Quality, Affordable Health Care for All
Moving Beyond the Employer-Based Health-Insurance System

A Statement by the Research and Policy Committee of the Committee for Economic Development
Quality, Affordable Health Care for All
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The Committee for Economic Development is an independent research and policy organization of over 200 business leaders and educators. CED is non-profit, non-partisan, and non-political. Its purpose is to propose policies that bring about steady economic growth at high employment and reasonably stable prices, increased productivity and living standards, greater and more equal opportunity for every citizen, and an improved quality of life for all.

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.

The full Research and Policy Committee participates in the drafting of recommendations. Likewise, the trustees on the drafting subcommittee vote to approve or disapprove a policy statement, and they share with the Research and Policy Committee the privilege of submitting individual comments for publication.

The recommendations presented herein are those of the trustee members of the Research and Policy Committee and the responsible subcommittee. They are not necessarily endorsed by other trustees or by non-trustee subcommittee members, advisors, contributors, staff members, or others associated with CED.
Health care is perhaps the major public policy question mark hanging over this nation’s future, in terms of both our prosperity and the quality of our lives.

The United States spends significantly more of its gross domestic product on health care than any other developed nation, but our quality of health – as measured by improvements in longevity, the prevalence of chronic disease, or infant mortality, for example – is mediocre at best. Some of this result undoubtedly comes from “life-style” choices, but some clearly comes from the nature of our health-care system. Lives are shortened and people suffer because our health dollars do not buy the care that we need.

Furthermore, the growing cost of health care threatens the budgets of households, businesses, and governments at all levels. Health insurance is beyond the financial reach of many American families, leaving them unprotected and often wanting for necessary care. Businesses strain to continue paying the insurance premiums for the coverage that their workers have come to expect. Important public issues are crowded out of government fiscal plans by the costs of health care for the elderly and the needy. If those costs continue to grow at current trends, they will soon consume all of the revenues now devoted to our national, state and local priorities.

The health-care crisis looms so large that it is natural to wonder which part of the problem to tackle first. For some years, the Washington policy community has focused its greatest concern on the cost of Medicare and Medicaid, linked as those programs are to the aging of the baby-boom generation. Budget analysts have noted, as has CED, that the confluence of the rising costs in those programs alone will make the current federal budget structure unsustainable. However, CED has long believed, and the consensus of opinion now appears to agree, that policy cannot achieve enduring reform of the public health-care programs taken by themselves. Because our health-care system is an interdependent whole that treats public and private patients side-by-side, sustainable reform must embrace the entire system. And the core of that system is employer-based health insurance.

The largest segment of our population – persons of working age and their dependents – customarily has obtained its health-insurance coverage through employment. Yet that part of our health-care system is failing. It is fully as deficient as the government-run and financed sector – just as financially unsustainable and inefficient, if not more so. Private budgets are just as threatened as public budgets, businesses are hard-pressed to maintain their health-insurance commitments to their employees and remain competitive, and the health of those privately insured is not what it should be, given the power of this nation, and the amount we pay. The lack of secure care for those without insurance is a threat to their health and finances, and in the long run, to those of the entire population.

CED recognized the crucial role of the employer-based health-insurance system in our 2002 policy statement, A New Vision for Health Care: A Leadership Role for Business. In it, we presented our recommendations for private employers to restructure their employees’ insurance for greater quality and sustainable cost. However, we have seen little progress toward the implementation of the recommendations of that statement, while quality, affordability and access to insurance have continued to deteriorate. Accordingly, we undertook a new project to review the issue, and determine what is needed for our working-aged population and their dependents to achieve affordable health care – as a first step toward quality and sustainability for the entire health-care system.

Our fundamental problem is two-fold. We as individuals can demand more and more health-care services without directly feeling their extra costs; and the dynamics of the health-care industry do not work to close the enormous gap between the most efficient providers of health care and the inefficient ones, as occurs naturally in the rest of our economy. This new CED policy
statement finds that employers acting alone or even in voluntary consortium cannot achieve the kind of systematic change to fix this problem and for which we had hoped in our previous policy statement. Instead, it recommends a new approach that marries market forces with appropriate government structures and incentives to drive improvements in coverage, quality, and value. The statement explains that such public-policy action is needed to head off the ongoing deterioration of quality, affordability and access that threaten both the health and prosperity of our entire society now and for decades to come.

CED does not support either a government-run command-and-control system, or a so-called consumer-directed system under which individuals would take at least implicit responsibility for choosing their own therapies and treatments. Instead, the statement recommends market-based consumer choice among competing insurance and care-delivery plans that meet quality and coverage standards. A key recommendation is that this consumer choice must be responsible — that is, the consumer, informed by mandatory and standardized reporting of quality and performance by insurers, must be able to save money by choosing a less-expensive plan. Another key recommendation is the establishment of an independent regulatory agency, fashioned after the Federal Reserve and the Securities and Exchange Commission, to report on the state of the health-care sector in terms of inflation and affordability, and ensure the efficiency and fairness of the insurance market. In the system’s ultimate form, after an ambitious but measured phase-in process, every consumer would receive a premium credit that would purchase the low-priced plan that met rigorous quality standards. CED believes that such a reform of our health-care financing system would lead insurers and providers, through market competition, to restructure fundamentally the health-care delivery system, improving both quality and affordability. Thus both universal coverage and financial sustainability would be achieved.

We hope that these findings will stimulate a constructive, nonpartisan debate of this truly crucial public-policy issue.

Acknowledgements

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The U.S. employer-based health-insurance system is failing. Fewer American workers have insurance now than did seven years ago; and fewer American firms are offering health insurance now than did then. Many people do without care because they are not covered, or fear – with justification – that one illness or the loss of a job will cost them their coverage. The competitiveness of American firms is threatened by the cost of health insurance. Public budgets at every level of government are eroded by the costs of health care, including costs that previously were paid by employers. Though the United States is the wealthiest nation in the world and arguably has the best care for persons with dire health needs who do have coverage, our overall health status is mediocre at best. We believe that our health-insurance system is in crisis, and needs immediate attention to stop steady erosion that may become sharp, quantum deterioration.

Is the U.S. Health-Care System Failing? Performance Standards for a Nation's Health-Care System. The standards by which to judge the overall performance of a health-care system are cost, quality, and access. “Cost” is the usual shorthand term for the amount a society spends on health care. Do health insurance and health care remain within reach for families of moderate means? Can health-insurance premiums fit within the total compensation that is affordable by the employers of most or all people?

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

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

For all of our country's wealth and power, our health-care system demonstrably fails to meet these basic criteria. On cost, the price of an average family insurance policy – $11,500 per year for a family of four in 2006 – is almost 20 percent of the earning power of the median household, and the cost is growing about 2.5 percentage points per year faster than GDP. Thus, health insurance is pricing itself out of reach. On quality, authoritative studies document numerous errors of prescription and treatment, and inappropriate and unnecessary surgery and hospitalization, that cause unnecessary suffering, illness, injury and cost. There are wide variations in medical practices from one community to another, and even among doctors in the same community. Moreover, a 2003 study by RAND found that consumers are receiving only about 55 percent of the care called for under generally accepted standards of medical practice. But perhaps most seriously, on access, 47.0 million Americans were without health insurance in 2006, up from 38.7 million in 2000.

Employer-Based Health Insurance Is in Decline. Most insured Americans get their coverage through employment, either theirs or a family member’s. But the number and percentage of Americans covered by employer-based health insurance (EBI) is declining. From 2000 to 2006, the absolute number of people covered by EBI fell from 179.4 million to 177.2 million; and the covered percentage of the population under age 65 fell from 68.3 percent to 62.9 percent. From 2000 to 2007, the percentage of firms offering health benefits fell from 69 percent to 60 percent, reflecting mainly small employers dropping EBI. There are underlying forces, especially the rapidly increasing cost of health insurance and small employers locked out by pre-existing conditions, that make this trend likely to continue.
Why Is This Happening? The entire health-care financing system rests on inflationary foundations. The incentives and the organization of health care work against affordable care.

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

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

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

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

Compounding these structural problems, there has been a large increase in the prevalence of chronic disease and our ability to treat it – and the cost of doing so. Twenty medical conditions accounted for 67 percent of the per capita growth in private health-insurance costs between 1987 and 2002. The health-care system is not oriented to early detection and treatment or to chronic disease management, but rather to a visit to the doctor and the collection of a fee for a service to treat symptoms when they arise.

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

EBI Costs Cause Employers Major Problems. Employers, the primary purchasers of health insurance, must deal with the insurance market as it exists; they cannot themselves change the structure of the entire system. EBI costs give employers a powerful incentive to try to avoid this growing burden – which employers do, in part, by tightening restrictions on who is eligible for EBI, and by increasing required employee contributions so that low-paid workers do not choose to pay their share and participate. Or, employers can simply close the plant or office and obtain the services from lower-cost labor overseas, or from low-cost employers in this country who do not provide health insurance. These policies may mitigate employer problems, but they cause serious human problems, and they do not help forestall the decline in EBI.

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

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

Proposed Solutions – Past and Present – Do Not Work

“Band-Aids.” For at least 35 years, there has been a slowly building realization that our health-care system is not sustainable. Public policymakers and private actors have tried to respond, yielding a discouraging history of espousing and adopting simplistic and partial “solutions” ranging from utilization reviews, or attacks on “waste, fraud and abuse,” to “managed care” – veritable “Band-Aids” on top of a fundamentally flawed system. Some of these contained germs of good ideas, and some could be part of a rational comprehensive solution; but none came close to addressing our fundamental problems. Likewise, new ideas such as health information technology and digital health records would help, but would not solve the fundamental, systemic weakness in health-care delivery.

Consumer-Directed Health Plans (CDHPs).

CDHPs are claimed to be something close to a complete answer for the problems of the nation’s health-care system. CDHPs are insurance plans with high deductibles, which the consumer must pay before insurance coverage begins. Consumers may have health savings accounts (HSAs), funded either by themselves or by their employers, to pay for care under the deductible. Because of the high deductible, the premium can be lower. Also because of the high deductible, consumers would be expected to engage in preventive care; and then, when illness or injury strikes, to use the latest information technology to find the most economical and efficient therapies and treatments, to minimize their out-of-pocket spending under the CDHP deductible, and to protect the balance in their HSAs. In this way, it is claimed, total health-care costs would be brought under control. Though CDHPs are better than no coverage at all, they are not a complete solution. Health expenditures are very concentrated on relatively few people. In any given year, well over 80 percent of health expenditure dollars will be spent on people who have exceeded their deductibles or can safely expect to do so, for any level of deductibles that is reasonable. Many people with chronic conditions can expect to reach their deductibles, as can anyone who has been an inpatient in a hospital, or is likely to enter a hospital. Once CDHP enrollees have reached their deductibles, they will in effect be in cost-unconscious fee-for-service medicine. CDHPs will be advantageous to those who are both healthy and wealthy, because they can both afford the higher deductibles and take the most advantage of the health savings account tax shelter (which benefits most those in the highest tax-rate brackets, but is worth next to nothing to the worst-off taxpayers who face a very low or even zero-percent tax rate). The loser may be the fairness of our private health-care financing system – not to mention the viability of health insurance for those who are not fortunate enough to benefit from CDHPs.

Single Payer, or “Medicare for All.” Another “big idea” for health-system reform is a “single-payer” system, like Canada’s. Probably at the federal level, government would serve as the single health insurer, cover everybody, and pay all the bills according to a government-determined or negotiated fee schedule. Another name could be “Medicare for all;” every American would be covered by the Medicare program or something very similar. In the United States today, this model has features with great appeal, like universal coverage and one billing system. However, the U.S. single-payer system, Medicare, is locked into uncoordinated, fragmented fee-for-service medicine; it has proven practically impossible for Medicare to break out, with the law allowing patient access to any willing physician. Medicare fee-for-service has built-in incentives for delivering volume, not quality. It motivates, or is compatible with, a great deal of over-use, under-use, and misuse of services. Studies show that Medicare patients in the last six months of life in Florida get several times as many doctor visits as similar patients in Minnesota, while reporting less satisfaction with their care. Thus, a single-payer system might provide universal coverage for a time, but costs would surely
continue spiraling out of control – as they are in Medicare today – threatening everyone’s coverage.

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

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

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

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

Health-care providers who need to satisfy cost-conscious consumers must organize their systems for **chronic-care management**. As of September 2004, 133 million people, almost half of all Americans, live with a chronic condition. Almost half of these people have multiple chronic conditions. In 2001, the care given to people with chronic conditions accounted for 83 percent of health-care spending. Today’s health-care and payment systems are designed to manage and pay for acute episodes, not chronic conditions. Fee-for-service generally pays for episodes such as doctor visits or procedures, not for on-going preventive and chronic care such as counseling sessions.

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

Although the share of health spending on patients in their last year of life has often been exaggerated, it remains significant: it is about 30 percent of Medicare, and Medicare is about 17 percent of national health expenditures. There is substantial regional variation. The high-spending regions spend 60 percent more per patient and provide more services than the low-spending regions, but Medicare enrollees in higher-spending regions do not experience better health outcomes or satisfaction with care. Providers in a cost-conscious system will need to develop more-humane alternatives for **end-of-life care** that are less specialist- and ICU-intensive than the acute inpatient setting.
The huge flow of medical information (over 10,000 randomized trials are published each year) is beyond the grasp of solo or small group practitioners. A successful system must translate this information into up-to-date science-based best-practice guidelines and conveniently integrate them into actual care delivery. Health information technology can include caregiver support tools – such as shared comprehensive electronic health records, guidelines, prompts, and reminders – to monitor performance and take corrective actions. Care should be delivered in the least-costly appropriate settings, considering total system costs, not just costs and revenues associated with one setting – with smooth transitions and hand-offs between care settings, so that, for example, outpatient providers are well-informed on inpatient care (and vice versa).

Although this restructuring would radically change America’s health-care delivery system, each of these expectations is nonetheless reasonable on its face – no more than what one would reasonably expect from a well-run world-class competitive company that adapts to technology and market challenges and opportunities in any other sector of the economy.

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

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

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

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

It would be essential that wide-access PPO plans be available, so that everyone who wanted to continue with such coverage and with his or her own physician could do so; every consumer could “keep what he (or she) has.” Plans could charge no difference in premium for age or preexisting conditions (unlike the current individual insurance market). These exchanges would set standards for plans to ensure quality, comprehensive coverage, and consumer protection through standardized “fine print.” Each exchange would provide side-by-side plan comparisons, and would organize an annual open season at which individuals could change plans – introducing competition into the marketplace for health insurance and care. Each exchange would “risk-adjust” premium revenue to insurers – that is, pay more to insurers that cover relatively more people with expensive conditions. Risk adjustment is already undertaken by insurers in some private systems that resemble what we propose and has just been adopted for the private Medicare insurers.

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

Second, subject to progress of the exchanges and the willingness of the public to provide the financing, every household would receive a fixed-dollar credit sufficient to purchase the low-priced quality health plan offered in its region. Every individual, therefore, would be able to buy quality health insurance at no out-of-pocket cost, and coverage would be universal. As an alternative to the low-price plan, an individual or household could choose to purchase a more-expensive plan by paying the additional cost above the low-priced plan, using after-tax dollars. Such fixed-dollar contributions have been used with success in the employer context by Hewlett Packard, Wells Fargo, the University of California, and Stanford University, and the states of Washington, Wisconsin, and California. The fixed-dollar credit would be financed by eliminating the current exclusion for employer-provided insurance, and by broadly based tax revenues – for example a payroll, value-added or environmental tax. In effect, every individual in the nation would contribute toward the health-insurance program, and every individual would be entitled to insurance – without costly “mandates” or means-testing.

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

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

This design would focus competition on value for money in the informed best judgment of consumers, and not in any way pick winners and losers in advance. The competitive market would do that, over time. The system should encourage differing delivery modes to foster competition and innovation. In the end, some existing models might be winners in the competitive marketplace, or the winners might be entirely new, as-yet-unimagined models. One thing would be certain: the outcome would be better than what has gone before because the incentives and opportunities for consumers to make economizing choices, and the need for insurers and providers to seek improvement to satisfy consumers, would be enormously increased.
The Cost of a Reformed Health-Insurance System. Universal coverage would increase the number of people seeking services, but cost-conscious consumers would gradually migrate toward less-expensive plans; and all plans would seek efficiencies to reduce their premiums. CED plans further research, including a full actuarial assessment of our recommendation in detail. However, basically similar legislation proposed by Senators Ron Wyden (D-OR) and Robert F. Bennett (R-UT) (which does differ in some significant details) is estimated to reduce total national health-care spending by a small percentage in the first year, rising to 7.7 percent in the tenth year. The savings would be the net of costs for additional services for the newly insured, more than offset by savings from the incentives of price competition for consumers and insurers, and additional savings in administration. In other words, under a system of responsible, cost-conscious consumer choice, the issue is not how much the nation spends on health care, but who pays a smaller total; if the nation can use the resources that are now devoted to health care – by employers, households, and governments – then it can afford coverage for all, with money left over, and the savings would grow over time. However, mobilizing all of the resources now used for health care would be a non-trivial task. We believe that a financing solution is attainable, and we plan further research.

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

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

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

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

Phase I: Building the Foundations for Responsible Choice. To create an administrative structure, modernize and adapt the FEHBP into a framework for a national system of health-insurance exchanges. Use fixed-dollar contributions to encourage responsible choice; introduce risk adjustment; establish a minimum benefit standard for all plans; and allow premiums to vary by region. To ease market entry in many locations across the country, to make the system more competitive and less costly, and to eliminate conflicts between state and federal health-insurance regulation, modernize and simplify health insurance regulation by creating an alternative federal regulatory system that participating multi-state health plans can choose instead of being regulated by states. To perform such regulation, build a new independent agency – a “Health Fed” – patterned on the Federal Reserve...
Board and the Securities Exchange Commission. To provide authoritative scientific information about the value and costs of clinical interventions, create a national institute for medical outcomes and technology assessment. And to reverse the recent growth in the number of the uninsured, expand existing safety-net programs, especially the State Children’s Health Insurance Program (SCHIP), pending the availability of true universal coverage.

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

Phase III: Achieve Market-Based Universal Health Insurance. To complete the transition to universal health insurance, replace all employer contributions with universal fixed-dollar contributions paid for with broad-based tax revenues. To help finance this, eliminate any tax break for employer-paid health insurance.

Conclusion

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

Merely extending coverage – even to universal coverage – under the current system would not solve the core problem, because with the cost of coverage growing faster than the economy’s capacity to pay it, no coverage is secure. Command-and-control systems have a poor track record in modern economies; and medical care is too complex to devolve all authority to the individual patient. Market-based universal health insurance, with individuals choosing the health plans and delivery systems that they deem best, shows great promise – much greater than any alternative.
The U.S. employer-based health-insurance system is failing. Fewer American workers have insurance, and fewer American employers are offering health insurance, than did seven years ago. Many people forgo care because they are not covered. Many fear – with justification – that one illness or the loss of a job will cost them their coverage. The competitiveness of American firms is threatened by the cost of health insurance. Government budgets at every level are strained by the costs of health care, including costs that had been paid by employers. The failing employer-based insurance system is dragging down the entire health-care delivery system. Though the United States is the wealthiest nation in the world, with what may well be the best care for persons with dire health needs who do have coverage, our overall health status is mediocre at best.

CED believes that our entire health-care finance and delivery system is in crisis, and in need of immediate attention – to stop steady erosion that may soon become a sharp deterioration. As employers, we are concerned for the health and financial well-being of our employees; but our concerns reach much further. The lack of care and the costs suffered by those Americans without insurance are a national blight. The compounded expense of emergency care for their neglected illnesses is a burden on those with insurance coverage. Furthermore, the growing cost of care for those with coverage is a threat to the health care of all Americans.

CED believes that business must play an important role in the future of health care. Since World War II, more by accident than design, business has accumulated most of the responsibility for, and much of the expertise on, the financing and the structure of the health-care system for the working-aged population and their dependents. The subsequent deterioration of the health-care system has handicapped business in international competition and in meeting the needs of its employees. Business has been entrapped in the problem, and business needs to be a part of the solution.

Furthermore, CED believes that business offers unique insight to find the solution. Government fiat cannot for long maintain affordable, quality health coverage. To summarize, we believe that the continuation of the dominant uncoordinated, small-practice fee-for-service model of health-care delivery, largely sheltered from competition and therefore lacking innovation in organization and process, has increased cost without improving access or most dimensions of quality. We believe that competition among private insurance plans, to attract informed, cost- and quality-conscious consumers, is the only way to achieve sustainable, affordable, quality health care for all Americans. By reforming the financing system for health coverage, we can create the incentives that will drive insurers and providers to reform the health delivery system. In sum, CED believes that the competition by which business lives every day, carefully channeled to reward only the delivery of quality care at affordable prices, holds the best promise of meeting the health-care needs of every American.

This introduction will explain why the current health-care system is plagued with high and rising costs and mediocre quality. The second chapter will show why purported remedies, past and present, have not worked and will not work. The third chapter will outline the improvements in care that would be possible with a market-driven system. The fourth chapter will describe such an incentive-oriented system, and the final chapter will lay out a road map to get there.

Why Another CED Statement on Health Care?

Five years ago, the Committee for Economic Development issued a policy statement entitled A New Vision for Health Care: A Leadership Role for Business. That

*A detailed summary of that statement and an evaluation of subsequent developments are included in Appendix A.*
statement presented major recommendations for large businesses, and for businesses in conjunction with government. The statement decried “…the closely entangled problems of escalating costs, uneven and poor quality, and inadequate access,” and stated that the “recommendations..., taken together, would address these problems and improve the system's efficiency and equity… This report is a call to action. We challenge our own members, the business community at large, public policymakers, and other sectors of society to join us in taking the difficult steps necessary to create an efficient system that will provide access to high-quality health care for all Americans.”

Although we continue to believe that the recommendations in that statement are sound, we see no signs of employer action. The number of Americans with employer-sponsored health insurance, and the number of employers who offer health coverage, have continued to decline. Meanwhile, the retirement of the baby-boom generation, with its demography-driven pressure on the nation's health-care system, has drawn ever closer. A national poll has found that sixty percent of Americans believe that the federal government should guarantee health insurance to every American, and are willing to pay higher taxes and forgo future tax cuts to achieve universal coverage.

The nation's health-care problems are becoming critical. Rising health costs strain both public and private budgets, and make many American businesses less competitive. Care needed by rich and poor alike is wanting. We conclude that even more-aggressive public-policy action is needed. The remainder of this chapter will explain why.

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

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

“Cost” is the shorthand term for health-care expenditures – that is, the amount a society spends on health care, measured either per capita or as a percentage of the gross domestic product (GDP). It makes sense that an affluent society, as it grows still more affluent, would choose to devote some (or even much) of its extra income toward its health. But beyond the question of whether growing expenditures buy improved care, or rather are merely a rear-guard action against the ill effects of unhealthy lifestyles, we must care about affordability. Do health insurance and health care remain within reach for families of moderate means? Can health-insurance premiums fit within affordable total compensation of employees? Finally, is the trajectory of health expenditures sustainable – that is, growing no faster than the GDP, or not much faster than affordable total compensation of employees? In these terms, cost as a percentage of the GDP measures a share of people's earning power.

Those costs that do not impose on family budgets are paid by government. More than 60 percent of national health expenditures (NHE) now passes through public-sector budgets (including the tax exclusions for employer-paid health benefits, and insurance costs for public employees) and is therefore a drain on government finances, leading to higher deficits or taxes, and crowding out other vital public services. If health insurance is not affordable to people with low incomes, is there room in public-sector budgets for subsidies to help those people purchase health insurance?

“Quality” has many meanings. Americans like to think that we have the highest quality health care in the world. That may be true in the sense of the most advanced medical technologies for well-insured people. But other concepts of quality have gained attention lately. How likely are Americans to receive recommended care – that is, those interventions that are well-supported by clinical evidence and are known to benefit patients? How likely are patients with serious chronic conditions to get the care they need? How likely are they to get appropriate care – that is, care of the kind and in just the amount that confers maximum benefit, but no more? Inappropriate care is the medical term for what is often called “unnecessary care.” How many people are in the hospital unnecessarily, or for a condition that could have been prevented by less-costly and less-invasive outpatient care? How many operations do people have that are not the best for their health? Is American medical care safe? How

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1 A more detailed evaluation of the evidence is included later in this statement.
often is the wrong limb amputated? How likely are Americans to die or suffer from hospital infections or errors in hospitals or in medications? And finally, is quality improving as a consequence of better-organized care, or is it suffering from increasing fragmentation of care delivery?

“Access” is shorthand for people’s ability to obtain appropriate care, and it has a financial component and a delivery-system component. The financial component generally refers to health insurance that makes care reasonably affordable to people who need it, and whose provisions, like coinsurance and deductibles, do not deter people from obtaining care that is important for their health. The delivery-system component refers to having geographic and transportation access to a facility and to professionals who will provide appropriate care, which can be a special problem in rural areas.

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

Does the American Health-Care System Meet These Standards?

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

On the question of cost, NHE have been growing about 2.5 percentage points per year faster than GDP over the past 25 years. NHE in 2006 were about 16.5 percent of the GDP. If these rates continue, NHE will reach about 28 percent of GDP by 2030. The price of an average family insurance policy, $11,500 per year for a family of four in 2006, can be weighed against typical family earning power. The median family income in the United States in 2006 was less than $60,000. Thus, a family health-insurance premium in 2006 – not including other out-of-pocket health-care costs – is almost 20 percent of the earning power of the median family. And in 2004, the government share of health-care cost was about one-third of the total of federal, state, and local budgets. Once the baby-boom generation begins to retire, public health-care costs (especially for Medicare) will grow even faster. Thus, if health outlays are not unbearable today, they soon will be. Both public and private health-insurance purchasers have been unable to constrain their shares of NHE to sustainable growth rates.

When it comes to quality, the Institute of Medicine (IOM) of the National Academy of Sciences reported that between 44,000 and 98,000 Americans die annually in hospitals from medical errors. A recent IOM report estimated that at least 1.5 million Americans are sickened, injured, or killed each year by errors in prescribing, dispensing, and taking medications. Drug errors cause at least 400,000 preventable injuries and deaths in hospitals each year, more than 800,000 in nursing homes and facilities for the elderly, and 530,000 among Medicare recipients treated in outpatient clinics. A 2003 RAND study found that only about 55 percent of the care called for under generally accepted standards of medical practice was actually being delivered. Adopting technologies to improve this situation has been very slow. RAND studies also have documented considerable overuse of care. Dartmouth studies have shown wide geographic variations

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7 Government health outlays (and the revenue cost of tax exclusions) at all levels were about 10 percent of GDP. In 2004, all government receipts at the federal, state and local levels were about 30 percent of GDP.
in medical decisions such as the frequency of hospitalizations and surgery per capita. Thus, strong evidence indicates that some people are getting too much (that is, unnecessary or unhelpful) care, and others too little.

Still, the failure of our health-care system in terms of access may be the most serious. According to an August 2007 Census Bureau report, 47.0 million Americans lacked health insurance in 2006, up from 38.7 million in 2000. The uninsured have worse health outcomes than similar people with insurance. This situation is clearly contrary to our nation’s values. People should not suffer and die for lack of ability to pay.

America has numerous patchwork public programs to compensate for the lack of universal insurance coverage. It would be simpler – and a lot cheaper – to make sure everybody had at least financial access to appropriate care. As just one indication of the potential savings from broader coverage with sound primary care, the New York Times recently reported that a Texas hospital found that it could actually save money by providing free preventive outpatient care to diabetics, instead of more expensive emergency hospitalization which the hospital was obligated to provide without reimbursement.

Is universal coverage a utopian, socialistic dream, or is it a practical, economically and morally compelling goal for our society? Most other advanced democracies have achieved it, and we could do so too – with a system built on our own history and consistent with our own values.

Why Is Employer-Based Health Insurance Declining?

Most insured Americans get their health coverage through employment, either theirs or a family member’s. But the number and percentage of Americans covered by employer-based health insurance (EBI) are declining. The Employee Benefits Research Institute (EBRI) found that the percent of all workers with EBI fell by 2.8 percentage points between 1987 and 1999. Another survey showed a decline from 1999 to 2004 of 3.5 percentage points. Linking the two series implies a decline of about 6.3 percentage points from 1987 to 2004. Data from the Bureau of Labor Statistics suggest a greater decline for full-time workers in the private sector – a decrease in coverage of 15 percentage points from 1989-90 to 2003. From 2000 to 2006, the absolute number of people covered by EBI fell from 179.4 million to 177.2 million. And the covered percentage of the population under age 65, the percentage of workers in all firms and their dependents who were covered by EBI, fell from 68.3 percent to 62.9 percent. From 2000 to 2007, the percentage of firms offering health benefits fell from 69 percent to 60 percent, reflecting mainly small employers dropping EBI. The rapidly increasing cost of health insurance makes this trend likely to continue. Falling EBI coverage shifts the costs of the health-care system onto those employers that do provide insurance, and onto government.

Health-insurance premiums are rising faster than the affordable increases in total compensation, and therefore, faster than incomes. Premiums in 2007 are estimated to be almost double those of 2000. Health insurance is pricing itself out of reach. Of course, the real problem is not the insurance policies themselves but the underlying cost of health-care services.

The Causes of High and Rising National Health Expenditures

Rapid health expenditure growth is widespread. Though other advanced industrialized nations have lower levels of health-care spending as shares of their GDPs, their expenditures are rising over the long term at faster rates than their GDPs (though somewhat slower than in the United States). So health expenditure increases are a global phenomenon. Within the United States, government health programs such as Medicare and the Federal Employees Health Benefits Program (FEHBP) are affected as much as employer-based insurance.

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4 These studies adjust for differences in the characteristics of the different populations.

5 Nor should others refuse to buy insurance they could afford and then impose their health costs on other people, either by presenting themselves for free care, or by trying to sign up for insurance after they already are ill.

6 These programs include the Emergency Medical Treatment and Active Labor Act (EMTALA), the law requiring hospitals to care for uninsured people; disproportionate share payments by the federal government to hospitals in areas that have above-average proportions of the uninsured; Medicaid; the State Children’s Health Insurance Program; Ryan White for AIDS; Maternal and Child Health; and so on.
The following causes of rapid health-cost growth interact with each other.

First, there is cost-unconscious demand. In the United States, we have created a system in which most people—patients and providers alike—have little direct personal interest in making the most cost-efficient health-care choices, and often little opportunity to do so.

Health care-delivery in the United States is dominated by fragmented, uncoordinated, small-practice fee-for-service medicine (FFS), under which patients have a wide choice of doctors, and insurers pay piece-by-piece for every service the patient receives. This system is filled with cost-increasing incentives, and rewards and encourages such inefficiencies as wasteful duplication of tests. It is poorly organized for overall economy and safety, systematic improvement, or even performance measurement. It lacks incentives for cost-saving innovations such as health information technology, which often are not in the economic interest of individual providers. FFS leaves insured patients cost-unconscious, because they are not responsible for the cost of any extra service. FFS even reduces the incomes of providers who innovate to reduce the need for services. Indeed, providing patients with more services, even if they have little or no medical value, results directly in greater incomes for providers. Unfortunately, FFS also sets the standard for economic performance in the non-FFS sector. For example, Medicare payments to health-maintenance organizations (HMOs) are tied to FFS costs in the same geographic areas, and so prepaid group practices have been able to raise their prices in step with FFS-based insurance.

Cost-unconsciousness is exacerbated by tax policy, in particular the exclusion of employer contributions for employee health care and insurance, without limit, from the taxable incomes of employees. Depending on the tax rates of the different states, this tax break means that an extra $100 in health benefits may cost many employees only $60 to $70 in after-tax income, or in extreme cases as little as about $50. This factor too biases choices in favor of more-costly health care.

Second, expenditures are increased by the extensive deployment of new medical technologies that benefit people’s lives, in some cases greatly. People want them, their doctors want to provide them, and society does not want to deny them. Consumption of these technologies has been increasing, often at double-digit rates. Examples include joint replacements and invasive cardiology procedures. There are costly new biologics that correct inherited enzyme deficiencies. Cerezyme, a biologic to treat Gaucher’s disease, now costs some $200,000 to $600,000 per patient per year depending on weight-related dosage. New drugs for some blood-clotting disorders can exceed $1 million per year, and some cancer drugs are also very costly.

Cost-unconscious demand encourages the development and deployment of many costly new technologies. Providers are often rewarded with prestige, patients and revenue for using them. Conversely, under FFS, there is little demand for expenditure-reducing technologies. Technology developers know that patients and their doctors will not weigh costs and benefits. Indeed, the Medicare program is prohibited by law from considering costs in coverage decisions. Doctors are essentially reimbursed for cost, and so save nothing for themselves or their patients by rejecting new and more expensive technologies. Many of the new technologies have been evaluated and improve health outcomes. Others go into widespread use without thorough evaluation and may not be more beneficial than existing, less-costly technologies, or may even be harmful on balance.

American culture values advanced medical technology and has great faith in it—witness, for example, the optimism surrounding the emerging fields of stem cell research and genetic medicine. A culture with such enthusiasm can regard cost reduction as unworthy. One young physician reported: “In training, we were taught that if you really care about cost, you are not a good doctor.” Who wants to be, or to go to, the “low-priced doctor?”

Third, there has been a large increase in the prevalence of chronic disease and our ability (and expenditures) to treat it. Among adults aged 20 to 74 over the last

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6 A detailed analysis of the failings of the fee-for-service system is presented in Appendix B.

7 Though Medicare HMO pricing is now on a risk-adjusted basis.

8 These hypothetical computations take into account the federal income tax (with rates as high as 35 percent), the federal payroll tax (with a rate of 15.3 percent for the self-employed), and state income taxes.
20 years, obesity has doubled; and diabetes, which is clinically linked to obesity, has increased by about half. Twenty medical conditions have accounted for 67 percent of the growth in per-capita health insurance costs over the same period. This problem is exacerbated by a health-care system that is not oriented to early detection or to chronic disease management, but rather to the treatment of symptoms when they arise.

The prevalence of chronic conditions and the cost of their treatment are of fundamental importance to the structure and focus of the health-care financing and delivery system. The Johns Hopkins University center called Partnership for Solutions studies the prevalence and cost of chronic conditions and finds that 133 million Americans in 2005 had a chronic condition. The number is growing faster than the population in general, because the population is aging, and also because medical advances have transformed formerly deadly diseases into costly chronic conditions, as in the case of HIV/AIDS.

The most prevalent chronic conditions are hypertension, arthritis, respiratory diseases, cholesterol disorders, chronic mental conditions, heart disease, eye disorders, asthma and diabetes, some cancers, congestive heart failure, and end-stage renal disease. In 2001, care given to people with chronic conditions accounted for 83 percent of total health-care spending, and 62 percent of all health-care spending was on behalf of people with two or more chronic conditions. As the Johns Hopkins report concludes, “...the care provided in the current acute, episodic model is not cost-effective and often leads to poor outcomes for patients with chronic conditions.” This problem led the IOM to recommend “[c]are based on continuous healing relationships,” which is particularly difficult to achieve when workers so frequently change jobs, and as a result, change or even lose health insurance and health caregivers.

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

**EBI Costs Cause Major Problems for Employers.** Employers have a powerful incentive to avoid growing EBI costs, while continuing to pay attractive cash wages. They do so by tightening restrictions on who is eligible for EBI, and by increasing required employee contributions so that low-paid workers do not choose to pay their share and participate. Thus, only about 79 percent of employees in firms offering EBI are actually eligible for coverage, and only about 82 percent of those eligible actually participate. These policies may mitigate employer problems, but they cause serious human problems, and they do not help forestall the decline in EBI.

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

Employers are constrained by the insurance that is available; they must deal with the market as it exists. In today’s health insurance market, there is little demand for economical care. One or a small group of employers cannot create competition and will not achieve the competitive health-care delivery system that would result if all employers acted together. The great diversity of interests, circumstances and views about health insurance among employers, however, has precluded

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1 They define chronic conditions as those that “last a year or longer and limit what one can do and/or require ongoing medical care.”
2 The anti-retroviral therapy for HIV/AIDS costs roughly $18,000 per year in the United States.
3 This does not necessarily mean that that much of the care was for chronic conditions – only that it was for people having chronic conditions.
collective action to create a market open to competition from efficient delivery systems. 32

Many employers use health insurance as a tool in the labor market to compete for employees, and offer or maintain more generous benefits which make employees even more cost-unconscious. A sustainable market system requires cost-conscious consumers.

**Employer Responses to Date Have Not Solved the Problem.** Employers have tried to control their costs and to innovate in the delivery of insurance and health care generally to their employees. The incentive to innovate can be strong, because individual U.S. firms can become less competitive relative to each other, and producers of tradable goods and services can lose market share to foreign firms. Because merely shifting costs to employees is a clearly visible dead end, firms of sufficient size have experimented with wellness programs, preventive care, and management of employees’ chronic conditions, backed up with financial incentives, and with on-site exercise and basic-care facilities. Firms have tried bargaining with providers; using health records to promote “evidence-based medicine” to choose the best treatments; and creating “high-performance networks” of physicians with strong records of cost-efficient care. 33 On the other side of the transaction, retailers have created quick-access low-cost health facilities, and cut-priced strategies for dozens of basic prescription drugs.

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

One approach toward changing insurance and health care more fundamentally, Consumer-Directed Health Plans (CDHPs) (sometimes called High-Deductible Health Plans (HDHPs)), involves some valuable elements, such as greater transparency in quality and prices, and greater consumer responsibility. 34 However, CDHPs are not, over the long run, a complete answer to the cost problem.

Some firms offer CDHPs as affordable insurance for their lower-wage workers. The CDHP premium can be lower because the cost of care below the high deductible is paid by the employee if and when care is needed. In the short run, CDHPs are one way for hard-pressed firms to shift the burden of EBI to employees, or “rebalance the compensation portfolio.” However, in the long run, such shifting will not mitigate the problem of expenditures growing faster than affordable total compensation, because health-care expenditures are very concentrated on few people – the most-costly 10 percent use 70 percent of the resources – so most spending will be on people who already have exceeded their deductibles, or can reasonably expect to do so. To those persons, the marginal cost of more care will be at or near zero. 35

The high-deductible approach has other problems. Many people do not have much money in the bank, if they even have bank accounts. They may lack the funds to pay the deductible expenses, and so have an incentive to forgo necessary care, leading to more costly future medical needs. Some HDHPs attempt

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32 In theory, large employers could try to go into the health-care management business and organize their own delivery systems, as did Kaiser Industries. But today, that would be very difficult. The building of the Kaiser system was long and difficult, at a time when health care was much cheaper than it is today. Only the largest employers, or very cohesive coalitions, could consider such a process. Generally, employer work forces in any one geographic area are small compared to the size (several hundred thousand members) that efficient delivery systems need to achieve economies of scale. Few, if any, employers have enough employees in any given area to support one integrated delivery system, much less the two or three that would be needed to create competition. Since Henry Kaiser, few employers have attempted this, and usually with poor results. Organizing efficient health-care delivery is complex, and not part of the core competence of most employers.

Alternatively, several employers could try to collaborate to create an efficient health-care system of sufficient size. The Minnesota Buyers’ Health Care Action Group (BHCAG), originally formed in 1991 by 14 large, self-insured employers in the Twin Cities, is a rare example. In 1997, BHCAG offered employees of participating employers a broad choice of “care systems” built around groups of primary-care physicians and affiliated specialists and hospitals. Each “care system” set its own price for covering an employee of standard risk, and its own provider fees. This was the best private-sector implementation of the principles of rational economic incentives. Its enrollment reached about 150,000 employees and dependents. With changes of key personnel and of company ownership through acquisitions, it proved difficult to sustain employer commitment, and attempts to export this model to other cities were not successful. Some of the success in the Twin Cities could be ascribed to special features of that market, such as the presence of multi-specialty group practices and national firms’ headquarters.

33 These valuable elements are included in other ideas as well, including CED’s own 2002 statement. We will discuss CDHP and HDHP in greater detail in the next chapter.
to mitigate this by exempting preventive care services from the deductible. The long-run success of this strategy is uncertain. Another tool to pay for large deductibles is the health savings account (HSA). However, persons with low incomes, facing low or zero marginal tax rates, have correspondingly low incentives and limited means to contribute to the accounts, and the employers of low-wage workers may not contribute.

In an alternative approach, some large employers have offered employees a wide range of health-care delivery systems with responsible choices. That is, employees save by choosing less-costly plans and are responsible for the additional cost of more-expensive plans. However, such employers are usually not large enough in any area to change the whole delivery system. And many employers that do offer choices also contribute some high percentage (often 80 or 100 percent) of the premium of any plan of the employee’s choice. Though apparently generous, these contributions subsidize the inefficient systems and bias choices toward more costly plans. Many of these employers are constrained by collective bargaining agreements and union demands that the employer pay the whole premium, as illustrated by the Detroit car companies. Ironically, it is not unheard of for employees who are confused by alternative complex insurance agreements, and who will pay little or nothing whichever they choose, to pick the most expensive, on the assumption that the costliest must be the best.

To illustrate the effect on the insurance market, consider a health plan that is competing in a group where the employer pays 80 percent of the premium. The health plan management asks: “Should we make the effort to cut costs and premiums by $1.00 to attract more customers?” The answer is: “Probably not; the customers considering choosing us will get to keep only 20 cents before taxes, and maybe only 12 to 14 cents after taxes. It would be better to spend the dollar on other things that would attract customers more.” Thus, there is a strong incentive to increase, not decrease, costs. Markets cannot discipline prices when consumers will pay any price (a condition that economists call “price-inelastic demand”).

**Buyers Cannot Hold Their Health Expenditure to Sustainable Growth Rates.** The biggest problem with EBI is that employers, acting individually, collectively, or in concert with government, in more than 50 years of trying, have been unable to conceive and execute any strategy to achieve sustainable expenditure growth.

Employers have been unable to create market competition so that more-efficient delivery systems can compete and take market share from the dominant fragmented, uncoordinated FFS small-practice model. Remarkably, alternative delivery systems cannot market superior efficiency through lower premiums; there is practically no market in which efficient systems compete to serve premium-price-sensitive consumers.

As one example of this market failure, a highly regarded RAND study found that Group Health Cooperative of Puget Sound, a leading prepaid group practice, delivered high-quality care for 28 percent fewer resources than did the local FFS sector. Yet, neither Group Health nor similar providers have been very successful in that market. Group Health Cooperative could not use its efficiency advantage to expand market share, and therefore force other providers to improve their efficiency. Instead, employer policies forced Group Health to become more like the inefficient providers. Employers preferred a network of FFS solo-practice doctors to provide “full replacement” coverage – that is, one plan serving a whole employment group. In this way, employer policies actually destroyed value by forcing an efficient delivery system to revert to a less-efficient delivery model.

It is most unusual to see a “market” in which producers offering more value for money cannot translate this advantage into a large and growing market share. Upon reflection, however, it should be clear why greater efficiency has not been rewarded in the health-care marketplace.

To create a market in which the efficient providers can drive the others to achieve greater efficiency, the great majority of employers would have to offer their employees responsible choices of delivery systems and affiliated health-insurance plans, such that employees who chose lower-priced, more-efficient plans could

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* We discuss this important incentive in more detail in our own proposal in chapter four.
keep the resulting savings. Fixed-dollar employer contributions would allow efficient insurance plans to pass their efficiencies on to customers through lower premiums. Employers should offer plans that select providers based on quality and efficiency, as well as plans that include virtually all physicians.

However, most employers do not offer such choices. And one employer changing to this model would not get the benefit of a fully competitive health-care system so long as most other employers did not do the same.

Instead, the prevailing practice is that a health insurer will ask, or demand, that an employer give that insurer 100 percent of its business. Insurers dislike “slice business,” where they must compete for some employees within a small group, because of an understandable concern over high administrative costs per insured worker, and the instability that can be caused by “adverse selection,” when one competing carrier winds up with all of the sick employees in the small pool. Employers, in turn, appreciate the administrative simplicity and savings that come from dealing with only one insurance carrier. However, those employers are caught on the other side of the transaction by employees who want to be able to choose their own doctors, rather than being dictated to by their employer or insurer. These demands of a single insurer and employees who want to choose their own doctors leave the employer with no options. The one type of plan that can satisfy both the insurer and the employees is a wide-access fee-for-service plan. Multiplied over thousands of employers, this conundrum dictates that fee-for-service medicine dominates the delivery of health care.

In such an environment, devoid of competition, the dominant FFS system contains incentives for over-use, under-use and misuse of medical technology. Other than revenues, there is no market-driven measure of a provider’s performance, and so there is no monitoring and no incentive for quality improvement. FFS pays for the volume of services, not for quality, not for actually curing the patient promptly. It actually pays more to providers – hospitals as well as physicians – who cause complications or are slow to make a diagnosis, because they provide more “services” along the way. The employer, the decision-making purchaser of the insurance, is not a cost-conscious consumer, but rather a middleman trapped between the demands of insurers and employees.

To provide some measure of “choice,” some firms give all their business to one insurance carrier, but the carrier offers two or three “plan designs” (for example, a Preferred-Provider Organization or “PPO”, and an HMO, or an HDHP). However, most often, all of these plans market the services of the same unaffiliated FFS doctors. This choice of “plan designs” is not competition either among carriers or delivery systems and does not increase the efficiency of uncontrolled FFS. For example, such “carrier HMOs” stand in the difficult position between patients who want to receive more services, and FFS doctors who want to perform more services, trying to impose restraint. Carrier HMO costs simply rise with industry costs.

The absence of meaningful choices of health plans extends across firms of all sizes. Small businesses can be locked out of insurance altogether because of a pre-existing health risk, or because of high prices, or because of the high per-worker cost of plan administration; and small-employer work forces are not large enough to be attractive risk pools for insurers. Only 42 percent of workers in firms with 3 to 24 employees, and only 51 percent in firms with 25 to 49 employees, are covered by their employer’s health benefits. Medium-sized firms, and small businesses that do manage to offer coverage, are usually constrained to the

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36 The tendency of insurers to demand and receive 100 percent of each employer’s business has a perverse side effect, in that it makes it more difficult for new insurers and providers to enter the business and enhance competition. A potential new entrant runs the risk of failing to win any one of the small number of large employer contracts, and thus never getting off the ground. In contrast, if individuals chose their own insurers and providers, it would be more likely that a new firm could attract enough business to have a chance at success.

37 Traditional FFS has largely been replaced by wide-access “preferred-provider organizations” (PPOs). PPOs are nearly all-inclusive networks of FFS providers who do not set their own fees, but rather accept the network’s negotiated fees as payment in full. But the PPO is a change more in form than substance; PPOs do not increase the efficiency of the delivery system or hold down prices. Usually, employers offer a single PPO so that every employee can choose any doctor. Because providers know that these networks must include them to give customers their choice of doctors, the networks are not in a position to drive hard bargains; they cannot exclude many providers. The premium of a PPO reflects the efficiency of all the participating providers in the community, not just the efficient ones.
services of one insurance carrier because of insurers’ aversion to “slice business,” described above. Even large firms sometimes offer employees only one plan, or one carrier (including arrangements under self-insurance), often because of past collective bargaining agreements. And even large firms that do offer distinct choices, as noted earlier, sometimes cover a high fixed percentage – 80 percent, or even 100 percent – of the premium of whatever plan the employee chooses, again often driven by collective bargaining.

In sum, most employers offer a single insurance carrier, because insurers give them incentives or even require them to do so – through minimum participation requirements or offers of better prices if they can cover the entire group. Employers with a single carrier are often constrained to offer a single wide-access FFS plan. As a result, there is no reward to insurers to provide good coverage at low prices – and little or no consumer pressure for them to do so. With limited incentives for better performance, it is not surprising that the health-care sector has seen rising prices with little or no improvement in health outcomes. Furthermore, and fundamentally, it is really employers who choose the health plans for their employees. With all of the good will in the world, there is no reason why employers, rather than the employees themselves, should be choosing health-care coverage. If employees had choices, and if they could reap the savings of a choice of a less-expensive plan, it is likely that insurers and health-care providers would try to find more-efficient ways of providing better health-care results, and the kinds of coverage that employees – rather than their employers – want.

Employers like the state of Wisconsin, the University of California, Wells Fargo and Hewlett-Packard, which offer their employees fully cost-conscious choices among delivery systems, often find that 75 to 80 percent choose among the least-expensive plans which, in these cases, are group-practice-based HMOs. With a price-sensitive choice, many people choose a delivery model other than FFS – unlike most other employer arrangements in which employees have no choice of carrier or little or no incentive to choose a lower-priced plan. The federal government’s experience as an employer is similar. The FEHBP, which gives employees multiple choices of health plans and also a semi-fixed-dollar contribution, delivery systems other than FFS often do well in their localities.

**Conclusion**

Thus, the current employer-based health-insurance system is devoid of competition and incentives to improve efficiency. It is not surprising that costs have risen faster than quality, and it is not likely that this outcome will change on its own.

Since World War II, the United States has experienced pressure for health-care reform every ten to fifteen years. The current episode, however, may be the most serious. More Americans now recognize that their health-care coverage is fragile – that the loss of a job, or the terms of a first job, or the onset of an illness

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1 Employers often evaluate insurance carriers on their administrative costs and profits, or “retentions,” apparently not realizing that some administrative investments, such as in provider profiling and incentives, practice guidelines and information technology, can yield cost savings in the long run.

2 The federal government also purchases health care for the elderly, and for current and former military personnel. In contrast, to the FEHBP experience, FFS predominates in Medicare, with no politically acceptable way to subject FFS to effective competition from more efficient alternatives. The Veterans Administration Health System (VAH) and DOD TriCare have operated their own integrated delivery systems for some time – and there has been great innovation, especially in the Veterans Administration, in such areas as chronic disease management and adoption of electronic health records. In the latter case, the VAH clearly leads the private sector.

3 There is an important deficiency and inflationary bias in the structure of the FEHBP. The government, as employer, contributes an amount set at 70 percent of the average price of the largest plans in the system. If a plan were to come in with a premium below the contribution level, the employee would get to keep 25 percent of the difference while the government would keep 75 percent. After tax, the employee would keep less, perhaps as little as 15 percent. So there is not much incentive for a plan to offer prices below the average and attempt to attract more customers. Also, there is an artifact in the pricing scheme that works to the disadvantage of HMOs in the FEHBP. The program contains several nationwide fee-for-service plans whose premiums reflect costs averaged over the whole nation, including many low-cost areas. HMOs, on the other hand, are local entities, and those in high cost metropolitan areas must bear the costs associated with doing business in those areas. HMOs tend to be in metropolitan areas. The program would do a better job of promoting competition if it used regional pricing.
can lead to loss of coverage and financial ruin, if not the lack of necessary care.

Why has this happened? Under our current health-care delivery system, dominated by FFS solo-practice medicine, costs are growing unsustainably, and quality and access are unacceptable. We pay more of our GDP for health care than any other country around the world, but our nation’s health outcomes are far below average. Certainly, something must change. Arguably, continuing the FFS model, largely sheltered from competition and therefore lacking innovation in organization and process, has contributed to cost increases without improving access or most dimensions of quality.

Many Americans hope to continue to receive health care through the traditional health-care delivery model. Although technological innovation might make that possible, the unaltered status quo is not an option. Ignoring the mounting costs will result in the loss of access – and hence severe harm – to an unfortunate segment of our population that is already too large and growing rapidly.

In virtually every other sector of the U.S. economy, competition has led to great and unpredictable change, but in the end to greater value for the consumer. More-effective competition in the health-care sector could only be expected to do the same. Although we cannot predict precisely what new health-care delivery models might emerge – perhaps even a revitalized FFS model – we can predict that consumers, empowered with choices and information about both cost and quality, will drive the health-care sector toward better outcomes – and perhaps avoid the three-way collision of cost, access and quality that now appears imminent.
Over at least the last 35 years, there has been a slowly building realization that our health-care system is not sustainable. Costs are growing so rapidly that at some not-far-off date, our economy will no longer be able to bear them. Even those who are satisfied with their current health-insurance arrangements have become less secure for the future. Even those who are most confident that their own health insurance is secure must see that more and more people have no coverage, to the detriment of our entire society. And even hardworking practitioners must see that the current system eventually must change.

Public policymakers and private actors have tried to respond, but today’s health-care system provides no incentive to individual doctors and patients to pursue cost-efficient medicine. Accordingly, America has a discouraging history of patching the fundamentally flawed system with simplistic, partial “solutions” – veritable “Band-Aids” – each of which was supposed to solve, or significantly mitigate, our uncontrolled health-expenditure growth. Some of these approaches contained germs of good ideas, and some of them could contribute to a rational comprehensive solution; but none of them came close to addressing our fundamental structural problems.

The basic problem has been and remains that the whole health-care financing system rests on inflationary foundations. The incentives and the organization of health care work against affordable care in both the public and private sectors. In the private-employment sector, most employees have been locked into fee-for-service (formerly indemnity insurance, now PPOs) without a choice. Medicare, also, is predominantly fee-for-service. As explained in Chapter One and Appendix B, FFS rewards the delivery of more services, regardless of quality or efficacy. Few employers offer employees choices among delivery systems, and if they do offer a choice, they often systematically pay more on behalf of the more costly plans (often fee-for-service plans) than on behalf of the less costly plans (usually integrated-delivery systems). Both of these employer practices deny employees the opportunity to save money and pay lower premiums by choosing less-costly health-care systems.

Furthermore, our traditional health-care system is oriented toward acute episodes, where people go to the doctor when symptoms arise, and pay for the services delivered at that time, with little emphasis on follow-up and continuing care. But health expenditures are now dominated by the care of people with chronic conditions, and this traditional system does not provide the incentives or the financial foundation to build an infrastructure for chronic disease prevention and management. This failing is exacerbated as people change jobs with increasing frequency, and then find that they must change both health insurers and providers.

There was and is little understanding of the basic problems of incentives and organization. Indeed, in the 1970s, most people thought that financial incentives and organization were irrelevant to health care. Legislatures and citizens were reluctant to address the fundamental problems and eager to find painless incremental solutions – veritable “Band-Aids.” Here is a list of some of them, in roughly chronological order:

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

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

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

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

Then the problem was identified as excess utilization of services, and the answer became Utilization Review and Professional Standards Review Organizations (PSROs). PSROs were local non-profit physician cooperatives that were supposed to detect overuse and admonish overusers. They failed, because there was no incentive for local doctor groups to curtail local spending when so much of the money came from elsewhere. A dollar saved in Des Moines was a dollar returned to Washington. Why would anyone in Des Moines want to do that? Moreover, and probably more importantly, meaningful standards of appropriate utilization, based on medical evidence and persuasive to doctors, simply did not exist.

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

Then came what could have been a significant part of a genuine solution, the Health Maintenance Organization Act of 1973. Importantly, it sought refinement of delivery systems, and competition among alternative systems, to achieve greater cost-efficiency. At the time, the leading alternative modes of organization were group practice HMOs and individual practice HMOs. In those days, “HMO” referred to a delivery system, not just to an insurance contract. Competition from HMOs helped, but it failed to achieve its potential because employers and government failed to create widespread cost-conscious individual consumer choice so that there would be a market for cost-effective care. Instead, the vast majority of individual health-care consumers either did not have a choice of a more-efficient, less-expensive health-insurance plan, or, if they had the choice, would not keep the savings from choosing the more-efficient system. Many employers fulfilled the HMO Act’s legal requirement not to discriminate against HMOs by paying the same 80 to 100 percent of the premium of the plan of the employee’s choice, whether it was fee-for-service or HMO. This deprived HMOs of the opportunity to market cost-effectiveness, because the employee who chose a lower-priced HMO would save either nothing (if the employer paid 100 percent of any premium) or only 20 percent (if the employer paid 80 percent) of the difference. Policymakers simply assumed that there would be a market for economical health care without carefully examining employer practices. The HMO Act should have been accompanied by more-fundamental and far-reaching reform of the EBI system, but there was not the vision or the felt need at that time.

The Prospective Payment System (PPS) for Medicare payments to hospitals was a logical and significant step toward a more-economical health-care system: it
improved incentives for hospitals by requiring them to accept responsibility for managing at least a significant part of the cost of care. Under PPS, hospitals are paid a pre-determined fee for each Medicare admission, based on the diagnosis. Thus hospitals would not increase their income by providing marginal services, and would save money by increasing efficiency.\footnote{It was a big success for a time after its introduction in 1983. However, it is limited to inpatient care, and much care escapes the limits on inpatient services. It does not include physician inpatient services (which the Netherlands has included in its version of PPS for some years). Also, it does not reward the prevention of inappropriate care, or of the need for hospitalization in the first place. The latter point is especially important. As was documented in Chapter One, chronic conditions are perhaps the key driver of health-care costs, and this is particularly true of Medicare. In 1987, 31.0 percent of beneficiaries were treated for five or more chronic conditions; in 2002, it was 50.2 percent. Chronic illness is responsible for virtually all Medicare spending growth. In 1987, beneficiaries with five or more chronic conditions accounted for 52.2 percent of all Medicare spending; in 2002, it was 76.3 percent.\footnote{Persons with, or at risk of acquiring, several important chronic conditions need far more coordinated treatment and counseling than is provided by the traditional medical model, under which the patient chooses to see the doctor only when symptoms arise.} Although PPS was successful on its own terms, the unsustainable growth of Medicare is very much still with us.

In the early 1980s, \textit{competition} became the “magic bullet,” but government and employers did not change the market to make consumers cost-conscious, and so competition did not happen. President Reagan advocated “free markets” and dismantled ineffective regulation, but he did not act to create a functioning market of competing delivery systems. His administration even let expire the provision in the HMO Act that required employers to offer choices of HMOs, which had at least encouraged some competition among different modes of organizing care. And the Reagan administration rejected strong recommendations to cap the exclusion of employer contributions for health insurance from employee taxable income. “Competition” was assumed to be whatever happened in the health-care market, however flawed that market might be.

Then Congress adopted the \textit{resource-based relative value scale} governing Medicare fees for doctors, in a sense expanding PPS from the hospital segment of the program. Like PPS, this was a good idea with limited reach. Its goal was a rational basis for Medicare fees, to take excess profit out of some services, especially procedures, and to assure adequate payment for evaluation and management services. But Medicare is still fee-for-service, and doctors increase volume to protect themselves from loss of income when fees are cut. In fact, Medicare has an office whose mission is to estimate the volume response to fee cuts. In any case, government simply cannot set all of the hundreds, or even thousands, of prices at efficient levels. In addition, government control makes such prices political prizes.\footnote{In the 1990s, many had great hopes for “managed care,” which promised to improve the mode of organization of medical care. However, what transpired was mostly insurance companies marketing the services of solo-practice fee-for-service doctors in “carrier HMOs,” under a comprehensive-care contract characteristic of HMOs, without reorganizing the fragmented, uncoordinated delivery system.\footnote{Some of the “carrier HMOs” were mostly about restraint, not about reorganizing care, though some, like Prudential, actually built delivery systems of group practices, and others like Health Net, PacifiCare, and Blue Shield and Blue Cross of California contracted on a per capita prepayment basis with existing multi-specialty group practices that were willing to accept responsibility to manage care and costs.} As under traditional fee-for-service medicine, the doctors wanted to do everything they could for their patients, and the patients wanted anything that might help them; so the insurance companies found themselves in the uncomfortable position of standing between wanting patients and willing doctors. A backlash followed because employers forced many people into “managed care” without a choice and without visible sharing of the savings, and without much explanation of what was happening or why. Understandably, people want to choose their doctors. They do not believe their employers should make that choice for them. Delivery systems that seek to...}
increase efficiency typically select doctors. So people must have a choice among delivery systems that limit the choices of providers, or a choice of whether to be in such plans at all. Research has shown that the dissatisfaction with managed care was concentrated among people who were assigned to it without a choice. To assign people to HMOs without a choice is to invite a backlash or to force HMOs to have very wide all-inclusive networks. Doing the latter reduces managed care to FFS in states with “any-willing-provider” laws. Managed care was not allowed to “interfere” with the way medicine was practiced, and it was not allowed to select providers. If managed care is forced to mimic FFS, it cannot innovate and develop systems different from FFS, and there is no reason to expect that it can sustain any significant cost reduction.

Why One Popular Idea – the Consumer-Directed Health Plan – Will Not Work

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

Firms have acted well to use the CDHP model to obtain coverage for their employees who otherwise would have none. CDHP coverage clearly has value. However, we are skeptical that CDHP will stop the deterioration of employer-based insurance and the unsustainable growth of health-care costs.

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

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

To some degree, this assumption is probably based on the computer revolution. CDHP anticipates that, as in other phases of life, consumers will use the Internet and other information resources to make more-cost-efficient health-care choices: shopping for the cheapest provider, learning about the implications of alternative treatments and therapies, and so on. CDHP calls for providers to release comprehensive information on their quality and prices, which would be incontrovertibly desirable, but would require a major change from current practice. The availability of computer-based health records would facilitate consumer responsibility. First recommended in the Institute of Medicine report, “Crossing the Quality Chasm,” this advance gives the consumer access to and control over his or her entire life-long medical record. Such records generally do not now exist. The coming evolution of consumer choice of treatments and therapies, and the opportunities surrounding personal computerized health records, are both uncertain.

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

High-Deductible Health Insurance. CDHPs require the insured to pay the first dollars (usually $1,000 to $2,500) of health-care expense (that is, the “deductible”) before the insurer begins to pay the bills. Some CDHPs are associated with health savings accounts (HSAs), a new tax break in the Medicare Modernization Act of 2003 intended to encourage the choice of high deductibles by equalizing the tax treatment of out-of-pocket spending and spending through tax-favored insurance. In some instances, the employer makes deposits into the HSA for the employee, either independently or as a match; in other instances, the employee alone is responsible for funding the HSA. Employer contributions to HSAs are tax-free, and employee contributions are tax-deductible, even if the employee does not itemize other deductions. The limit on tax-sheltered savings is the deductible in the health-insurance plan, up to $5,650 (for families)

b That is, employee contributions are excluded from adjusted gross income (AGI) independent of the decision to itemize deductions.
in 2007. The balance in an HSA can be withdrawn without tax to pay for care up to the high deductibles associated with the CDHP insurance policy. Unspent balances in HSAs can be rolled over from year to year without tax.  

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

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

In other words, consumers would be expected to engage in preventive care; and then, when illness or injury strikes, to use the latest information technology to find the most economical and efficient therapies and treatments, to minimize spending under the CDHP deductible, and to protect the balance in the HSA. In this way, it is claimed, total health-care costs would be brought under control.

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

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

Apart from the word “health” in the name, HSAs can for some affluent persons be mainly a tax deferral device. If withdrawn for non-medical purposes, the withdrawals are subject to income tax plus a 10 percent penalty. However, if the balances are not used until the owner becomes eligible for Medicare, the 10 percent penalty is waived. If the owner passes away, the balances can be bequeathed to the individual’s heirs, and the 10 percent penalty is waived.
Third, the main appeal of CDHPs is to consumers who have reason to believe that they will remain healthy, and thus will be able to build their HSAs. To that extent, the resulting migration of healthy people from the remaining pool of risks will shift the costs mainly to people with chronic conditions who will not choose CDHPs because they would expect to exhaust their deductibles.

CDHPs will be especially advantageous to those who are both healthy and wealthy, because they can both afford the higher deductibles and take the most advantage of the HSA tax shelter. For high-bracket taxpayers, those most likely to receive such large employer contributions, the tax savings on HSAs will be worth over $1,900 a year, plus possibly additional savings from state income taxes, plus tax-free accumulations—a very attractive opportunity to shelter income from taxes. Because the HSA is an exclusion from adjusted gross income, the tax benefit is most valuable to the best-off taxpayers who are in the highest tax-rate brackets, but is worth next to nothing to those households with lower incomes who face low or even zero-percent tax rates, who are also less likely to receive employer contributions to HSAs. In 2005, 35 percent of firms offering HDHPs made no contribution to the employees’ HSAs. Healthy, well-off persons in CDHPs also benefit from the lower premiums and can escape pooling risks with their less-fortunate fellow employees. Favorable risk selection will help CDHPs to grow rapidly, while leaving the higher risks behind in the standard low-deductible plans. But the loser may be the fairness of our private health-care financing system—not to mention the viability of health insurance for those who are not fortunate enough to benefit from CDHPs.

Fourth, about 83 percent of health-care spending is associated with the 133 million Americans who suffer from chronic conditions: hypertension, arthritis, asthma, cancer, heart disease, AIDS, diabetes and its consequences including renal failure, etc. These persons need to be, in the words of the Institute of Medicine (IOM), in “continuous healing relationships” with their health-care system. Obesity is epidemic, which will lead to many problems of heart disease, diabetes, etc. The costs will ultimately be borne by all of us through Medicare, Medicaid, and disability insurance. Our health-care delivery system must teach and motivate these patients to adopt healthier life styles and behavior, support them in their efforts, and monitor their medications. Health-care organization and finance should provide the foundation for disease-management infrastructure. However, CDHP assumes that a key to economy is keeping people away from the doctor, which might be true for acute care in uncoordinated fee-for-service, but is not for the many people having and developing chronic diseases. CDHP moves in the wrong direction—attempting to keep people away from health care rather than reaching out to support them in improving their lifestyles and managing their conditions to keep them out of the hospital and away from more costly complications.

To be fair, many advocates of CDHP would exempt preventive care from deductibles and co-pays. But in equal fairness, it is by no means clear that such exemptions would work in a system whose entire philosophy is to keep people away from their physicians. For example, it is far from certain that those who enroll in CDHPs because they cannot afford the higher premiums for conventional insurance, but equally cannot afford the high CDHP deductibles, will go to the doctor for exempt preventive care when they know that they cannot afford any non-exempt treatments or therapies that the doctor might recommend. If people forgo prevention, it could lead to under-funding of primary care, and could reinforce the present trend of young American doctors not going into primary care. Primary-care physicians could have increased difficulty collecting their bills, because those costs would be the ones to which deductibles would most likely apply. Interestingly enough, 22 percent of large employers now offer in-house clinics to their employees, to make access to the doctor more convenient, while CDHPs seek to discourage doctor visits. Alternatively, advocates of CDHP have expressed concern that common low-deductible policies have led to over-utilization, and yet Americans still have under-utilized preventive care. Should we expect that CDHPs would yield more use of preventive care, when the CDHP’s terms for that care are no more generous than those under current low-deductible policies?

Fifth, CDHP emphasizes the decisions of informed consumers, a model that may seem to fit well with a population of professors in universities with medical schools whose families have enough free time to keep up with the medical literature, but that makes less sense for others. These consumers are supposed to
shop confidently for doctors and negotiate with them over prices and treatments. However, medical care is very complex and uncertain. John E. Wennberg’s research has documented remarkably wide variations in physician practice patterns, indicating that most doctors do not have a very well-informed idea of the best practice. Typical Americans are surely no better informed. Only recently, the most famous heart bypass graft patient in America, former President Bill Clinton, living in the state with the best outcomes-related information, chose the hospital with the highest risk-adjusted mortality in the state. His choice arguably did not fit well with the CDHP model. More broadly, the experience in New York has been that the publication of such quality-related information did not drive changes in market share. Arguably, the information requirements for choices among individual providers and treatments are much greater than those to make an informed choice of a care system. Thus, it makes more sense to ask consumers to shop based on standardized, published quality information during a routine open season for a cost-efficient health-care plan, rather than to require them to shop perhaps in a time of crisis when they need an expensive and potentially life-saving treatment or therapy.

Why Canada’s “Single-Payer” System or “Medicare for All” Will Not Solve Our Health-Care Problems*

Beyond Consumer-Directed Health Plans, another health reform idea with substantial support is a “single-payer” system, of which Canada’s is a prominent example. Many people think that the logical replacement for the employment-based system would be a Canadian-style system. That is, government, probably at the federal level, would serve as the single health insurer, cover everyone, and pay all bills according to a government-determined or negotiated fee schedule.

Another description of this approach is “Medicare for all;” in other words, every American would be covered by the Medicare program or something very similar. In 2006, the California Legislature passed a single-payer bill. Single-payer proposals have also appeared as ballot initiatives in California, but they usually have not fared well. That could change, and probably will if the consequences of soaring insurance costs are allowed to play out.

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

*See Memorandum, page 84.

4 What changes in performance there were apparently came from extra-market forces such as state regulation, or the threat of it, and from the professional aspirations of doctors and hospital managements and boards, most of whom wanted to be among the best.

Physicians in prepaid group practices take part in systems that accept responsibility to manage total per capita expenditure of their enrolled members. There is a great deal of evidence that they do the best job.

4 In Canada, hospitals are paid prospective “global budgets.”

4 There are many alternative ways for government to play a role in health insurance that might be characterized as “single payer.” The Canadian-style or “Medicare for all” approach is the most prominent, and the most widely understood. We do not consider a system under which the Federal government would collect premiums (or taxes) and pay them to a multiplicity of private insurers who accepted the risks of coverage to be a “single-payer” system in this sense.

4 This aspect of single-payer plans can be more complicated if aliens or non-working non-elderly adults are not covered.
Single-payer models are generally based on fee-for-service payment because, if there is only one system, then all physicians must be allowed to participate, and most are in small or solo practice which is most conveniently reimbursed by FFS. In a sense, government, as the sole provider of health care, would find itself in the same position as an individual employer: Because its constituents want an unconstrained choice of physician, the only single plan that meets that constraint is a wide-access fee-for-service system. Indeed, government’s ability to restructure the health-delivery system could be even less than a typical employer’s. Because of “job lock,” an employer has at least some theoretical ability to impose its health-care decisions on its employees. In contrast, because of elections, public policymakers can be fired if a significant bloc of their constituents believes that their choice of physician has been constrained. As experience under Medicare has demonstrated, any U.S. single-payer system is likely to maintain fee-for-service medicine as the dominant delivery mode.

Depending on one’s point of view, the continued dominance of fee-for-service would be an advantage or a major disadvantage. It would be familiar, and administrative processes exist. Most doctors and medical groups are paid that way today and prefer it. However, for the organization of medical care and its impact on economy and quality, locking in uncoordinated, fragmented fee-for-service would be a major disadvantage. As noted above and in Appendix B, fee-for-service has built-in incentives for delivering volume, not quality. It motivates, or is compatible with, considerable over-use, under-use, and misuse of services. It would leave in place existing medical organization, with all the deficiencies of quality and economy discussed in the previous chapter. It would continue to be oriented to acute episodes – rather than chronic disease management, where most of the cost occurs. It would deny us the benefits of any potential new and better-organized delivery systems. In sum, all of the organizational flaws that have rendered the current system inflationary and unsustainable would remain.

There are other problems with single-payer systems. Perhaps the next most important one is the entanglement of provider payment with politics. The medical-industrial complex already is a huge source of political money. Medical device companies and drug companies employ persons in many Congressional districts, either directly or through contractors. Every Congressional district has doctors and hospitals. If all of their revenues flowed through government, attempts to influence the allocation of funds through lobbying and political contributions would intensify. Payment by government would become, literally, a matter of life and death to health-care providers.

Some think that a single payer would be able to control health expenditures. But government today is having a very difficult time controlling the costs of its existing health commitments to Medicare and Medicaid. Merely regulating prices cannot control health expenditures. Expenditures are the product of prices and quantities, and squeezing down on prices motivates a “volume response” – that is, doctors react to a reduction of prices by increasing the volume of services they provide. Experience with Medicare bears this out. Congress has responded with a “sustainable growth rate” formula: What the doctors take collectively through increased utilization will be recaptured through lower fees across the board. Obviously, that is hardly an optimal system. It punishes the frugal along with the prodigal. It remains to be seen if it will be sustained. So far, its implementation has been postponed each year because of the objections of the medical profession.

Government simply cannot know how to set so many and such complex prices, taking account of local market conditions. Congress must and does use across-the-board rules for setting prices, and those rules have proved hard to change. For example, Medicare has created a boom in cardiology procedures by overpaying and making them more profitable than other kinds of care, which in turn is leading to a boom in heart hospitals that the Congress is now seeking to curb.

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1 It has proven practically impossible for Medicare to break out of fee-for-service, even though Congressional leaders have long said that they want to offer choice to beneficiaries. Medicare does offer HMOs, called “Medicare Advantage” plans, but the amount Medicare pays to those plans is tied to the prevailing fee-for-service per-capita costs (risk-adjusted) in each geographic area. Canada’s Medicare system destroyed their prepaid group practices because the dominant payment system left no opportunity for Canadians to save money by joining more-efficient delivery systems.
Government appears unable to discriminate among providers. It is very unlikely that government could refuse to deal with providers who appear to be costly or inefficient, if some beneficiaries – that is, voters – demand their services. To date, Medicare’s attempts at incentives for complex-care patients to go to regional centers of excellence have foundered. Non-discrimination by any payer is a principle for which provider organizations will fight.

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

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

Single-payer systems, like Medicare, are touted as having great administrative efficiency. Medicare, for example, has been estimated to spend 3.6 percent of billings on administration, whereas private insurers spend 11.5 percent. However, this is not unalloyed good news for Medicare. Because Medicare is mostly fee-for-service, it entails enormous numbers of billings, with the result that there is considerable opportunity for error and abuse. As was noted earlier, the Office of the Inspector General of the Department of Health and Human Service identified significant excessive and erroneous Medicare payments. Thus, the low administrative cost likely results from serious under-administration of the program. Single-payer systems have had difficulty encouraging alternatives to fee-for-service delivery, but some alternatives – including, but by no means limited to, capitated prepayment – can reduce administrative cost without necessarily creating opportunities for abuse.

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

Many Other Current Favorite Ideas Are Being Oversold as Solutions in Themselves; Others Would Not Work

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

One idea that has generated much excitement is Information Technology (IT). This seems like a safe course for politicians; it offers glitter without apparently threatening any important interests. IT is being ascribed magical powers. In fact, information technology will surely be indispensable in any reformed, modern, high-quality delivery system, which is why the major integrated delivery systems are spending billions to roll it out in their practices. But merely superimposing a veneer of IT on top of the current mal-constructed health-care system will not solve the underlying problems. IT will not help if the delivery system is not reorganized to take advantage of it. In a fundamentally dysfunctional and disorganized delivery

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1 In Canada, government has limited expenditure growth by limiting hospital budgets, leading to growing waiting lines and shortages of specialist care.
2 Capitated prepayment is a fixed periodic per-patient fee to providers, regardless of services delivered.
3 The Veterans Administration Health System, Kaiser Permanente, the Mayo Clinic, and the Palo Alto Clinic, among others, are leaders in the development and application of health IT.
system, IT may merely give an inefficient system an electronic means of communication to automate inefficient practices. One perceptive analysis pointed out that deployment of IT is not in the interest of the doctors, hospitals, and laboratories in the uncoordinated FFS sector, which probably explains why it is happening so slowly there.\textsuperscript{62}

To illustrate, consider that a well-organized solo primary-care practice has no particular need for IT for itself.\textsuperscript{66} The real benefit from IT adoption in that office would accrue to the health-care system as a whole, in better informed specialists to whom the patient is referred, with fewer wasted visits, more productive visits, less time lost on history taking or tracking down lost information, better coordination between the specialists and the primary-care physician, and fewer lost or duplicated test results. But these system benefits would not be benefits to individual FFS physicians, who would experience less revenue from fewer visits and tests. And the primary-care practice itself would bear all of the costs of implementing the IT system. No wonder there is slow or no adoption of IT in the solo-practice FFS sector. Some might mandate the adoption of IT, but this mandate would raise the same questions as all other government mandates; and adoption would surely be halfhearted, if there were only compulsion and no positive incentive to make the system truly work.

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

Pay for Performance (P4P) was started in California by the Integrated Healthcare Association, to encourage insurers who paid doctors through capitated prepayment to use common measures of the quality of preventive services and patient satisfaction as the basis for additional bonus payments to those doctors.\textsuperscript{63} P4P could establish a single measure of practice quality and get away from confusing “dueling report cards.” Its main limitation is that it is based largely on process measures and not on medical outcomes, which are far more difficult to measure fairly.\textsuperscript{65} P4P made sense in its original context because the physicians involved had already accepted responsibility for the cost of treating their patients. But now, P4P is being interpreted as something that might help limit expenditures in the uncoordinated fee-for-service context. In fact, it might even be cost-increasing. With a fundamental shift to a market based on responsible consumer choice and competition among physician organizations to produce value for money, performance information can be helpful.

With the prominence of costly chronic conditions, Disease Management is already an integral part of prepaid group practices, whose financing through capitated prepayment provides both the incentive and the up-front funds for successful disease management. In contrast to this close fit with prepaid group practices, disease management must be tacked on to fee-for-service, which lacks both the incentive and the financial platform. It is being promoted as an optional program to consumers to overcome the fragmentation of fee-for-service. Recent data suggest savings are small, with both low enrollment and low follow-through by consumers.\textsuperscript{64} Disease management is potentially very important, and should be integral to the health-care system, not patched on from the outside.

Evidence-Based Medicine (EBM) is an attempt to synthesize the scientific literature and detailed health records to determine which treatments work under which circumstances and to steer the practice of medicine toward those treatments. It is important and could improve care, reduce medical uncertainty, and save money. But those results are not guaranteed. There must be incentives to practice EBM and

\textsuperscript{62} However, IT potentially could be a valuable tool for the doctor to use in managing chronic disease patients.

\textsuperscript{66} This process was a part of the so-called California Delegated Model, under which doctors practice in groups and in independent clinics linked through Independent Practice Associations (IPAs). As noted, the doctors involved receive most of their compensation through annual per-person fees, or capitation. These physician organizations therefore bore some of the risk for resource use, and the bonuses computed using P4P provided an added incentive.

\textsuperscript{65} The best measurement of outcomes would be adjusted for risk; such measurement would be even more difficult.
monitoring systems to make it happen, along with incentives to choose economical guidelines. Research shows that mere publication of guidelines has no effect on physician behavior.\(^\text{65}\)

**Tort Reform** could help reduce expenditures and is surely well worth doing on its own merits.\(^\text{66}\) Research by Kessler and McClellan suggests that, at least in the case of fresh heart attacks, reform could save five to ten percent of costs if there were any incentive to reduce expenditures.\(^\text{67}\) Five to ten percent is surely significant. However, this may prove to be a one-time change in the level of expenditures, with no long-term reduction in their growth rate.

The goal of **Tiered High Performance Networks** (THPN) is to route all patients to high-quality, low-cost physicians. Those physicians (usually specialists) are identified using data on the costs and results of episodes of care (usually acute care) from insurance claims. While promising, this approach has important limitations. THPN obviously is designed as a cost-saving device for individual employers or insurers; it has much less relevance to attaining system-wide savings. For example, superimposing THPN on a single-payer system would be totally contrary to the experience of Medicare, under which policymakers have zealously guarded the right of every patient to choose any physician.

It may be misleading to assign every episode of care to one physician, because there is always some collaboration in complex cases, and there are differences in the severity of those cases. Even assuming that the analysis yields sound results, THPN will do little good if employers are unwilling to create sufficient financial incentives to induce patients to switch to economical doctors. Perhaps most importantly, THPN focuses on specialists and acute-care episodes, and ignores the important roles of primary care and prevention. Tiered high performance networks could end up with high volumes of preventable medical problems, which even if handled efficiently would not reduce cost. THPN could do more good if insurance plans gave people real incentives to choose economical doctors, and still more good if plans had strong systems for primary care and prevention that used the data to guide patients to quality cost-effective specialists, and to oversee the appropriateness of treatments and procedures.

**Transparency** is also cited as a potential overall solution. Transparency is an attribute of all well-functioning markets. Advocates of transparency in health care argue that consumers, not just insurance company or medical group managers, should know what hospitals charge. Of course, purchasers who are using their own money or their company’s money need to know the cost of the things they are buying, and contracting between insurance companies and providers is now a well developed, if imperfect, art. But one wonders what the ordinary insured consumer with a $2,000 deductible is going to do with such information. The doctor says: “I must admit you to the hospital.” The consumer thinks: “There goes my $2,000! Now bring on the technology: More scans. More tests. Do anything that might conceivably help me.” If people have reason to believe they are likely to reach their annual deductibles, as would be the case with pregnancy, a costly chronic condition, or any hospitalization, mere $2,000 deductibles will provide no cost-reducing incentive. And much higher deductibles are likely to make care unaffordable for average-wage people.\(^\text{68}\)

**Conclusion**

This history of “Band-Aids” and their latest successors shows that there are no easy, simple reforms – things that sound good and have popular appeal – that would solve America’s health-care problem. These ideas are attempts, sometimes useful, sometimes not, to control spending without the “heavy lifting” of reforming the market and the delivery system. Excess expenditure growth is too fundamental, too pervasive, and is driven by forces that are too powerful for any such superficial change to be effective.

In contrast, in an efficient health-care market, all consumers would have informed cost-conscious choices of delivery systems. Under such consumer choice, cost-effective delivery systems would prosper and have strong incentives to improve efficiency, quality and service, which would drive the entire market toward better performance. Such a market would naturally align the incentives of providers with the interests of patients in high-quality affordable care. The next chapter explains how such an efficient health-care system would differ from the prevailing patterns today.
The above analysis of the current employer-based health insurance system is troubling. Costs are rising faster than incomes. Firms that have borne a significant share of those costs are threatened financially, especially if they are subject to competition from foreign firms that are not so burdened. Employees, especially those who earn modest wages or already have health problems, are in danger of losing their coverage – if they have not already. The history of employer-based insurance is replete with attempts to patch the system, with results ranging from minimal benefit to nil to outright harm. Options currently on the table, as described in the preceding chapter, will fare no better.

To approach this apparently dismal prospect from a different angle, what would a successful delivery system look like? As we argued in discussing the single-payer option, we do not believe that an efficient health-care system can be managed through a command-and-control mechanism. Rather, the best approaches to the many dimensions of health-care delivery can emerge only through a process of competition.

Just as competition has produced unpredictable results in every other industry, so it would in health care. In fact, the answer would change constantly, because the process of innovation and improvement would never stop. Thus, the object of health-system change is not to anoint any one delivery model from today’s landscape as the definitive answer, but rather to unleash the forces of competition through structured financial incentives to work their will. In time, the successful systems might even be significant improvements of models that today appear outdated, or alternatively might be models that do not yet exist. The one certain thing is that the systems that succeed in a fair, competitive environment will be those that best meet the needs of the population at large.

Despite the uncertainty, some reasonable general inferences can be drawn on the basis of delivery systems that appear more efficient within what limited competition today’s health-care market imposes today. Their attributes also meet the apparent requirements for a system that would respond to America’s needs for greater quality, affordability and access.

This perspective is far more encouraging. There are systems in place today whose attributes, taken together, provide an attainable vision of higher-quality, more-affordable health care. These characteristics would amount to a fundamental transformation of the health-care delivery system. Their benefits would be felt in better health for Americans, as well as dollars-and-cents resource savings.

Goals

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

Second, because many people lack health insurance, society must ensure that everyone has affordable access to a financially sustainable health insurance program. To motivate innovation in health-care organization and finance, everyone should have the purchasing power needed to buy insurance, and informed,
responsible, cost-conscious choices of delivery systems and providers.

This chapter reviews the attributes of a health-care financing and delivery system that would meet America’s needs, which are closely related and interact with one another:

- Affordability, or in the sense of the entire system, sustainability;
- Quality and effectiveness; and
- Access.

**Sustainability**

For at least the past 40 years, health expenditures have grown faster than incomes and tax revenues. Healthcare’s cost has grown on average about 2.5 percentage points per year faster than the GDP, and therefore consumed an ever-increasing share of the GDP.

Businesses have responded by shifting more of the cost to their employees, in the form of higher shares of premiums and reduced coverage, including the introduction of high deductibles. In recent months, the states have tried to play a role—again, with structures that often include higher deductibles to minimize costs. However, the new “reform” plans—the Massachusetts plan, Governor Arnold Schwarzenegger’s plan, the proposal of the Health Coalition for the Uninsured—are purely financing plans designed to gather together available resources and rearrange them to cover everyone. Because of the resource constraints on the states, they cannot address the structural incentives that drive the delivery system and its inflationary nature. These plans will not be sustainable over time unless the growth rate of health expenditures is brought much closer to that of the GDP.

A sustainable system must build on the efforts of business and the states to achieve better care at a lower cost that grows at a rate closer to the pace of the nation’s incomes. Some key attributes of such a sustainable system are explained below.

**Incentives Alignment and Efficiency.** Today, most people insured through employment are not likely to know what their insurance costs, and even if they do, they have little choice or incentive to act on the information. Efficient alternatives may exist, but people usually have no opportunity to choose them and keep the savings. Efficient delivery systems will not be developed unless there is a market for them—that is, a demand for efficiency. There is virtually no demand for efficiency today. If all or most people had a reason to choose efficient systems, care providers, to succeed, would need to create and offer them.

As explained in detail in Chapter One and Appendix B, the incentives in today’s dominant fee-for-service system are often perverse. This model punishes economizing behavior.

Senator Charles Grassley, then Chairman of the Senate Finance Committee, was quoted in the *New York Times* as saying, accurately, that “Medicare now pays the same amount regardless of quality.” He added that Medicare “rewards poor quality” by paying doctors to treat complications caused by their own mistakes. Fee-for-service also discourages teamwork, because it pays separately for the actions of individual members of the care team.

Health-care systems could produce better care at less cost if provider incentives were aligned with the needs and wants of the American people for high-quality affordable care. In the broadest sense, every member of a health-care team must have an incentive to develop

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* Geography, especially in rural areas, can be a significant barrier. However, where rural residents have the reliable purchasing power to buy insurance, insurers and providers have sought ways to deliver care.
and follow the most-effective, evidence-based care processes. Providers must make comprehensive judgments of the best treatment, rather than piece-by-piece decisions on what items and prices the insurer will approve. To bring these broad principles to life, payments could be set for more-globally-defined “products” – say, the complete treatment of a particular illness or injury – rather than for the individual items of care – like one pharmaceutical tablet delivered in a hospital. Salaried physicians with significant bonus payments for quality, patient satisfaction, efficiency and teamwork might be more in keeping with this goal. An insurance plan with prepaid capitation, and ideally with risk adjustment as well, would be one way of achieving this goal, but there may be others – including even some as yet unknown restructuring of the fee-for-service model, perhaps driven by digital technology.

Conflicts of interest – the quintessential misalignment of the interests of patients and providers – are widespread in treatment and procurement decisions in medicine. An important part of incentives alignment must be rigorous policies to minimize such conflicts of interest. Physicians who decide which item of equipment or technology or which pharmaceutical to use should not have financial links with suppliers. As George Bernard Shaw observed 101 years ago, the contemporary fee-for-service model – tellingly, essentially unchanged over those 101 years – is inherently a conflict of interest. Alternative financing systems can reduce conflicts of interest and produce strong incentives for quality improvement, error avoidance, disease prevention, and efficient treatment choices.

In any case, incentives alignment, engaging both patients and providers, is a necessary condition for an efficient delivery system.

Continuous Improvement and the Learning Organization. The concepts of continuous improvement and a learning environment should become core competencies of every delivery organization. Providers should integrate these activities into actual care delivery, and extend continuous improvements from the larger headquarters organizations into their local practices. Because there are more new clinical trials and studies than any single physician could possibly absorb while still seeing patients, successful delivery systems in a cost-conscious market would devote some of their manpower to devising practice guidelines and ensuring, with the assistance of information technology, that they are followed. Physicians, like all other workers, do not enjoy being monitored, but performance measurement is used in virtually every other industry because it works: it yields better performance.

Integration and Coordination of Care. American medicine is a fragmented non-system. Institutions and settings in which patients receive care are like separate “silos,” with poor communication among them. Doctors practicing in community hospitals are mostly free agents with interests that conflict with each other and with the hospitals. An important and remarkable feature of the uncoordinated FFS system is that, for the most part, it does not keep records in usable form. As a result, Americans are receiving just over half of recommended care, and errors of omission are widespread.

To remedy these failings, successful health systems must continually evaluate and redesign work processes to improve efficiency and take full advantage of IT. Providers must keep continuous, comprehensive, longitudinal medical records, analyze them, and feed the results back into practice improvement. They must follow patients over time and learn what works and what does not. They must deploy and use health information technology to create caregiver support tools such as shared comprehensive electronic health records, guidelines, prompts, and reminders, to monitor performance and to take corrective action, where appropriate, to assure optimal care. Doctors can be better informed about each patient, electronic prescribing can reduce errors, and secure doctor-patient

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1 The Dutch, for example, pay hospitals for complete inpatient cases including all associated physician services. The British National Health Service is moving in the same direction.
2 Risk adjustment, sometimes called risk equalization, is a process that measures relative expected health expenditures in different enrolled groups, and compensates those health plans that enrolled a more costly group at the expense of those that enrolled a less costly group. All individuals, regardless of their medical condition, see and pay the same premium; premium revenue is transferred behind the scenes from insurers who enroll proportionately fewer risky patients to insurers who cover relatively more of the risky patients.
3 The Doctor’s Dilemma, written in 1906. “That any sane nation, having observed that you could provide for the supply of bread by giving bakers a pecuniary interest in baking for you, should go on to give a surgeon a pecuniary interest in cutting off your leg, is enough to make one despair of political humanity. But that is precisely what we have done. And the more appalling the mutilation, the more the mutilator is paid.”

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communication by email or mobile phones can lead to better-prepared doctor visits and reduce the need for visits as well. The integrated-delivery systems are far ahead of the traditional FFS sector in deploying IT.\textsuperscript{77} It is apparent that the benefits of IT – reducing the need for hospital days, doctor visits and diagnostic tests – are not in the interest of individual FFS providers.\textsuperscript{78}

Delivery systems that are responsive to cost-conscious consumers would integrate and coordinate the continuum of care – at home, the doctor’s office, the hospital and the outpatient setting – to improve both quality and efficiency. Costs can be reduced when doctors and hospitals are part of the same team with common interests. Care should be delivered in the least-costly appropriate settings, considering total system costs, not just costs and revenues associated with one setting.\textsuperscript{3} Quality can be increased with smooth transitions and hand-offs between care settings, so that, for example, outpatient providers are well-informed on inpatient care (and vice versa). Automated tracking should follow actual practice versus the standard, with a message sent to the appropriate provider to inquire about any deviations.

**Match Resources Used to the Needs of the Population Served.** Because the traditional model involves separate payments for each item after the fact, it cannot use a “budget” to plan or to allocate resources. It does not practice some of the elementary principles of good management, such as matching the resources supplied to the needs of the population served, or the services produced. Successful systems could reduce costs by deploying physicians in the numbers and types needed to provide high-quality care to their enrolled populations. Specialty imbalances contribute to the large inefficiencies often observed in American medicine. Too many surgeons can lead to too much surgery, and to surgery done by non-proficient surgeons.\textsuperscript{79}

Cost-conscious systems would select and train physicians and other health professionals for quality and willingness to work in teams, establishing programs to keep them proficient and well-informed. Physicians must be committed to the delivery model used by their systems; no health plan can succeed or even survive in a competitive environment if its providers are not dedicated to its objectives and methods. That objective could be met in at least some plans with salaried physicians with significant bonus payments for quality, patient satisfaction, efficiency and teamwork. Trained non-physician personnel can perform additional services, reserving physicians for where they are needed. Equipment can be deployed in appropriate quantities for efficiency and economies of scale.

**Supply-Chain Management.** Hospitals compete for doctors who bring them patients. One way they do so is to cater to each doctor’s preferences for particular types of equipment. Accordingly, hospitals often use several different types of devices from different suppliers for the same purpose, thus diluting their purchasing power and adding to cost, complexity and the chance of error. Efficiency and quality would improve if the doctors in each specialty in each institution would collectively study the available products and recommend the product lines that offer the most value for money, so that the hospital could concentrate its purchasing power on the selected suppliers.\textsuperscript{f}

**Market Reorganization to Streamline Administration and Customer Service.** The administration of our employment-based health insurance is unnecessarily costly. The typical large health-insurance company spends between 15 percent and 20 percent of revenue on administrative expenses (and profits). Billing and insurance-related costs in California for acute health care, including doctors and hospitals, have recently been estimated at 19.7 percent to 21.8 percent of spending.\textsuperscript{80} The optimum administrative expense is far from zero, as noted above in the context of Medicare, but fee-for-service payment generates unnecessary expense. Health-care quality and decision-making would improve if systems utilized per-capita prepayment, or set prices for complete inpatient cases rather than individual services. Such streamlining would also drastically reduce administrative costs.

\textsuperscript{1} Integrated delivery systems now engage in such planning better than disaggregated providers. Other providers, for example multi-specialty group practices, hospital-medical staff organizations, physician-hospital organizations, insurer partnerships with provider networks, individual practice associations, etc., might plan effectively if given appropriate tools and incentives.

\textsuperscript{f} See also the above remarks about conflicts of interest.
Universal health insurance based on competition could reduce administrative expenses even further. A good example is provided by the experience of the health insurance program of the California Public Employees’ Retirement System (CalPERS), which brokers coverage for about 1.2 million California state and local government employees, retirees and dependents. Once a year, Kaiser Permanente signs one contract with CalPERS to cover over 400,000 persons. CalPERS’s administrative expenses are less than one percent of the premium. Similarly, universal health insurance, working through a central broker such as CalPERS or the FEHBP, would eliminate underwriting and contracting expense for individuals and firms. All beneficiaries would pay the same price for the same coverage, regardless of health status. Biased risk selection can be avoided by risk equalization for whole populations, computerized behind the scenes; insurers already accept and practice risk equalization in some existing health-insurance systems. Health insurance contracts would be standardized, reducing cost and red tape. Employers could eliminate the health insurance component of their benefits management departments (except to the extent that they chose to provide information and support to their employees), while CEOs would be freed to spend many hours on their core businesses rather than on health-insurance costs.

Health plans would face much greater competition in a transparent market serving cost-conscious individual customers, which would give them an incentive to squeeze out unproductive administrative expenses and reduce profit margins to competitive levels. Thus, the consolidation of health-insurance purchasing into a universal competitive system with a central broker can reasonably be expected to yield substantial administrative savings, while also creating ongoing competition among delivery systems.

Quality and Effectiveness

The incentives in the current health-care financing system drive health providers away from both quality and affordability. To give a sense of what could be achieved in both of these dimensions, following are some of the major improvements of organization of health-care delivery systems that would result from market-driven alignment of incentives.

Reorganize Around Medical Conditions, Not Medical Specialties

Reorganize for Chronic-Care Management. As was documented above, chronic conditions are now a major – perhaps the major – driver of health-care costs. And yet, today’s health-care and payment systems are still designed to manage and pay for acute episodes, not chronic conditions. Insurance plan designs, and the thinking that goes into them, are too close to the casualty-insurance model, rather than encouraging the maintenance of health.

The New York Times reported in a series of articles on diabetes that “Insurers, for example, will often refuse to pay $150 for a diabetic to see a podiatrist, who can help prevent foot ailments associated with the disease. Nearly all of them, though, cover amputations, which typically cost more than $30,000.” Such a system is an anachronism. Fee-for-service generally pays for episodes such as doctor visits or procedures. There is no incentive to provide on-going preventive and chronic care such as counseling sessions.

Appropriately trained non-physician personnel such as dieticians can perform important chronic-care services, reserving physicians for where they are needed. Better designed payment systems – perhaps insurers making fixed periodic payments to hospitals and their medical staffs for comprehensive care of patients with chronic conditions – would encourage chronic disease management programs, including monitoring patients; adjusting medications as timely and appropriate; educating patients on how to do their part to manage their diseases; and removing financial barriers to patients’ obtaining necessary care. Such incentives would not necessarily require comprehensive integrated delivery systems. Risk-adjusted premiums would ensure that delivery systems that attract and care for patients with chronic conditions are paid appropriately.

As was noted in Chapter One, some hospitals have found it cheaper to offer low-income persons with acute diseases resulting from poorly managed chronic conditions free chronic disease management on an outpatient basis, because of the savings in reduced uncompensated emergency care.
**Health Promotion and Disease Prevention.** Chronic disease often arises from the failure to engage in good health behaviors – such as obesity-prevention, exercise, diabetes-control, smoking-cessation, and appropriate prevention methods such as cancer screening. Costs could be reduced in the long run by systems that change patient behavior and emphasize primary care, disease prevention, and early detection and treatment. One of the negative consequences of fee-for-service is that it generates the greatest income opportunities for doctors in specialties such as oncology and radiology, and poor pay for primary care – leading progressively fewer graduates of American medical schools to seek careers in primary care. Primary-care physicians provide coordination and continuity of care, health promotion counseling to patients, and a medical home for care based on continuous healing relationships. Successful health-care delivery systems must educate patients to avoid lower back and other injuries, stop smoking, and pursue proper diet and exercise. Our unhealthy lifestyles begin far before the reach of the health-care delivery system; public-health measures, school-based programs, work-site programs and more are needed. But it could help a great deal if the health-care delivery system, with all its resources in intelligent, well-educated personnel, technology and money, firmly pursued improving people's health.

**Regional Centers for Complex Care.** Far too many complex medical procedures are performed in facilities that work in inefficient and dangerously low volumes. Fee-for-service payment rewards such choices. Both economy and quality require concentrating complex care in regional centers of excellence. Efficient incentives would drive delivery systems to create their own centers or subcontract the work to centers outside their systems, based on continuous healing relationships. Successful health-care delivery systems must educate patients to avoid lower back and other injuries, stop smoking, and pursue proper diet and exercise. Our unhealthy lifestyles begin far before the reach of the health-care delivery system; public-health measures, school-based programs, work-site programs and more are needed. But it could help a great deal if the health-care delivery system, with all its resources in intelligent, well-educated personnel, technology and money, firmly pursued improving people's health.

**End-of-Life Care.** Although the share of health spending on patients in their last year of life has often been exaggerated, it is still significant, accounting for about 30 percent of Medicare, while Medicare accounts for about 17 percent of national health expenditures. Elliott Fisher and his Dartmouth colleagues recently examined Medicare spending per beneficiary (adjusted for regional price differences) in the last six months of life, and found substantial regional variation, with the high-spending regions spending 60 percent more per patient than the low-spending regions. They reported, “Neither quality of care nor access to care appear to be better for Medicare enrollees in higher-spending regions... Medicare enrollees in higher-spending regions receive more care than those in lower-spending regions but do not have better health outcomes or satisfaction with care.”

A recent RAND Health study found that “The existing health care system generally classifies patients by disease and setting of care, but this method is becoming less effective because it works poorly for the increasing number of elderly individuals who have multiple diseases and need care in more than one setting... End-of-life care should be organized according to the kinds of services that groups of people need, rather than by disease diagnosis or where patients receive care... Palliative care and conventional medical treatment should be thoroughly integrated rather than viewed as separate entities.” Again, these recommendations support greater continuity and integration. Integration of end-of-life care, including integrated billing, would reduce the incentive to over-utilize ultimately fruitless specialist and intensive-care services, and encourage more-humane alternatives.

**Core Competencies That Are Not Encouraged by the Traditional Model Are Urgently Needed**

The modern firm, especially in the service sector, treats capital investment in information technology as a critical core competence. Rather than focusing solely on automation of individual client records, they use those front-line data in every aspect of their work. A health-care system reorganized along the lines of medical conditions, as suggested above, would pursue numerous improvements, some (but by no means all) of which are explained below.

**Effectiveness.** John E. Wennberg and his Dartmouth colleagues have documented very wide practice variations among doctors in different parts of the country, and even variations among doctors in the same community that cannot be explained by variations in medical need. Wennberg ascribes much of this variation to medical uncertainty, to supply-side factors (such as too many surgeons), and to idiosyncrasies in practice
style.\textsuperscript{88} Several efforts are underway to identify the best standards for care delivery, under the headings of "evidence-based medicine" and "guideline development." These processes could speed the transfer of scientific discovery into medical practice.

It is extraordinarily difficult to manage the huge flow of medical information. Over 10,000 randomized trials are published each year. This massive literature exceeds the grasp of solo or small-group practitioners. To provide affordable, quality care to cost-conscious consumers, this information must be translated into up-to-date science-based best-practice guidelines by physicians with a serious interest in economical practice, and made conveniently available to doctors. A consortium of medical groups in Minnesota called the Institute for Clinical Systems Improvement, and the Kaiser Permanente Care Management Institute, are pursuing this task.\textsuperscript{89} The Veterans Health Administration has a similar program called the Quality Enhancement Research Initiative.\textsuperscript{90} Such programs, combined with monitoring and feedback, should greatly reduce the medical uncertainty that contributes to the very wide variations in medical practice.

Getting practice organizations to implement these guidelines will be a major challenge. Though experience suggests that such guidelines are best applied by multi-specialty group practices with organizational missions of efficient high-quality care, other small groups of practitioners who choose to focus on a niche service could have similar goals.

Building on this best-practice research, the health-care system must move away from "flat-of-the-curve" medicine – that is, practices whose marginal health benefit is very small and uncertain relative to the cost. It must evaluate new technologies and use them only where evidence supports that they are beneficial to patients. Such evaluation involves technology assessment, including cost-effectiveness or value for money in actual practice over time, and not just in controlled trials. Fair regulators must create a legal framework under which health insurers can offer policies that do not cover some technologies because of cost, to make insurance more affordable. Doing so will be exceedingly difficult, but such restrictions may be necessary to achieve long-term sustainability. At the same time, we must not shut down valuable life-saving innovation.

Genomics offers exciting opportunities for better care – and also large challenges to the health-care system. There are hundreds of genetic tests now available, some quite costly. Genomics offers opportunities to diagnose people at high risk of disease and to develop targeted therapies. Effective use of these resources will require systematic approaches, including evaluation of who should be tested, and what prevention strategies and therapies they should be offered. Legislation to facilitate market entry by companies that want to create and sell generic substitutes of very costly biologics once the patents held by the original developers have expired will also be needed.

There has been considerable work to measure the quality of care and service in health plans and medical groups. The National Committee for Quality Assurance, a non-profit organization dedicated to this purpose, undertakes a well-tested survey and publishes ratings of health plans on quality of service and access; performance of preventive services such as cancer screening and immunizations; and helping people to stay healthy, get better, and live with chronic illness. Such information is now on the Internet.\textsuperscript{91} If it is conveniently available to people choosing health plans, it will give those plans a powerful incentive to improve.

**Access to Quality Coverage**

We need humane coverage – coverage that is comprehensive, protecting everyone from severe financial hardship related to medical expenses, and also secure, so that people do not lose their coverage when they lose their spouses or change their jobs, divorce, become sick, or retire before age 65. People need the right to stay with their preferred delivery system so long as they do not move out of its service area. Insecure coverage is a major problem in our health-care economy today, because many people are just a layoff away from economic insecurity and uncovered health-care costs.

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

Finally, we need a more vigorous and effective anti-trust policy including breaking up any regional
provider monopolies created by mergers whose main purpose is to achieve market power.\(^h\)

**Conclusion**

These attributes of existing successful health-care systems, taken together, would radically reshape health-care delivery, yielding both higher quality and lower cost. Yet each of these expectations is reasonable on its face. None is more than what is already expected of a well-run, world-class competitive company in any other sector of the economy.

This transformation of health-care practices cannot be imposed by the government top down, or even by employers. It would be very difficult to define such a system in legislation, and no one knows exactly what the best system for health-care delivery is, or what it will become as health technology continues to evolve. But the market forces of informed cost-conscious consumer choice can drive a successful transformation. Better systems can emerge only by success in a competitive market.

Could such restructuring solve the problem of unsustainable cost growth? There is no guarantee, just as there is no guarantee with any other system. But it is eminently reasonable to conclude, at least, that the system reforms outlined here could reduce the *level* of health expenditures. Given the range of premium costs among insurance plans using different delivery systems at this time, people who would move from the most- to the least-expensive plans would cut their costs by as much as half.\(^i\) As more-costly plans respond to competition, savings would accrue across the board. The motivation of competition would also appear to be our best chance to counterbalance the expenditure-increasing effects of expanding technology and the proliferation of chronic conditions, and thereby reduce the *rate of growth* of costs as well – facilitating quality and sustainable coverage for all.

There remains the task of finding the policy steps that can implement such a sweeping transformation. The next chapter will address that task.

\(^h\) In its important report, *Crossing the Quality Chasm: a New Health System for the 21st Century* (Washington, DC: National Academy Press, 2001), the IOM put forward a shorter list of ideal health-system attributes that is well worth considering carefully. The paragraph headings of their list were: 1. Care based on continuous healing relationships. 2. Customization based on patient needs and values. 3. The patient as the source of control. 4. Shared knowledge and the free flow of information. 5. Evidence-based decision making. 6. Safety as a system property. 7. The need for transparency. 8. Anticipation of patient needs. 9. Continuous decrease in waste. 10. Cooperation among clinicians. The ideas are completely compatible with the views expressed above.

\(^i\) Based very roughly on the differences between the most and least expensive premiums charged where employees do have responsible choices among competing plans.
Chapter Four: Essentials of Market-Based Universal Health Insurance with Consumer Choice of Health Plan

So if the single-payer or consumer-directed approaches will not solve the problems of high levels and growth of expenditure, not to mention the uninsured, poor quality, and poor disease management, what will?  There are no easy, simple solutions.

And there are no guarantees. The nation cannot simply decree a reimbursement reduction for health-care providers: doing so would discourage the supply of health care. As has been the case in stopgap reimbursement cuts in the federal Medicare program, doctors and hospitals would respond by performing more individual services to maintain their total billing amounts. Likewise, the nation cannot decree an arbitrary limit to the volume of medical services provided; that could prevent the delivery of needed services. An arbitrary halt to the development of medical technology would inhibit innovations that could benefit people enormously, and would prevent the discovery of cost-reducing, as well as cost-increasing, treatments and therapies. And there are no clear models from overseas. Virtually all the industrialized countries are facing similar unsustainable expenditure growth rates, though from lower levels of spending than ours measured as percentages of GDP.

Thus, there likely is no strategy that would yield a precisely measurable, accurately predictable amount of health-care cost savings.

However, there are feasible changes that might make a large difference and, in the long run, move the system in the right direction. The heart of the arbitrary halt to the development of medical technology would inhibit innovations that could benefit people enormously, and would prevent the discovery of cost-reducing, as well as cost-increasing, treatments and therapies. And there are no clear models from overseas. Virtually all the industrialized countries are facing similar unsustainable expenditure growth rates, though from lower levels of spending than ours measured as percentages of GDP.

The only way to achieve sustainable, quality health care is to obtain from the health industry the same level of process and efficiency improvement that we have come to expect from other sectors of our economy.

Merely shifting the nominal responsibility for the cost from one party to another (say, from business to government), when the cost is growing faster than the capacity of the economy as a whole to pay it, obviously will not suffice. But as the earlier chapters of this report have suggested, a systemic restructuring of the health-insurance system, with sharpened incentives for cost-conscious behavior on the parts of both individuals and providers, could reduce both the level and the rate of growth of costs while improving quality.

Competition motivates innovation and efficiency. For virtually the entire non-health-care economy, competitive pressures have increased quality and tempered prices in unpredictable ways. Consumer choices have signaled price standards and preferred product and service attributes to the marketplace, and suppliers have improved their processes and methods to meet and then to surpass those standards, thereby setting new ones. Even given the unique nature of health care, some elements of competition provide the best hope for a more cost-efficient health-care system.

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

Such systems exist. The University of California offers employees a range of choices including both FFS and group practices, with a fixed-dollar contribution set at the risk-adjusted premium of the low-priced plan, which, like all plans, must meet quality and coverage...
standards set by the University. The state of Wisconsin has a similar system for its employees, and the Netherlands has recently enacted its own national reform along these lines. In such arrangements, every consumer can benefit financially from choosing a lower-priced plan, and the low-priced plan can protect its market share by maintaining or widening the gap between its premium and those of its competitors. Employees make their choices at an annual enrollment at which the prices are displayed side-by-side, and switching plans is made easy. Under these conditions, 81 percent of the employees of the University have chosen the lower-cost plans (in this case, group-practice-based HMOs), as have 90 percent of the employees of the state of Wisconsin. Wells Fargo Bank in California has a similar model whose enrollment in low-cost group-practice-based HMOs is 78 percent. The Federal Government does something similar for its employees, and 58 percent of Federal employees in California have chosen the same HMOs offered to employees of the University and Wells Fargo. The reform in the Netherlands has been in operation for only one year, but in that year has seen a decline in the rate of cost growth.

Under these systems, cost-conscious employee choice drives patients to the most-efficient providers and motivates the others to reduce costs and increase quality to maintain their competitive positions. Unfortunately, only a small percentage of employees are in such models now. As explained earlier, most employers do not offer choices, and many of those that do pay all, or nearly all, of even the highest premiums for their employees. This apparent generosity gives even generally cost-inefficient providers a secure market, with no incentive to improve. What is needed is for essentially everyone, possibly excepting groups such as the disabled and the population undergoing long-term care, to receive a regionally based fixed-dollar payment toward his or her insurance premium, accompanied by a menu of meaningful choices of insurance plans.

Many people might doubt that the quality and cost of health care can be driven by consumer choice of a health-insurance plan. We believe that such doubt arises from the distortions in the present markets and their negative consequences, as documented earlier. However, in this section, we examine an alternative that eliminates the current system’s distortions – by offering consumers choices of different plans, and giving each consumer a fixed-dollar payment to purchase the plan of his or her choice. In this system, consumers have an incentive to be cost-conscious.

To attain such a system, CED recommends two broad policy steps:

- **Create competitive insurance markets and exchanges;** and
- **Provide universal premium credits financed by broadly based taxes.**

These two changes to the financing system will lead naturally to a dramatic change in the health-care delivery system:

- **Delivery systems and insurance carriers strive for quality and affordability.**

The model is based on observation and analysis of the success of employers such as the federal government; state governments in California, Washington, Wisconsin and Minnesota; and the University of California, Stanford University, Wells Fargo and Hewlett-Packard in California. These employers have demonstrated its practicality.

**Competitive Insurance Markets and Exchanges**

**The Need for a Market Organizer.** The markets for health insurance, or health insurance combined with health-care delivery, are unique. Their uniqueness does not mean that competition in these markets is impossible, but the nature of these markets does mean that the competitive process needs rules – much as do the markets for other insurance products or for securities, for example – to yield efficient and fair outcomes. The unique attributes of the health-insurance market are:

- **Risk Selection.** When different health insurance plans compete for the same people, the health risks

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*a See Memoranda, pages 84-86.

*b Again, these are not cheap or bare-bones “plan designs,” but rather comprehensive coverage associated with large multi-specialty physician organizations that are committed to economical use of resources.

*c What little competition exists in the current system has motivated many doctors who prefer the FFS model to form Independent Practice Associations (IPAs) that include management controls and enable them to compete.
or expected medical costs may not fall equally on the different insurers. Biased or “adverse” selection can lead to spirals of instability in which some plans attract worse-than-average risks, forcing those plans to raise premiums, making them even less attractive to good risks who then exit the plans, leaving even worse risk pools in the plans – until the plans become non-viable. Worse yet, the possibility of biased selection can create perverse incentives in which the insurers and associated providers, for survival, try to avoid enrollment by sick people, producing the opposite of what a health insurance system is supposed to be: financing care of the sick. This perverse incentive can cause providers to avoid achieving expertise and distinction in the care of costly chronic conditions. In a completely free market, insurers would inspect and underwrite each applicant and reject those with high expected costs, which is not compatible with widespread or universal coverage, and would be costly and time consuming.

- **Moral Hazard.** Most employed Americans today do not even have a choice of insurer, or if they do have a choice, their employers (and the government, through the tax code) pay more on their behalf if they choose a more-costly health insurance plan. This lack of competition biases choices toward more-costly care. Moreover, once people are insured, their health-care services are free, or almost free, and people demand services that they would not choose if they had to pay their cost – in other words, services that are not worth their cost. So insured people choose more services, often of limited value, than do people without insurance. This perverse incentive is exacerbated by fee-for-service payment to providers – under which both patients and providers have incentives to demand and provide services they would not choose if patients had to pay and providers were not paid for each service. There is no perfect answer to this problem. As explained earlier, high deductibles do little to mitigate this problem, because health expenditures are highly concentrated on relatively few people who will have exceeded their deductibles and would not pay for additional services out-of-pocket. The most effective answers include incentives for providers to deliver care efficiently and not over-sell services of doubtful value, and consumer cost-sharing for services that are mostly consumer-preference items. However, aside from plastic surgery and “lifestyle drugs” such as for baldness or erectile dysfunction, drawing the line between “necessary care” and “consumer-preference care” can be difficult.

- **Unusual Complexity.** Health insurance contracts – their language and the underlying technology – are extremely complex. There are too many possible future events. Few consumers really understand their health insurance policies or actually read them. Even the “simplified” presentations of employee benefit packages usually take 40 to 50 lines just to describe the services covered or excluded, the limitations, and the co-payments or coinsurance rates. Medical care is even more complex. It generally takes seven or eight years of post-graduate education and training to be considered a qualified physician, plus continuing education thereafter. Although some people can become sufficiently informed to contribute to strategic choices in particular cases, the vast majority must rely on the advice of their doctors, which makes them less than equal participants in a competitive market.

- **Information.** As discussed in the following chapter, there is a paucity of reliable, understandable information on the costs and comparative efficacy of interventions and technologies. Merely publishing hospital charges for individual episodes would address only a part of the problem. No matter how much information is accumulated and disseminated, and with the exception of a small and highly motivated population, the doctor will know a lot more about a patient’s medical condition than the patient. That is why patients consult doctors, and why the doctor’s incentives are important in the design of a system.

**What the Market Organizer Must Do.** Because of these complexities, to establish and enforce rules that maintain fair competition and its efficiencies for individuals and families as decided by the employer or the legislature, health insurance markets must be organized by a neutral third party – an entity with a name such as “market organizer,” an “exchange,” a “connector,” a “pooled purchasing arrangement,” a “Health Insurance Purchasing Cooperative,” a “Health Market,” a
“Health Help Agency,” or a “Sponsor.” For simplicity, let us call such an entity an “exchange.” There are ample precedents for such a market organizer in the federal and state agencies for transactions in securities (as well as in the quasi-regulatory functions performed by the private financial exchanges themselves) and other forms of insurance.

The exchange would be the single point of entry for all consumers to purchase health insurance; buyers and sellers would execute transactions through the exchange according to established rules. There could be one national exchange managing insurance choices in all regions, or each region could have its own exchange (more discussion of that choice is provided below). Exchanges would pool large numbers of individual risks and spread administrative overhead so that small-business workforces could afford insurance. An exchange for health insurance, like a securities exchange, could perform much of its service in digital electronic form.

The exchange would offer choices of alternative health insurers and providers, who would be free to use alternative delivery system models. It would be essential that wide-access PPO plans be available, so that everyone who wanted to continue with such coverage and with his or her own physician could do so; every consumer could “keep what he or she had.” The exchange would either select participating plans for economy and satisfaction of consumer choices, or, if there is to be free entry and a relatively large number of plans, organize the information for consumers with “plan-chooser” software to make it easy for them to find the plans that best suit them.

The exchanges would facilitate individual choices and switching among plans during periodic open-enrollment periods. To provide universal coverage, the exchange would need to engage in outreach services such as advertising, and placing personnel and computers in public libraries and other locations where people—especially low-income people—could enroll easily, including online.

Each subscriber would notify the exchange of his or her choice of health plan, and the exchange would notify the plan, so that the plan had no opportunity to screen applicants. This is normal in employment settings, but unfortunately is not the case in Medicare and Medicaid.

Every eligible person would be covered, and eligibility would be guaranteed. No exclusions would be allowed for preexisting conditions. The same premium would be charged for the same coverage regardless of health status. Coverage would be continuous. Persons choosing a plan priced above the low-priced plan would pay the premium difference with their own money (as explained in more detail below).

To make demand price elastic, and therefore to make competition effective in motivating improvements in efficiency and quality:

- The exchange must enforce public quality-related information-reporting requirements, and distribute information about plans, including their quality, coverage, performance, and price, in a convenient side-by-side comparison so that people can switch plans to save money if they so choose;

- The exchange must standardize the fine-print contract language and reasonably standardize plan designs, so that consumers can make meaningful price comparisons at a reasonable search and study cost, and switch easily and with confidence at the annual enrollment. Coverage contracts must be standardized to focus comparison on price and quality, not features, to counter market segmentation and the use of the coverage contract to select risks; and

- Choice must be at the individual or household level, not the employment group level, so that each person is free to switch plans regardless of the preferences of co-workers.

Importantly, to prevent the ill effects of risk selection, the exchange must risk-adjust premiums. The

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d This approach has been attempted in Medicare Part D, but the number of plans was so large that it required considerable effort to create a system for the elderly to study and compare the alternatives.

e A major issue in creating any system of universal health insurance will be to define who are eligible to be covered through it. In the United States, the most salient issue is likely to be coverage for undocumented aliens.

f This standardization does not mean identical contracts, but it does mean that fine print exclusions need to be the same, that differences in some key coverages (including mental health and fertility treatments) be minimized to avoid adverse selection, and that variations in front-end cost sharing must be reduced to the point that most people can understand the choices.
exchange would process and analyze information on each enrollee to estimate the cost of that person’s covered medical services. Estimates in the near future will most likely be based on prescription drug use, which is recorded in electronic form for most people and which indicates the presence of chronic conditions, as well as the person’s age, sex and location. However, research continues and continued improvement can be expected, especially with public-policy support. These estimates would then be pooled to produce a relative risk score for each plan’s enrollees. The exchange would then transfer some of the premium revenue to compensate those insurers that enroll the greatest numbers of relatively poor risks, from the revenues of those that enroll more relatively good risks. The prices that consumers see and pay would be the prices that a plan would ultimately receive if it had enrolled an average population of risks. The adjustment would be a behind-the-scenes computerized process, invisible to consumers. It would eliminate all need for underwriting individual people. Insurers already accept risk adjustment in existing systems similar to this proposal. Risk adjustment would maintain incentives for plans to enroll and care for sick people, not to avoid them, and avoid the instability caused by spirals of adverse selection.

Next, should there be one national exchange, or should there be separate regional exchanges? (“Regions” could be market areas such as Southern, Central, and Northern California; upstate and downstate New York and Illinois; etc.) Should operations – including contracting, enrollment, publication of information on quality and patient satisfaction, and analysis and reporting on local market conditions – be decentralized to regional offices? On the one hand, a single central operation in Washington would be simpler and cheaper, especially for plans entering new markets. One level of approval would admit plans to markets anywhere in the United States. The federal Office of Personnel Management (OPM) has managed the FEHBP centrally and successfully for 47 years, at times managing relationships with hundreds of different health plans.

Alternatively, decentralization to regional exchanges would recognize that health care is delivered locally and varies widely by region. Regional exchanges would study market conditions in their regions, prepare “Beige Books” analyzing the regional performance of health care, and report to the national exchange. The regional exchanges could work with local non-profit provider-sponsored plans to help them enter the market and increase competition. The national exchange could assign auditing functions to regional exchanges using uniform national standards. The regional exchanges could represent the system as a whole to people in their regions and also represent their regions to the national exchange. In any case, detailed knowledge of different localities would be needed somewhere in the system. And a Washington-based centralized system might be less sensitive to local conditions and less interested in working with small local provider-sponsored health plans.

The system could succeed in either a centralized or a decentralized model. Legislators or the exchange system would need to study the issue and make a decision.

In either case, the boundaries of regions for administrative purposes should not determine the service areas of health plans. Rather, health plans should establish the boundaries of their own service areas. For a successful example, the Wisconsin Department of Employee Trust Funds, which runs the State Employee Group Health Insurance program, invites bids from qualifying health plans for each county. A health plan could bid on all 72 Wisconsin counties, or only one county, or any combination in between. In essence, each health plan defines its own region, which ensures that plans have what they believe are strong networks of providers. Employer contributions are then keyed to the low-priced plans in each county.

The competitive insurance market that would evolve from these policy innovations would be based on price competition, but the price in question is the annual premium for comprehensive health-care services, not the price of each individual service. The annual premium, including any copayments and deductibles, represents the plan’s total annual cost per person. It gives the subscriber an incentive to choose the health plan that provides the best combination of quality and cost.

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6 Risk equalization might also include a reinsurance mechanism for very-high-cost cases, designed so as not to weaken the incentives of health plans to prevent the onset of high-cost illnesses or to manage the cases effectively.
People can understand and respond to such a choice effectively, during the annual enrollment when they have information, a clearly defined menu of alternatives, and the time for consideration.\textsuperscript{94}

Such a competitive insurance market can obtain maximum value for money for consumers and taxpayers, using fair rules derived from rational microeconomic principles, and from experience. Those health plans with the best combination of quality, low cost, and patient satisfaction succeed and have the most subscribers. Success is decided by the judgment of informed, cost-conscious consumers. The rules must not reward health plans for selecting good risks, avoiding sick people, refusing costs, or otherwise defeating the goals of efficient competition.\textsuperscript{95}

Thus, an exchange-based system would provide every individual with a menu of choices of health plans that meet clear standards for coverage and value. Every individual could change plans during regular open seasons to seek better quality and value for money, and would be guaranteed coverage by the plan of his or her choice. Prices to individuals would be independent of pre-existing conditions; and insurers who covered disproportionately high-risk populations would be compensated, and would not suffer from adverse selection. The health-insurance exchange would be half of the foundation of a working, competitive market for health insurance.

\textbf{Universal Premium Credits}

The exchange itself would deliver the second major building block of effective competition. \textit{Every eligible person would receive a credit, which would act as a premium contribution toward purchase of the plan of his or her choice, and also a guarantee of ability to purchase insurance from that plan.} The payment should equal or approximate the price of the lowest-priced plan that serves the enrollee’s area and meets comprehensive standards. As already is the case for the state of Wisconsin, the University of California and the Federal Employees Health Benefits plans, only quality plans with broad coverage may compete. If an individual chooses to buy a more-expensive option, he or she must pay the difference, which creates a powerful incentive for people to choose efficient systems – that is, systems that they believe offer the best value for their money. Experience shows that more-cost-efficient systems do very well in such competitive, cost-conscious environments. Providers would then have a corresponding incentive to create and join efficient systems.

With a credit that was significantly lower than the price of the low-priced plan, many people would choose not to pay the difference to enroll. In 2007, only 82 percent of workers offered health insurance by their employers actually accepted the offer.\textsuperscript{96} A premium support payment of 100 percent of the low-priced plan provides a logical incentive for full participation without complex mandates or other enforcement, and without costly means-testing. Funds for these payments should come from broadly based tax revenues raised through, for example, a payroll, value-added or environmental tax.\textsuperscript{9b} Employers are not in this picture, other than, should they so choose, helping their employees to make their choices (and possibly, depending on the program design, collecting employee payments and forwarding them to the exchanges).\textsuperscript{i}

Funding through a broad-based tax would enable enormous simplification. There would be no question whether a particular individual qualified for coverage. Because everyone in the society would participate in the broad-based tax, everyone would have paid, and would be eligible. Payment of the tax, whatever its form, would meet the standards of personal responsibility that are appropriate for coverage. There would be no need to enforce any individual mandate to purchase coverage. Such enforcement could involve significant additional complexity under the individual income tax, or through some new freestanding administrative apparatus. There would be no need to collect premiums for the low-priced plan. Should some individual fail to enroll in a plan at the inauguration of the system or at subsequent first eligibility, that person would already have paid for coverage; the only question would be that person’s choice of plan.\textsuperscript{j}

\textsuperscript{9b} This question is discussed in more detail below. Another revenue source would be the elimination of the current income-tax exclusion for employer-paid health-insurance premiums.

\textsuperscript{i} Employers might choose to continue dental insurance and coverage for other services not covered by the universal health insurance program, but probably without the benefit of tax subsidies.
Health-Care Financing and Delivery Systems Pursue Quality and Affordability

Together, establishing a health-insurance exchange and the availability of fixed-dollar contributions would lead naturally to a competitive marketplace for healthcare providers and insurance plans. Every consumer would have health insurance through the fixed-dollar premium credits, but more importantly would have an incentive to choose the plan that he or she believed to be the best combination of quality and value for money, because he or she would pay any cost beyond the fixed-dollar credit with after-tax dollars. Consumers could change plans freely at annual open seasons if they were dissatisfied. Therefore, to attract and to keep customers, plans would have to pursue efficiency and quality. This system might be called “market-based universal health insurance.”

This design would focus competition on value for money in the informed best judgment of consumers, and not in any way pick winners and losers in advance. The competitive market would do that, over time. The system should encourage differing delivery modes to foster competition and innovation. It should include plans with fee-for-service organization and wide choices of physicians, so that those who currently use such systems and want to continue to do so can keep what they know and prefer. In the end, some existing models might succeed in the competitive marketplace, or the winners might be entirely new, as-yet-unimagined models. One thing would be certain: the outcome would be better than today because the incentives and opportunities for consumers to choose quality, affordable care would be enormously increased.

At this time, the health-care institutions that appear most to embody the attributes of efficiency include the various integrated delivery systems based on multi-specialty group practices, and network models linking multi-specialty group practices. Experience in California, Wisconsin, Minnesota, Washington and Massachusetts, and in the FEHBP, including all of these models, shows that relatively efficient organized delivery systems do exist, their performance can be measured, they can and do improve, and they have the potential to deliver better-quality and more-cost-efficient care.

As was noted above, there is an existing model of what the whole market for health-care financing and delivery could be, in the choices presented to a University of California or a Wisconsin state employee: a menu of quality competing health plans, with information on quality and patient satisfaction, and a responsible financial choice – that is, the employer pays the price of the low-priced plan, and the employees who want plans that cost more pay the difference.

A similar suggestion by some prominent elected officials from both political parties is to use the FEHBP as a model for everyone. The FEHBP offers employees and retirees a wide range of choices and a semi-fixed-dollar employer contribution. The FEHBP is a large and nationwide system and serves as another good metaphor, although it should correct several significant design deficiencies, either for serving its existing population, or as a national model.

1 Note that an individual who failed to enroll in a timely way, and subsequently, upon needing care, chose to participate in a plan more expensive than the low-priced plan, would rightly be responsible for the incremental cost of that more-expensive plan since the last open enrollment.

2 One valid concern about such a model is that it could encourage a “race to the bottom,” under which insurance carriers would attempt to lower prices by reducing value rather than increasing efficiency. Such a development must be prevented, and it would be a part of the role of the exchange to do so. (In the FEHBP, the federal Office of Personnel Management (OPM) already plays this role.) One obvious way for insurers to try to cut prices would be to introduce and increase deductibles. To prevent such manipulation, we believe that insurers that offer high-deductible health plans must be required to fund, out of their premium revenue, health savings accounts in the amount of the deductibles. Advocates of HDHPs with HSAs in the current employer setting have argued that they are cost-effective to the employer, even with employer contributions to HSAs. If that is true, then a requirement for insurers to fund HSAs should not prove an unfair handicap to the HDHP plan design. FEHBP is discussed further in the following chapter.

3 See Appendix C for a discussion of existing health-care delivery models, and how they might adapt.
The Cost of a Reformed Health-Insurance System

Some features of the system that we propose would reduce total health-care spending; others would increase it. As coverage increases and approaches the universal, more people would seek care. On the other hand, there would be savings over time as newly covered people receive preventive care, and engage in healthier lifestyles as a result. More fundamentally, cost-conscious consumers would gradually migrate toward less-expensive plans; and all plans would respond by seeking efficiencies to reduce their premiums. Some of these changes might occur sooner, while others might materialize in the future; some might affect costs on a one-time basis, while others could change the rate of growth of costs over a longer period.

CED plans further research, to include a detailed actuarial analysis of our recommendations. However, we can draw some tentative conclusions from estimates for similar legislation proposed by Senators Ron Wyden (D-OR) and Robert F. Bennett (R-UT). Those estimates indicate that total national spending on health care would be less than what it would be if the current system remained in force – by (assuming for purposes of analysis that the plan had been effective this year) $4.5 billion (which is a very small percentage) in 2007, and by $336 billion (or 7.7 percent) in 2016. The savings in the first year would be a net total that would include $49.0 billion of additional services for the newly insured, $54.9 billion of savings from the incentives of price competition for consumers and insurers, and net savings in administration (with costs of the new “exchanges” offsetting reductions in insurer and employer costs) of $29.8 billion (plus other, smaller line-items). The annual growth rate of national health spending is estimated to be reduced by 0.86 percent.

In other words, if the nation could use the resources that are now devoted to health care – by employers, households, and governments – under a system of responsible, cost-conscious consumer choice, then it could afford coverage for all – with money left over. Furthermore, the amount left over, relative to the results under the status quo, would grow over time.

However, mobilizing the resources now used for health care would be a non-trivial task. For reasons of fairness, efficiency and administrative simplicity, we believe that the federal government should finance the premium credits for every consumer to pay private insurers for coverage, and so employers, individuals, and state and local governments, who now pay much of the cost of health care, would no longer need to. For the federal government to obtain each of those dollars now spent on health care, it would need to tax employers and individuals – which is never popular – and impose “maintenance of effort” requirements on state and local governments – which are always inexact and politically divisive. Keeping employers’ premiums flowing to health care would raise the issue of whether firms that do not now purchase insurance – often, arguably, because they cannot afford it – should be made to pay; or, alternatively, whether firms that now do pay for their own employees should be made implicitly to pay for other firms’ employees as well. Some households now pay nothing for their health insurance, because their employers pay in full; they might resent any assessment for health care. Individuals and households that now...
eschew insurance also might resent being forced to pay anything at all, although it is surely arguable that personal responsibility should require participating in the nation’s health insurance risk pool. The requirement to purchase auto insurance is a fair analogy.

In sum, though a reformed health-insurance-financing system could cut the nation’s total cost of health care and slow its growth, it would by no means end disputes over who should pay how much of that total, at least in the short run. Although no feasible payment scheme could hold every individual and every firm harmless, we believe that a fair solution is attainable, and plan further research on this issue.

**Effects on the Health-Care Industry**

The health-care industry is now about one-sixth of the U.S. economy. Any marked change in the structure of the industry would have correspondingly broad impacts. It is important to understand this process, both because of its effect on the economy, and because of its implications for the political debate on health-care reform.

In the broadest sense, improving the efficiency of health-care delivery would be no different from improving the delivery of any other good or service: the economy and the nation as a whole would benefit. Process improvement in health-care delivery could reduce the 16.5 percent of the GDP that is now devoted to health care, or the rate of growth of that spending in the future, or both.\(^6\) The savings in purchases of health care would be used for other things. However, the aggregate benefit of any savings would not protect everyone in the health-care sector from any loss of income. Every dollar of the current 16.5 percent of the GDP that is spent on health care is income to someone who works in the industry. If that share of GDP declines, some people’s incomes will decline, and some people may lose their jobs altogether.

Society should be sensitive to these effects, and should cushion them as much as possible. However, concern about those dislocations should not prevent progress for all. The deterioration of the current system has left growing millions of people without coverage, to the detriment of their health and of the health-care system, which must provide uncompensated emergency care. Inaction would extend that deterioration – and could lead even to a sudden collapse of the system, if a major corporate bankruptcy cost large blocks of workers and retirees their coverage, and induced that firm’s competitors to try to abrogate their similar commitments to remain cost-competitive. The current system is simply not sustainable, and the ill effects of the status quo far exceed the dislocations of a carefully phased transition to a sustainable system.

**Care Providers.** Many segments of the health-care sector would benefit from reform. Physicians and other practitioners, hospitals, pharmaceutical firms, and providers of health-care devices would be better off, in that having more people covered would mean more users of, and reliable payers for, their products and services. At the same time, of course, those firms and individuals would be subject to greater competition, and to more examination of the efficacy of treatments and procedures. Some practitioners and hospitals might need to change their practice styles to match more closely what cost-conscious individual purchasers demand. Sellers of pharmaceuticals and medical products might find that cost-conscious providers of health care – doctors, hospitals, and integrated group practices – would be more mindful of demonstrated performance and would drive harder bargains, though perhaps for higher volumes because more persons would be covered. However, over the long run, the outlook for stability and growth in the health-delivery sector would be much improved under a system of sustainable and universal coverage. Those individuals and firms that are willing to compete should welcome reform of the nature that we recommend.

**Insurers.** Health-care restructuring could be difficult for some parts of the insurance industry. The availability of insurance to all through exchanges would increase the number of customers. However, it also would obviate the need for underwriting and insurance sales to firms. Some persons who work in those

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\(^6\) Such employees and their employers will face a bargaining issue over whether any employer’s net savings (if its broad-based tax liability is less than its prior health-insurance premiums) should be passed through to its employees in higher cash wages.

\(^7\) Of course, society could choose to spend more, although more effectively, on health care.
fields would be needed for the presentation of insurance products to individual consumers through the exchanges, and for the work of the exchanges in risk-equalization of premium revenues. However, the numbers of such new jobs would be relatively small. Insurance firms themselves would be subject to greater competition, which would favor those firms that are most able to improve quality and hold down costs.

**Employers.** Many employers see health care as an important part of their workers’ lives, and want to be involved and support them in maintaining care and good health. For employers with highly skilled, highly paid employees, health-insurance premiums might still be a relatively small share of labor costs, and might still appear manageable. However, the trends documented at the outset of this statement are inexorable: a declining percentage of U.S. employers offers health coverage, and a declining absolute number — not just a percentage — of American workers and their dependents have employer coverage. Those workers who have coverage face declining employer premium contributions and rising deductibles and co-payments. With health-care costs rising faster than incomes, this situation will not improve. With all the good will in the world, employers as a group cannot maintain affordable, quality health insurance for their employees under the current flawed system.

Some employers might find health insurance to be administratively simple enough, because they buy “full-replacement” coverage, under which one carrier provides insurance for all of a firm’s employees. Insurers prefer this approach as well, as protection against “slice business.” However, as explained earlier, this type of coverage is inherently inflationary. Therefore, all things considered, employers who seek to provide coverage should be pleased at the establishment of a large and stable risk pool, with employees choosing the care they want, and the entire administrative burden assumed by the exchange. Employers also should be relieved that the growing burden of insurance costs is lifted from them, and that they can direct their efforts more at competing in their own markets and less at managing health care.

Managers of some firms might believe that they have special expertise at providing health insurance and that their plans provide a worker-recruitment advantage; such firms might regret health reform. However, the number of such firms must have shrunk markedly over the last 20 years. Furthermore, such firms could use the savings from more-efficient health care to recruit employees in other ways. Firms that have not sought to provide coverage for their employees might resist making any contribution toward health care, even if the same responsibility is placed on all employers. Within employing firms, there would be fewer human resources devoted to health care – which has been a growing activity for many years. Firms could choose to continue to provide information and decision-making support to their employees. New firms might arise to provide such support either directly to individual households or through employers.

**Labor Unions.** On the other side of the labor market, workers should be relieved to have guaranteed health-care coverage. The last few years have demonstrated clearly that even the apparently most-secure coverage can be at risk. At the same time, insurance-market competition could be a substantial change for many organized workers. Unions typically have bargained for their employers to pay the full cost of health insurance. As explained above, such arrangements lead directly to health-cost inflation. It would be in the long-term interest of organized workers to bargain for cash wage increases equal to their employers’ net savings from no longer paying 100 percent of health-insurance premiums, net of any health-insurance-earmarked tax increases, and then use the higher wages to choose their own cost-efficient health-care plans.

**States and Localities.** Several states already have acted, or have begun to act, to reform health-care finance. However, few if any states would be concerned if the federal government should preempt the issue; policymakers of the states that have acted invariably have said that they did so because the federal government had not. And although state action is welcome, and will foster innovation and expand coverage, the states clearly are not best positioned to advance strong reform. The federal government has the first access to the substantial resources needed to do the job properly. Left to their own resources, wealthier states will have a marked advantage over neighboring, poorer states, meaning that the wealthier states may increase their advantages as locations for future job creation. And most fundamentally, individual states have insufficient leverage over the entire U.S. health-finance system to
achieve process improvement and cost control. With the federal-level reform we contemplate, on the other hand, the heavy state responsibility for the Medicaid program should ease substantially. Both states and localities, including local public hospitals, should do better because of reduced cost to care for the uninsured and the low-income population.

In sum, cost-saving economic change has occurred in countless sectors of the economy – in shifts from mechanical to electronic wrist watches, from film to digital photography, and from paper to digital information transmission, to name only a few. International trade, broadly, fits the same mold. All such changes make society as a whole better off, but entail some dislocation. In every such instance, economists are nearly unanimous that productivity advancements must be encouraged, but that those who are dislocated must be helped. Resisting productivity improvements would reduce standards of living for the nation as a whole and would continue to drain government budgets and crowd out other public investments. In the instance of health care, these dangers are already evident, as workers receive lower after-health-insurance pay, firms burdened by health-care costs lose business to competitors from abroad, and state and local governments cut education spending to pay for health care. Health-care reform remains imperative even accounting for any economic dislocations.

**Conclusion**

It is unclear whether the nation could move to a radically improved health-insurance system in one giant step. The health-care sector constitutes a massive one-sixth of the economy. It has invested billions of dollars in buildings and health-care hardware (such as the various diagnostic testing machines), which cannot instantaneously be liquefied and re-cast as different health-care instruments that might be more useful and efficient. It also includes many thousands of professionals who have learned particular skills and cannot themselves be redeployed instantaneously in other specialties to reduce costs. And, incidentally, health care is a growing employer – one of the largest in the economy. Any efficiency-improving reform will take years of painstaking innovation, and will affect the lives of many people as workers and investors – not just as patients.

The next chapter will describe a practical transition from where we are to sustainable and more-efficient medical care. It will emphasize the need for steady, visible progress toward clearly articulated goals, while moving at a pace that is manageable for the existing industry and its work force.
Chapter Five: How Might We Get There? A Path to Consumer-Choice-Driven Universal Health Insurance in Feasible Incremental Steps

Our democracy moves in incremental steps. The political process resists sudden, large, discontinuous changes with uncertain consequences. Quantum change is rare in peacetime or in the absence of a major upheaval such as deep recession or depression. Medicare, which now spends about $350 billion per year, was started in 1965 with the thin end of an implementation wedge and wildly unrealistic estimates of how much it would cost: there was limited awareness of just how momentous a decision it was.

The failings in cost, quality and access in American health care today have become extremely serious, and the changes needed in our health-care financing and delivery system are fundamental and far-reaching. Fundamentally reorienting the underlying financial incentives of a $2 trillion industry is a huge undertaking. The industry must change from being cost-unconscious and cost-increasing to cost and value conscious. Some see the entire health-care problem as the large and growing number of people without health insurance, and there is a crying need for universal coverage. However, as the analysis above makes clear, there can be no secure coverage for anyone unless the growth of costs is slowed to a sustainable rate, through a transformation that optimistically will take a decade of constant effort and innovation, with attendant dislocation in the health-care industry.*

To achieve this fundamental restructuring through a political process that values stability, this chapter lays out a path of bold – but feasible – incremental steps that could produce steady progress, and in the end achieve market-based universal health insurance. We do not claim that the proposed transition is the only way to get our country to universal market-based health insurance, or even the best way. Rather, we believe that it demonstrates that, given political will and support, it would be possible to get there from here. It is what mathematicians call "proving an existence theorem."

The proposed transition builds on the experience of existing models – which in many cases have worked well for decades. It adapts some existing institutions, such as the FEHBP, to new roles. Also, it builds a new institution – a “Federal Health Insurance Board” or “Health Fed,” patterned on the governance, expertise and regional structure of the Federal Reserve System – to oversee, regulate and manage the system.

Phase I: Building the Foundations for Responsible Choice

To move from the current health-care system to sustainable, affordable, quality care for all, CED recommends the following transitional policy steps:

- To create an appropriate administrative structure: modernize and adapt the FEHBP to make it the framework for a national system of health insurance exchanges. Put the FEHBP under the supervision of a new agency patterned on the Federal Reserve Board. Here we will refer to it as the “Health Fed.”

- To ease market entry across the country, to make health care more competitive and less costly, and to eliminate conflicts between state and federal regulation of health insurance: modernize and simplify health insurance regulation by creating an alternative federal regulatory system that multi-state health plans can choose. Designate the Health Fed as the regulatory agency.

- To provide reliable, objective and authoritative scientific information about the value and costs of clinical interventions: create a national institute for medical outcomes and technology assessment, or build it onto the National Institutes of Health (NIH) Translation-al Medicine Program which determines the effectiveness of new technology and procedures in the delivery system.

*See Memorandum, page 86
• To reverse the recent erosion of health-insurance coverage, and the consequent growth in the number of the uninsured: expand existing safety-net programs, especially the State Children’s Health Insurance Program (SCHIP), pending the availability of true universal coverage.

First, to adapt the FEHBP to a new expanded mission, policy-makers must correct some of its features that would conflict with that role. Those steps should include:

• Replace the present employer-contribution amount (70 percent of the average of the largest plans) with a genuine fixed-dollar contribution, regionally adjusted, so that those who choose plans that cost less than the contribution keep 100 percent of the savings, not the 25 percent they now may keep. Today’s model gives little incentive to any health insurer to offer a plan priced below the contribution amount, and instead tilts the financial incentives in the direction of higher prices.

• Risk-equalize premium revenue, similar to what is done in Medicare, nationwide in the Netherlands, and in similar delivery systems in the United States. As explained earlier, risk equalization is essential to getting incentives right — and particularly to avoiding uncompensated adverse selection.

• Establish a minimum benefit standard for all plans, allowing them to offer broader coverage at their own choice. Otherwise, there would be an endless “race to the bottom,” as plans would raise deductibles so that they could attract a better risk mix. For Federal employees now, and later for citizens in general, there must be a floor under the benefits that must be covered — especially to protect people with modest incomes. Today, under the FEHBP, the OPM has the authority to decide whether a proposed benefit plan is adequate.

• Health plans in the FEHBP today quote the same prices wherever they operate, rather than charging different prices in different regions. Instead, plans should set regional market prices reflecting costs in each geographic area. Single national prices distort market signals. For example, with uniform national pricing, a national plan with significant operations in low-cost areas may be able to use the profits gained there to undercut local delivery systems in high-cost areas. Insurers should not compete on the basis of market strategies to take advantage of geographic differences, but instead should organize better care at less cost. In turn, the government’s premium credits or fixed-dollar contribution payments should be adjusted for regional costs and prices, as in Medicare’s prospective payment system for hospitals. National pricing is unnecessarily expensive: good coverage costs less in Minnesota than in Massachusetts.

The FEHBP is a sound model because it has a successful history of more than 40 years; it is well known at least to Members of Congress and their staffs, who use it to obtain their health insurance; and several prominent current and former Senators of both parties have spoken favorably of opening up the FEHBP, at least to small employers. Building on the FEHBP would demonstrate that the proposed system would work. For Federal employees, this step could increase choices and competition centered on satisfying employees. It might also ease the strain on the Federal budget.

Using the FEHBP as a model would give new exchanges a rich experience base. Actually adding non-federal workers to the FEHBP might cause federal employees, including Members of Congress, to fear a worsening of their risk pool, saddling them with higher premiums. One solution would be to manage two separate risk pools: federal employees and private-sector-group employees. However, as proposed, private employers might bring in younger, less-costly employees. In any case, this problem could be measured and appropriate adjustments made, and it would seem fair for Members of Congress and Federal employees to live under the system that serves the American public.

The FEHBP should be put under the supervision of a new Federal Health Insurance Board or “Health Fed,” modeled on the Federal Reserve Board. The Health Fed would oversee a network of regional exchanges and direct their operation, and become the regulator of health insurance for insurers choosing the national regulatory option (described below). Like the Federal Reserve, the Health Fed Board would make judgments about complex issues such as the specific details of coverage contracts and acceptable business practices. Also like the Federal Reserve, the Health Fed would be fee-
funded and thus not subject to annual appropriations. One potential funding source is a small percentage of all health insurance premiums; for example, in 2006, a one percent assessment on premiums would have yielded over $6 billion.

The Health Fed would be semi-independent. Its governors would be appointed for fourteen-year terms. They would not be drawn as ex-officio, but rather would be the best candidates with knowledge of the complexities of health care, without personal conflicts of interest. They would be supported by an expert staff that could be drawn from the existing agencies of Congress and the executive, such as the Medicare Payment Advisory Commission, the Agency for Health Research and Quality, and perhaps the Centers for Medicare and Medicaid Services, as well as from state governments. The board and its staff could build on the work of the National Association of Insurance Commissioners (NAIC), which has been successful in moving to national financial standards. It could seek input broadly to establish the regulatory framework for those insurers who choose national accreditation.

If a network of independent regional exchanges was chosen to manage the regional markets, the Board would establish their locations and responsibilities. Regional exchange presidents or chairs could be selected by the national Health Fed Governors, while the remaining officers could be elected from among the appropriate stakeholders. The Health Fed would establish standards to be used by all regional exchanges. The standards would ensure that the exchanges operated fairly, transparently and uniformly, that the plans' offerings were easily understood, and that the plans met financial, quality and service standards. Regional exchanges could have both regulatory and research staffs to understand and evaluate innovative programs. Risk equalization methods would be set forth by the Health Fed, informed by the experience and insights of the regional exchanges.

Create an alternative federal regulatory system that participating multi-state health insurers can choose. Designate the Health Fed as the regulatory agency. Health insurance, like all other forms of insurance, is regulated by the states – and was so even before the McCarran-Ferguson Act of 1946 codified their authority. Regulation by the states is costly, complex and various. It is a barrier to firms entering new states, and a cause of conflict between federal and state laws. Health insurance is now a national industry, and public policy should encourage established health-care financing and delivery systems to expand to other states in the interest of greater competition, by offering them an option of uniform national regulation – especially in a national system of health insurance.

State insurance regulators recognized the difficulty of individual states dealing with very large national and international insurers. To develop appropriate tools and standards, they created a private entity, the NAIC, which promotes uniform national standards. But no matter how sophisticated these standards, state regulators have been unable to facilitate and accelerate market entry. To market a new national insurance product, an insurer must go hat-in-hand from state to state to secure approval. Beyond the sheer red tape, each state imposes unique standards, such as different minimum benefit requirements. Most states, furthermore, regulate health insurance rates, further delaying market entry. Contrast this with a federally chartered banking product or a mutual fund: once approved by a federal regulator, the new product can be marketed throughout the United States.

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*a The Federal Reserve is funded by the interest on its portfolio (mostly U.S. Government securities) and fees for its services to banks. It returns the excess above its expenses to the U.S. Treasury.

*b more extensive discussion of the management functions of the Health Fed is presented in Appendix D.

*c An example is regulation of managed care in California, which was created in the aftermath of a scandal with respect to Medicaid in the 1970s, and endures and becomes increasingly complex even though it bears no relation to established prepaid group practices or other health insurers, and market conditions have changed dramatically.

*d The NAIC's greatest success has been in the development of uniform financial standards – for example, risk-based capital standards, standard statutory accounting principles, and uniform financial statements. Those standards are enforced through a detailed system of accreditation, which all but one state (New York) follow. The NAIC has also developed uniform financial examination and market-conduct examination procedures, and encouraged multi-state examinations to achieve consistency from state to state.
Particularly in the health-insurance market, however, insurers do not uniformly oppose state regulation. Many Blue Cross-Blue Shield plans are one-state corporations and would not choose to supplant state regulation with a federal regulatory system. It would make sense, therefore, to consider an optional federal charter for health insurance: dual federal and state regulation of health insurance similar in concept to the dual regulatory structure for banking. Through Medicare, Medicaid, the FEHBP, the Health Insurance Portability and Accountability Act of 1996, the Employee Retirement Income Security Act, the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), and the HMO Act, the federal government already actively regulates health insurance. A federal regulatory option would enhance simplicity and consistency.

It is timely to rethink regulation today. The situation now – especially as it would be with consumer choice and universal health insurance – is very different from 1977 or even 1997. The regulatory framework today should reflect new conditions and public-policy goals.

First, in a regime of consumer choice, many earlier concerns about insurer behavior would be lessened or eliminated. For one example, the earlier backlash against managed care, which sparked much regulatory activity, was concentrated among the people who were assigned to such plans by their employers, without choice and without visible savings for themselves. Also, physicians were upset that managed care was spread coercively. However, more recently, the leaders of the American Medical Association have proposed universal coverage through a system of subsidized, responsible individual consumer choice of health plan quite similar to our proposal. Finally, the very high market shares, approximately 80 percent, of managed care in groups with responsible choices belies the notion that the American people do not like managed care plans that they themselves can choose.

- Furthermore, in the proposed universal health insurance model, every person would be in the “large-group” market that would be far more customer-friendly than today’s markets for individuals and small groups.
- A consumer-choice-of-plan model gives people a more convenient outlet for expressing dissatisfaction than contacting a regulator. They can simply “vote with their feet” at the next annual enrollment, and the offending plans would have to respond to those concerns to survive.

- More so than 20 years ago, there is now an urgent need to improve value for money and limit cost growth to sustainable rates.

Given these changing concerns, and under the proposed new health-care market, the following guidelines for national regulation of health plans are appropriate:

- Regulation should be uniform toward all types of health plans. No plan model should have restrictions or permissions not applied to all others. A patients’ bill of rights and responsibilities should apply to all plans equally.
- Regulation should allow reasonable cost-benefit tradeoffs. Technologies that confer small marginal health benefits at great costs should not be required in a system that strives to make health care affordable.
- Because innovation to improve value for money is a central goal of policy, there should be an optional single source of regulation at the federal level to speed new product approval, spread cost-reducing innovations from one state to another, and slow health-expenditure growth to a sustainable rate.
- Regulation should encourage large multi-state insurers to enter many or all regional markets with risk-bearing plans, to increase competition.
- Regulators should recognize that an informed-choice system would obviate the need for much existing regulation, so that different delivery-system designs, including those that share cost-reduction gains with providers, can challenge one another in the marketplace to spur efficiency.

This Health Fed is a fitting model for the agency that would modernize and simplify health-insurance regulation, and also provide an alternative federal regulatory system. It is based on a trusted semi-independent governmental agency: the Federal Reserve Board of Governors. The Federal Reserve model would convey impartiality, expertise, freedom from narrow political interests, stability, and a long-term perspective with a board of governors serving long terms.
Although health care is both different from and more complex than banking, it already is a shared responsibility of the state and federal governments – like the banking industry since 1913, when the final legislation establishing the Federal Reserve was enacted. That law was a political compromise, which echoes the health-care environment today.104

Create a national institute for medical outcomes and technology assessment.105 In contrast to the dynamism of other industries, the health-care delivery system is largely unevaluated after more than 50 years of stagnant business practices and third-party payment. There is a paucity of reliable and objective scientific information about the value and costs of clinical interventions, even while costly technologies are widely deployed because the Medicare law in effect forbids cost consideration in approving new technologies, and private insurers are reluctant to deny coverage of technologies for reasons of cost. Most patients assume that their doctors are up-to-date on widely accepted standards of care; but the data on practice variations among apparently well-qualified doctors raise serious doubt. Much is spent on services of little or no value, as evidenced by the lack of demonstrably better outcomes in the United States compared with countries that spend much less on health care.

The lack of authoritative evaluation has led to highly publicized, costly, and bitter political and legal disputes.6 History illustrates a lack of knowledge of comparative effectiveness, with high dollar and human costs.7 We need a widely respected institution to sponsor the needed research and offer authoritative judgments.

For decades, there have been calls for more systematic assessment of medical technologies, clinical interventions, and outcomes – and more recently, similar calls for formalized comparative effectiveness studies.106 Yet federal support has been limited and seemingly haphazard. Existing organizations cannot objectively evaluate medical technologies and practices, because of inadequate resources and fragmented efforts.8 In one well-publicized case, a federal agency that did such a study suffered severe budgetary retaliation from disgruntled surgeons who did not like the findings, and who took their disagreements to Congress.107 Private entities have tried to fill the gap, but their work has been limited and rarely targeted towards the needs of the general public.

The health-care system urgently needs a new entity, which might be called the Institute for Medical Outcomes and Technology Assessment (IMOTA), to assess the effectiveness, cost and overall value of health interventions and practices – including drugs, devices, diagnostic tests, and medical practices and procedures. IMOTA could make recommendations for how to integrate new drugs or devices into the delivery system to realize savings – that is, process redesign. For example, it might consider how a new product enables improved processes.

IMOTA would need a stable budget, large enough for its complex mission, to provide thorough insulation from short-term political pressures. It must be rigorously protected from conflicts of interest, and accountable to the public. One potential model would be to make IMOTA, like the health-insurance exchange

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6 One example is the battle over High Dose Chemotherapy combined with Autologous Bone Marrow or Stem Cell Transplant (HDC/ABMT) therapy for metastatic breast cancer. This treatment was very costly ($150,000 or more if complications occurred) and hastened the deaths of some patients. At least one health plan suffered a $77 million punitive damages award, and an $89 million total awarded to the plaintiff, for not providing or paying for it. Under intense Congressional pressure, the Office of Personnel Management (OPM) reversed its previous policy of waiting for evidence of efficacy and directed all health plans for Federal employees to cover it. Randomized clinical trials published in 1999 found that it conferred no survival value, and the procedure is no longer used. More than 30,000 women received the treatment, shortening their lives and adding to their suffering. See R. A. Retrig et al., False Hope: Bone Marrow Transplantation for Breast Cancer (New York: Oxford University Press, 2007); Michelle M. Mello and Troyen A. Brennan, “The Controversy Over High-Dose Chemotherapy with Autologous Bone Marrow Transplant for Breast Cancer,” Health Affairs 20, no. 5 (2001): pp. 101-117; David Atkins, Joanna Siegel, and Jean Slutsky, “Making Policy When the Evidence Is in Dispute,” Health Affairs 24, no. 1 (2005): pp. 102-111. A later development in the same general field, causing similar controversy, is computer-aided detection, or CAD, in mammograms for breast cancer. Gina Kolata, “Study Questions Computerized Breast Cancer Detection,” New York Times, April 5, 2007, p. A14.

7 A new vivid example of the uncertainty about effectiveness is a dispute over the use of two different drugs, one relatively inexpensive, one enormously costly (ironically manufactured by the same firm), to treat macular degeneration in elderly persons. Marilyn Chase, “Genentech’s Big Drug for Eyes Faces a Rival,” Wall Street Journal, February 22, 2007, p. A1.

8 For example, the entire budget of the Agency for Health Research and Quality is less than 0.025 percent of total health spending – $500 million compared with $2 trillion.
system, a part of the Health Fed. Like the Federal Reserve Board, IMOTA should be freestanding and semi-autonomous. Its board should resemble the Federal Reserve in selection of members, numbers and terms. The board should set priorities, approve research, oversee staff and operations, coordinate with outside health groups, and ensure integrity and independence. The director should brief Congress periodically. Like the funding of the Health Fed, funding for IMOTA should come from the health-care financing system without annual appropriations.\(^h\)

IMOTA would provide analyses, evaluations and findings. *It would not itself make decisions about coverage. Rather, such decisions would remain with the same agencies and private insurers now responsible for them.*\(^i\)

**Expand existing safety-net programs, especially the State Children’s Health Insurance Program.** The primary motivation for health-care reform is to ensure secure protection for every American. It follows that special early effort is required to protect those who currently have no protection at all – even though cost-reducing restructuring ultimately will be needed to make all coverage sustainable. The State Children’s Health Insurance Program (SCHIP) has successfully extended Medicaid coverage to children in households with incomes below 200 percent of the poverty threshold in most states.\(^j\) Further efforts could raise the income limits, extend coverage to the now-eligible children’s parents, or otherwise provide Medicaid coverage to reduce the number of the uninsured pending the provision of true universal coverage. This is an effort similar in spirit to the various state reform plans, and it should be widely accepted as an interim step in a comprehensive program to provide universal access to private health insurance.

**Phase II: Progressively Expand Coverage**

*As the second phase of transition to market-based universal health insurance, CED recommends:*

- Extending the availability of a wide range of responsible choices of insurance carriers and delivery systems within the employment-based health insurance system by including all small employers (of up to 50 or 100 employees) in the new exchange system.

- Progressively expanding participation in the new system until all employers are included. Include the self-employed. The system could, and perhaps should, be open to entire states at the request of the governors and legislatures.

- When all employees have a wide range of competitive plan choices, creating employee cost consciousness in plan choices, and saving billions of tax dollars for subsidies for health-insurance purchases by low-income people by capping the tax exclusion for employer health benefits at the level of an efficient health plan premium in each region.

- Expanding the functions of the “Health Fed.”

**Include all small employers in the new exchange-based system.** Small employers could more easily secure affordable, reliable health insurance if included in large, balanced, and stable risk pools in the regional exchanges.

One key to sustainable health-insurance coverage is a stable risk pool. Creating such a pool is not easy.\(^109\) Seven states, including California, Florida and Texas, tried to create voluntary purchasing exchanges for small employers. None succeeded; none achieved a large enough market share to have significant economies of scale.

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\(^h\)Another approach would be to attach IMOTA to the Translational Medicine Program of the NIH, whose mission includes measuring the comparative effectiveness of new delivery-system technology. That program integrates effectiveness comparisons into new product development, and its work could be seamlessly added to delivery science. However, the NIH lacks the secure funding and political independence of the Health Fed. Independent funding would enable IMOTA to meet the needs of the public even when it threatens powerful political interests.

\(^i\)This point is the key difference between what we recommend and the similar British National Institute for Health and Clinical Excellence (NICE), which in the nationalized British system is perceived to have greater control of actual practice decisions. For a more extensive discussion of the functions of IMOTA, see Appendix E.

\(^j\)The Employee Retirement Income Security Act would have to be changed by Congress and the President to allow states to make such decisions for all their residents.
These purchasing exchanges encountered numerous barriers. Contrary to expectations, employers did not find the approach particularly attractive; offering competing choices of health insurers has rarely been a high employer priority. The exchanges also had structural defects. Finally, such efforts are highly vulnerable to adverse selection, witness particularly the experience in California.

Despite this troubling experience, it is in the long-term interest of every small employer – even one with a low-risk group – to be in a large, stable pool and buy through the proposed exchanges. A low risk today may become a high risk tomorrow, with no guarantee that affordable insurance will remain available when an employee becomes seriously ill. Furthermore, all groups buying through an exchange would have greatly reduced administrative costs, more-stable premiums, and choice for every employee.

Thus, the community at large is far better off as health-insurance risk pools become larger and more stable. A large part of the deterioration of secure health-insurance coverage over the last 50 years has been the onset of “cherry picking” of comparatively large, young and healthy employment groups by aggressive insurers, which leaves increasing numbers of small groups out in the cold. Reestablishing a large risk pool is essential to affordable health-care security for every American. A public-policy initiative is required to attract numerous individual smaller groups to band together and stay together, to form a viable risk pool.

Although a purely voluntary risk pool would not succeed, there is an enduring American preference for voluntary action over compulsion, so strictly mandatory risk pooling is unwelcome. However, the present “voluntary” health insurance system is actually much less voluntary than it appears. It is motivated by huge tax subsidies. The Federal Government first takes from taxpayers nearly $200 billion per year, and then gives it back in the form of tax remission if they or their employers purchase health insurance. These tax subsidies impose their own powerful conditions; in particular, they are much more generous if insurance is provided by employers, and they are open-ended. Thus, these subsidies unfortunately encourage the purchase of more-costly rather than less-costly insurance, and steer people toward insurance provided by their employers, which has had the effect of limiting choices.

So it seems reasonable to reshape the tax subsidies to encourage more, and more-economical, choices, and broader-based pooling.

One way to accomplish those objectives would be to require all employers of 50 or fewer (or 100 or fewer) employees to buy their insurance through the local regional exchange to continue to receive the tax exclusion. This incentive would motivate the good risks to join with the bad risks in a large and stable pool. A 100-employee cutoff would create a pool of about one-third of the labor force, which would be more than large enough to absorb and spread the risks of even the less-healthy employees of small firms – given that healthy groups would participate to receive the tax exclusion.

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1 In California, participating PPOs were driven from the exchange by adverse selection, and many company owners then left because they apparently wanted the PPO for themselves, but were willing to pay only for HMOs for their employees. Agents did not like the exchanges and did not try to sell them, because the exchanges at first did not pay agent commissions. When the exchanges did start paying commissions, their administrative costs increased. Insurers did not like the pools because they do not like “slice business,” with its higher administrative costs and possible adverse selection.

1 For example, at least some pools did not have master contracts, thus necessitating separate contracts between each health plan and each employer, and thereby precluding hoped-for savings. The exchanges had a social mission – making insurance available to small groups – but had to compete in a business environment. The small-employer exchanges attracted a disproporionate share of tiny groups (two or three), which tend to buy coverage through the proposed exchanges. A low-risk today may become a high-risk tomorrow, with no guarantee that affordable insurance will remain available when an employee becomes seriously ill. Furthermore, all groups buying through an exchange would have greatly reduced administrative costs, more-stable premiums, and choice for every employee.

4 In California, participating PPOs were driven from the exchange by adverse selection, and many company owners then left because they apparently wanted the PPO for themselves, but were willing to pay only for HMOs for their employees. Agents did not like the exchanges and did not try to sell them, because the exchanges at first did not pay agent commissions. When the exchanges did start paying commissions, their administrative costs increased. Insurers did not like the pools because they do not like “slice business,” with its higher administrative costs and possible adverse selection.

6 The HIPC, started in 1993 on a small budget, was transferred to the ownership of Pacific Business Group on Health (PBGH), a large employer coalition, in 1999. In 2006, PBGH closed the exchange because one of the participating carriers was persistently losing money, apparently because of adverse selection. Another voluntary small employer pool, California Choice, has survived. It is a private for profit business, not encumbered by rules requiring it to underwrite more generously than the market in general. Its managers believe that they cannot require participating employers to make fixed-dollar contributions, so price competition within the pool is attenuated.

9 This follows the thinking behind the Managed Competition Act, H.R. 5936, 102nd Congress, 2nd session, September 1992, introduced by Congressmen Cooper, Andrews and Stenholm plus about 80 cosponsors from the Conservative Democratic Forum. There are likely to be serious administrative and enforcement problems with using the number of employees as the basis for deciding which employers get into a pool and which do not. Do part-time employees count? And what about employers whose workforces fluctuate? These problems would be more severe if the intent were to stop the process at employers of 50 or 100. They should be less severe if this is part of an overall plan to cover everyone through exchanges. The reason for starting with small employers is that they need exchanges more, being less likely to provide insurance now.
and the advantages of the exchange. A similar incentive is at work today, because employer contributions are usually available only to employees who enroll in the plan the employer sponsors. A Federal employee, for example, cannot escape the FEHBP pool without forfeiting the large employer contribution. Thus, the tax exclusion already is a powerful incentive to pool risks. This same incentive could motivate pooling in exchanges.

Starting with small firms would help them to maintain insurance at stable premiums. One serious illness can cause small-group premiums to skyrocket. The tax break should be enough incentive to get a representative sample of risks from many small firms into the exchange. Also, participating firms must be required to make fixed-dollar contributions, not to exceed the price of the low-priced plan. Participating firms that outgrow this size class could be allowed to continue in the exchange, subject to some underwriting rules that protect the pool from adverse selection, if necessary. The exchange could also combine contributions from multiple employers if members of a household have part-time jobs, or jobs that otherwise do not support family health insurance.

When the new system is up and running, demonstrating its success, the firm-size threshold should be raised progressively to 200 employees, then 500 employees, and so on, until all employees are covered. Exchanges could cover size-qualifying smaller branches of large national employers who would like to participate, with any necessary underwriting conditions to protect the new system. Alternatively, entire states could be allowed or encouraged to opt into the exchange system.

The self-employed could join the system at this point, if not sooner, equalizing the tax treatment of health insurance among the self-employed, other individuals, and recipients of employer-based health insurance (as President Bush proposed in his fiscal year 2008 budget). The exchanges could offer the self-employed guaranteed coverage, provided they enroll promptly and stay enrolled. Exchanges should create rules, such as an individual mandate or an additional tax incentive, to deter the self-employed from opportunistic switching in and out of coverage.

Individuals and firms would be, of course, entirely free to buy and sell health insurance outside of the exchange framework, but in that case they would not be eligible for the tax subsidies.

Third, to build universal cost consciousness in the choice of a health plan, and also to free resources to subsidize access for low-income people: once all employees have choices of plans, limit the amount of the employer contribution to employee health insurance that can be excluded from the taxable incomes of employees and from employer taxable incomes. The President’s Advisory Panel on Federal Tax Reform recommended a limit on the exclusion from employee taxable incomes, though it was initially for an amount likely to be higher than the needs of an efficient plan. President Bush, in his 2007 State of the Union address, proposed a version of this limit to help finance a tax incentive for people without employer-based health insurance to buy in the individual market. Some objected to this proposal because employed people who are not offered efficient choices by their employers could not respond to the new incentive. The market for individual policies would not help those employees, because in most states that market has no community rating or guaranteed issue, and the many people with chronic conditions would not have access to affordable coverage — or possibly any coverage at all. However, with market-based universal health insurance including consumer choice, everyone would have guaranteed issue and the same price for the same class of coverage regardless of health status. Therefore, a limit on the tax preference would be an important and necessary step to create incentives for economical choice and fairness. Why should taxpayers continue to subsidize more-costly choices, when good-quality, less-costly choices are available?

The limit on tax-free contributions would prevent employees from demanding supplemental payments from their employers that would subsidize more-expensive, inefficient health plans, and undermine competition to attract cost-conscious consumers. To the same end, employers should be required to make fixed-dollar contributions as a condition of employees receiving the exclusion of employer contributions from taxable income.\footnote{This follows from the HMO Act and the Managed Competition Acts of 1992 and 1993, H.R. 5936, 102nd Congress, 2nd session, September 15, 1992.}
Fourth, expand the functions of the “Health Fed.” Research on the progress of Phase II should begin with its inception. The Health Fed should integrate data from the exchange system and other national agencies. Like the Federal Reserve, it should issue periodic “Beige Books” to describe available plans and their affordability, and the performance of the plans and providers. This would facilitate public discussion of the affordability of health plans, what services should be covered, and targets and strategy for performance, efficiency, and quality improvement with universal coverage. If health expenditures continue to grow unsustainably, the Health Fed should analyze the causes, and report to the Congress with recommendations.

Phase III: Achieve Market-Based Universal Health Insurance

As the final stage of the transition to market-based universal health insurance, CED recommends:

- To complete the transition to universal health insurance: replace all employer contributions with universal fixed-dollar credits financed by broad-based tax revenues.
- To help finance these credits: eliminate any tax break for employer-paid health insurance or health-care benefits.

Completing the transition to MB-UHI. At the end of Phase II, the transformation to UHI would remain incomplete. Health insurance would still be based on employment, although there would be economies of scale in administration, near universal access to choices, and transparency in prices. The inability of employers to create competition would be overcome. However, those left out of the present employer-based system – including non-poor individuals not eligible for Medicaid, such as pre-Medicare widows; those not poor but not employed; other non-employed, unemployed, self-employed uninsurable persons, and others – would still lack coverage unless other remedial actions, perhaps financed by the proceeds of the cap on the tax exclusion of employer-paid health insurance, were taken in the meantime. With such initiatives, the exchange infrastructure could create a platform to expand coverage to more and more people. It could do a lot of good even short of complete UHI.

How would we get from there to market-based universal health insurance? At some point, all employer contributions should be replaced by fixed-dollar contributions (or “premium credits”) paid for by broad-based taxes, supplemented by the large savings to the federal and state budgets from phasing out the many tax subsidies and programs that would be supplanted by UHI.

Existing federal health-insurance programs might be at least partially replaced by the universal health insurance program. Medicaid should be left alone until the new program is up and running. Then, some Medicaid beneficiaries, including lower-income non-elderly families, might be given a choice of the new system or Medicaid. Medicaid pays for nursing home arrangements and other custodial care that would not fit into health insurance as we know it; such services clearly need to be continued. Detailed analysis is needed. Similar analyses would be needed for Defense Department programs for the military and their families, and for veterans.

Medicare, to remain fiscally viable and to complete these reforms, must eventually evolve into an efficient, competitive system along these lines, possibly as an

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[7] Programs to help such uninsured people could include the insurance continuity under the Consolidated Omnibus Budget Reconciliation Act (known as COBRA continuity), administered by the exchanges without a time limit and with possible government subsidies, and other subsidies for low-income people. The COBRA continuity could be to membership in the exchange, with freedom to change plans at the annual enrollment. Unemployment insurance could include a health-insurance subsidy, similar to the Health Coverage Tax Credit of the Trade Adjustment Assistance program.

[8] First in the list of redundant programs would be the large federal and state tax subsidies to employment-based health insurance, estimated at $209 billion in 2006. The portion of Disproportionate Share payments to hospitals to compensate for serving large numbers of uninsured people would be replaced by insurance reimbursement. SCHIP would be replaced by MB-UHI. The new system also could and should replace Federal and state employees health benefits programs. Perhaps some billions could be saved in substance abuse and mental health services. Indian health, and some programs from the Health Resources and Services Administration, whose costs and services would be included in the MB-UHI estimates. Further CED research will present estimates of the costs and revenues of some of the main possibilities.
extension of the Medicare Advantage program, but with competitive pricing by plans. The new MB-UHI system could absorb Medicare by allowing people, as they reach age 65, to remain in the plan and delivery system of their choice, with appropriate federal premium support and risk-adjusted pricing.

As mentioned earlier, as a funding source for the fixed-dollar contributions, a payroll tax could be seen as replacing employer contributions to health insurance without drastically changing money flows or being seen as a “new tax.” Also, the administrative processes for collecting payroll taxes already exist. Many employers who now insure their employees might prefer a payroll tax that is a defined and predictable amount, rather than their commitment to today’s soaring health insurance costs. (Today, employer-based health insurance acts like a head tax.) But there are other possibilities, including a broadly based consumption tax that would not tax productive effort, and likely would be harder to evade by people working “off the books.” Environmental protection and reduced dependence on foreign oil might be served by a tax on carbon or gasoline. One way partially to phase out the subsidy of the premium credit without increasing marginal income tax rates would be to include the credit in taxable income.

As an alternative to our recommended financing system, which provides a fixed premium credit to everyone, premiums could be collected through the income tax system, with subsidies for low-income people phased out with increasing income. There could be individual mandates to require that everyone participate in the risk pool. Phasing out subsidies, of course, raises implicit marginal tax rates; and individual mandates are still taxes with their own administration and enforcement problems. In any case, the urgent need for a reformed health care system should not be held hostage to the details of the tax mechanism to support it. The financing step from Phase II to Phase III would not be large in the lives of most people, but the coverage step would be very important in enhancing the health and financial security of all Americans.

Conclusion

The program outlined here has the greatest prospect of achieving the three goals of restraining health-care cost, achieving universal insurance coverage, and improving quality. Without significant process improvement in the health-care industry, even the current coverage and quality of service — for both private insurers and public programs — will become increasingly unaffordable, as it has consistently for decades.

Merely extending coverage under the current system — even to universal coverage, such as offered by “Medicare for all” — would not solve the problem. It would significantly increase total costs, even after whatever savings might be achieved by expanding preventive care and reducing administrative expense. More importantly, it would not slow the unsustainable growth of health-care expenditures, and so would force rationing, cutbacks in coverage, or other unsatisfactory policies. Alternatively, “consumer-directed health plans” — with high deductibles, possibly offset by health savings accounts — would provide no incentive to providers to increase efficiency with respect to the vast bulk of health spending that is beyond reasonable deductibles. CDHPs also would leave many persons of low or modest income with uninsured deductible costs that they could not afford, and with little or no tax benefit to help them.

If the United States is to achieve sustainable, quality, affordable health care, the health sector must achieve the improvement in efficiency that has become commonplace in virtually every other sector of the economy. This necessarily will entail some change in the way care typically is delivered. Under the proposed system, those who prefer today’s dominant fee-for-service model of care will be able to keep it, if they are willing to pay any difference in price. However, most people with choices have proven happy to consider new, evolving, and improving delivery modes with more emphasis on maintaining health through preventive care and healthy behavior, early intervention against and sustained control of chronic diseases, and better use of contemporary digital technology and communications.
The health-insurance model presented here relies on incentives for individuals to choose both plans and providers that offer what those individuals judge to be the best combination of quality and price. Exposing the health-care sector to such competitive forces will create a new dynamic toward improvement. Without such an incentive, health-care delivery has trundled along essentially unchanged, and prices have grown much faster than average incomes in the economy – leaving growing numbers of people who cannot afford coverage at all.

Before those unsustainable trends advance even further, at ever-mounting cost to reverse, the nation must change course. Command-and-control systems have a poor track record in modern economies; and health care is too complex to devolve all authority to the individual patient. Market-based universal health insurance, with individuals choosing the health plans and delivery systems that they deem best, shows great promise – much greater than any alternative.
CED’s 2002 statement on health care contains many sensible and important recommendations for business and government. For example, for employers:

1. Demand transparent quality information and adherence to best medical practices; use comparative performance information to select plans and providers; incorporate accountability for cost and quality into contract specifications.

2. Offer wide, responsible health plan choices to employees in exchange for their greater financial responsibility. Such plans would incorporate contribution policies that encourage workers to choose efficient, high-quality plans...help to establish, operate, and manage regional purchasing cooperatives that offer affordable plans to small firms.

For government:

1. Restructure Medicare on the model of the Federal Employee Health Benefit Program (that is, a wide range of responsible choices).

2. Cap the currently open-ended federal tax exclusion of employer contributions to promote cost discipline and equity; this could also provide some funding for policies to expand access.

3. Provide vehicles, funding, and technical assistance to establish purchasing cooperatives for small employers.

We have seen very little progress towards these recommendations. Transparent quality information based on results or outcomes is difficult to come by, despite some ongoing efforts. Many opportunities have been missed, such as extending to the whole nation the research being done by the state of New York and a few other states on risk-adjusted outcomes for cardiology procedures. We need guidelines on best medical practices, and then information systems to measure adherence to the guidelines. Toward these ends, leading integrated delivery systems like Health Partners in Minnesota and its cooperating medical group practices had created the Institute for Clinical Systems Improvement; businesses have worked together in the Leapfrog Group; Kaiser Permanente had created their Care Management Institute to define practice guidelines before 2002; the Veterans Health Administration had created a similar Quality Enhancement Research Initiative. But aside from these examples, there has been little progress.

The availability of wide, responsible employee health-plan choices is difficult to judge because it is not measured in regular surveys. The two most important surveys were done in 1997 and 2000. The earlier survey found that the employers of 77 percent of employed insured Americans did not offer a choice of carriers, and only 28 percent of establishments that offered a choice gave employees an incentive to make a cost-effective choice by contributing a fixed-dollar amount. This leaves only about 6.4 percent (23 percent of 28 percent) with both a choice and a fixed-dollar contribution. The later survey found that fewer than 10 percent of Fortune 500 employees combined a choice of carrier and a fixed-dollar contribution.

There have been no subsequent surveys, and there is little evidence that this situation has improved. On the positive side, both Wells Fargo and Hewlett-Packard, which previously offered choices, have recently adopted a fixed-dollar contribution for their employees. However, these examples are practically the only indication of progress.

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*The Henry J. Kaiser Family Foundation and Health Research and Educational Trust publish an annual Survey of Employer Health Benefits, which touches on the subject of employee choices. Unfortunately, they survey and report on “choice of plan,” meaning “plan designs.” Their survey would report that an employment group offering one carrier, with three plan designs (for example, HMO, PPO, POS (Point of Service) or High Deductible Health Plan) all providing insured access to the same networks of FFS providers, would be offering three plans. But this “choice” is competition neither at the insurance-carrier level nor at the delivery-system level, and so does not bring about delivery-system competition. And even by that defective measure, the survey shows little change in the frequency of offering a “choice of plan.”*
Chapter One explains that employers that consider offering choices are inhibited by concern over administrative costs, the possibility of adverse selection, and insurance company preferences to be the sole carrier for the group. The CED report recommended forming large multi-employer exchanges, like the California Public Employees’ Retirement System (CalPERS), to pool large numbers of employers and therefore create an attractive market for many carriers. That approach would require sustained collective action by employers. Unfortunately, employers find it difficult, if not impossible, to organize collectively, because their interests and priorities are so diverse: some are large, some are small; some have foreign competition, some do not; some are unionized (and most, but not all, unions demand that employers subsidize more costly choices), some not; some have mostly high-paid employees, while some have mostly low-paid workers (for whom health-insurance costs are a larger percentage of total compensation); some are concentrated in one or few locations, like universities, while others are scattered in many small groups. Multiply this diversity by the myriad views and understandings of what health care is all about – plus the fear that some other employer would increase the riskiness of the pool – and the difficulty of collective action becomes understandable.

In the summer of 2006, the Pacific Business Group on Health announced that PacAdvantage, a voluntary pooled-purchasing arrangement for small employers of two to 50 workers, was closing because one of its insurance carriers was persistently losing money. If pooled-purchasing arrangements are wholly voluntary, and without a strong incentive for a large representative sample of employers to participate, a spiral of adverse selection against the pool is almost inevitable. Only strong incentives, such as access to tax exclusions, can hold such pools together. A system of reinsurance of very-high-cost cases could help, though not without causing its own problems. Creating competition is a collective-action problem. One employer offering responsible choices will not get the benefit of a reformed competitive delivery system. Concerted action by many employers is needed. If employers are unable to collaborate to create an effective competitive market, some public-policy response to the problem of soaring costs of insurance will be necessary.

As to the recommended government action, the idea of restructuring Medicare to work like the FEHBP has attracted some rhetorical support, but progress has been limited. The Congress did take an important step forward in the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) by providing that Part D of Medicare would be organized through price-sensitive individual choice of prescription-drug insurance plans from among many alternatives. The new competitors in the Medicare Advantage program, such as regional PPOs and private fee-for-service plans, have added a competitive dynamic, but they will participate only so long as underlying payment levels are attractive. The shift in the program from administered-pricing to quasi-competitive-bidding by plans could create a new competitive force – limited by the retention of statutory pricing to determine government payments. More important will be any move toward quality-based payment for providers and health-care organizations that rewards both efficiency and good outcomes.

In 2005, the President’s Advisory Panel on Tax Reform recommended capping the tax exclusion of employer health-insurance contributions to induce cost-consciousness. President Bush proposed it in his 2007 State of the Union message, but no action is pending. Purchasing cooperatives for small employers are, for the most part, closing rather than proliferating.

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b The problem may be mitigated, and possibly solved, by the use of a risk-adjustment procedure under which groups with predictably higher costs pay proportionately more, relieving employers of comparatively healthy employees of the burden of sharing in the costs of the more costly groups. Technology exists to do this. However, this would work against the ideal of broadening the risk pool and evening out costs and risks so that everyone could afford insurance.

c Any reinsurance of high-cost cases must be carefully designed to provide incentives for insurers to control very high costs, and to avoid incentives artificially to categorize more-moderate risks as high cost so as to offload that expense onto the reinsurance program.

d The Congress has not considered serious proposals to condition continued access to the tax exclusion on the offering of choices and fixed-dollar contributions, which might induce small employers to form or join pooled arrangements to achieve economies of scale.

e There is a successful broker-created multiple choice arrangement for small employers that offers, in Southern California, a choice of six or eight delivery systems to employees of participating employers, called California Choice. It covers 170,000 lives and is growing. It is not entirely clear how this survives and prospers when PacAdvantage could not. Apparently, California Choice has stricter underwriting criteria.
Some recent changes have been in the wrong direction. For example, the emphasis on high deductibles, despite the best of intentions, could weaken primary care, disease prevention and disease management, thereby lessening the already insufficient market forces of competition.f

Conclusion

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

And yet, there is the potential for a better health-care system at the same or lower cost. As was noted at the outset, patients today are treated at considerable cost, but receive only about half of what best practice would define as appropriate care. U.S. health-care spending is the highest in the world as a percentage of GDP, but U.S. health-care outcomes are far below the average – suggesting strongly that better practice would yield better health and lower costs down the line. In the same vein, reputable studies have identified excessive and inappropriate treatment and expense, suggesting opportunities for savings that would have no cost in terms of health. Thus, our health-care system could deliver better care at low additional cost or even savings – without the feared necessity of withholding beneficial care in the interest of cost. The nation should pursue greater efficiency in the existing system before contemplating limits on care.

f Chapter Two addresses the merits of the high-deductible approach in greater detail.
Appendix B: The Traditional Fee-for-Service-Indemnity Model of Health-Care Finance Is a Major Cause of Rising Costs

The growing number of uninsured Americans is truly troubling. This problem is surely driven in substantial part by high and rising health expenditures and the cost of health insurance. For years, health-care expenditures have been growing two and a half percentage points per year faster than incomes. If we could control cost growth, it surely would ease our coverage problem, at least somewhat. So we must ask the question: Why are health-care costs growing so fast?

Medical practice in the United States is dominated by the fragmented, uncoordinated fee-for-service model of health-care organization and finance, based on solo or small single-specialty group practices. It is important to understand this model, its origins, and its consequences for health expenditure in this country. The dominance of this model is not the natural consequence of market forces. Rather, it has been sustained by inertia and the absence of normal competitive forces in the health-care market. It must be subjected to competition from better-organized systems to serve informed, financially responsible consumers. In those limited instances when competition is at work today, alternative health-care delivery systems perform much better.

How the Fee-for-Service Model Works

The traditional fee-for-service, solo-practice model of medical organization and finance is as old as medical science itself. In the early days of this country, when there was only one doctor for wide swaths of the frontier, solo practice was inevitable. For years thereafter, the body of medical knowledge was sufficiently narrow that there was no such thing as a “specialist”; apart from differences of individual skill, one physician was interchangeable with any other. Again, solo practice was the inevitable result. Health insurance did not exist, and so people paid for each service when they needed the doctor. Fees and costs were restrained by the limits of patients’ willingness and ability to pay.

The patients were using their own money and went without care they could not afford unless they were poor enough to be considered charity cases.

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

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

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

No one can know what the results of greater competition in health-care delivery would be — and of course, one can speak only of the results of competition at any one moment, because further innovation and change go on endlessly. It is even possible that future innovations would breathe new life into the FFS solo-practice model. The one thing that we do know with certainty is that the cost of the status quo is rising unsustainably, threatening access and quality for every American. We cannot continue on this path.
FFS solo-practice medicine came to be based on the following principles:122

- **“Free choice of doctor”** at all times. That means that the insurer that pays the bills has no bargaining power with the doctor because it cannot influence whether or not the patient goes to any particular doctor.

- **“Free choice of treatment,”** that is, nobody “interferes” with the doctor’s treatment decisions and recommendations. This means that there is no monitoring of compliance with established practice guidelines, no utilization management, no quality management and no peer review. Process, organization and management innovations such as these have been the lifeblood of progress in virtually every other industry in the developed economic world.

- **“Fee-for-service payment,”** which means that the doctor can always earn more by doing and prescribing more treatments, and more-costly treatments, whether or not they significantly benefit the patient’s health – a conflict of interest for the doctor.

- **“Direct doctor-patient negotiation of fees.”** The patient is in a very weak position to bargain or shop because he or she depends on the good will of the doctor and lacks information about the underlying medical science, what other doctors charge, how capable they are, or how many visits or procedures they would take to solve a given problem. Insurers, on the other hand, have a great deal of such information and could use it in the patient’s interest, but they are not allowed to do so in the FFS model.a

- **“Solo (or small single-specialty group) practice.”** The idea of physician autonomy is deeply ingrained in medical culture.123 In today’s world of complex modern medicine, that idea is dysfunctional. Teamwork is essential, with other physicians and also with many allied health professionals. Doctors depend on other doctors for referrals. Within a multi-specialty group practice, primary care doctors can refer patients to their own specialist partners, thus eliminating potential pressure from outside doctors who would want referrals. This puts multi-specialty group practices in business conflict with solo primary-care practitioners.

This traditional FFS model maximizes autonomy and economic benefits for physicians. Arguably, it is not the best model, and probably not even a sustainable model, for our society. It does not meet the important and legitimate need for affordable care and insurance. It has survived, and its performance has been taken as the standard for the health-care system, in large part because of the lack of effective competition to test it and force it to improve.

After years of patients using their own money and going without care they could not afford, employment-based health insurance became widespread during and after World War II. Most health insurance was FFS by Blue Cross and Blue Shield (“the Blues”). Hospital and physician associations created the Blues to assure payment on terms acceptable to them. There were agreed-upon fees, but providers sat on both sides of the bargaining table where the fees were determined.124

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

In the FFS model, the doctor decides what he or she wants to do and what he or she wants to charge, and

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a This aspect of the model has been superseded by Medicare fees and by the wide-access PPO in the private sector.
the patient’s role is merely to pay and then seek reimbursement from his health plan or employer. This is a model that leaves employers and employees with minimal control over the costs of health care – and the employees with minimal concern about the costs in the first place. Now, as costs have soared, the FFS model has been strained to the breaking point.

**Inappropriate Care and Variation in Practice Patterns**

Under FFS, providers are not held responsible for the cost of care and face little economic restraint on fees. PPOs negotiate fees, but because they commonly offer wide access – that is, practically every provider in town is in the network – the PPO has little bargaining power. It cannot offer providers more volume in exchange for a better price. A doctor who keeps his or her patients in the hospital longer than other doctors, for the same condition and case severity, is rewarded with more money and the esteem of the hospital administration for generating more revenue.

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

There were and are very wide variations in medical practices from one community to another and even among doctors in the same community. John Wennberg, M.D., Professor of Medicine at Dartmouth Medical School and director of Dartmouth’s Center for the Clinical Evaluative Sciences, documented variations of ten-fold and more. Doctors in some parts of Vermont did ten or more times the per-child rate of tonsillectomy as in others. Such variation suggests doctors were following their own practice patterns, perhaps doing what they were told in their training programs years ago, rather than following up-to-date science. Wennberg’s findings bear quotation at length.

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

For example, the practice style factor affects whether patients with menopausal symptoms, with hypertrophy of the tonsil, with hyperplasia of the prostate, with mild angina, or with a host of other ailments receive conservative treatments in an ambulatory setting or undergo a surgical operation in a hospital. It also affects whether patients with relatively minor medical conditions such as bronchitis or gastro-enteritis, or who need minor surgical procedures such as cystoscopy, teeth extractions, sterilization, or breast biopsy receive their care in a hospital or elsewhere. The practice style that favors inpatient treatment greatly affects the demand for hospital care and has serious implications for efforts to constrain costs.

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

These findings undercut the notion of “medical necessity,” as judged by the individual doctor, and the notion that there is a “standard of care.” Clearly, some people were getting more therapies or procedures than were beneficial while others might be getting too few. Scientific evidence-based practice guidelines would help to control costs. Dr. Wennberg has continued this line of research and periodically publishes the *Dartmouth Atlas of Health Care*. The *Dartmouth Atlas 1999* reports that in 1996, radical prostatectomy for Medicare beneficiaries was performed 9.4 times as often in the hospital referral area with the most such procedures than in the referral area with the least. For carotid endarterectomy, the ratio was 7.7.  

Scientific, evidence-based practice guidelines, produced by teams of doctors and other experts, are clearly needed, as are procedures to monitor compliance. In view of the massive amounts of medical literature appearing every week, the individual doctor — unaided by some organized effort — cannot possibly keep up and also have time to see patients.  

Arguably and understandably, many doctors’ decisions and behavior are at least influenced by the financial incentives in FFS, as well as by traditions and training, and by loyalty to the physician’s particular specialty. The *Wall Street Journal* recently reported an example in an article entitled, “Hysterectomy Alternative Goes Unmentioned to Many Women.”  

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

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

“It’s sad,” says Juergen Eisermann, a gynecologist who is medical director of the South Florida Institute for Reproductive Medicine. “We do a disservice not to mention all the options.” Some gynecologists blame the failure to inform patients about UAE on the fact that gynecologists generally don’t perform the procedure. Instead, members of a specialty known as interventional radiology do UAE. When gynecologists lose the chance to perform a hysterectomy, they also lose the roughly $2000 fee the gynecologist might have earned.  

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

A good example of a proliferation of unevaluated technology in FFS is arthroscopic surgery for osteoarthritis of the knee, as documented in a 2002 *New England Journal of Medicine* article reporting a clinical trial that compared arthroscopic surgery with a pretend or sham or “placebo” operation. Patients with osteoarthritis of the knee were randomly assigned to and received “arthroscopic debridement” or “arthroscopic lavage” (two frequent operations), or placebo (that is, pretend or sham) surgery. The authors concluded that: “At no point did either of the intervention groups [that is, those who got a real operation] report less pain or better function than the placebo group.” In other words, this operation conferred no medical value.  

But other research has shown that “Postoperative thromboembolic events [blood clots] are serious complications, and retrospective studies have reported an incidence of 0.2 percent to 7 percent for clinically apparent deep venous thrombosis (DVT) and pulmonary embolism (PE).”

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*These figures are computed on an age-adjusted per-capita basis. The procedure counts are based on the area of residence of the beneficiaries, not where the procedure was performed.*
can lead to strokes, death, and heart damage, and to long and costly treatments in and out of hospital with anti-coagulation drugs. According to a report from the Baylor College of Medicine: “In the United States, it is estimated that more than 650,000 arthroscopic debridement or lavage procedures are performed each year, many of these for arthritis, at a cost of about $5,000 each” — totaling $3.25 billion per year, not including the costs of treatment of the complications. As is often the case with evaluation of surgical procedures, this one was not without controversy. There are reasonable criticisms of the research design, but this reinforces the point that the procedure became widespread before proper evaluation.133

In this example as in the others, the FFS insurance model gives patients no guidance as to the best procedures and the least costly doctors, and little reason to care. All the incentives lead to doing too much care, or care of little or no marginal value.

Another important driver of cost inflation in the FFS model is that hospitals compete for doctors – because doctors bring in paying patients – by offering amenities such as low-cost convenient office buildings next to hospitals, and by buying the latest and best high-tech equipment. Hospital recruiting leads to a “medical arms race” of proliferation of high-tech equipment, much of which is not used to full capacity. Underused specialists and facilities can result in a lack of proficiency – and thus, the proliferation of hospitals doing costly, complex and inherently risky procedures such as open-heart surgery in volumes that are so low as to be both dangerous and uneconomic.134

**FFS Is Inadequate for Treating Chronic Conditions**

A recent estimate indicates that 83 percent of healthcare spending is associated with people with chronic conditions, and that this share is rising.135 The FFS model is particularly poorly adapted to this kind of care. FFS is oriented to acute, episodic care. It pays for doctor visits and procedures. Chronic care needs what the Institute of Medicine of the National Academy of Sciences (IOM) calls “care based on continuous healing relationships” usually performed by allied health professionals.136 FFS has a hard time paying for nurses to telephone patients to ask them about their weight and recommend changes in their medications.

**Error, Fraud and Abuse**

Largely because FFS requires millions of individual acts to be billed and paid for, improper billing because of fraud, carelessness, or errors is a huge problem. Both governmental and private payers must sort through millions of claims and separate the appropriate and legitimate from the inappropriate and false. Physician demands for prompt payment do not make this task any easier. The insurance industry has had to innovate to do this job: perfection is not possible, and reasonable approximations must be used. Otherwise, transactions costs would soar even more than they have.

The Report on the Financial Statement Audit of the Health Care Financing Administration for Fiscal Year 1996 by the Office of the Inspector General of the Department of Health and Human Services estimated that in that year, the Medicare Program made about $23.2 billion in improper payments; subsequent reports have indicated that such payments have continued in somewhat reduced but still substantial amounts.137 The main reasons the payments were judged to be improper were insufficient documentation, no documentation, lack of medical necessity, incorrect coding, and non-covered or unallowable services.138 As the Inspector General’s Report said: “The Medicare program is inherently vulnerable to incorrect provider billing practices.”139 The same could be said of all insurance under FFS. Malcolm Sparrow’s book, License to Steal: How Fraud Bleeds America’s Health Care System, provides many examples.140 Abuse that is particularly hard to detect is, for purely economic reasons, increasing the volume of services that confer no additional benefit to the patient.141,142,143

**Lack of Performance Tracking**

FFS has been very slow to adopt comprehensive longitudinal records. Thus, doctors have no systematic way to follow their patients and track the outcomes of different procedures and treatments. They follow their patients who want to come back and be seen, but have little knowledge of the others who must be included in any analysis of the quality of care or the efficacy of treatments.
Appendix C: Potential Alternative Delivery Systems

The broad outlines of our recommendation, even with several practical examples such as the state of Wisconsin, the University of California and the FEHB, leave important implementation questions. Some of the examples are public, and some are private. Which mode should be chosen? If it is the private, University-of-California-type model, why is it that this successful model has not spread on its own? What changes in public policy would be needed to scale such a model to national implementation? Also, the private model is based on employment. How could that approach be implemented to achieve broader or even universal coverage to attack the problem of the uninsured? But if the public model should be chosen, what would be the cost, and how would it be financed?

Many people find it hard to imagine health-care financing and delivery systems other than the dominant, uncoordinated “free choice” fee-for-service small practice system. This system is hard to change, and its adherents fairly successfully fought off the “managed care” revolution of the 1990s. To imagine how it might change, it is important first to imagine an insurance world in which every individual or household has an annual, cost-conscious choice among alternative financing and delivery systems in a model structured to make sure their choice is informed and easy to make. How would things be different if health insurers had to compete for members, not employers?

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

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

Although we cannot forecast which systems would prosper in a reformed, truly competitive market for health plans, the following are likely candidates.

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a One plan along these lines has been introduced in Wisconsin by a bipartisan pair of legislators and can be seen at www.wisconsinhealthproject.org.

b As noted earlier, this is a state of affairs that exists, for example, for employees at the University of California and Stanford University, Wells Fargo Bank and Hewlett Packard, and Federal and California state employees, but otherwise only in a small minority of employment groups.
Tiered High-Performance Networks (THPN) Combined with Capitated Primary Care Networks (CPCN)

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

The weaknesses of THPNs might be addressed by pairing them with Capitated Primary Care Networks (CPCNs). Starting in the late 1970s, HMO of Pennsylvania, later U.S. Healthcare, developed a network of selected primary care physicians who were committed to the concept of cost-efficient medicine, who would be paid on a per capita payment basis for all primary care services, and who would accept extensive quality measurement. In addition, they would share in the savings, if any, in a budgeted pool of money for specialist services. This model grew rapidly and was very successful, enrolling more than one million members. It was eventually acquired by Aetna, which apparently no longer uses it because it does not fit well with Aetna’s “single-source” business model. But such a Capitated Primary Care Network could build in the important functions of health education, early detection, disease management and management of referrals to cost-effective doctors. And it could grow rapidly because it uses doctors already established in practice. The
effectiveness of the model was limited because it lacked the data needed to identify the most efficient doctors.

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

Individual Practice Associations

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

But the leading IPA in Northern California, Hill Physicians Medical Group, caring for nearly 400,000 members, has survived and prospered in an environment where there are strong multi-specialty medical group practices. They contract with the major network HMOs on terms similar to those of the multi-specialty group practices. They have more than 3,000 physicians and other providers in more than 1,300 practices. They are developing an electronic medical records solution that will make comprehensive patient
records available to participating physicians. In 2005, they paid out $26 million in performance bonuses for physicians. They are deploying other electronic systems to assist their physicians with appointment setting, patient eligibility, claims status, electronic claims processing, etc. They have the benefit of strong and effective management.

Tufts Health Plan in Massachusetts serves over 560,000 members. It works through hospitals and hospital staffs. To align incentives and to compensate hospitals for revenue loss through reduced hospitalization, the hospitals receive a portion of the savings from those reduced hospitalizations, preserving what would have been their small "profit" and fixed overhead portion, but not incurring the significant variable costs.

IPAs could have a strong future if they could attract the loyalty, commitment and responsible participation of physicians, if they could select physicians to address specialty balance and teamwork, and if they could achieve a high degree of virtual integration through shared electronic medical records and electronic systems for administration, such as for appointments and payments. They would need to move more toward improving efficiency through better integration.

Prepaid Group Practices

A prepaid group practice (PGP) is an integrated entity that includes both a health-care delivery system (doctors, other clinicians, laboratories, clinics, and hospitals) and an insurance function (financing arrangements, benefit plans, marketing, and customer service systems) "under one roof." Critical components of the PGP include the following:

- A multi-specialty group practice – that is, a group of clinicians, including primary care generalists, non-physician providers such as nurse practitioners, and specialist physicians, sharing finances, facilities, equipment, and responsibility for all enrolled members and committed to the team practice of medicine;
- Any hospitals or other facilities owned by or affiliated with the multi-specialty group practice;
- A voluntarily enrolled population that contracts with the PGP through a sponsor (employer or public program) or as individuals;
- Comprehensive health-care services provided directly or indirectly by the PGP;
- Per capita prepayment;
- Accountability for the quality and cost of the care that is delivered; and
- A relationship (usually, but not necessarily, mutually exclusive) between the delivery system and the insurance entity.

PGPs now cover roughly 12 million people. The main examples of PGPs are Kaiser Permanente, now operating in nine states and the District of Columbia; Group Health Cooperative of Puget Sound; Health Partners in Minnesota; and Health Insurance Plan (HIP) of New York. Harvard Community Health Plan in Boston was a PGP until it merged with Pilgrim to become a mixed group/IPA model.

Properties and attributes of Prepaid Group Practice include the following: Physicians are paid salaries, depending on their specialties and market conditions, and usually substantial bonuses for measured patient satisfaction, indicators of quality and teamwork. This facilitates incentives alignment. The culture emphasizes teamwork and shared responsibility for enrolled patients. PGPs emphasize primary care, disease prevention, early detection and treatment of disease, and chronic disease management. The model facilitates development of the infrastructure for chronic disease management, and also provides a smooth way of transferring savings from the inpatient sector to the ambulatory-care sector that prevents the need for hospitalization by superior care for patients with ambulatory-sensitive diagnoses. PGPs feature longitudinal comprehensive medical records and analysis of practice patterns and outcomes, to determine what works best in practice. Prepaid group practices are among the leaders in adopting health information technology.

In the RAND Health Insurance Experiment, a randomized controlled trial, Group Health Cooperative in Seattle delivered care of equal quality for 28 percent fewer resources than fee-for-service in Seattle. And they accomplished this in the absence of competition in kind from similar delivery systems and, for the most part, premium-price-sensitive customers.
Large Multi-Specialty Group Practices Evolving Toward PGP

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

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

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

Roles of Academic Health Centers

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

Of course, their unique roles would be teaching and research. The products of these services are public goods, which are and must be subsidized at their appropriate value by government. Academic health centers now often provide considerable care to the uninsured poor, to some extent subsidized by Disproportionate Share payments. With universal health insurance, the need for these payments would be greatly reduced but not eliminated.

Some AHCs would choose to create comprehensive care programs based on per-capita prepayment to compete in the general market for health insurance, though such plans usually would not be their core competence. Probably all AHCs would compete for regional referrals for complex care from the region’s suppliers of comprehensive care, as they do today for organ transplants, neonatology, and “quarternary care” in the grey zone between ordinary care and research—such as heart surgery in utero. These efforts logically would be financed by negotiated global condition-based payments per case.

And finally, AHCs would compete in the market for “destination medicine” in which patients in need of their care will travel even great distances to receive it, as in the case of the Mayo Clinic. These treatments might be on a fee-for-service basis, or paid for by negotiated global condition-based payments.
The proposed system would be managed by the “Health Fed” under broad guidelines written by the Congress. The Health Fed would insulate the details of the health care system from narrow short-term political concerns and would facilitate continuing policy adjustments that would need to move more quickly and flexibly than the legislative process.

Reconciling the Benefit Package, the Prices of the Low-Priced Plans, and the Government Tax-Financed Fixed-Dollar Contributions

The benefit package (that is, the schedule of what is covered by insurance, on what terms, and including what rates of patient co-payments, coinsurance and deductibles), the resulting prices of the low-priced plans in each district, and the government’s fixed-dollar payment to each individual or household to assist with purchase of health insurance, will not necessarily coincide, being themselves the results of quite different processes.

The broad outline of the benefit package should emerge from a political process that produces guidelines from the Congress, with more detailed decisions by the Health Fed Board to insulate the details of benefit design from politics. The benefit package should be reasonably comprehensive to encourage access to care for early detection, screening for chronic conditions and disease management. Importantly, the great majority of health spending is concentrated in relatively few high cost cases, and very little is actually spent on unnecessary primary care visits. Well-organized systems can make that even lower by using paramedical personnel and coaching patients on appropriate use of physician and emergency room visits. Thus, the scope for premium reduction by reducing benefits and increasing cost sharing is very limited. An important contribution of primary care is early detection of potentially serious acute conditions (appendicitis, pneumonia) and chronic conditions, and managing them appropriately to prevent them from leading to hospitalization.

Also, the basic benefit package for medical care services must be sufficiently comprehensive that it will not leave a market for supplemental insurance products that further insure the same services. Medicare for many years has encouraged a large market for supplemental policies, thereby adding both complexity and cost, and implicitly and inadvertently forcing Medicare to subsidize those supplemental insurance policies. People who have supplemental policies use significantly more Medicare services than similar people who do not, because the supplemental policies buy out the coinsurance and deductibles they otherwise would have to pay.

It is desirable to have the government’s fixed-dollar premium payment to individuals coincide with the prices of the low-priced plans in each district, so that everyone can have free access to the low-priced plan, and therefore no financial barrier to enrollment. A higher fixed-dollar payment would destroy the incentive of plans to offer lower prices. A lower payment would leave some amount to be paid by consumers, likely causing some not to enroll. The reduced “take-up rate” in turn can lead to additional administrative costs (see below). A payment of 100 percent of the low-priced plan premium, at least for an individual policy, is made at the University of California and Stanford, and for state employees in Wisconsin. The Federal Government bases its contribution on a percentage of the average of the premiums of the largest plans in the system. The state of California now contributes fixed-dollar amounts that are based on a historical path with annual percentage adjustments, generally below the price of the low-priced plan.

If the policy is to set the payment exactly at the price of the low priced plan, with the contribution determined after the bids are in, the model would be subject to some volatility, as some competitors might submit unsustainably low bids in an attempt to buy market share. Plan administrators might believe that the choice of a plan is “sticky,” once individuals began working with their doctors, and so might set a low premium price at
first but assume that they could raise premiums later without losing enrollees. For this reason, the state of Wisconsin Department of Employee Trust Funds has imposed an alternative rule. Plans are grouped into tiers by their quoted premiums. Tier I includes the lowest-priced plans, and employees who choose a Tier I plan will have the premium fully paid by the State. As well as greater stability, this approach tends to spread the load of caring for people with low incomes among several plans. People who choose higher-priced plans are expected to pay the difference between the cost of Tier I and the higher-priced tier or plan. It is desirable to preserve a model in which a health plan can always attract more members by lowering its premium, so people who choose plans priced below the Tier I average should be allowed to keep the difference (in cash, or in their health spending accounts, if any).

The prices of health plans would be determined by competition to serve premium-sensitive customers. The experience in employment groups suggests that premium-price-sensitive consumers migrate to the low-priced plans, so the competition is likely to produce strong incentives for health plans to achieve efficiencies and reduce prices.

A plausible way of determining the taxpayer-supported fixed-dollar payment would start with actuaries studying the distribution of actual premiums, estimating what a comparatively efficient plan would cost, and then adjusting the estimate regionally using indices of input costs in each region (similar to what is done for the Medicare Prospective Payment System for Hospitals). Then, if plans bid premiums below the fixed-dollar payment, and the Health Fed determines that they are realistic and sustainable, individuals and households choosing such plans would be allowed to keep the difference in cash or in their health spending accounts (if any), to give the plans incentives to offer lower prices. If the recipients cannot pocket the benefit from choosing plans with lower premiums, plans will simply not charge lower premiums, and competition will not drive prices down.

On the other hand, if, as widely feared, premiums grow faster than the tax revenues supporting the consumers’ premium credits, a process must be defined for dealing with the problem. For background, in 1965, Congress created open-ended entitlements in Medicare and Medicaid, which made consumers cost-unconscious and gave providers strong incentives to provide more services. Congress has watched each year as patients and providers have increased the use of services at a rate greater than the growth of total revenues, and in many years has done little to change the course of spending, and in few years has done enough to make any lasting impact. So it is not possible to make uncontrollable expenditures easily controllable right away. Moreover, recall that the system being recommended here would give all consumers incentives to choose economically, and would allow competition to force alignment of provider incentives with the needs and wants of consumers for affordable care.

If premium growth exceeds growth in available or estimated resources, the government might continue to pay its fixed-dollar contributions out of general revenues at the increased amount needed to keep up with premium growth. There might also be pre-planned policy changes (spending or taxes) to accommodate the shortfall. The Health Fed would be required to analyze the causes of the problem and present to Congress options and recommendations which might include stepped up antitrust action or other government activities, trimming the package of covered benefits, or raising the relevant tax rates. If Congress were not to act in a timely manner, some default action could be predetermined. (One such option could be to raise consumer cost sharing amounts to the extent needed to keep the program solvent. In all cases of increased cost sharing, there would need to be exemptions for people with low incomes.)

Managing Wide Regional Variations in Price-Adjusted and Disease-Adjusted per Capita Spending

Dr. John Wennberg and his Dartmouth colleagues have identified very wide regional variations in price- and disease-adjusted per capita spending. Medicare’s uncoordinated fee-for-service reimbursement encourages such variations and has no built-in incentive or management system to correct them.

A reasonable goal is to work toward equalization in aggregate per capita spending, adjusted for prices and epidemiology (that is, adjusted for age, sex, and diagnosis, and for regional costs of living). A poor outcome would be to tolerate the wide variations in adjusted per-capita spending not justified by variations
in prevalence of illness. That would be inequitable and wasteful.

If the premiums of the low-priced plans in a high-cost district exceed the national standard, the Health Fed could, under guidelines created by Congress, pay the price of the low-priced Tier I plans in the initial year, but then institute a 10-year phase out plan in which, by year 10, the fixed-dollar contributions would be at the adjusted national average. Each year that the premiums of the low-priced Tier I plans exceeded the standard, the Health Fed could increase consumer cost sharing to bring the premiums back to target. Alternatively, the Health Fed would be charged with investigating the causes of higher regional costs, and could make specific recommendations to the Congress and to regional providers, in a manner similar to that followed by the Medicare Payment Advisory Commission. Dr. Wennberg's research could be used to put a public spotlight on egregious overuse of services. For example, the Health Fed (or the Institute for Medical Outcomes and Technology Assessment) might commission studies on the prevalence of inappropriate or avoidable hospitalizations, or other indicators of poor quality or overuse of services.

However, it is very likely that competition in high-cost areas will work to eliminate wasteful overuse and to bring the health plan premiums down to efficient levels.

Managing the Problems Created by the Failure of Eligible Persons to Enroll in a Health Plan

Despite good outreach efforts, it is likely that some significant number of people will fail to enroll in a health plan. For one thing, some people simply will not act until they are sick. Others may feel that their life styles do not fit in with enrolling in a health plan and carrying a card. What can or should be done about that? There are several approaches. The Health Fed might run experiments and demonstration projects with different strategies. To a significant degree, the best solutions will depend on the character, incomes and life styles of those who fail to enroll, and will also depend on the financing mechanism chosen for the program.

In the first instance, such problems are likely to be moderate in the plan proposed here because government would pay an amount equal to the price of the low-priced plan (or a “Tier I” plan), and unclaimed amounts could be paid to the insurer to which the uninsured person is assigned. If a person chooses a plan priced higher than Tier I and then fails to make premium payments, after an appropriate process, the person's enrollment could be terminated and the person could be assigned randomly to a Tier I plan in which no further premium payment is required.

An analogous solution being developed for a similar MB-UHI model, the Wisconsin Health Plan, would be to assign uninsured people who show up at a provider in need of medical care, randomly, to one of the Tier I plans (that is, the lowest-cost plans, which they could have for no out-of-pocket premium cost). That plan would be paid all the unused back fixed-dollar payments that it would have received if the person had enrolled on time. No one to whom this happens should be able to complain if the policy was clearly articulated in advance. (In the Wisconsin Health Plan, as in our proposed program, all Tier I plans are “free.”)

Without such a financing plan, failure to enroll could be more problematic. A second approach would be simply to create a default insurance plan into which everyone without coverage is enrolled. It could, by design, be cheaper than the lowest-price plan by having higher cost sharing. However, such cost sharing might not be appropriate for people with low incomes.

A third approach would recognize that state and local government public provider systems of last resort (or “safety net providers”) have always been an important part of our health-care delivery system. Public subsidies should be made available to strengthen these systems, particularly to strengthen their capabilities in primary care, disease prevention and disease management. In effect, such systems, under state leadership and with federal help, should evolve into comprehensive care organizations, as some have done already. Then when eligible persons fail to enroll in a health plan, the default could be that they are enrolled in the public system, and the fixed-dollar contributions to which they would have been entitled are directed to the public system.

Alternatively, some have suggested an individual mandate, which has gained popularity recently. It is a component of the new Massachusetts Health Plan, and
Governor Schwarzenegger has included an individual mandate in his proposal for universal coverage in California. The key problem with the individual mandate, of course, is enforcement. California has mandatory auto insurance, but many people go without it. What do we do with people who have not purchased insurance? One approach is to require them to make an extra payment on their income tax return. But many of the people most likely to go without insurance are not liable for income taxes. In Massachusetts, the mandate is conditioned on the availability of affordable insurance, and there has been some trouble finding insurance that meets the definition of “affordable” without resorting to deductibles that are unreasonably high for low-income persons. Nationally, only some 82 percent of employees offered health insurance by their employers actually take the offer. Of course, in the model we are proposing, in which fixed-dollar contributions would approximate the price of the low-priced plan, insurance would be affordable for everyone. And if the contributions were financed by broad-based taxes, there would be no need for an enforcement mechanism.

The Dutch have mandatory universal health insurance based on regulated competition in the private sector, with web-based enrollment processes, and also public subsidies for low-income people. What happens if someone shows up at a hospital uninsured? In the first instance, the person is liable for his medical bills. If someone does not purchase insurance, this person is liable to a penalty of 130 percent of the premium over the period of not being insured, with a maximum of 5 years. The penalty has to be paid to the new insurer, who has to transfer this money to the government. If an uninsured person makes use of health care facilities, the person is liable for his medical bills. Alternatively, the person can, before getting the treatment, enroll with an insurer (for example, by telephone or website) who is not allowed to refuse because of the open enrollment requirement.

If an individual in the Netherlands is enrolled but does not pay the premium, the insurer is legally allowed to cancel the contract within a reasonable period of time after having sent a warning letter. The open enrollment requirement is a problem for the insurers. The insurer who has cancelled the contract is not obliged to accept this person in the next five years, but all other insurers are not allowed to reject the expelled person. If the person enrolls with another insurer and again does not pay the premium, the second insurer may cancel the contract after some time. And the person might go to a third insurer, etc. So the insurers fear a “merry-go-round,” when an individual would pay premiums only when actually in need of care (which, of course, defeats the purpose of insurance). The insurers agreed not to cancel the insurance contract of defaulters during a period of 18 months that ended July 1, 2007. They are now negotiating with government over who should bear the loss of forgone premiums. Preliminary estimates are that the number of uninsured among those who are obliged to purchase insurance is 1.1 percent. The number of persons who illegally stay in the Netherlands (and most likely are uninsured) is between 0.5 percent and 1.1 percent. The number of defaulters (“no premium paid for at least 6 months”) is around 2 percent.

But again, in a system of fixed-dollar payments that are large enough to purchase a comprehensive low-cost plan, such draconian measures should prove unnecessary. Those who fail to enroll when first eligible should be able to join a low-priced plan later with no adverse consequences to the health-care financing system.
IMOTA might fund clinical trials, but more often would assemble information from the published literature and unpublished data pertinent to its evaluations. IMOTA might commission studies, typically to universities and other nonprofit contractors; but over time, full-time staff should perform a growing portion of its work. IMOTA would need to prioritize among competing objectives. For example, IMOTA would need to anticipate the most likely improvement in outcomes. It would have to decide how to prioritize among treatment variations that had little impact on costs and large impacts on clinical outcomes, and variations with large cost impacts but little clinical difference. Its evaluations should be comprehensive, systematic, credible, and widely disseminated in accessible forms.

In addition to prioritizing, IMOTA should make subjective judgments needed for comparative effectiveness analysis. Here are three examples of these issues:

- How should evidence from different types of data be addressed? For example, researchers and stakeholders will need assistance in assessing comparative effectiveness when evidence for one treatment (a drug) comes from a randomized trial and evidence for an alternative treatment (a device) comes from registries.

- How should differential impacts on morbidity and mortality be addressed? How should stakeholders compare effectiveness for a treatment that extends life, but with greatly diminished quality, against a treatment that improves quality of life without extending it?

- How should treatments with differential impacts over time be addressed?
Page 27, Harold M. Williams

While I prefer our plan, I am not convinced that government-run single-payer health systems are inherently less efficient than market-oriented health systems. While a government-run single-payer system may not be compatible with our culture and ideology, a market-oriented health system that doesn’t provide access to 45 million people is not compatible with our culture or societal values either. Much of what we recommend could be implemented as well under a single-payer system.

Studies show that Americans are not healthier nor are they living longer than people in industrialized nations that spend much less per capita than we do. Despite having the most costly system in the world, the United States consistently underperforms on most dimensions of performance relative to other industrialized countries that have government-run universal health plans.

In health, our country rates 33rd and 32nd in the world respectively for longevity of males and females and 40th in child mortality. Measured in terms of purchasing power, we spend nearly two-and-a-half times as much per capita as the United Kingdom, almost twice as much per capita as Canadians and Germans and half again more than the Swiss even though both Germany and Switzerland have much older populations.

Page 42, Michael Chesser

While this proposal purports to make fundamental changes in the health care delivery system, the primary proposals are related to the financing of the program. The proposal does not show a clear set of changes that would lead to fundamental change in the health-care delivery system.

The report does an excellent job of noting that delivery issues are at the heart of the health-care debate. Regina Herzlinger, a Harvard business school professor, has put forth strong and well researched analysis of changes in the delivery system that are needed to bring efficiency into the health-care arena. This CED report fundamentally does not address the core issues of changes in the health-care delivery system.

There are two fundamental changes that the program proposes. First, using a broad based federal tax revenue to fund health care through insurance credits is proposed. Second, creating insurance pools that make access to insurance universally available is suggested.

Without fundamental delivery system changes, the sustainability of the program is in question. In addition, there are serious questions about the Federal Employee Health Benefits Program as it is organized. The decision to remove employer financing is attractive and would make our health-care program more similar to other nations’ health-care-program financing. This specific proposal clearly is a step in the right direction.

The issue of universal availability is fundamentally an issue of risk management. Without fundamental changes in the underlying delivery system, the pricing of these pools will become an issue. The risks underlying an insurance pool, no matter how big, determine the costs. The proposal, as noted above, does not address that fundamental issue.

It is recommended that this program be disapproved. If the analysis could more concretely address the issues in the delivery system, then the financing and universal-coverage provisions could be very attractive.

Page 42, David R. Nachbar

John Adams wrote in 1770, “Facts are stubborn things.” While few issues draw as much passion as the nation’s health-care problem, the stubborn facts remain. As this report shows, we have crossed the line from having hope that the system will remedy itself to the reality of a problem that needs a cure.

The number of uninsured Americans, now over 46 million, is increasing. The costs of insurance are vastly outstripping the rate of growth of American household
incomes. Faced with the known needs of feeding the family, putting gas in the tank, providing a roof over the head or buying insurance against unknown health risks, Americans are paying known expenses. Insurance can wait. American households have crossed the line.

It is unclear how long American businesses can afford our current system. As the report indicates, the number of business offering health benefits fell nine percent in a recent seven year period. While other countries have made health care coverage statutory, the US has relied on American industry, embedding health insurance into the costs of goods. This is a strong blow to our nation's competitiveness. American businesses have crossed the line.

This issue ignores state lines and knows no community border. The invisible uninsured become visible in our emergency rooms and public-health facilities. National health expenses are 16 percent of the GDP and the Baby Boom generation has just started to retire. American communities have crossed the line.

To adequately address this issue, I believe that three criteria must be met:

- There must be coverage for all Americans, ensuring that no patient is left behind.
- Market forces must be unleashed to counter the upward drift of costs.
- The plan must be simple and easy to understand.

This proposal comes close to meeting those criteria and the details need to be worked out in the legislative process.

I also support the proposal for its call to action. Health care has been a subject of conversation since Theodore Roosevelt. We need to act not only because of the pain inflicted on citizens and communities but also because we believe, in the words of Hippocrates, the founder of medical philosophy, that “health is the greatest of human blessings” and that it is inconsistent with our country's standing as a strong, self-sufficient nation, that this problem should exist for another day.

Moving forward will take hard work and most importantly, political courage. Such courage is needed to oppose forces that defend things as they are and scare away change. Two hundred years after Adams, another great American, John Wayne said, “Courage is being scared to death – but saddling up anyway.” We have crossed the line and its time to saddle up.

Page 42, Ian D. Spatz

“Quality, Affordable Health Care for All: Moving Beyond the Employer-Based Health-Insurance System” carefully describes many of the problems of current health-care delivery in America and accurately pinpoints areas of needed change. Chapter Four captures the necessary elements for creating a consumer-choice-driven, universal health-insurance system – competitive insurance markets and exchanges; broadly financed subsidies for low-income Americans, and reorganized delivery systems focused on quality and efficiency. The report also argues persuasively that government-run reform proposals would not achieve desired goals.

Yet, despite the report’s cogent criticisms of employer-based insurance (EBI), it remains the most common way of providing health insurance in the U.S. today and for the foreseeable future. The vast majority of the non-elderly insured get their coverage through their employers or through employed family members.

Contrary to what some may believe, the evidence does not support the view that EBI is disappearing any time soon. According to the 2006 Kaiser/HRET Employer Health Benefits Survey, while the percentage of workers covered by EBI has declined somewhat in recent years, that percentage is just three percentage points lower in 2006 compared to 1999 (59 to 62 percent). Nearly all large firms (with more than 200 employees) offer EBI (98 percent) and they employ the vast majority of U.S. workers.

Further, just six percent of surveyed firms reported that they were very or somewhat likely to drop

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coverage and, among large firms, just two percent said they might drop coverage.

With the vast majority of those without insurance either employed or living in households with those who are employed, with the right policies – including many recommended in the report – the workplace can provide a forum for expanding access to affordable coverage.

This context suggests that the report’s recommendation to build a new health-care system to replace the fundamental role of employers is unnecessary. Worse, it is politically out of tune. The leading efforts for systematic reform at the state level today build on, not replace, the current system of EBI. Notably, the Massachusetts plan, adopted on a bipartisan basis, seeks to strengthen the ability and willingness of firms to offer EBI and the ability of employees to enroll. Similarly, the California proposals make EBI the building block of reform. These plans and others under consideration at the state level are now sparking significant national interest including from Presidential candidates of both parties.

Fundamentally, the health reform the United States needs must be a political solution as well as a thoughtful policy solution. The CED report's recommendations to phase out the role of employers in EBI are inconsistent with a promising, growing consensus for change. Therefore, with great respect for the report’s authors and contributors, I must dissent.

Page 53, Harold M. Williams

The plan we are proposing, if successfully implemented, is one I strongly support. However, all the interests that have resisted the past efforts to reform the system are alive and well and vested in the status quo. Insurers and providers resist any effort that might threaten their central role and profitability, and practitioners worry that change could impact how they practice and their income. Americans who have coverage are by and large satisfied with their own care and coverage and fear change more than the status quo. The 47 million and growing population without health care plus those who fear that the insurance they have may become unaffordable are not an effective lobbying group.

Much responsibility must rest on employers. Struggling to contain the spiraling costs of health care and remain competitive internationally can provide strong leadership for fundamental change.

Even assuming it is ultimately successfully implemented, it will take at least a decade and probably longer before we have anything resembling universal coverage. This is unacceptable. Our nation is facing a crisis that requires immediate attention. There are some steps we can take now that are not inconsistent with the plan we are proposing.

In the interim, insurance companies could be authorized to offer coverage nationally and be required to cover everyone with no exclusion for pre-existing conditions.

The states should be encouraged to continue to explore their own solutions to effective universal health care so we can all learn from their experience.

We should be strongly advocating the reauthorization and expansion of the State Children’s Health Insurance Program (SCHIP) – as the report recommends. The least we can do now is to provide a safety net under our children today who do not otherwise have access to health care, thereby assuring preventive care and reducing future health-care costs. While we are struggling with fixing the system, at least this generation could count on realistic access to health care. Hopefully, compassion and humanity can prevail over ideology.
**Access:** A patient’s ability to obtain medical care, determined by factors such as the availability of medical services, their acceptability to the patient, the location of health-care facilities, transportation, hours of operation, and the cost of care.

**Acute disease:** Illnesses or health problems that are of a short-term or episodic nature, from which the patient is expected to return to his or her normal or previous level of activity.

**Adverse selection:** A characteristic of a health plan when a disproportionately high percentage of enrollees are more likely to utilize health services (and file claims for reimbursement) because of abnormally high health risks, such as when a high number of AIDS patients all select one health plan because it is perceived as having better AIDS providers.

**Agency for Healthcare Research and Quality (AHRQ):** AHRQ was created in December 1989 as the Agency for Health Care Policy and Research (AHCPR), a Public Health Service agency within the U.S. Department of Health and Human Services. The agency was reauthorized in December 1999 under its current name. AHRQ’s mission is to support research to improve the outcomes and quality of health care, reduce its costs, address patient safety and medical errors, and broaden access to effective services.

**Allied health personnel:** Specially trained and licensed (when necessary) health workers other than physicians, dentists, optometrists, chiropractors, podiatrists, and nurses, who perform tasks which must otherwise be performed by a physician.

**Ambulatory care:** All types of health services which are provided on an outpatient basis, in contrast to services provided in the home or to persons who are inpatients. While many inpatients may be ambulatory, the term ambulatory care usually implies that the patient must travel to a location to receive services which do not require an overnight stay.

**Ambulatory setting:** A type of health care setting at which health services are provided on an outpatient basis. Ambulatory settings usually include clinics and surgery centers.

**Any-willing-provider laws:** Laws that require managed-care plans to contract with all health-care providers that meet their terms and conditions.

**Appropriate care:** Care for which the expected health benefit exceeds the expected negative consequences by a wide enough margin to justify treatment.

**Beneficiaries:** Persons who receive health care benefits that are paid for by a third-party fiscal intermediary, such as Medicare, Medicaid, HMOs, indemnity insurance companies, etc.

**Benefit package:** A defined array of specific services or benefits that an HMO or insurer is obligated to provide under terms of its contracts with subscriber groups or individuals.

**Buyers Health Care Action Group (BHCAG):** A coalition of 26 self-insured employers in Minnesota which emphasizes care quality and cost effectiveness in its program. Its overall mission is to stimulate reform of the health care system by building a program founded on four principles: 1) increased quality; 2) increased provider competition; 3) increased consumer knowledge and responsibility for their own health care decisions; and 4) enhanced efficiency of health care delivery. BHCAG provides its members with a health plan that allows the consumer to choose among care systems (integrated teams of providers) according to their cost, their providers, and their performance in areas of quality and customer service.

The BHCAG model is a modified fee-for-service payment system which provides incentives for efficiency based on utilization. Care systems (see definition) submit a per capita target rate bid for a
specified set of benefits each year. These claim targets are adjusted based upon risk to reflect differences in the illness burden of their population from the average. Care systems are evaluated on a quarterly basis, and adjustments are made to match the annual claim target. Therefore, if a system’s costs exceed the claim target, the payment amount is reduced for the next quarter, and if costs are below the target rate, the payment is increased for the subsequent quarter. BHCAG began implementation of the model January 1, 1997.

**Cafeteria benefits plan:** An arrangement under which employees may choose their own benefits, allowing employees to tailor their benefits package to meet their specific needs. For example, an employee with no dependents may forgo life insurance but may prefer more comprehensive health insurance.

**Capitation:** Per capita payment for providing a contractually specified set of health services to a defined population over a predetermined period of time. For example, medical group practices that contract with HMOs usually receive, in advance, a negotiated monthly payment that covers all services rendered by the group for the period, irrespective of the actual volume of service rendered by the group.

**Care systems:** A primary-care centered health system with its affiliated specialty, hospital, and allied professional arrangements. It is organized to provide (or contract for) the full continuum of medically necessary services for an enrolled population. Primary care physicians are typically affiliated with only one care system. Care systems may be organized by physicians, PPOs or any other entity.

**Carriers:** A fiscal intermediary, usually an insurance company or HMO, which subcontracts with HCFA to process and pay claims for Medicare Parts A and B services, or which performs the same services for private purchasers.

**Catastrophic care needs:** Service needs which are so expensive that they are financially ruinous.

**Centers for Medicare and Medicaid Services (CMS):** The government agency within the Department of Health and Human Services that directs the Medicare and Medicaid programs and conducts research in support of those programs. Formerly known as the Health Care Financing Administration (HCFA).

**Centers of excellence:** Network of health care facilities selected for specific services, e.g., organ transplants.

**Chronic disease:** A disease that has one or more of the following characteristics: is permanent; leaves residual disability; is caused by nonreversible pathological alteration; requires special training of the patient for rehabilitation; or may be expected to require a long period of supervision, observation, or care.

**Claim:** Information submitted by a provider or covered person to establish that medical services were provided to a covered person, from which processing for payment to the provider or covered person is made.

**Claims review:** The method by which an enrollee’s health care service claims are reviewed before reimbursement is made. The purpose of this monitoring system is to validate the medical appropriateness of the provided services and to be sure the cost of the service is not excessive.

**COBRA:** Consolidated Omnibus Budget Reconciliation Act of 1985 - A federal budget act which required that employers offer departing employees the opportunity to continue in the employer’s health insurance plan at the employee’s expense. COBRA provisions were updated in HIPAA.

**Coinsurance:** The portion of the cost of covered services for which an insured is financially responsible. Usually the amount is determined as a fixed percentage of the total cost of providing the service. Often, coinsurance applies after a specified deductible has been met.

**Co-morbidity:** A conditions that exists at the same time as the primary condition in the same patient (e.g., hypertension is a co-morbidity of many conditions such as diabetes, ischemic heart disease, or end-stage renal disease).

**Competitive bidding:** A rate-setting methodology wherein premium rates are determined through bids submitted by competing health plans or networks, based on the information and rules of bidding established by the purchasing organization. The purchasing organization may reserve the right to reject all bids, to reject the highest bidders, or to negotiate for a lower price. However, bidding remains the primary basis for rate setting.
Complication: A condition that arises during the hospital stay that prolongs the initial length of stay.

Copayment: A payment made by an insured at the time that selected services are rendered. Some employer benefit packages require a copayment ranging from $2.00 to $20.00 for each visit to a physician's office. Some impose a fixed dollar amount for inpatient hospitalization.

Cost effectiveness: Usually considered as a ratio, the cost effectiveness of a drug or procedure, for example, relates the cost of that drug or procedure to the health benefits resulting from it. In health terms, it is often expressed as the cost per year per life saved or as the cost per quality adjusted life-year saved.

Cost reimbursement: A payment method in which providers of health services are reimbursed on the basis of their cost experience in providing the services. The reimbursement may be either a percentage of cost or cost plus a dollar amount. At one time, Medicare reimbursed hospitals and other facilities on a cost plus basis.

Cost-shifting: A condition created when deficits resulting from inadequate reimbursement to providers from one source (e.g., Medicare or Medicaid) are offset through higher reimbursement from other public or private sources (e.g., indemnity insurance plans) for the same or similar services.

Deductible: The portion of an individual's insured health care expenses that the person must pay before payment from the insurer commences.

Defined benefit: A type of health insurance that assures the enrollee that will receive a specific set of health services. These services, however, may be confined to those that are “medically necessary.”

Defined contribution: A type of health insurance where the employer provides the employee with a specific amount of funding and the employee purchases the actual health insurance or health services. Employers may provide the employee with discounted provider networks, on-line health information and tax sheltering in this model.

Department Of Health And Human Services (HHS): The Federal Department of Health and Human Services is the agency directed by law to administer programs involving health care, Medicare, Medicaid, family and children's services, financial self-sufficiency programs, and other human service programs of the Federal government.

Dependent: An individual who receives health insurance through a spouse, parent, or other family member.

Diagnosis-related groups (DRGs): A classification system developed at Yale University using 490 major diagnostic categories based on the International Classification of Diseases, 9th revision (ICD-9) code, in which groups of patients are classified for measuring a medical facility's patterns in delivery of care. These classifications are employed to determine payments by Medicare for hospital inpatient services, and are based on primary and secondary diagnosis and procedures, age, and length of hospitalization.

Disease management (DM): A mechanism to provide cost-effective long-term case management for individuals with chronic or expensive conditions (e.g., diabetes, asthma, burn recovery).

Disproportionate Share (DSH) Adjustment: A payment adjustment under Medicare's prospective payment system, or under Medicaid, for hospitals that serve a relatively large volume of low-income patients.

Elderly: Individuals age 65 and over.

Employee Retirement Income Security Act of 1974 (ERISA): A law that mandates reporting and disclosure requirements for group life and health plans. Most self-insured employers' health plans are covered by ERISA.

Enrollee: A person who is covered for health benefits under an HMO contract. An enrollee is not necessarily a member in the health plan: e.g., an enrollee may be a dependent of a member. The terms “enrollee” and “member,” therefore, are not synonymous in all instances. An enrollee is the equivalent of a beneficiary in an indemnity insurance plan.

Enrollment: A term used in the context of HMOs to mean, (1) the process of converting eligible members of a subscriber group into HMO enrollees, or (2) the number of enrollees in an HMO at a given time.

Experience rating: A method of determining premiums based on the actual utilization of individual subscriber groups.
Evidence-based medicine (EBM): The use of current best external evidence, balanced with the desires of the patient and the clinical expertise of health-care providers, in making decisions about the care of individual patients.


Fee-for-service (FFS): The traditional method by which physicians or other providers have charged patients for professional services. For each professional or diagnostic service, a separate fee is applied, irrespective of volume. Under a fee-for-service payment system, expenditures increase if the fees themselves increase, if more units of service are provided or if more expensive services are substituted for less expensive ones. This system contrasts with salary, per capita, or other prepayment systems where the payment to the physician is not changed with the number of services actually used.

Fee schedule: A comprehensive listing of fees used by either a health care plan or the government to reimburse physicians and/or other providers on a fee-for-service basis.

First-dollar coverage: A feature of an insurance plan in which there is no deductible, and therefore the plan's sponsor pays a proportion or all of the covered services provided to a patient as soon as he or she enrolls.

Group contract: An agreement between an HMO and a subscriber group specifying rates, performance, covenants, relationships among parties, schedule of benefits, and other conditions. The term of the contract is generally limited to a 12-month period.

Health Care Financing Administration (HCFA): An agency of the Department of Health and Human Services (HHS), HCFA performs many functions including the administration of the Medicare and Medicaid programs, compilation and publication of health care statistics, development of health policy and budgetary recommendations, and sponsorship and review of pilot service and financial programs.

Health insurance: Financial protection against the medical care costs arising from disease or accidental bodily injury. Such insurance usually covers all or part of the medical costs of treating the disease or injury. Insurance may be obtained on either an individual or a group basis.

Health Insurance Portability and Protection Act (HIPPA): The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. 104-191, sometimes referred to as the Kennedy-Kassebaum bill, was enacted in 1996. HIPAA provides, among other things, improved continuity (also called “portability”) and availability with respect to group health-plan coverage and group health insurance provided in connection with employment, and insurance coverage in the individual insurance market (not connected with employment).

HIPAA provisions are designed to improve the availability and portability of health coverage by:

- Limiting exclusions for preexisting medical conditions;
- Providing credit for prior health coverage and a process for transmitting certificates and other information concerning prior coverage to a new group health plan or issuer;
- Providing new rights that allow individuals to enroll for health coverage when they lose other health coverage or have a new dependent;
- Prohibiting discrimination in enrollment and premiums against employees and their dependents based on health status;
- Guaranteeing availability of health insurance coverage for small employers and renewability of health insurance coverage in both the small and large group markets; and
- Preserving, through narrow preemption provisions, the States' traditional role in regulating health insurance, including State flexibility to provide greater protections.

Health maintenance organization (HMO): An organization that provides both financing for, and the delivery of, physician and hospital services to an enrolled population for a fixed sum of money, paid in advance (prepaid), for a specified period of time. These health services include a wide variety of medical treatments, inpatient and outpatient hospitalization, home health services, ambulance services,
and sometimes dental and pharmacy services. The HMO arranges for the provision of health services through contracts with providers, who may be organized as a group model, an independent practice association (IPA) model, a network model or a staff model. With few exceptions, enrollees are required to use the services of participating providers, except in point-of-service (POS) HMO plans.

**HMO - group model:** (1) An HMO contracting for professional services with a single medical group practice closely related to but legally separate from the HMO, with the contracting relationship being substantially (or totally) and reciprocally exclusive; or, (2) an HMO that contracts with a network of group medical practices for professional services, usually on a non-exclusive basis. The group practices are independent from the HMO(s), and perform services for other health plans, as well as for private patients, Medicare and Medicaid patients, etc.

**HMO - network model:** A network of group practices under the administration of one HMO.

**HMO - staff model:** The staff model HMO is the purest form of managed care. All of the physicians are in a centralized site, in which all clinical and perhaps inpatient services and pharmacy services are offered. The HMO holds the tightest management reins in this setting, because none of the physicians traditionally practice on an independent fee-for-service basis. Physicians are employees of the HMO in this setting, as they are not in a private or group practice.

**Health plans:** Organizations which contract with providers to deliver health care services to enrolled members. These include, but are not limited to, managed-care entities.

**Hospice:** A health care facility that provides supportive care for the terminally ill.

**Indemnity:** Health insurance benefits provided in the form of cash payments rather than services. An indemnity insurance contract usually defines the maximum amounts which will be paid for the covered service.

**Indemnity carrier:** An insurance company or benevolent association that offers selected coverages within a framework of service definitions, fee schedules, limitations, and exclusions as negotiated with subscriber groups. Insured persons are reimbursed after carriers review and process filed claims.

**Indemnity insurance:** Traditional fee-for-service medicine in which providers are paid according to the service performed.

**Individual (or Independent) Practice Association Model (IPA):** An individual practice association contracts with independent physicians who work in their own private practices, and see fee-for-service patients as well as HMO enrollees. Physicians are paid by capitation for the HMO patients and by conventional means for their fee-for-service patients. Physicians belonging to the IPA guarantee that the care needed by each patient for whom they are responsible will fall under a certain amount of money. They guarantee this by allowing the HMO to withhold an amount of their payments (i.e., usually about 20% per year). If, by the end of the year, the physician’s cost for treatment falls under this set amount, then the physician receives his entire “withhold fund.” If it does not, the HMO can then withhold any part of this amount, at its discretion, from the fund. Essentially, the physician is put “at risk” for keeping down the treatment cost. This is the key to the HMO’s financial viability.

**Inpatient:** A patient admitted to a hospital and who is receiving services under the direction of a physician.

**Integrated System (IS), Integrated Delivery System (IDS), or Integrated Health Care System (IHS):** An organization in which hospital(s) and physicians combine their assets, efforts, risks and rewards, and through which they deliver comprehensive health care services.

**Job lock:** A situation when an employee is forced to remain in a job he or she otherwise would leave because that job provides necessary health-insurance coverage.

**Leapfrog Group:** An organization of large health-care purchasers who seek to use their purchasing power to influence providers and improve patient safety. Members follow a set of purchasing principles to recognize and reward providers and practices that reduce medical errors.

**Long-term care:** Services ordinarily provided to the infirm in a skilled nursing, intermediate-care, personal-care, supervisory-care, or elder-care facility.
Managed care: Systems that integrate the financing and delivery of health care services to covered individuals by means of: 1) arrangements with selected providers to furnish comprehensive services to members; 2) explicit criteria for the selection of health-care providers; 3) significant financial incentives for members to use providers and procedures associated with the plan; and 4) formal programs for quality assurance and utilization review.

Managed competition: A system of providing health care where individuals choose from a number of competing health plans or HMOs. The HMOS compete based on the cost and quality of their services.

Mandated benefits: Health benefits that health care plans are required by state or federal law to provide to members.

Market area: The targeted geographic area or areas in which a health plan’s principal market potential is located. It may or may not be the same as an HMO’s defined service area. Frequently, a market area overlaps the service areas of providers.

Medicaid (MA, Medical Assistance): A federal program authorized by Title XIX of the Social Security Act. The program subsidizes state programs for insuring that certain health care services are available to individuals who lack resources to pay for such services. Some states have broader Medicaid coverage than others, but certain minimum federal requirements must be met by all states.

Medical errors: Errors made by practitioners or organizations that cause harm to patients undergoing treatment. Errors can include misdiagnosis, providing inappropriate therapy, or not providing treatment when it is required.

Medical protocols: Medical protocols are guidelines that physicians may be required to follow to have an acceptable clinical outcome. Protocols provide the caregiver with specific treatment options or steps when faced with a particular set of clinical symptoms or signs or laboratory data. Medical protocols are being designed through an accumulated database of clinical outcomes.

Medical savings account (MSA): A type of health insurance that provides a tax-sheltered account from which an individual can purchase health services. MSAs typically provide 100% coverage for preventive care and have a high deductible ($2,000 or more) catastrophic benefit. Savings in the MSA can be rolled into future years and eventually deployed as a tax deferred retirement fund.

Medicare: A federal health care payment program authorized by Title XVIII of the Social Security Act. The program operates as a federally financed health insurance program for the aged and disabled, and is administered by the Health Care Financing Administration through contracts with fiscal agents in each state. Part A of the Medicare program provides insurance coverage for hospital care, and Part B for other medical care. The program includes Medicare recipients who are enrolled in an HMO under a cost, risk, or HCPP (Health Care Prepayment Plan) contract. (See also "Part A" and "Part B.”)

Medicare+Choice: A Medicare program created by the 1997 Balanced Budget Act. Medicare+Choice allows the Centers for Medicare and Medicaid Services (CMS) to contract with a variety of different managed-care and fee-for-service entities offering additional alternative modes of care, including managed care, to Medicare participants.

Medicare Payment Advisory Commission (MEDPAC): This federally chartered commission is comprised of experts in health policy and finance who advise Congress and the Administration on changes in payment rates and methods for the Medicare program.

Medigap: Insurance provided by carriers to supplement the monies reimbursed by Medicare for medical services. Because Medicare pays physicians for services according to their own fee schedule, regardless what the physician charges, the individual may be required to pay the physician the difference between Medicare’s reimbursable charge and the physician’s fee. Medigap is meant to fill this gap in reimbursement, so that the Medicare beneficiary is not at risk for the difference.

Member: A participant in a health plan who makes up the plan’s enrollment.

Morbidity: The incidence and severity of sickness in a defined class of people.

Mortality: The death rate at each age, calculated from prior experience.
Office of the Inspector General (OIG) of HHS: The investigatory arm of the Department of Health and Human Services, with jurisdiction over alleged violations of a variety of statutes, including Medicare and Medicaid fraud and abuse laws.

Open enrollment period: The period of time stipulated in a group contract in which eligible persons in a group may choose a health plan alternative for the coming benefit year.

Out-of-pocket costs: The share of health services payments paid by the enrollee.

Outpatient: A patient who receives health care services without being admitted to a hospital.

Part A: Also known as “hospital insurance” (HI), Part A of the Medicare program pays for certain inpatient hospital, nursing facility, hospice and home health services for individuals age 65 years or older, and certain other individuals.

Part B: Also known as “supplementary medical insurance” (SMI), Part B of the Medicare program reimburses beneficiaries for certain physician services, outpatient hospital services, miscellaneous outpatient services, durable medical equipment, ambulatory surgery services, home health services and certain diagnostic tests.

Payer: An organization, such as insurance company or HMO, that pays or reimburses a provider for health care services rendered by that provider to a patient or health plan member. A fiscal intermediary between purchasers and consumers of health care.

Peer review: Reviewing a practitioner’s practice to determine if they meet qualitative standards, fall within an acceptable range, and employ efficacious procedures. Peer review is performed by practitioners in the same specialty and geographic area.

Peer Review Organization (PRO): A private organization that subcontracts with HCFA to review the medical appropriateness of services and quality of care provided to Medicare beneficiaries.

Physician Organization (PO): A generic term for an organization of physicians, which technically could be a professional corporation, partnership, IPA, PPO, foundation, etc., as well as physicians organized as partially or fully integrated group practices.

Point-of-service model: Sometimes referred to as an “open-ended” HMO, the point-of-service model is one in which the patient can receive care either by physician contracting with the HMO or by those not contracting. Physicians not contracting with the HMO but who see an HMO patient are paid according to the services performed. The patient is given an incentive to utilize contracted providers through the fuller coverage offered for contracted care.

Practice guidelines: Explicit recommendations for the management of specific clinical problems. Guidelines are developed from medical literature and expert panels and may be endorsed by professional societies. Guidelines may be used by insurers to evaluate the quality and appropriateness of medical care by comparing actual practices with a guideline’s recommendations. Results of such comparisons may be used for several purposes: reimbursement, provider education, provider feedback, and credentialing or re-credentialing.

Pre-existing condition: Any medical condition that has been diagnosed or treated within a specified period before the member’s effective date of health coverage under the group contract.

Preferred providers: Physicians, hospitals, and other health care providers who contract to provide health services to persons covered by a particular health plan.

Preferred Provider Arrangement (PPA): Generally, an arrangement in which a payer contracts with providers who agree to provide health-care services to beneficiaries in exchange for discounted fee-for-service reimbursement. The term is interchangeably used to refer to: the relationship between an insurer (or other payer) and the beneficiary (i.e., an insurance product); the discounted fee arrangement between the payer and provider; or an organization created to obtain discounted fee contracts for providers (see PPO).

Preferred Provider Organization (PPO): Often confused with a PPA, a PPO may represent any one of the three definitions identified for PPA, above. As an insurance product, a PPO is a discounted fee-for-service indemnity arrangement in which members receive financial incentives to select their care from a panel of “preferred providers” (physicians and hospitals). Members may select care from non-panel providers, usually at additional cost.
to the member. As a “provider” organization, a PPO is a joint venture among physicians that seeks PPO contracts with payers; an arrangement developed by insurers to induce providers to discount their fees; or, an independent enterprise that brokers contracts between payers and providers.

**Premium**: The price or amount which must be paid periodically (e.g., monthly) to purchase insurance coverage or to keep an insurance policy in force. Virtually all health insurance programs require the payment of a premium by the beneficiary, and/or by someone else (such as the employer) on the beneficiary’s behalf. Premiums paid to HMOs are often called capitation payments.

**Preventive care**: Health care emphasizing priorities for prevention, early detection, and early treatment of conditions, generally including routine physical examination, immunization, and well-person care.

**Primary care**: Basic or general health care focused on the point at which a patient ideally first seeks assistance from the medical care system. Primary care is considered comprehensive when the primary provider takes responsibility for the overall coordination of the care of the patient’s health problems, be they biological, behavioral, or social. The appropriate use of consultants and community resources is an important part of effective primary care. Such care is generally provided by physicians but is increasingly provided by other personnel such as nurse practitioners or physician assistants.

**Primary-care network**: A group of primary-care physicians who have joined together to share the risk of providing care to their patients who are members of a given health plan.

**Primary-care provider**: An assigned medical practitioner who is responsible for developing the care plan, delivering and coordinating services and arranging for appropriate use of specialty services. A primary-care physician in an HMO, or in a group-practice provider to an HMO, is the initial provider for a patient seeking medical services, and controls referrals to other specialists, sub-specialists, diagnostic services, and other providers of health care, to optimize responsibly the utilization of service, thereby reduce the costs of care.

**Professional Review Organization or Peer Review Organization (PRO)**: An organization that reviews the activities and records of a health-care provider, institution, or group. The reviewer is generally a physician if a physician is the subject of the review; a group of administrators, physicians, and allied health care personnel if a hospital is the subject of the review; etc. The PRO can be state-sponsored or independent.

**Professional Services Agreement (PSA)**: An agreement in which physicians (and possibly other professionals) agree to provide their services to a person or organization. For example, physicians may enter into a PSA with an Integrated Health care System to provide services to the IHS’ patients.

**Prospective payment**: A prospective payment is a payment that is received before care is actually needed. It gives the provider organization a financial incentive to utilize fewer resources, as they get to keep the difference between what is prepaid and what is actually used.

**Prospective Payment System (PPS)**: A payment method used by Medicare for hospital inpatient services in which predetermined amounts, based on the DRG system, are paid to hospitals as reimbursement for their inpatient operating costs for treating beneficiaries.

**Provider networks**: An organized group of care providers selected by a health plan because they meet the plan’s standards for efficient quality practice. The network manages health care costs through several techniques:

- **Credentialing**: This process is undertaken to document the provider’s professional qualifications and ability to meet standards for quality, cost-effectiveness, and access required by the health plan.
- **Shared financial risk**: Providers often share the financial risk of health care delivery by accepting a capitated payment. Alternatively, a percentage of provider’s fees may be withheld to cover a health plan’s deficits at year end. Under a withholding system, providers receive an annual payment from the withheld pool based on the financial experience of the plan and their own performance.
- **Rate negotiation**: The health plan negotiates lower provider fees in exchange for anticipated increased volume. These
discounts are then passed along to purchasers.

- **Consumer incentive**: The consumer has a financial incentive to use the network because the consumer assumes greater out-of-pocket expense when using a provider outside the network.

**Providers**: Institutions and individuals who are licensed to provide health care services (for example, hospitals, skilled nursing facilities, physicians, dentists, etc.) May also refer to medical supply firms and vendors of durable medical equipment.

**Purchasing pool**: Organization that groups together workers in small businesses, those who are self-employed, and other uninsured into larger pools that can achieve better ratings and deeper discounts. These better rates come from being able to spread risk over larger numbers of individuals. Besides the economies of scale, purchasing pools hope to maintain volume purchasing power for their members.

**Quality improvement**: A continuous process that identifies problems in health care delivery, examines solutions to those problems, and regularly monitors the solutions for improvement.

**Rating - community rating**: A rating method in which actuarial statistics are used regarding a total population to determine a uniform premium.

**Rating - experience rating**: A rating method in which actuarial statistics are used regarding a specific group (e.g., age, sex, etc.) to determine the premium.

**Referrals**: Based on client need, a process of arranging appropriate services to ensure coordination, follow-up, non-duplication of services, and communication between providers. This process may or may not include authorized payment for services.

**Reimbursement**: A payment to a provider in exchange for the performance of health services. The term more technically is applicable to payments made to providers by Medicare or Medicaid.

**Reinsurance**: Protection purchased by insurers including HMOs, IPAs or PPOs from insurance companies that specialize in underwriting risks that substantially exceed basic or conventional limits of liability.

**Resource-Based Relative Value Scale (RBRVS)**: A HCFA payment method by which physicians receive an amount set forth in a fee schedule based on the relative prices and values of the procedures.

**Revenue**: The gross amount of earnings received by an entity for the operation of a specific activity. It does not include any deductions for such items as expenses, bad debts, or contractual allowances.

**Risk**: There are two distinct types of risk: financial risk and insurance risk. All three levels of government have financial risk in the funding of health and human services. County government has both a direct responsibility to its residents to manage financial risk to county property tax revenues and responsibilities under statute as a subdivision of state government, which involve financial risk. The challenge is to determine how each level of government should contribute to sharing the financial responsibilities and financial risk, which involves consideration of the appropriate tax to provide the funding.

Insurance risk, or risk-bearing as a term of art in the insurance industry, is specifically in reference to the business of insurance and is regulated by government.

**Risk adjustment or risk equalization**: A means of adjusting capitation rates paid to prepaid plans in order to reflect more accurately the expected cost of providing health care services to an individual. The Johns Hopkins Adjusted Clinical Groups (ACG) case-mix system is one method currently being used.

**Risk pool**: A defined patient population to be covered by insurance, from which revenue and expenses are determined.

**Self-insured**: An organization (usually an employer) that assumes the financial risk of its members’ health benefits’ costs, rather than purchasing insurance from an insurance company, HMO, or other fiscal intermediary. Also, a hospital may self-insure for malpractice insurance, rather than purchase from an insurer.

**Service area**: A geographical territory that an HMO or other provider organization designates for offering and providing enrollment or service to members. Since reasonable access to the health care services is a primary objective of HMOs and providers, a common standard is that members or patients should not have to travel more than 30 minutes in order to reach a service site.
Single-payer system: A health care system in which all payments for defined benefits or services are paid from a single source, typically the national government. Most of the western industrialized nations, with the exception of the United States, have some form of a single-payer system.

Skilled nursing facility (SNF): Typically an institution for convalescence or a nursing home, the skilled nursing facility provides a high level of specialized care for long-term or acute illness. It is an alternative to extended hospital stays or difficult home care.

State Children’s Health Insurance Program (SCHIP): SCHIP was enacted as part of the Balanced Budget Act of 1997 as the new Title XXI of federal statutes. It provides funds for states to expand health insurance to children of low-income families. Each state has a unique SCHIP program.

Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA): The federal law that created the current risk and cost contract provisions under which health plans contract with HCFA and the Medicare program.

Technology assessment: The term used to describe the evaluation process for new or existing diagnostic and therapeutic devices and procedures. Technology assessment evaluates the effect of a medical procedure, diagnostic tool, medical device, or pharmaceutical product. In the past, technology assessment meant primarily evaluating new equipment, focusing on the clinical safety and efficacy of an intervention. In today’s health-care world, it includes a broader view of clinical outcomes, such as the effect on a patient's quality of life, and the effect on society.

Tertiary care: Tertiary care is administered at a highly specialized medical center. It is associated with the utilization of high-cost technology resources.

Third-party payer: An organization that pays for or underwrites coverage for health care expenses.

Total Quality Management (TQM): A method originally developed by W. Edward Deming for examining systems and processes at medical group practices to identify and remedy inefficiency, error, or redundancy in operations or the total patient care experience. The system is based, in part, on obtaining information and comments from staff and patients in order to evaluate and resolve procedural or service deficiencies.

TRICARE: The health-care program for members of the military, eligible dependents, and military retirees. TRICARE was formerly called CHAMPUS (Civilian Health and Medical Program of the Uniformed Services).

Uncompensated care: Service provided by physicians and hospitals for which no payment is received from the patient or from third-party payers. Some costs for these services may be covered through cost-shifting. Not all uncompensated care results from charity care. It also includes bad debts from persons who are not classified as charity cases but who are unable or unwilling to pay their bills.

Underinsured: People with public or private insurance policies that do not cover all necessary medical services, resulting in out-of-pocket expenses that exceed their ability to pay.

Underwriting: In insurance, the process of selecting, classifying, evaluating, and assuming risks according to their expected costs. Its purpose is to ensure that the group or individual insured has the same probability of loss and probable amount of loss, within reasonable limits, as the universe on which premium rates were based.

Uninsured: People who lack public or private health insurance.

Utilization: The frequency with which a benefit is used, a service is performed, or a referral is made. For example, HMO utilization of inpatient (hospital) services is commonly expressed as the number of inpatient days per year per thousand members. The relative rate of service utilization is a critical factor for the financial success of providers in prepaid contracting.

Utilization review (UR): A systematic, retrospective review designed to determine the medical necessity and economic appropriateness of health services.
End Notes:


3 David M. Cutler, *Your Money or Your Life: Strong Medicine for America’s Health Care System* (New York: Oxford University Press, 2004). Cutler argues that additional spending on health care has had a significant beneficial effect on outcomes.


End Notes:


22 Ibid., p. 1, exhibit A.


End Notes:


40 Ibid.


47 Berk and Monheit, “Concentration of Health Care Expenditures” (see note 46); Stanton and the Agency for Healthcare Research and Quality, “High Concentration of U.S. Health Care Expenditures” (see note 34).

48 Newhouse and the Insurance Experiment Group, *Free for All?* (see note 35).


50 Johns Hopkins University and the Robert Wood Johnson Foundation, “Chronic Conditions” (see note 29). This is based on the 2001 Medical Expenditure Panel Survey. The definition of chronic conditions is that they last a year or longer, limit
what people can do and/or require ongoing medical care. A lower estimate can be found in an earlier study: C. Hoffman, D. Rice, and H. Y. Sung, “Persons with Chronic Conditions. Their Prevalence and Costs,” *Journal of the American Medical Association* 276, no. 18 (1996): pp. 1473-1479. This was based on the 1987 Medical Expenditure Survey.

51 Committee on Quality of Health Care in America, Institute of Medicine of the National Academies, *Crossing the Quality Chasm* (see note 30).


58 For example, three years before the heart-damaging effects of COX-2 inhibitors (Vioxx, Bextra and Celebrex) became widely publicized, Kaiser Permanente entered into collaborative research with the FDA to evaluate the safety of these drugs. At that time, the Kaiser market share of COX-2 inhibitors was about 5 percent of all NSAIDs compared to about 45 percent for the community in general. After Vioxx was withdrawn, COX-2 inhibitor prescriptions at Kaiser accounted for less than 1 percent of the market for all NSAIDs compared to about 25 percent in the community at large. Senate Committee on Finance, *Testimony on Vioxx and Drug Safety*, by Sandra Kweder, Deputy Director, Office of New Drugs, Center for Drug Evaluation and Research, U.S. Food and Drug Administration, 108th Cong., 2nd sess., November 18, 2004; Beverly Hayon, “Kaiser Permanente Study Confirms Direct to Consumer Advertising Influences Physician Prescribing,” Kaiser Permanente, October 9, 2005, http://ckp.kp.org/newsroom/national/archive/nat_051007_dtcdrugstudy.html.


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64 On October 13, 2004, CBO Director Douglas Holtz-Eakin wrote to Senator Don Nickles, Chairman of the Senate Budget Committee: “According to CBO's analysis, there is insufficient evidence to conclude that disease management programs can generally reduce overall health spending.” This generally refers to disease management programs that are independent of general medical care, and not to disease management programs embedded in primary care. Douglas Holtz-Eakin, Director of the U.S. Congressional Budget Office, Letter to Senator Don Nickles, Chairman of the Senate Budget Committee, October 13, 2004, http://www.cbo.gov/ftpdocs/59xx/doc5909/10-13-DiseaseMngmnt.pdf.


69 Committee on Quality of Health Care in America, Institute of Medicine of the National Academies, Crossing the Quality Chasm (see note 30).


End Notes:

75 McGlynn et al., “Quality of Health Care” (see note 11).


78 Kleinke, “Dot-Gov” (see note 24).


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92 Naik, “In Holland, Some See Model” (see note 23).

93 This description was provided by David Riemer of the Wisconsin Health Project, whose contribution is gratefully acknowledged.


95 Ibid.

96 Henry J. Kaiser Family Foundation and the Health Research and Educational Trust, 2007 Annual Survey (see note 31).

97 Recall that the Group Health Cooperative of Puget Sound was found in one study to deliver high-quality care for 28 percent less cost than the fee-for-service sector in the same area. Newhouse and the Insurance Experiment Group, Free for All? (see note 35).


99 Advocates of extension of the FEHB to the general population have included Senators John Kerry, Bill Frist, and Bill Bradley. An early, perhaps the earliest, discussion of this idea in print was Odin W. Anderson and J. Joel May, The Federal Employees Health Benefits Program, 1961-1968, A Model for National Health Insurance? (Chicago: Center for Health Administration Studies, University of Chicago, 1971).


101 M. A. Hall, “The Geography of Health Insurance Regulation,” Health Affairs 19, no. 2 (2000): p. 177. “…the need to seek regulatory approval in each state whenever even small changes are made in insurance products may discourage frequent product innovations.”


105 This section of the Statement consists largely of excerpts and paraphrases from an as yet unpublished manuscript by Ezekiel Emanuel, Victor R. Fuchs, and Alan M. Garber entitled “Better Information for Better Health Care Decisions: A Proposal to Create an Institute for Medical Outcomes and Technology Assessment.” Their contribution is gratefully acknowledged.

104


114 Research and Policy Committee of the Committee for Economic Development, New Vision for Health Care (see note 1).


118 Henry J. Kaiser Family Foundation and the Health Research and Educational Trust, 2007 Annual Survey (see note 31).

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123 Starr, Social Transformation of American Medicine (see note 122).


126 Wennberg and Gittelsohn, “Variations in Medical Care” (see note 13); Wennberg et al., “Changes in Tonsillectomy Rates” (see note 13).


135 Hoffman, Rice, and Sung, “Persons with Chronic Conditions” (see note 50). A recent study by a team at Johns Hopkins estimated that 83 percent of U.S. health-care spending is on people with at least one chronic condition. Johns Hopkins University and the Robert Wood Johnson Foundation, “Chronic Conditions” (see note 29).

136 Committee on Quality Health Care in America, Institute of Medicine of the National Academies, Crossing the Quality Chasm (see note 30).


139 Ibid.

140 Sparrow, *License to Steal* (see note 38).


143 Helliker and Etter, “Silent Treatment” (see note 129).


147 Professor Wynand van de Ven of Erasmus University, Rotterdam, provided the information on the Dutch plan. His assistance is gratefully acknowledged.
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<th>Acronym</th>
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<td>Circulo de Empresarios</td>
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<td>CEDA</td>
<td>Committee for Economic Development of Australia</td>
<td>Sydney, Australia</td>
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<td>China Institute for Reform and Development</td>
<td>Hainan, People’s Republic of China</td>
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<td>EVA</td>
<td>Centre for Finnish Business and Policy Studies</td>
<td>Helsinki, Finland</td>
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<td>Forum de Administradores de Empresas</td>
<td>Lisbon, Portugal</td>
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<td>IDEP</td>
<td>Institut de l’Entreprise</td>
<td>Paris, France</td>
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<td>Stichting Maatschappij en Onderneming</td>
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Quality, Affordable Health Care for All
Moving Beyond the Employer-Based Health-Insurance System