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REFORMING MEDICARE: WHAT CONGRESS CAN LEARN FROM THE HEALTH PLANS OF AMERICA'S CORPORATIONS

INTRODUCTION

Congress is trying to reform the financially troubled Medicare system, the huge, 30-year-old government program that insures almost 38 million elderly and disabled Americans. The House of Representatives recently passed the Medicare Preservation Act (H.R. 2425). The Senate is working on similar legislation. As both chambers consider this legislation, and how it might work in practice, Members of Congress can learn much from the experience of private corporations, where innovative plan designs have cut costs—sometimes dramatically—while improving the quality of care.

Congressional action on Medicare is historic. The House bill will save approximately $133 billion in the Hospital Insurance program (HI, or Part A) over a seven year period and keep the hospitalization trust fund solvent until 2010. It also will save $137 billion in Part B, the part of Medicare that reimburses physicians, by freezing Part B premiums at 31.5 percent of program costs, restructuring payments to providers, and introducing market based reforms.[1] And it establishes a "Medicare Plus" option, where private plans, including plans with medical savings accounts, may compete for the business of senior citizens who wish to obtain different benefits or special medical services or procedures beyond what is currently provided by traditional Medicare.

1 A key provision of the House bill is a "lock box" mechanism that ensures that all savings from changes in Medicare Part B, or the Supplemental Medical Insurance (SMI) program, are accrued in a newly established Medicare Preservation Trust Fund. This means that none of these savings can be used, for example, to finance tax reductions or other government programs.

Note: Nothing written here is to be construed as necessarily reflecting the views of The Heritage Foundation or as an attempt to aid or hinder the passage of any bill before Congress.

Financial Necessity. Congressional action is also financially necessary. Medicare is growing at 10.5 percent a year, a rate of growth that most policymakers think is unsustainable without unprecedented tax increases on working American families.[2] Therefore, the price of failing to reform Medicare will be alarming for America's taxpayers. There are structural reasons why the program is so costly. The program is based on 1960s-style concepts of government central planning and price controls.[3] And both of its key components have failed to control costs. While costs have been exploding, draining an ever-larger share of general revenues from other government programs, the system has not been able to adapt quickly to innovations in the financing and delivery of health care services that are becoming common in the private sector.

Congress can learn much from the experience of private corporations. To be sure, it must realize this experience has not occurred within a normal market. The private-sector health insurance market is distorted by the federal tax system, which discriminates against individual and non-employer coverage, and hampered by complicated rules and mandated benefits at the state level. Nevertheless, Congress can apply key lessons from the experience of the private sector to reform of the Medicare system. In particular, it can obtain some insights into how a reformed Medicare might evolve by examining the remarkable degree of innovation in corporate plans.

The shape of private-sector insurance is changing rapidly. Two-thirds of the private sector is covered by some kind of managed care health plan, including health maintenance organizations (HMOs), preferred providers (PPOs), and point of service (POS) plans. Medical savings accounts (MSAs) are emerging in various forms, but their emergence has been frustrated by the tax code. "Scheduled benefits" or "defined contribution" plans are rare, but they provide employees with a broader set of personal options, particularly in terms of choice of doctors or specialists, than is commonly found in conventional company-based insurance plans. The empirical evidence shows that where there is the widest freedom of choice and the most intense competition among providers and health insurance options, one finds the lowest costs.

Among the innovations in the private sector:

- ✔ **The International Paper Company established a "scheduled reimbursement" plan** for its employees based on the median costs of medical services in the community. After an annual deductible, the plan reimburses employees for 100 percent of the charges up to the amount of the scheduled reimbursement. Employees are thus encouraged to choose wisely among medical providers. The result: International Paper saw no increase in medical costs in 1994 and 1995.

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2 For a detailed discussion with econometric analyses of a congressional failure to reform the Medicare system in terms of the potential tax burdens on American families and businesses, see Stuart M. Butler, "The High Cost of Not Reforming Medicare," Heritage Foundation *F.Y.I.* No. 56, May 4, 1995; Robert E. Moffit, John C. Liu, and David H. Winston, "What Americans Will Pay If Congress Fails to Reform Medicare: The State and Congressional District Impact," Heritage Foundation *F.Y.I.* No. 62, September 19. 1995; and David H. Winston, Christine L. Olson, and Rea S. Hederman, "The Cost of No Medicare Reform: What Industry and Government Would Pass On to Consumers, Investors, Taxpayers, and Workers," Heritage Foundation *F.Y.I.* No. 67, October 16, 1995.

3 For an overview of the Medicare system, see Robert E. Moffit and John C. Liu, "A Taxpayer's Guide to the Medicare Crisis," Heritage Foundation *Talking Points*, September 27, 1995.

✔ **Golden Rule Insurance Company established a medical savings account** for its employees, along with a catastrophic health insurance plan, as an alternative to traditional health insurance plan offered by the company. Over 90 percent of the employees participated in the MSA option. Under this option, whatever employees do not spend, they keep. The result: In 1994, Golden Rule employees had approximately $1,000 per person left over in their accounts, and the company's insurance premiums have been flat.

✔ ***Forbes* magazine started a cash bonus system** for employees who refrained from filing unnecessary health insurance claims. The result: The company has lowered its health care costs by 25 percent since the inception of the program.

✔ **Coors Brewing Company established a "wellness," or health promotion program,** for its employees in 1981. The result: The company has saved an estimated $1.9 million annually by decreasing its medical costs, reducing sick leave, and increasing productivity.

Congress thus has an opportunity to improve the Medicare system as well as re-establish Medicare on a firm financial footing. At the same time, taxpayers should understand that failure to do so will have a profoundly negative economic impact on working families: High payroll taxes will have to be imposed just to sustain the current level of Medicare spending.

In discussing the need for Congress to reform Medicare, the Medicare Trustees call for "prompt, effective and decisive action" because "under the present financing schedule for the Hospital Insurance program, it is sufficient to ensure payment of benefits only over the next 7 years."[4] Beyond inevitable tax increases on working families, the failure to reform Medicare also has broader negative economic consequences. According to Martin A. Regalia, Chief Economist for the U.S. Chamber of Commerce, the tax increase needed to save Medicare would bring the economy to the "brink of recession."[5] The Chamber's study concluded that the Medicare payroll tax would have to be raised from the current level of 2.9 percent to 6.42 percent. This would have the effect of lowering the Gross Domestic Product (GDP) $179.4 billion within two years, a decline of 3.1 percent, thus threatening the national economy with a recession. Employment levels would be cut 1.5 percent. For a typical worker earning $30,000 a year, the Medicare tax would be $1,928 instead of the current $876.[6]

Barring huge tax increases, Congress must import free-market principles of consumer choice and competition into the antiquated Medicare system. Otherwise, costs will always be just one step ahead of financial disaster. If Congress fails to reform Medicare, not only will the hospitalization trust fund face a shortfall, but the drain on the federal treasury will increase, taking critical funds away from other federal priorities and programs.

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4 See *1995 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund*, April 3, 1995.

5 Cited by R. Bruce Josten, "On Medicare Reform," Statement before the Committee on Ways and Means, United States House of Representatives, September 22, 1995, p. 2.

6 *Ibid.*, p. 3.

In reconciling House and Senate versions of Medicare reform, Congress therefore must make the right decisions in reforming the program. The experiences of the private sector, to the extent that consumer choice and competition are vital operating principles, can provide Congress with solid lessons for improving Medicare and eventually adopting overall reform of the American health care system.

THE EVOLUTION OF EMPLOYER-BASED HEALTH PLANS

In a free market, informed people make rational choices among competing services. History shows that the free market creates the best products at the best price.

Most Members of Congress appear to favor the reconstruction of Medicare on the basis of the market principles of consumer choice and competition. For this very reason, the private, employer-based health insurance system is an inherently flawed model. The reason: The market principles of consumer choice and competition are severely frustrated by the tax-related distortions that exist in employer-based insurance, and, in many cases, consumer choice is a precious market principle that appears in truncated form or not at all.[7] Generally, American consumers of health care services do not make the key decisions over the financing and purchasing of those services; these decisions are reserved, in many cases, exclusively to corporate benefits managers or employers. As a result, the consumers of health care services, including health insurance, and the customers for health care services are different personalities with different, and often conflicting, economic incentives: Employees want high quality health care, and employers want to protect their corporate bottom line.

Historical Accident. These peculiar patterns exist nowhere else in the American economy. They are an accident of history, not the product of congressional deliberations over the kind of health care financing and delivery systems Americans should have.

Before the Second World War, most health care was purchased out of pocket, and costs were in line with general inflation. With the outbreak of the war, President Franklin D. Roosevelt and Congress put the national economy on a war footing and imposed wage and price controls throughout the economy. Labor could not bargain for higher wages, and business could not compete for labor under the Roosevelt Administration's wage and price guidelines. To rectify this compensation problem, the IRS, with the support of Congress, established the principle that health benefits would be counted as compensation which would be exempt from the standard wage and price guidelines and tax-free. As a result of these major tax policy decisions drafted under wartime conditions, the United States developed a unique system of tax-supported employer-based insurance, which in effect amounted to prepaid medical care, exclusively supported by the federal tax code through the place of work. Employers bought health insurance tax-free, and employees consumed health insurance tax-tree. This new system of "third-party payers"

7 For a complete discussion of the perverse incentives and distortions of the health insurance market by federal tax policy, see Stuart M. Butler, "A Policy Maker's Guide to the Health Care Crisis, Part I: The Debate Over Reform," Heritage Foundation *Talking Points*, February 12, 1992, and Edmund F. Haislmaier, "Why America's Health System Is in Trouble," in Stuart M. Butler and Edmund F. Haislmaier, eds., *A National Health System for America* (Washington, D.C.: The Heritage Foundation, 1989).

separated employees' decisions to use health care services from the economic consequences of their use of health care. With the development of first dollar coverage, it is not surprising that many American employees have come to look at health insurance as a "free good," or a beneficial "add on" that simply comes with a good, solid, high-paying job. Worse, many think that the employer's contribution to their health benefits package is the employer's money and not their own, thus failing to realize that increases in health care benefits packages are a trade-off for decreases in wages and other compensation. The central economic problem with this arrangement is that on the demand side of the economic equation (the employees' demand for medical services through the third-party payment system) as well as on the supply side (the supply of medical services by doctors and hospitals), there was no incentive to control costs. Thus, especially in the 1960s with the advent of the giant government health insurance programs, costs began to grow at a rate greater than inflation. As out-of-pocket health care spending declined and third-party payment assumed a greater share of the purchases, national health care costs increased. From 1960 to 1993, out-of-pocket costs dropped from 56 percent to 20 percent. For each 10 percent decrease, the national expenditure for health care, as a percentage of Gross Domestic Product, increased 2.4 percent.[8] With the nation's elderly coming under Medicare in 1965, a government third-party system with the addition of taxpayer subsidies, and even higher rates of utilization, health costs skyrocketed.

While Medicare has changed little in design over the last 30 years, its growth rate has accelerated much more than the general levels of inflation. Taxpayers can look for continued acceleration, largely because of the rapid aging of the American population.

Although restricted by federal tax policy that separates insurance consumers from customers and health care costs from the consequences of consumer decisions, private employer-based health insurance has made some significant and positive changes in the financing and delivery of services. Experience shows that these different health care options result in very different costs.

The following is the cost control performance of several types of private plans in 1994.

The cost is per employee and covers employees, dependents, and retirees.

PLAN TYPE	Cost per Employee (1994)	% of Market	Change in Cost
Traditional Indemnity	$3,850	34%	Up 100%
Managed Care Preferred Provider	$3,386	13%	Up 2.1%
Point of Service	$3,609	21%	Up 10.5%
HMO	$3,485	32%	Up 6.4%
Medical Savings Accounts	$2,900*	1,500 companies	No Change
Scheduled Benefits	$2,786	1 company	No Change

* estimate

8 Calculations are from "National Health Spending Trends: 1960-1993," cited in *Medical Benefits* Vol. 12, No. 3 (February 15, 1995), p. 2.

(Data in the table above are from a stratified random sample drawn by Foster and Higgins from the Dunn and Bradstreet database of private firms to assure a statistically valid sample in eight company size categories. The Census of Governments was used to draw a sample of state, county, city, and local governments. A weighted scheme was used to combine the results and create one database. The last two options are such a small part of the 1994 market that they did not appear in the larger random study. The companies with these plans were contacted directly by the author to obtain cost information.)

These costs include both employer and employee costs. During this same time frame, Medicare costs were $4,360 per person. Even given the actuarial disparities between the older, retired element and the younger, working element of the American population, the difference is significant: Medicare costs per person were $500 more than the most expensive coverage for employees and their dependents in the private sector.

Degrees of Freedom. Information and choice are possible on two levels. Corporate benefits managers and employers can choose at a system level between medical groups and between insurance plans. Or, at the level of individual service, patients can compare costs and benefits of different plans or choose among doctors or hospitals. Obviously, there is greater scope for market pressures where more detailed and frequent choices can occur. It is therefore relatively easy to rank the prominent private-sector options on an index that includes consumer choice, information, the level of competition, and the financial consequences that follow from individual choices. This free-market index, with the actual costs in each of these systems, is calculated in the chart that follows:

PLAN	Choice	Information	Competition	Consequences	Free Mkt. Index	Actual Costs
Indemnity	XX				2	$3,850
Medicare	XX				2	$4,800[1]
HMO	X	X	X	X	4	$3,485
Preferred Provider	X	X	X	X	4	$3,386
MSA	XX		X	X	4	$2,900[2]
Defined Contribution	XX	X	X	X	5	$2,786

Note: The author has one X for a system-level decision and 2 X's for individual-level decisions. The cost of all plans except Medicare is cost per employee and covers employees, dependents, and retirees.
1. per individual
2. estimate

Members of Congress can evaluate the specific provisions of the House and Senate bills reforming the Medicare system in accordance with their conformity to free-market principles of consumer choice, competition, and openness to new information. If legislative provisions increase consumer choice, competition, and availability of information, the likely consequence is a decrease in cost. If they decrease consumer choice and competition, then these provisions will likely increase costs, either directly or indirectly. On the one hand, premium caps or price controls (as found in the House bill, for example) are classic mechanisms to shift costs to consumers in non-controlled sectors of the health care economy. On the other hand, House proposals to allow seniors the opportunity to choose both providers and plans, and to reform antitrust laws so that competitive new systems can be developed, should increase market efficiency.

Medicare reform also should establish a user-friendly framework for new information systems available to doctors and patients, as well as organizations or associations serving the needs and interests of senior citizens. In a reformed Medicare system, the federal gov-

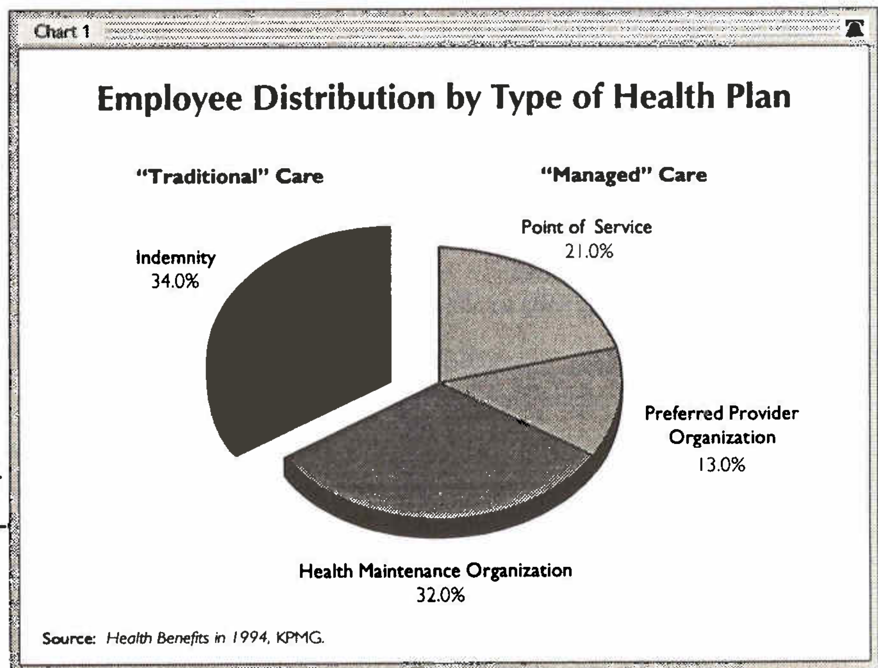
ernment should not intrude into every aspect of the financing and delivery of medical services; it should establish the ground rules of a free market and a level playing field for different types of health care options, with individuals and private organizations working together to make informed decisions. When Congress mandates coverage beyond a basic minimum (as it does in the House bill) or resorts to price-fixing, both the flexibility and the efficiency of market-based reform, with its promise of high quality health care at a reasonable price, are compromised. The inevitable result: increased costs and decreased availability of different or innovative medical services.

PATTERNS OF PRIVATE-SECTOR EXPERIENCE

Experience #1: Using Managed Care

Complete choice of doctors is one of the main strengths of the current Medicare system. Seniors generally value their ability to choose their own doctors and correctly fear any change that would block that choice.

One way private employers have responded to the increasing costs of employer-provided health insurance is by limiting this choice for employees and their families. Managed care arrangements such as HMOs and preferred providers allow patients to choose from a limited number of providers. Companies and corporations, through insurance firms, have negotiated tough bargains with doctors, hospitals, and other "providers" to lower costs. In this sector of the economy, as penetration of the market by HMOs increases 1 percent, costs have decreased 1.14 percent.[9] In recent years, the number of workers covered by managed care firms has increased dramatically. Today, some 66 percent of all workers are now covered by such managed care arrangements (see Chart 1).[10]



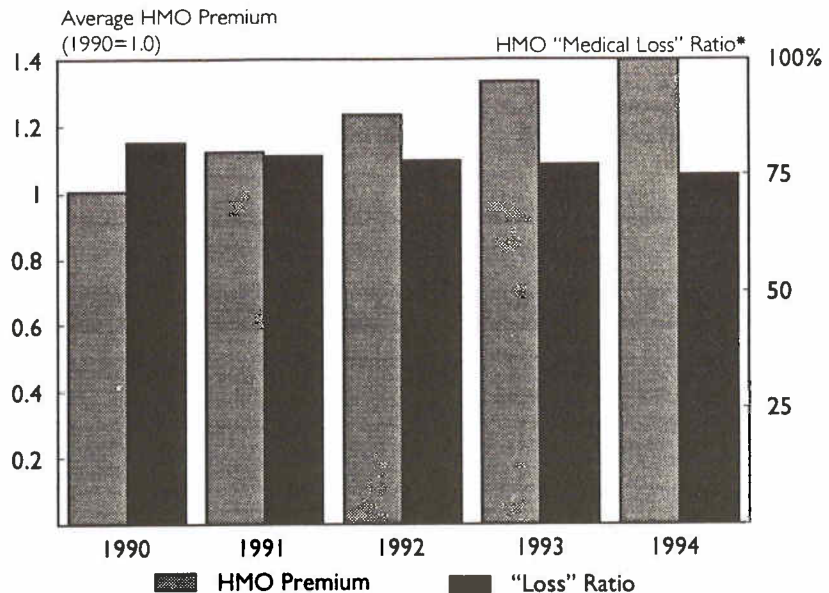
Source: *Health Benefits in 1994*, KPMG.

Currently, HMOs are rapidly increasing their market share by offering premiums that rise more slowly than other health care models so that costs initially decrease and grow more slowly than in traditional indemnity programs. Two features of private-sector man-

9 Millman and Robertson Inc., *National Health Expenditure Forecast 1994-1996*, Document No. 6045.

10 A. Foster Higgins Inc., *National Survey of Employer Sponsored Health Plans 1994*, puts the figure at 63 percent.

aged care experience are emerging. First, the amount HMOs actually spend on medical care is decreasing, but insurance premiums continue to rise. As noted in Chart 2, KPMG has reported that although the annual growth rate of premiums has been 6 percent to 8 percent, the costs of providing actual care decreased from 82 percent of premiums in 1990 to 75 percent of premiums in 1994.



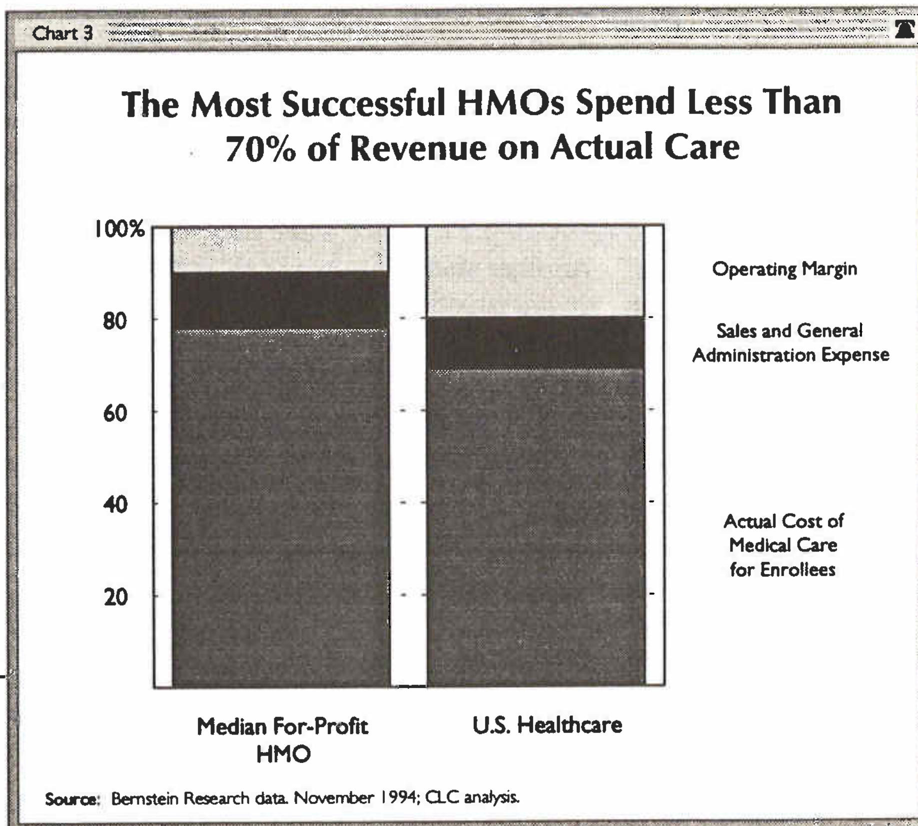
In fact, according to Bernstein Research Associates, the largest HMOs spend less than 70 percent on actual care (see Chart 3).

Of course, the employer shift to managed care has had an enormous impact on the financial position of the managed care industry. The HMO industry alone had pre-tax earnings of $3.3 billion in 1994.[11] Many managed care companies use this capital to consolidate their holdings and expand their share of the employer-based health insurance system. Indeed this process is accelerated by state health care reform proposals based specifically on the "managed competition" theory, which is designed to promote geographically based networks of managed care companies and increase the government's regulatory control over the new "managed market." As Heritage Foundation analysts and others have argued, "managed competition" leads to even more government control over the health care system and the likely concentration of the market in the hands of large, geographically based health insurance cartels.[12] In other words, there is more management, less competition, and greater levels of regulation.

11 Marion Merrell Dow Inc., *Managed Care Digest* (Update edition, 1994), p. 2; *HMO Industry Profile 1994*, p. 51; Bernstein Research Data, December 1994.

12 For a discussion of the theory of "managed competition" and the likelihood of such a health care reform approach to lead

Minnesota, for example, has adopted and recently modified a major health care reform proposal based originally on "managed competition." Minnesota COACT (Citizens Organized Acting Together), a grassroots organization that has evaluated health care in Minnesota, finds that consolidation has occurred to such an extent that just four vertically integrated managed care companies now provide 80 percent of the medical care for Minnesota residents. It points out that the latest studies of cost by the Health Care Financing Administration (HCFA) and Physicians Payment Review Commission (PPRC) found that Minnesota's health care costs are now 5 percent above the national average.[13]



In addition, COACT is concerned about heavier provider workloads, decreased health care quality, and the undue political influence of new networks on health care policy decisions made by the state legislature. The Basic Health Care Action Group, composed of 22 large corporations in Minnesota, also is concerned over the economic concentration of insurance power in the state and is planning to contract outside these networks beginning in 1997. Given the penetration of HMOs into private-sector insurance around the nation, it is important to remember that while their initial bargaining power helps curb costs, these cost savings are blunted as their economic control increases. It is no surprise that a state's insurance system can be dominated by a few strong companies, thus rendering it an oligopoly.

HMOs control costs by reducing the use of services. Staff model HMOs (those HMOs that actually have doctors on a payroll) reduce services by nearly 20 percent according to a February 1995 CBO evaluation of managed care.[14] Most studies indicate that people in

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to even more government control over the market, see Robert E. Moffit, "Overdosing on Management: Reforming the Health Care System Through Managed Competition," *Heritage Lecture* No. 441, February 25, 1993.

13 Cited by Kip Sullivan, *Strangled Competition: A Critique of Minnesota's Experiment With Managed Competition,* Minnesota COACT and the COACT Educational Foundation (July 1995), p. xi.

reasonably good health do well in HMOs.[15] Preventive care may even be better than in fee-for-service plans. But a Rand Health Insurance Experiment found that individuals who were low-income and in poor health when they entered the study had more serious symptoms, more bed-days due to poor health, and a greater chance of dying if assigned to the HMO.[16]

A second longitudinal study in Boston, Chicago, and Los Angeles followed 1,208 chronically ill patients with hypertension, diabetes, heart disease, depression, or a combination of these problems. The patients were divided into fee-for-service or prepaid care groups (HMOs or IPAs). Those in the prepaid group had improved coordination of care but reduced physician continuity and a less comprehensive level of care. More patients reported organizational access difficulties, such as problems obtaining emergency care, or problems seeing a doctor when they thought they needed one, with the prepaid plans.[17] Another study of home health care services reported that outcomes of home health care are superior for Medicare fee-for-service patients when compared with Medicare HMO patients.[18] So chronically ill, older patients may not do as well with traditional HMOs.

Lesson #1 for Congress. In terms of private-sector experience with managed care, the lesson for Congress is that managed care plans often generate initial savings but do not guarantee long-term control of health care costs. Moreover, in terms of quality care, their record is mixed. As with any health care delivery option, there are excellent plans and poor plans. Managed care plans often provide superior preventive medicine and often are excellent options for persons in reasonably good health. While they are enormously popular with private-sector employers, they may not be the best option for low-income individuals with poor health. This means that Congress should be neutral in devising a defined contribution for Medicare and should avoid any government contribution or statutory provision biased in favor of managed care at the expense of other private health care options for the elderly.

Experience #2: Scheduled Benefits.

Instead of paying their workers' health care compensation in the form of a standardized, defined set of benefits, or limiting their choice of doctors or access to medical specialists through a company-based managed care arrangement, other companies have limited their contributions to a specific dollar amount while simultaneously encouraging complete freedom of choice in selecting doctors and medical specialists.

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14 Congressional Budget Office, "The Effects of Managed Care and Managed Competition," CBO Memorandum (February 1995), p. 2.

15 D.G. Safran *et al.*, "Primary Care Performance in Fee for Service and Prepaid Health Care Systems," *Journal of the American Medical Association*, May 25, 1994, p. 1583.

16 Cited by John E. Ware Jr., *et al.*, "Health Insurance: Comparison of Health Outcomes at a Health Maintenance Organization With Those of Fee for Service," *Lancet* I, 8488, (1986) , pp. 1017-1022.

17 Safran, *op. cit.*, pp. 1578-1585.

18 *Medical Benefits*, Vol. 12, No. 3 (February 15, 1995), pp.7-8; the original citation was a study done by Peter W. Shaughnessy, Ph.D., in *Health Care Financing Review*, Fall 1994.

Example: International Paper. Perhaps the best example of this approach is International Paper Company, headquartered in Memphis, Tennessee. A *Fortune* 500 multinational producer of paper and forest products with 52,000 U.S. employees in 44 states, International Paper considers employee choice vital to its success in curbing health care costs.

Like so many other large corporations faced with runaway increases in employee health care costs during the 1980s, International Paper began to introduce standard cost sharing, with employees paying larger premiums and copayments. Like many other companies, it shifted from traditional first dollar coverage to an 80/20 ratio, a standard employer and employee cost-sharing arrangement. That arrangement, in terms of the company's bottom line needs, failed to solve the problem, so International Paper tried managed care-type plans, as most companies are doing today. Although these plans clearly restrict choice, increased health care costs were so overwhelming that the managed care option was especially appealing to the company. But International Paper's experiences were similar to many others examined by the U.S. General Accounting Office, the investigatory arm of Congress.[19] As with so many other companies, despite an initial decrease in the cost of health care insurance, the rate of growth soon erased any savings. In fact, it took International Paper just two years under its HMO plan to reach previous cost levels.

In 1990, International Paper's corporate leadership conducted an innovative pilot project for a new plan that maintained full employee freedom to choose providers but used "scheduled reimbursements." Their scheduled reimbursement plan, the brainchild of Jerry Bowers, one of their employees, is designed to help employees become more knowledgeable consumers of health care by giving them a meaningful financial incentive to seek out doctors and medical specialists who are both effective and cost-efficient. The company's "scheduled reimbursement" is a set amount for a medical service that is based on median costs for that service in the community. In other words, the contribution is geographically based. After an annual deductible, the plan reimburses the employee for 100 percent of charges up to the amount of the scheduled reimbursement. Under a separate arrangement, to cover medical catastrophic events, the plan also pays 100 percent of "usual and customary" charges, the traditional insurance reimbursement of physicians under fee-for-service arrangements, after an employee reaches an annual out-of-pocket maximum.

For International Paper Company, the results of this financing arrangement have been dramatic. For employees who shifted from the 80/20 plan in 1991 to the scheduled reimbursement plan in 1992, total medical costs per employee (including out-of-pocket expenses) actually declined a total of 12.5 percent. That was a savings of 14.5 percent for the company and an average savings in out-of-pocket costs of 5.7 percent for the employee. During 1993 the cost remained largely steady, even in the face of large cost increases for the company's more traditional 80/20 managed care plan. International Paper, using the scheduled benefits plan, did not have increased medical costs in 1994 or 1995.[20]

19 See U.S. General Accounting Office, *Managed Health Care: Effect on Employers' Cost Difficult to Measure*, October 1993.

Lesson #2 for Congress. The lesson is clear: Americans can have the same or superior quality of health care and enjoy more choice at less cost. Instead of restricting the market principles of consumer choice and limiting choice of physicians to control costs, International Paper has employed consumer choice to control costs directly, with significant savings to the company and to employees. The key is putting dollars directly in the employees' (patients') hands. As is true of all other purchases in a market economy, consumers indisputably are much more careful with their own money than with someone else's. The positive experience of International Paper clearly demonstrates the economic effectiveness of a defined contribution approach. Its application goes beyond Medicare to broader health care reform, including the principle of direct tax relief in the form of tax credits and vouchers for individuals and families.

The market experience of International Paper can also provide a model for the "look back" mechanism to control Medicare costs to meet budgetary targets. Congress is considering an across-the-board cut in rates, as Medicare has done in the past, to guarantee this objective. The problem with this solution is that non-discriminatory providers who are overpricing services will be hurt a little, but providers who are pricing wisely will be hurt even more. It is a perverse system of rewards and punishments. The consequences of the market must be real.

A better model for value, and a solid basis for budgetary control, is the "scheduled benefits" model, another variant of the "defined contribution" model, developed by the International Paper Company. With this model, which pays up to the median cost, prudent providers will be rewarded with more business and overcharging providers will not be paid more than is reasonable. International Paper, in using this principle, is spending $1,000 less than the average fee-for-service program while still offering complete choice of doctors. Its experience proves that normal people, given information and a reason to use that information, can control costs and make wise health care decisions

Private Sector Experience #3: Medical Savings Accounts.

Medical savings accounts are another new method of health care financing that puts the power of the dollar directly in employee hands. The current tax laws do not allow company-based medical savings accounts to be set up so that individuals may contribute to them with pre-tax dollars. But companies can contribute pre-tax dollars for the employee and can purchase a back-ended catastrophic health care insurance plan.

Example: Golden Rule. While relatively new in concept, the medical savings account model is used by about 1,500 companies nationwide. Plans vary widely. Perhaps the most famous example is the one developed by Golden Rule CEO Patrick Rooney and used by managers and employees of the Golden Rule Insurance Company, based in Indianapolis, Indiana. At Golden Rule, the company deposits $2,000 for family coverage into a medical savings account (MSA) to pay for routine medical expenses, even those traditionally not covered by insurance, such as eye glasses or medication. There is a catastrophic health care insurance policy purchased by the

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20 Jerry Bowers, Director of Special Projects-Health Care, International Paper Company, Memphis, Tennessee, personal communication, September 1995.

company with a $3,000 deductible. This costs $1,862 per year for family coverage. The savings account covers the first $2,000 of the deductible; if needed, the additional $1,000 is out of pocket. What employees do not spend on doctors, they get to keep. In 1994, this amounted to about $1,000 per person in leftover funds. Golden Rule's premiums have not risen since the plan was offered to employees. Over 90 percent of the company's 1,100 employees participate in the plan and are highly satisfied. The Luntz Research Company has reported that 98 percent of Golden Rule employees are satisfied with the MSA and 88 percent prefer it to past plans. Actual costs for the Golden Rule Company are about $2,900 per family, which includes the catastrophic policy and the actual $1,000 spent from the MSA fund.[21]

A cautionary note is provided by the Morris County Hospital in Council Grove, Kansas. It had a medical savings account-type program from 1983 to 1992. At first it worked well. But in the seventh year, the total work force increased 25 percent and there was a huge employee turnover. Medical spending below the deductible increased 44 percent in just one year and another 27 percent the following year. For the first seven years, the increase had been only 3.5 percent per year. The large increase was thought to be caused by failure in employee education. In the last three years, the employees, especially new ones, thought the fund was a "free" benefit, and spending increased dramatically. The hospital then converted to a traditional indemnity policy.[22] The message is clear: For MSAs to provide the savings that are needed, they must be structured correctly. However companies may design the medical savings account option, their experiences generally show lower costs with MSAs than with traditional indemnity policies.

Stephen Barchet, M.D., an expert on health policy based in Washington State, reports actual costs for seventeen different plans in the current *American Compensation Association Journal.* An examination of the data provides a clear picture of the potential success of Medical Savings Accounts (see Chart 4).

Each of these examples shows the financial impact of consumer choice of physicians and other medical specialists. But consumer choice of plans still is not a predominant feature of private, employer-based health insurance. Since the private sector operates on the basis of a third-party payer system, consumer choice of doctors and other medical specialists is a matter of corporate, rather than consumer, decision. The company may choose from groups of doctors or other providers who agree to lower costs or capitate payment (the HMO or preferred provider model). This lowers cost but decreases the patient's choice, including the choice of a doctor. The evolution of employer-based insurance presents a major challenge to the traditional doctor-patient relationship, so fundamental to the ancient ethical imperative of the medical profession itself.[23] In the Interna-

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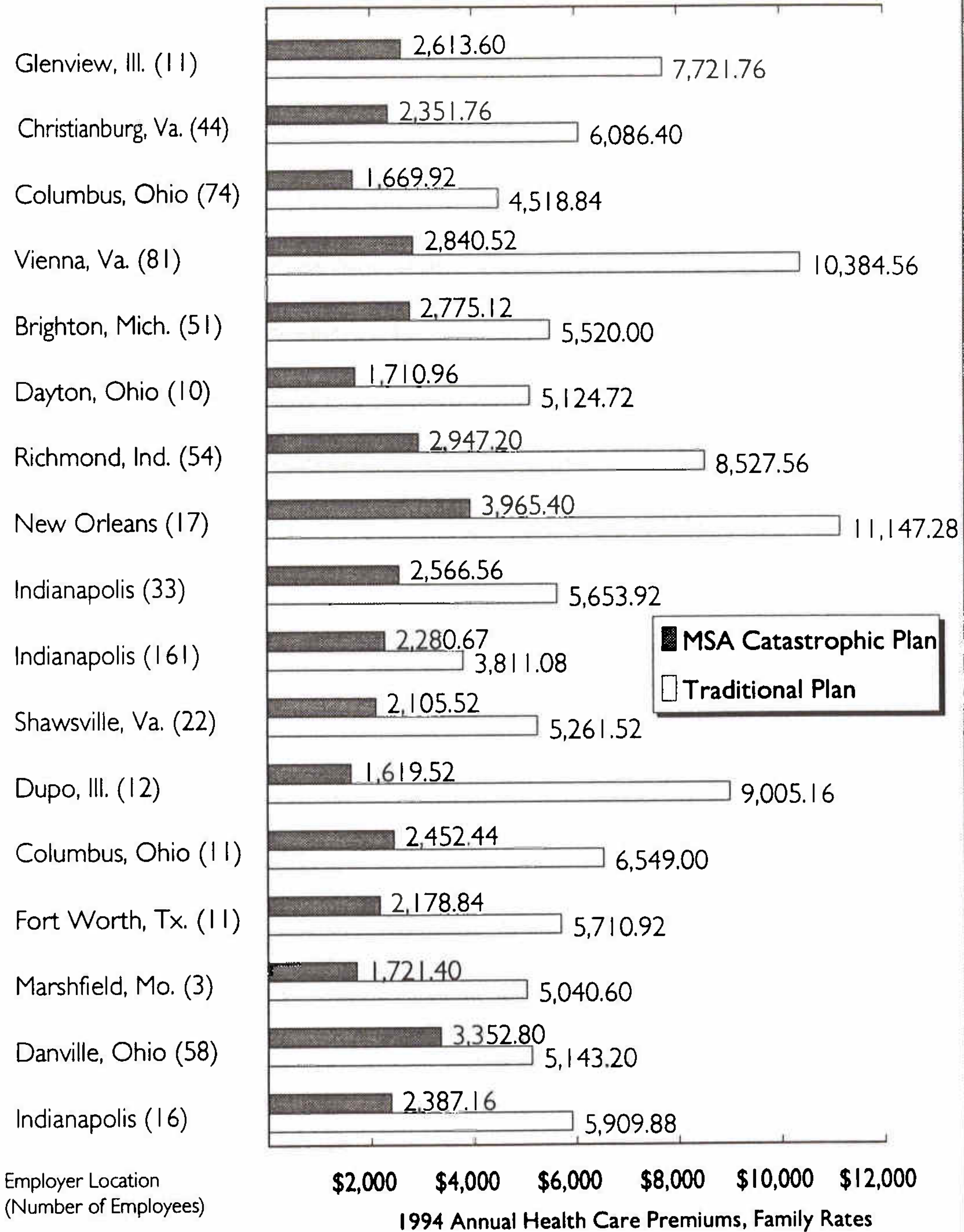
21 Brian McManus, Golden Rule Insurance, Lawrenceville, Illinois, personal communication, October 1995.

22 Gary Tiller, Administrator, Morris County Hospital, personal communication, October 1995. It should be noted that the hospital's MSA plan was tied to other employee benefits. Complicated tax problems also encouraged the hospital to change plans when costs increased. Nevertheless, Mr. Tiller notes that the main problem of increased costs was the change in employee behavior. He adds that if the tax problems could have been avoided, the hospital would have restructured the MSA and continued to offer it for medical coverage.

23 For an excellent discussion of this problem, see Kevin Vigilante, M.D. on "The Ethical Imperative," in Robert E. Moffit, *et*



al., "Restoring The Doctor-Patient Relationship," *Heritage Lecture* No. 541, June 13, 1995.

tional Paper Company's "scheduled reimbursement" or "defined contribution" model, consumer choice of providers is encouraged, and the employee is rewarded directly, not only with a revitalization of the traditional doctor-patient relationship, but also with the personal economic benefit of choosing value for money.

Perhaps the most dramatic development in health care financing in recent years is the medical savings account. Once considered a marginal contribution to health care reform efforts, MSAs have become politically popular and are finally getting the theoretical attention they merit from the health care policy community. The American Academy of Actuaries, in attempting to estimate average costs nationwide for MSA plans, reports that costs will depend ultimately upon three critical variables. First is the existing distribution of health care costs. Eighty-five percent of insurance claims today are below $3,000, so a $3,000 deductible policy should cover 85 percent of possible charges. The second factor is utilization. The Academy says that this depends largely on the amount that must be out of pocket in the insurance policy. The last factor is perhaps the most important: whether users of the medical savings account option consider the MSA balance as insurance or savings. At Golden Rule, for example, it clearly is savings for the employee, since what is not spent is received by the employee in cash rebates. Because of these variables, the American Academy of Actuaries says that total expenditures for health care per individual could be a band of costs ranging from $2,695 to $2,976 using an MSA model.[24]

Lesson #3 for Congress. While medical savings accounts hold great promise, it is essential for Congress to design them correctly. Specifically, Members should make sure the patient using the account understands that the money is his money and he receives the direct financial benefit by spending it wisely.

Private Sector Experience #4: Private Competition in the Public Sector.

A third model is one with which Congress already is intimately familiar: the right of an individual to choose among various private health care plans, well beyond the range of choice afforded by private companies choosing between health care plans. This model is illustrated uniquely by the Federal Employees Health Benefits Program (FEHBP), the popular system with almost 400 private health care options competing for the business of Members of Congress, congressional staff, federal workers and retirees, and their dependents—roughly nine million Americans. The Heritage Foundation, the American Medical Association, and several other prominent institutions and organizations, have suggested that Congress should use the FEHBP as a basic model in reforming Medicare.[25]

In the FEHBP, individuals are offered private insurance options once a year. No other class of Americans enjoys the choice of plans and benefits available today to federal workers and their families. For all practical purposes, federal workers and retirees can do something that most Americans cannot even imagine: choose the kinds of plans and bene-

24 American Academy of Actuaries, *Medical Savings Accounts: Cost Implications and Design Issues*, May 1995, p. ii.

25 On the use of the FEHBP as a model for Medicare reform, see Stuart M. Butler, Robert E. Moffit, and John C. Liu, "What To Do About Medicare," Heritage Foundation *Backgrounder* No. 1038, June 26, 1995, and Robert E. Moffit, "FEHBP Controls Costs Again: More Lessons For Medicare Reformers," Heritage Foundation *F.Y.I.* No. 64, September 25, 1995. See also Stuart M. Butler and Robert E. Moffit, "The FEHBP As a Model for a New Medicare Program," *Health Affairs*, Winter 1995, forthcoming.

fits they like at prices they wish to pay. There is no government-standardized benefits package, but a wide variety of benefit options. There are no set copayments and deductibles, but a wide variety of copayments and deductibles. The government offers federal workers and retirees a contribution, fixed by a formula, for any plan they choose. The government contribution is about 72 percent of the cost of premiums. If these consumers wish to pay more, they may do so. If they buy a less expensive plan, they can pay less, and thus take advantage of the savings from picking less expensive health care options. As a model for Medicare reform, the FEHBP is important also because 40 percent of its policyholders are retirees and therefore represent an older workforce compared to the private sector.

The result of consumer choice and competition in the FEHBP is a solid performance in controlling health care costs, especially in recent years. For 1996, according to the Office of Personnel Management, the federal agency that oversees the program, the projected overall increase in premiums is only four tenths of one percent. Premium growth for the past three years has been essentially flat.

The role of the federal government in the FEHBP is to make sure that plans offered are sound. The government does not actually run a plan, as in the Medicare system, or even in the reformed Medicare system envisioned in House and Senate legislation. It simply ensures that all plans are solvent and meet standard marketing and consumer protection requirements. The law creating the FEHBP does not outline a system of standardized benefits like Medicare's; nor does it standardize co-payments and deductibles as Medicare does. And, of course, there are few Medicare-style price controls.[26] The law merely lists the categories of benefits, such as hospitalization and physicians services and outpatient services, that plans must offer; the health plans themselves, responding to OPM's call for negotiation on rates and benefits each year, largely determine the health benefits they want to offer without OPM's trying to micromanage the process.[27] From the standpoint of administration, the program is comparatively simple. Washington economist Walton Francis compares FEHBP and Medicare: "The FEHBP is run by 150 government bureaucrats. Medicare is run by more than 3000 bureaucrats (neither of these numbers include people paying claims). To be sure, Medicare serves three times as many people, but FEHBP runs three times as many plans (counting Medicare's 100 participating HMOs)."[28]

Within the FEHBP, there are two persistent problems, both aggravated by federal government policy. The first is "adverse selection," the tendency of younger and healthier people to migrate to lower cost plans, leaving older and sicker workers in high-cost plans. This has been a special problem for the Blue Cross/Blue Shield plans in the program. In recent years, this problem has abated: "More recently, the risk segmentation has stabilized, in the sense that the high risk groups have separated so that high risks are in

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26 There is one recent exception to this rule. For federal retirees, private plans must abide by the Medicare reimbursement limitations.

27 See Alison Evans, *The Federal Employees Health Benefits Program, Managed Competition, and Considerations for Medicare*, National Academy on Aging, September 1995, p. 4.

28 Walton Francis, "The Political Economy of the Federal Employee Health Benefits Program," in Robert B. Helms, ed., *Health Policy Reform: Competition and Controls* (Washington, D.C.: The American Enterprise Institute, 1993), p. 299.

the high option plan with high premiums, and the low risk predominate in the standard option with lower costs. In fact, for awhile the Blue Cross plan was required to increase its premium even more in order to create greater reserves in anticipation of high claims. Thus, the spiral has slowed, but the pricing issue remains."[29]

While the adverse selection problem may have abated in recent years, it remains, but persists only because of congressional insistence on a crude form of community rating. Retirees and active workers pay the same premiums regardless of age. Since older workers have higher health care costs, private plans competing in the FEHBP market cannot price for those differences, offsetting the risks of enrolling older and sicker workers by charging them higher premiums. This problem could be resolved by allowing plans to underwrite on the basis of age, sex, and geography, at the very least treating retirees and active employees differently, and offsetting the resultant increase in retiree premiums with an increase in the government contribution for retiree health care. This might not save money, but it would minimize the adverse selection problems the federal government created in the FEHBP market. FEHBP's current government contribution formula, based on the premium performance of the six largest plans participating in the program, is also an odd political artifact. According to the Clinton Administration, if federal workers and retirees were under a defined contribution formula not unlike that being proposed for Medicare, rather than the current FEHBP financing arrangement, they would be ahead in compensation by $424 million in 1996 alone.[30]

A second problem is the regulatory potential of OPM to undermine market forces and frustrate consumer choice and competition by restricting options, mandating benefits that workers or retirees may not want, or dropping specific benefits that federal workers may want. The FEHBP has no flexible spending account or medical savings account options, and OPM historically has been biased against allowing high-deductible insurance plans to compete in the system. While OPM has played largely a passive role in FEHBP administration, to the general benefit of the program, this could vary with presidential administrations.

Lesson #4 for Congress. Congress should treat the elderly like congressional retirees and make available to citizen retirees a degree of choice equal to or superior to the level of choice available to retired Members of Congress and their spouses. Moreover, Congress should introduce improvements in the design of a consumer choice system in Medicare that would lessen the problems of adverse selection and forestall the kind of government regulatory interference which frustrates consumer choice and competition in the FEHBP.

29 Evans, *The Federal Employee's Health Benefits Program*, p. 6.

30 Letter from James King, Director of the United States Office of Personnel Management to Representative John Mica (R-FL), September 28, 1995. Under the conference agreement on the congressional budget resolution, a defined contribution formula, a federal employee's family would be eligible for $3,547 for health coverage in 1996, compared to the $3,432.26 available to them under the current "Big Six" formula.

Private Sector Experience #5: The Use of Cafeteria Plans and Flexible Spending Accounts.

Within the private sector, there is a limited version of the consumer choice found in the FEHBP. Currently, one of four American workers has some degree of choice in selecting benefits. Over the past 25 years, 250,000 employers have turned to flexible benefit plans.[31]

TRW, the aerospace industrial giant, and the Educational Testing Service of Princeton, New Jersey, both claimed to have started the first cafeteria plans in 1974. Congress encouraged this corporate policy by establishing flexible benefits accounts under Section 125 of the Internal Revenue Code in 1978. Under this section, employees can deposit otherwise taxable cash compensation into a pre-tax account for the purchase of benefits. But employees cannot roll this account over tax free from one year to the next. Nevertheless, the option has become very popular, particularly among large corporations. According to an analysis conducted by the Employee Benefit Research Institute, 48 percent of employers with 1,000 or more employees offered flexible spending accounts in 1991 for health care.[32]

Cafeteria plans, flexible benefits options, and flexible spending accounts have been successful in controlling costs. Employers have realized that by allowing employees to choose their benefits, making decisions based on value for money, they have been able to control overall costs. According to the Employers Council on Flexible Compensation, while average medical claims costs for all employers rose by approximately 15 percent in 1992, costs for those with flexible plans rose by 11 percent.[33]

Lesson #5 for Congress. As the private sector experience with cafeteria plans and flexible benefits shows, increased consumer choice means increased cost control.

Private Sector Experience #6: Using Private Associations.

An American cannot get tax relief for health insurance unless it is purchased through an employer. Thus, most Americans are covered by employer-based plans. Yet, despite the tax discrimination against them, non-employment health insurance plans continue to exist. If private association plans were on a level playing field with traditional insurance plans, their market share could be enormous. Indeed, in a reform of the general health insurance market of the sort suggested by The Heritage Foundation and others, they could be a perfect way to address the problem of many uninsured Americans. It is noteworthy that in the FEHBP, where there is a level playing field, about one-third of all workers and retirees choose plans sponsored by federal unions and employee organizations.

Already, over six hundred private associations, organizations, and groups provide health insurance for their members.[34] They range from professional organizations like the Alabama Oilmen's Association, American Society of Travel Agents, Colorado Grain

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31 "Flexible Compensation and Healthcare Reform," Talking Points, The Employers Council on Flexible Compensation, Washington, D.C., 1994.

32 "Flexible Benefits, Choice and Work Force Diversity," Employees Benefit Research Institute *Issue Brief*, July 1993, p. 1.

33 "Background on Cafeteria Plans," Talking Points, Employers Council on Flexible Compensation, 1994; data originally cited in "New Priorities for Flex Plans," *Business Insurance*, January 18, 1993.

and Feed Association, and Independent Garage Owners of North Carolina to fraternal, legal, and political organizations like the Association of the United States Army, B'nai B'rith, Federal Bar Association, and National Organization for Women. Many medical and health care groups also have plans: the American Dental Hygienists, American Academy of Family Physicians, American Society for Microbiology, and many more.

One of the attractions of association or organization plans is that they combine a professional or fraternal interest with health care concerns of their members. The Golf Course Superintendents Association of America and National Sash and Door Jobbers Association may not have much else in common, but they do offer health insurance to their members. Religious institutions and labor unions also have a potentially beneficial role in this area. Indeed, the stronger the personal affinity of consumers with these organizations, the more likely these institutions will be to emphasize consumer protection and information.

Lesson #6 for Congress. Members of Congress have personal experience with being able to join health plans sponsored by groups with which they have an affinity. Numerous associations, unions, and organizations now offer health insurance in the private sector. They should have the opportunity to market solid plans in the Medicare system as well.

THE INFORMATION EXPLOSION

In order to control cost most effectively, consumer choice requires informed consumers. Nowhere is the need for solid information, for consumers as patients and doctors as providers of health care services, more evident than in a reformed health care market. While consumers need solid information on plan options, and the prices and benefits available to them, doctors and hospitals and medical specialists in a new consumer-based market will have a continuing need for up-to-date information, including clinical and scientific data, on the treatment and cure of disease, as well as cost.

The good news is that the information explosion, a post-industrial revolution that promises to improve the quality of life and the efficiency of America's economic system, is shattering the traditional way doctors and patients interact with one another: "Patients are interviewing physicians, hiring and firing them."[35] At the same time, the information superhighway is an avenue of information on specific illnesses where patients can exchange information on treatments, physicians, and outcomes. America Online, Prodigy, and CompuServe already are providing such services to American consumers. Moreover, through the Internet, consumers can get access to federal health documents and databases.[36] While the information revolution is well underway, it is straining the capacity of corporate structures of delivery and intensifying the internal contradictions between an information age that is inherently compatible with personal freedom, consumer choice, and competition and older, paternalistic systems of health care delivery in which the pa-

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34 For information on the range of private association plans, the author is grateful to Heritage Foundation research intern Kim Allen of Princeton University, who compiled valuable information on private association health plans in 1994.

35 Diana Sugg, "Informed Patients Take Control of Care," *The Baltimore Sun*, April 16, 1995, p. A-14.

36 *Ibid.*

tient is on the receiving end of somebody else's decisions. The contradiction is nicely articulated by Dr. Catherine De Angelis of the Johns Hopkins University School of Medicine: "It's crazy. On the one hand you're raising expectations and raising the level of understanding of patients regarding disease process or illness, and on the other hand corporate medicine is forcing physicians to just crank out patients. You don't have the time to respond to patients."[37]

While managed care may be the latest evolution of "corporate medicine," it is managed care that has contributed to the very information explosion that is taking place in a rapidly changing private sector. Perhaps the most important contribution of managed care has been its intense concentration on the actual costs of providing medical care. In the recent past, insurance reimbursement for doctors and hospitals often was "usual and customary" or "cost-plus" reimbursement. In a system without consumer pressures to control cost, this type of arrangement is a natural incentive to drive up costs. Moreover, until recently, even with closer attention to the problems of administration and overhead, hospitals did not always have the software used by manufacturing companies in their production process—software that would enable them, for example, to look at the actual cost of each step in the process of treating or caring for patients. Given the incentives of the predominant third-party payment system and the cost-shifting that is rampant in the health care sector of the economy, hospital bills that include $10 for an aspirin should not seem shocking.

An Existing Network. For congressional and federal employees and retirees, the consumer information infrastructure for the informed purchase of health insurance plans is already in place. Beyond the personal experience of shopping for the best value for money in the FEHBP insurance market, there is a vast network of public and private information on health insurance plans, including the level of benefits and the quality of care and medical services. Approximately one half of all people with health insurance in the Washington, D.C., metropolitan area are covered by the FEHBP's 35 competing plans.

While the Office of Personnel Management publishes a comparative FEHBP "Guide" to private health insurance plans, that effort is supplemented by a variety of other information sources, including advice to employees from federal agency personnel managers; newspaper articles outlining comparative plan benefits; television, radio, and newspaper advertisements; federal union and employee association information campaigns; and even town hall programs, sponsored by Members of Congress with large numbers of federal employees and retirees in their districts, outlining the best offering for the coming year. The National Association of Retired Federal Employees (NARFE), which describes all FEHBP plans as "good," publishes a booklet comparing plans and benefits for retirees, even describing which plans provide the best treatments of interest to this age group. Perhaps the most widely quoted information source is *Checkbook's Guide to Health Insurance Plans for Federal Employees*, published by Washington Consumers Checkbook, which outlines all of the plans in the FEHBP, including information as to which will be better for certain medical conditions. Everyone from government couriers and janitors to

37 *Ibid.*

postal workers and senators use this information to choose health care plans yearly. Where only the employers make choices, the cost control has not been as impressive.[38]

Just as enrollees in FEHBP get solid information on different insurance plans, employees of the International Paper Company get solid information on the cost of services and qualifications of local providers. Relying on consumer choice and promoting the availability of such information, International Paper experienced no increase in costs for three years.

New Consumer Information Technology. With the limited exceptions of the FEHBP and companies that provide a degree of consumer choice through flexible spending accounts and medical savings accounts, there is no broad consumer choice in employer-based insurance. But the technology for giving consumers even more information on the price and performance of providers already is well underway. One innovative approach is the proposed R.E. MEDI system developed by Dr. Jack Tawil, an economist and President of Research Enterprises of Richland, Washington, Inc. R.E. MEDI is a software system that can accumulate and present all of this diverse information on price and performance in a simple format. Each patient has a computer disk, protected by an individual password, that contains medical information and cost data. Access to the main memory bank is effected by an access code, just as is done with a bank teller card. When the patient goes to the doctor, the code handles electronic billing in a quick, efficient manner and records the cost of the visit in the central system. The central computer system gathers all of the charges from multiple patients and then produces a comparison of physician charges. This has enormous potential application for companies and systems (International Paper, for example) trying to bring down the cost of health care through consumer choice and competition among providers. Beyond price information, the R.E. MEDI system also collects treatment outcomes and provider qualifications. This gives each patient access to a periodic publication of price, performance, and qualifications.[39]

Hospital and Physician Information. Largely because of the economic pressures exerted by new managed care arrangements, doctors and hospitals need precise cost information. The actual number of hospitals that have effective, decision-directing cost analysis is not known. The estimate by companies which produce such software is around 15 percent.[40] Those hospitals able to use such software have dramatically improved their ability to provide better care at lower costs.

For example, Hoag Memorial Hospital Presbyterian in Newport Beach, California, has lowered patient costs and improved hospital profits by using a data system called the "Affinity Program." The hospital used the computer to generate information in a clinical pathway. The steps were to find a process to improve; organize a team of physicians, nurses, and staff; understand the variations, such as length of stay; plan the improvement; implement improvement; check results; and revise. From 1990 to 1994, the hospital low-

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38 It ranges between 6 and 8 percent. See the Corporate Leadership Council, "The Third Wave of Health Care Cost Savings," 1995, p. 19.

39 For a complete discussion of this system, see Jack J. Tawil and Frederick Bold, *Reinventing Health Care* (Richland, Washington: Research Enterprises, Inc., 1994).

40 Lou Bunz, Transitions Systems Inc., Boston, Massachusetts, personal communication, October 1995.

ered its charge per case of Coronary Bypass (DRG107) from $55,418 to $42,093 (24 percent) and its charge per case of total hip replacement (DRG209) from $20,793 to $18,688 (10 percent).[41] The implications for the nation are staggering. This is not an isolated case. For example, in 1993, the average charges for another coronary procedure, transluminal coronary angioplasty, ranged from $16,770 in Ohio to $28,110 in Colorado.[42] Using the "affinity program" for this procedure, Hoag Memorial has reduced its charges to $12,650 for coronary angioplasty. And the hospital has increased its profit.

Beyond price, however, is the sheer explosion in biomedical research and technology. Biomedical sciences, including anatomy, biochemistry, microbiology, pathology, pharmacology, and physiology, at the 125 medical schools all over the United States are in a period of tremendous growth. Beyond this academic complex, private biomedical research and technology firms are making progress on many fronts—everything from AIDS and Alzheimer's disease to cancer and cardiac devices. At least 90 percent of the nearly $5 billion spent in 1992 on research and development has come from private-sector investors. And since it takes seven to ten years, under current regulatory timelines, most biotech companies must seek successive rounds of financing. Most of the nation's 1,300 biotech companies are small start-up businesses with a powerful entrepreneurial spirit. More than three quarters have fewer than 50 employees, and most are less than ten years old. More than 50 percent of their costs are research and development.[43]

Moreover, some of the companies fostering new health care breakthroughs are providing information about the cost impact of their products in addition to their medical usefulness. American Biogenetic Sciences Inc. is such a firm. It is conducting clinical trials of a new test, called the Thrombin Precursor Protein, which could save billions of dollars.

Cardiovascular diseases rank as America's number one killer. The cost of cardiovascular disease in 1995 is estimated by the American Heart Association at $137.7 billion. Much of that money is spent on the treatment of patients who present themselves to emergency departments with symptoms of chest pain. All such patients must be treated as if they are having a heart attack until heart attack can be ruled out. Approximately eight million Americans present themselves to emergency departments annually with symptoms of a heart attack, but only 20 percent actually are having an attack. This creates many hospital admissions and procedures which could be prevented if doctors could diagnose accurately at the time they first see the patient. According to Dr. Paul Gargan, the firm's research expert, the new test will detect a blood clot that causes a heart attack immediately after chest pain begins. Current tests pick up evidence of heart muscle damage at 12 to 24 hours after pain begins. The new test, pending FDA approval, would make immediate diagnosis possible for the first time.

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41 Steve Moreau, Hoag Memorial Hospital, Presbyterian, Newport Beach, California, personal communication, October 1995.

42 "Average Hospital Charges for Percutaneous Transluminal Coronary Angioplasty in 1993: Geographical Variations," *Medical Benefits,* Vol. 12, No. 4 (February 28, 1995), p. 3.

43 *The Washington Times*, November 9, 1993, p. A15.

American Biogenetic Sciences calculated the amount Medicare patients could save just by using the new test to screen patients before admitting them to coronary care units. According to the firm, the amount saved by using the test in this way alone would be $130 billion during the next seven years.[44]

In addition, there are new "clot-busters" that actually may reverse the heart attack process and prevent heart damage if doctors give them in the first two hours after the onset of an attack. Since it has been very difficult to tell who is having a real heart attack, and since these "clot-busters" have rare but serious side effects (like strokes), doctors have not been able to use them as much as they would like. With a new test that accurately makes the diagnosis, doctors should be able to save many lives and prevent heart damage that leads to chronic heart problems in many more. This new technology could offer impressive new methods of prevention and thus reduce the unnecessary long-term costs and effects of cardiovascular conditions.

NEW MODES OF COMPETITION

Traditional market competitiveness—either between health insurance plans as in the FEHBP or between doctors and other providers as at International Paper—lowers costs. For Members of Congress engaged in reforming Medicare, the private sector has suggested new models that promote competition.

Total systems of care like HMOs offer a complete range of services. Theoretically, a complicated patient can receive better care if all the care is coordinated. In the private sector, there is a trend toward larger and larger HMOs. The larger companies spend less on actual care, and large companies are charging about 30 percent above health care costs. That means the same care perhaps can be given at lower cost to the consumer. Smart providers looking at these numbers have suggested that provider networks, organizations run directly by doctors, could give the same or better care at lower cost by decreasing management costs. The problem has been that antitrust laws prevent more than 30 percent of doctors in a community from joining in such a provider network, even on a non-exclusive basis (they also provide care outside the network). The HMO could have 100 percent of the doctors in the same community in its network, however, and be perfectly legal. The American Medical Association recommends that the Department of Justice and Federal Trade Commission develop guidelines that allow physician-sponsored coordinated care organizations to operate on an equal footing with traditional HMOs. The House bill provides for such physician-sponsored organizations. Final congressional guidelines should permit greater numbers of physicians to join in networks and should define financing structures that recognize physician services as a financial asset.

Other provider networks have offered new plan designs that should give better care to specific groups. One such group is older people with chronic medical problems. For example, Wesley Woods, an Atlanta, Georgia, senior citizen care facility, reports that 30

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44 Alfred Roach, Chairman of the Board of Directors, American Biogentic Sciences Inc., Personal Communication, September 1995; the American Biogentics Sciences calculation was conducted by Karean Eissler, M.S., using data (Statistical Supplement) taken from the *Health Care Financing Review*, February 1995.

percent of its residents have mental difficulties. It is very difficult for them or their families to handle all the paperwork of traditional Medicare. New systems that would coordinate all needed care with one capitated payment would make this much easier. The director of Wesley Woods supplies a case study illustrating the point. Mrs. B is over 70 years old. She lives in an apartment and is low income. She has a long history of chronic mental illness, but that problem is managed when she is on medication. Under the current Medicare system she does not always receive her medication. When that happens, she hears voices, accuses neighbors of threatening behavior, and becomes a police problem. Her behavior problems lead to eviction, involuntary psychiatric hospitalization, and discharge. This pattern recurs every two years at a current cost of about $27,000 per cycle. A new provider network would permit quarterly psychiatric visits and a weekly psychiatric nurse visit, and would cover her medication at a cost of $4,400 per year. Even better, Mrs. B could stay in her own home.[45]

Using Consumer Incentives

Whenever the copayment in fee-for-service plans is increased, over all costs and utilization decrease.[46] When a policy increases the financial consequences of the consumer's decisions, the consumer uses it more carefully. This principle underlies "defined contribution" plans like that of the International Paper Company. This has implications for broader health care reform, including reform of the Medicare system. If a person wants to spend more for health care than the company provides, he assumes the extra cost, utilization of care is decreased, and costs are controlled.

Example: *Forbes* Magazine. *Forbes* magazine illustrates a more direct effect of using financial incentive to control costs. With its cost-sharing plan, costs were decreased. But *Forbes* did not achieve maximum cost savings until it initiated a plan whereby employees received bonuses for not filing insurance claims. Employees may receive a bonus of $1,500 if they do not file any insurance claims. For claims up to $750, the amount below $750 is doubled. For example, if an employee files a claim for $300, the difference would be $450 and the bonus to the employee would be $900. *Forbes* also pays the extra taxes on the bonus for the employee. *Forbes*, not surprisingly, has lowered health care costs by 25 percent since initiating this program.[47]

Encouraging Wellness

Historically, company-based programs focused on preventive medicine, health care promotion, and wellness have been uncharacteristic of private employer-based insurance. But this is changing. As more and more companies seek to control health car costs, they are relying upon such methods as preventive health care programs emphasizing diet, exercise, and lifestyle changes.

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45 William L. Minnix Jr., President and CEO of Wesley Woods Inc., Atlanta, Georgia, personal communication, September 1995.

46 The Rand Corporation bore out this principle in a notable study of families enrolled in fee-for-service plans between 1974 and 1977.

47 Brett Fromson, "Healthy, Wealthy and Wise," *Sky*, September 1995, pp. 41-43.

Example: Coors Brewing Company. One of many companies encouraging wellness among its employees, Coors Brewing Company opened a wellness center in July 1981. James R. Terborg, a professor at the Graduate School of Medicine at the University of Oregon, conducted a cost benefit study of this program. He found that for every dollar invested, the company saved $6.15 and estimated that the program saved the company at least $1.9 million annually by decreasing medical costs, reducing sick leave, and increasing productivity.[48] One very clear example of this is the cardiac rehabilitation program. Coors officials provide a free, comprehensive cardiac-rehabilitation program to employees, spouses, retirees, and dependents recovering from cardiac illnesses. The program's main object is to return employees to work in their original jobs as quickly as possible. To date, 98 percent of employees have completed the program and returned to work in about 1.3 months. The national average is 70 percent and eight months, respectively. Many of these Coors employees were able to assume their original jobs, and the program has saved a total of more than $3.5 million in lost wages and $2.6 million in actual costs overall. Coors pays $662 per patient for the cardiac rehabilitation program, but the average external cost of such a program is $1,700.[49] In addition, Coors offers special incentives to employees to develop and maintain healthy behaviors. For example, nonsmokers pay 50 percent less for supplemental life insurance than smokers do.

In January, Coors adopted a flexible benefits package that allows employees to earn up to $250 in additional benefit dollars, as well as $250 for spouses, when they make these six wellness pledges: to abstain from tobacco; to consume alcohol responsibly; to use safety equipment, such as seat belts and helmets; to assume responsibility for their mental health by promising to seek counseling for stressful situations; to stay physically active; and to have their blood pressure checked every six months. Employees are on their honor to keep these pledges, and Coors deducts the benefit dollars they earn from their insurance premiums.

Example: Quaker Oats Company. Quaker Oats Company also has developed a positive incentive wellness program. Employees who exercise three times a week, use seat belts, use no tobacco, and promise no drug or alcohol abuse earn $150 annually in flexible benefit credits. Employees who take and meet the company's Health Risk Appraisal earn an additional $110 in flexible benefits. The positive cash incentives and emphasis on wellness have resulted in a reduction of almost 50 percent in hospital admissions over ten years.[50]

CONCLUSION

Members of Congress can learn a great deal from the experience of the private sector, particularly the innovations of America's corporations. While the private sector's employer-based, third-party payment system is far from an ideal model of a normal market,

48 Cited in Francis W. Clifford and Robert J. Diaz, "Wellness on Tap at Coors," *Financial Executive*, March/April 1995, p. 21.
49 *Ibid.*, p. 22.
50 Cited by Stephen Barchet, M.D., *Medical Savings Accounts* (Olympia, Wash.: Evergreen Freedom Foundation, 1995), p. 32.

it has responded rather quickly, if imperfectly, to cost pressures and introduced genuine innovations in the financing and delivery of health care. Using advanced computer systems, making information more available to employees and promoting wellness, and using flexible spending accounts and medical savings accounts, corporations and private businesses have accumulated ample experience in controlling costs.

If Congress changed the tax treatment of health insurance and levelled the national playing field, giving equal tax treatment to employment-based and non-employment-based health options, the competition would be intense and the private system even more flexible. Organization and association plans sponsored by fraternal and religious institutions, unions, and employee organizations would likely flourish. But a free market with real consumer choice, intense competition, and access to solid information through America's emerging network of information superhighways can reduce costs even more while providing Americans with even higher levels of quality health care. While the interaction of all these forces may seem complex, a simple relationship is evident. The closer a system is to a free market, the lower are the costs of that system.

What applies to the innovative firms in the private sector and the Federal Employees Health Benefits Program applies also to Medicare: A market provides the best service at the best price. It is characterized by choice, information, and competition. Americans deserve this kind of health care system.

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