

Page 26, RICHARD W. HANSELMAN

While much has been written, said, and broadcast about managed care, the central issue is affordability. Without affordable health care, businesses large and small will be unable to provide health benefits to employees, the governments' budgets will be under profound strain, and the number of uninsured will skyrocket.

There are significant cost pressures. Financial expectations of the participants in the system continue to rise. Administrative costs are a persistent headache. Finally, the cost of litigation and its byproduct, defensive medicine, exert a pernicious influence on quality and cost issues.

In looking at these vexing issues, managed care companies believe that business can help by focusing on a few key issues.

The debate over the patients' bill of rights masks some very important underlying questions. Will a right to sue ever ensure

a patient gets the health care he or she needs when he or she needs it? No. The right to sue will only create new barriers to care, more red tape and a potential windfall for trial lawyers.

The important issue is that patients have a clear and speedy recourse for coverage decisions where there is legitimate medical debate regarding safety and efficacy. Should an adverse version of the bill be enacted, it would open health plans to liability over a wide range of issues and force coverage for products and procedures that are unproven. This will add to cost without adding anything measurable to quality.

The key is to have remedies in place for speedy, independent third party review of such disputes. Such a system exists today in California and it works. This ensures that patients get the right care in the timeliest fashion possible.

At the same time, business should oppose mandates that demand coverage of more services unless a comprehensive, independent cost/benefit analysis demonstrates the value of such a mandate.

On another front, the health care system in the U.S. spends far too much time, money, and effort on administration. In order to address this, leading health plans have formed two groups—an industry-wide effort called the Coalition for Affordable, Quality Healthcare (CAQH) and an independent company called MedUnite.

CAQH is developing standardized procedures for fundamental administrative processes such as checking eligibility, determining coverage, including pharmaceutical coverage, providing prior authorization for procedures, submitting claims, and others. Physicians repeatedly complain about the administrative hassles and health plans are doing something about it.

CAQH is also developing programs aimed at lessening improper use of antibiotics and other quality initiatives.

MedUnite is a company formed by leading managed care plans to put many of these processes online, so that physicians, hospitals, labs and other suppliers can conduct business easily and quickly over the Internet. In one test of a similar system, simply checking eligibility online reduced the incidence of rejected claims from incorrect patient information by 100-fold.

Managed care plans are not perfect. But, they are taking steps to improve the health care system and ensure that health care insurance remains affordable for American business and American workers.

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For 60 years, the Committee for Economic Development has been a respected influence on the formation of business and public policy. CED is devoted to these two objectives:

To develop, through objective research and informed discussion, findings and recommendations for private and public policy that will contribute to preserving and strengthening our free society, achieving steady economic growth at high employment and reasonably stable prices, increasing productivity and living standards, providing greater and more equal opportunity for every citizen, and improving the quality of life for all.

To bring about increasing understanding by present and future leaders in business, government, and education, and among concerned citizens, of the importance of these objectives and the ways in which they can be achieved.

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Through this business-academic partnership, CED endeavors to develop policy statements and other research materials that commend themselves as guides to public and business policy; that can be used as texts in college economics and political science courses and in management training courses; that will be considered and discussed by newspaper and magazine editors, columnists, and commentators; and that are distributed abroad to promote better understanding of the American economic system.

CED believes that by enabling business leaders to demonstrate constructively their concern for the general welfare, it is helping business to earn and maintain the national and community respect essential to the successful functioning of the free enterprise capitalist system.

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