

Employment-Based Health Insurance Is Failing: Now What?

A strategy, based on managed competition, to free employers from the health care cost spiral and produce effective managed care.

by **Alain C. Enthoven**

ABSTRACT: Employment-based health insurance is failing. Costs are out of control. Employers have no effective strategy to deal with this. They must think strategically about fundamental change. This analysis explains how employers' purchasing policies contribute to rising costs and block growth of economical care. Single-source managed care is ineffective, and effective managed care cannot be a single source. Employers should create exchanges through which they can offer employees wide, responsible, individual, multiple choices among health care delivery systems and create serious competition based on value for money. Recently introduced technology can assist this process.

EMPLOYMENT-BASED HEALTH INSURANCE is failing. Costs are once again rising out of control. This will drive up the number of uninsured people. Employers still have no effective strategy to deal with this. Business leaders must understand how their past purchasing policies have contributed to the problem and must think strategically about fundamental changes.

This analysis reviews the causes of the recent acceleration in health care spending. I review employers' purchasing policies and explain how they have contributed to rising costs and blocked the growth of economical care. Finally, I describe how and why employers should instead create exchanges through which employees could make responsible choices among carriers and delivery systems.

Today's Health Care Environment

■ **Continued resistance to managed care.** Employers' efforts to control costs through the use of "managed care" were temporarily successful in the 1990s. For a few years they brought the growth of health spending into line with U.S. gross domestic product (GDP), mainly by squeezing provider payments and shortening hospital stays, strategies that have been played out. They did not bring about a funda-

Alain Enthoven is the Marriner S. Eccles Professor of Public and Private Management, Emeritus, at the Stanford University Graduate School of Business in Stanford, California. He is the author of numerous works on managed competition, published in Health Affairs and elsewhere.

mental reform in the way health care is organized and delivered.

Managed care has broken down under an onslaught from lawyers, politicians, consumers, and doctors. Now, in 2003, we are back to health care inflation with a vengeance: annual premium increases of 15–20 percent and in some cases more. Mercer reported a 14.7 percent average premium increase for employers of ten or more in 2002 and projects a 14 percent increase for 2003.¹

Health care providers have become demoralized. The market shows evidence that the consumer backlash against managed care still exists. Health maintenance organizations (HMOs) are under attack as consumers resent and resist any attempt to limit their care, while doctors and hospitals resent and resist any attempt to limit their use of resources.

There are two types of HMOs existing today. “Carrier HMOs” are insurance companies that offer a comprehensive benefit package, characteristic of HMOs, but deliver the services by contracting with independent doctors or medical groups whose main mode of payment remains fee-for-service (FFS). This is in contradistinction to “delivery system HMOs” that are based on their own dedicated medical groups and working mainly under per capita prepayment. The latter are a much more powerful lever for reshaping health care.

Carrier HMOs tried to manage care but failed. Physicians did not accept their legitimacy. Their comprehensive benefit packages took away any financial restraint on consumers’ demands. By continuing to pay FFS, they perpetuated rewards for doctors to do more. When the carriers alone tried to restrain costs, against the desires of doctors and patients, it was an unequal contest. Any successful cost containment strategy must give doctors and patients good personal reasons to limit spending.

■ **Rising costs.** Today’s cost inflation is the product of several interacting factors in addition to the breakdown of managed care. Most notable is the diffusion of costly, but often valuable, technologies. Victor Fuchs and others have documented the rapid growth in the age-specific consumption of costly procedures such as joint replacements and invasive cardiology.² New breakthrough drugs are adding considerably to the length and quality of life for many people, but they are costly. The litigation culture also adds to the costs of care.³ Huge punitive damage awards against Health Net and Aetna, for example, have led the carrier HMOs to abandon any serious attempt to limit care, even unnecessary care. Providers in many areas are forming cartels to enhance their bargaining power, and active antitrust enforcement is needed. Serious incentives to find good, but less costly, ways of meeting patients’ medical needs are the rare exception.

The U.S. health care system remains oriented toward treatment of acute episodes rather than toward chronic disease management, despite the fact that some 60–75 percent of health expenditures are associated with people with chronic conditions.⁴ In the long run, chronic disease management could avoid significant costs.⁵ There remain very wide variations in medical practice, which suggests

much overuse and underuse. The medical profession has not yet organized itself to translate scientific knowledge into best-practice guidelines and implement them.⁶ Underuse can add to costs in the long run. Finally, costly problems of poor quality are rampant in our health care system, and there is a “chasm” between what our quality is and what it could reasonably be expected to be.⁷

■ **Return to the problems of FFS.** As employers and employees rush away from HMOs and back to free-choice FFS plans, they are bringing back the same problems of the FFS system that led them to flee it. In that old model, providers were not responsible for quality or the total per person cost of care. They did not have systems to improve quality. If the patients suffered complications or if their problems were not resolved by the treatments provided, that usually meant more revenue for providers. The financial and legal environments provided powerful incentives to resolve all doubts in favor of providing more services, despite the fact that more medical care may be unnecessary and even bad for the patient’s health.

■ **Employers in disarray.** Worse yet, employers have no strategy to deal with today’s explosion in expenditures. The popular “consumer-driven” or “defined-contribution” models are no more than a cover for high deductibles, intended to make consumers cost-conscious shoppers. They offer no real solution, because health expenses are concentrated among high-cost patients whose personal expenses exceed deductibles. In 1998, of the U.S. population with employment-based insurance, the 22 percent who spent \$2,000 or more on health care accounted for 77 percent of all that population’s health spending.⁸ For many people, a high deductible provides little or no incentive to be cost-conscious consumers of medical care because a high-cost episode or a chronic illness will quickly absorb their deductible, at which point their additional cost of more care that year would be at or near zero.

An effective strategy for cost containment must find ways of reducing the costs of care for the highest-cost cases and, through disease management and prevention, reduce people’s likelihood of becoming high-cost cases. The main effect of the high-deductibles strategy will be to shift costs to the chronically ill, a policy many will consider unfair.

The U.S. Employer-Based System: A Barrier To Effective Managed Care

Why don’t we have a rational, modernized, efficient delivery system in which quality improvement is the way of life, a system focused on consumers’ needs and economical practice? One key reason is that doctors are very resistant to change in the ways they organize and manage care. They see the traditional model, and the way they practice within it, as being in everybody’s best interest, and they have fought tenaciously to preserve it. The other main reason—one that employers could do something about—is to be found in employer-created market conditions. For the most part, employers’ purchasing policies do not reward economical health care; they punish it.

Few people realize how unfavorable market conditions are for the starting and growth of any selective health care delivery system that wants to market cost-effectiveness. Private-sector employers' purchasing policy can be characterized by three main themes: first, a preference for a single source of health insurance; second, effectively subsidizing the most costly carriers by paying most or all of the premium of whatever plan the employee chooses; and, third, self-funding.

Each of these policies has a rational basis when judged in its historical context. But each is antithetical to the development of economical delivery systems. Each denies effectively managed care an opportunity to enter the market, to market its superior efficiency, or to create provider incentives to improve efficiency.

■ **Single-source policy.** In 1997 only 23 percent of insured workers were offered a choice of carriers.⁹ Two key reasons are (1) the effort and inconvenience of offering two or more choices and (2) carriers' resistance to competing within a group because of administrative costs and fear of adverse selection. Both are real issues. Carriers price a group based on predicted enrollment versus actual enrollment. This dynamic leads to risk selection rather than risk management as a goal, and to higher premiums. However, new software solutions are now being marketed that can adjust premium payments for the various population characteristics enrolled by the various carriers as well as automating the enrollment and payment processes, thus addressing both concerns.¹⁰

What's wrong with not offering a choice of carriers? For one thing, competition for the individual employee is more effective than competition at the whole-group level because it is easier for an individual to change carriers in a well-organized, multiple-choice model than for the whole group to change.

The single-source policy fails to take advantage of the existence of effective managed care. It means that "one size fits all." In the single-source environment, typically the employee can use the most or least costly providers for much the same personal cost. The employer's total cost is thus tied to that of the most costly providers. This model denies choice to those people who would prefer less costly care if they could keep the savings. Multiple plan designs offered by the same carrier might help some with employee satisfaction, but they do not provide the competition among delivery systems that motivates improvement.

In the 1990s many employers signed up with various types of carrier HMOs as a single source and then found that the providers their employees wanted were not always in the network. So they demanded wider and wider networks that would cover all areas where their employees lived and would include all providers their employees wanted to see. Once the providers figured out that they had to be included in these networks, the carriers' bargaining power was destroyed.¹¹

Lack of provider selection. Provider selection is a key to quality and economy. The single-source employers forced the carrier HMOs to include doctors that the latter had reason to consider uneconomical. Moreover, wide networks are inherently ineffective because they are not cohesive provider organizations, and care delivery

improvement requires teamwork.

Employers set up HMOs to fail. One-fifth of insured workers had an HMO as their single source.¹² Research supports the finding that this was one of the two main causes of the anti-managed care backlash.¹³ (The other was the determined opposition of physicians who didn't want to be there.) People without choice were far more likely to be dissatisfied than were people with choice.

When employers that felt they had to back off from the old FFS system moved to HMOs, they positioned the HMOs as the agents of their “takeaway.” For consumers accustomed to free-choice FFS care, every economizing act by an HMO was an insult. It would have been far wiser if employers had said to their employees: “We can no longer afford free-choice fee-for-service; we can only afford a low-cost managed care plan. We will pay that amount and give you the choice.” In that case, employees who chose managed care would have had a personal reason to accept the economizing behavior.

Why “effective managed care” can't be a single source. What is “effective managed care?” And why can't it be a single source of coverage for a group? While there are a few exceptions, efficient delivery systems generally have the following characteristics. First, they are based on a cohesive group of physicians and other health professionals working under common management and committed to a common goal. Physicians are there by choice: They see the system as meeting their professional goals. Second, efficient delivery systems integrate financing and delivery. The system usually works within prospective per capita payment so that it can benefit from improvements in efficiency and in the health of its members. It can allocate a part of the capitation to paying for chronic disease management infrastructure.

Third, efficient systems can plan resources to match the needs of their enrolled populations. They integrate the full spectrum of care so that they can plan and deliver care in the least costly appropriate setting. Providers share in the risk of the cost of care. They keep comprehensive records that provide more complete histories and that can serve as the basis for evaluation of practice patterns. And patients are usually there by choice. Fourth, effective managed care organizations select their physicians for quality, economy, and willingness to work in teams. They use teamwork for continuous process improvement. They use technology assessment to create evidence-based guidelines and seek to implement them in ways that assure that doctors are using new technology appropriately.

A good example of an efficient delivery system was Group Health Cooperative, found by RAND to use 28 percent fewer resources per capita than the traditional sector in Seattle.¹⁴ I say “was” because their cost advantage today is much less clear. Group Health yielded to employers' demands for a single source and recruited a network of solo practitioners to offer wide choice of doctors to qualify as a single source. Their 28 percent cost advantage was based on multispecialty group practice. Networks of solo doctors are inherently less efficient.

The efficient group practice model cannot and should not be a single source of

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health insurance. People, reasonably and understandably, want to choose their own doctor, so in a model in which health insurance is linked to specific doctors, they must be able to choose their health insurer. Many people will want to stay with their familiar doctor, and they should be given responsible choices that permit that. It is hard to create a good doctor-patient relationship with an unwilling patient.

■ **Role of the premium contribution.** Employers that offer a choice of carriers typically pay nearly the entire premium of the plan the employee chooses. Or they charge the employee the same low amount, regardless of which carrier the employee chooses. These employees have little or no incentive to choose a low-price carrier. Of those employees offered a choice of carriers in 1997, about 25 percent received a fixed-dollar contribution from the employer, letting them keep the savings from an economical choice. Only about 6 percent of the insured workforce had a choice of carriers and reaped the full economic reward for choosing economically.¹⁵ Even among the Fortune 500, only 9.6 percent of employers offer such a cost-conscious choice.¹⁶ Why?

First, many employers got into the habit of paying the entire premium or a high percentage because employer-paid health insurance premiums were tax-free to the employee without limit. Before the enactment of Section 125 of the Internal Revenue Code, the employee's premium payment came from after-tax income. Now it can be tax sheltered. Second, some union leaders—even if they know that employer-paid health benefits ultimately come out of wages—have seen how highly health benefits are valued by their members, so they bargain to enrich them. (However, many public-sector employee unions have accepted multiple-choice, fixed-dollar-contribution models.) Union leaders must be convinced that they and employers have a shared interest in controlling health costs and that they should join forces in establishing policies that reward economical choices.

To offer a simple but all-too-common example, an employer offers employees a choice between a preferred provider organization (PPO) with a monthly premium of \$200 and an effective HMO with a premium of \$150, and it pays 80 percent of the premium of the plan of the employee's choice. That means that this employer subsidizes the high-cost versus the low-cost plan, usually FFS versus capitation, at the rate of \$40 per employee per month. This punishes the economical delivery system and reduces price elasticity of demand. Inelastic demand means a loss of revenue for cutting price—an incentive to raise, not lower, price.

Once an employer is in the pattern of paying all or a high flat percentage of the premium, it is difficult to change to a fixed-dollar employer contribution set at or below the price of the low-price carrier. There is a “giveaway-takeaway” dilemma.

If the employer sets the contribution at the price of the low-price carrier, those employees who were being subsidized in higher-cost carriers suffer a “takeaway.” If it contributes the full price of the high-price carrier but lets those who choose the low-price carrier keep the savings, it suffers the cost of a “giveaway” it was not paying under the previous policy. An intermediate contribution can produce a combination of “giveaway” and “takeaway.” Stanford University adopted a fixed-dollar contribution set below the low-price plan, suffered a temporary anti-Stanford (but not anti-managed care) backlash, and resolved the problem by a creative use of a flexible benefits plan. But there is a short-term cost in dollars and good will.

■ **Self-funding.** Employers prefer self-funding or self-insurance to buying insurance, for several reasons. It gives them control over their cash flow and, when interest rates are high, can yield a substantial investment return. Under the provisions of the Employee Retirement Income Security Act (ERISA) of 1974, self-funding employers are exempt from costly state benefit mandates and pay no state taxes on insurance premiums. Also under ERISA, employers’ liability from employee lawsuits is much more limited than the liability of insurance companies and HMOs.

However, self-funding usually (although not always) means FFS payment, with its cost-increasing incentives and penalties for improving efficiency and reducing cost. (The Buyers Health Care Action Group, or BHCAG, in Minnesota’s Twin Cities is one notable exception.) PPOs can extract reductions in fees, but they do not reward providers for the more crucial job of finding less costly ways to care for patients. To motivate continuing improvement, delivery systems must be rewarded rather than punished for reducing the cost of care.

Managed Competition As An Alternative To Current Employer Policies

“Managed competition” is an alternative to these employer policies.¹⁷ The idea is for the employer to increase competition by offering employees a wide choice of carriers and plan designs, a responsible choice (employees are fully responsible for premium differences), individual choice, informed choice, and multiple choices of delivery systems. If a critical mass of employers were to do this in a market, they could create conditions in which efficient delivery systems could enter, market their superior value for money, and achieve economies of scale.¹⁸ In managed competition, insurers need to be linked with specific, geographically overlapping delivery systems. (Six carrier HMOs, each offering practically every provider in town, would not be “competition” in this sense. The point is competition among delivery systems, not just carriers.)

The full recipe is a little more complicated than this. Plan designs need to be standardized, or at least managed, so that they are not a tool for selecting risks or creating inelastic demand. Also, premium payments to carriers need to reflect the demographic risk and health status of the people that actually enroll in a particu-

lar plan. However, price tags need to be adjusted so that the price differences paid by employees reflect the relative efficiency of the delivery systems.

■ **Examples.** Many employers, undaunted by administrative costs and other barriers, practice managed competition (or a tolerably good approximation). The largest and best known is the Federal Employees Health Benefits Program (FEHBP), which covers more than eight million employees, retirees, and dependents, through which 131 carriers are marketed.¹⁹ Another is the California Public Employees Retirement System (CalPERS), which covers 1.3 million people—the employees, retirees, and dependents of more than 2,500 different public-sector employers through eight health plans.²⁰ Both have been in successful operation since 1960. Neither program practices risk adjustment of premiums or a pure fixed-dollar contribution, but they could and ought to. Similar programs for state employees are in operation in Oregon, Washington, Minnesota, Wisconsin, and Massachusetts. Some private-sector employers, such as Wells Fargo and American Management Systems, practice managed competition, as do some universities, including Stanford, Harvard, and the University of California.

Multi-employer arrangements of this type are known as “exchanges,” institutions where numerous employers and their employees can meet with numerous carriers and offer choices. California Choice is one example of a broker-sponsored exchange.²¹ A new exchange model sponsored by health plans, known as BENU, is available in Washington State.²² In this innovative model, the employees are offered a choice of three Group Health Cooperative plans and three CIGNA Health plans; premiums are risk-adjusted after enrollment so that each carrier is paid for the risk actually enrolled; and the rest of the administration is performed by BENU so that the employer has the simplicity of a single source. Some states, such as California and Florida, have sponsored multiple-choice exchange models for small employers.

■ **Diagnosis-based risk adjustment.** The technology of diagnosis-based risk adjustment in a convenient form is new. Medicare is adopting it for Medicare+Choice, and this will make it the standard for all carriers to meet. Employers that have adopted the other principles of managed competition have not used this technology before because it was not available, because individual employers lack economies of scale to do this efficiently, because adverse selection has been less severe in practice than in theory, and because they could use other less costly but less satisfactory solutions.

Although a single-source carrier creates problems, as described above, theoretically a single carrier could offer a suite of different delivery systems. As far as I know, this has happened only in one case, BHCAG. This model implements the principles of managed competition, but it has not spread even to most of the Twin Cities’ workforce, whereas millions of people spread over many states are in multicarrier managed competition.

■ **Single carrier, multiple delivery systems.** The model of a single carrier and

multiple delivery systems has not proliferated because effective delivery systems want to be able to market their own services and not be dependent on carriers with separate interests to do their marketing for them. They cannot be confident that their cost reductions will be translated dollar for dollar into lower prices for their patients and greater market share, or into greater net incomes to finance expansion. Medical groups in such arrangements find their cost reductions translated into greater profits for carriers or employers, so they are not motivated to make them.

A medical group that deals with fifteen different carriers (the California average) must deal with fifteen different drug formularies (none of which is of its own making), fifteen different coverage policies for services and technologies, and fifteen different attempts at clinical policies, all with organizations that are adversaries, not partners. The resulting ineffectiveness is too high a price to pay for outsourcing the management of risk selection.

Moreover, there is a collective action problem. One or a few employers acting alone cannot be expected to transform the whole health care delivery system, even in small locales. Those that have done managed competition have realized some important benefits. But if the great majority of employees are covered under the typical employer model, efficient selective delivery systems will not be able to achieve critical mass. Institutions have not existed to broker multiple choice efficiently. And many employers have not seen many cost-effective delivery systems to offer. Of course, there is a chicken-and-egg problem here: There won't be many cost-effective delivery systems if employers do not create the market conditions that support them.

■ **Benefits of managed competition.** The managed competition model, implemented communitywide, creates an environment that welcomes cost-reducing innovation. It opens the market to selective networks. It creates price-elastic demand and effective market forces. It maximizes consumer satisfaction by offering a range of choices to suit different preferences. It removes a major cause of the backlash against managed care: Nobody is in an HMO involuntarily. The customer is the employee, not the employer, so the carriers will be more motivated to improve customer service than they are under any single-source model. The model gives consumers a reason to choose and accept cost containment.

Use Of New Technology To Facilitate Exchanges

Managed competition exists mainly among government employers and universities because they have large enough concentrations of workers to make it practical. Most other employers need to cooperate through exchanges, as described above. A neutral exchange is needed, one that health insurance plans and providers can recognize as providing a "level playing field." The exchange sets the business rules such as the risk-adjustment formula, the common standards that coverage contracts must meet, and rules about payment. The exchange manages the presentation of choices to employees and enrollment and payment transactions; it

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consolidates billing and reconciliation of payments. All of this can now be done electronically. For long-term success and appropriate incentives, an exchange must offer risk-adjusted premium payments. There are models to do this now.²³ A major barrier to the formation of voluntary exchanges has been employers’ unwillingness to join arrangements in which they may have to pay the costs of other employers. The exchange does not need to pool the risks of different employers. It can bill each employer for the overall risks of its employee population and pay each carrier for the member-level risks it has actually enrolled.

A key role for the exchange is to mitigate adverse selection so that competition is focused on improving the delivery system, not on selecting risks. Although simpler methods have sufficed, this should be done by diagnosis-based risk adjustment of premiums and, possibly, pooling of risks for very costly cases. Without such adjustment, it would not be in a delivery system’s interest to earn a reputation for excellence in the care of chronic conditions.

Need For Business Leadership To Improve The Health System

The employer-based system has numerous other deficiencies as a foundation for health insurance in this country. It leaves out people with no employment group and people whose employers do not provide health insurance. It leaves out the self-employed and the nonemployed nonpoor. The market for individual insurance is extremely vulnerable to risk segmentation, adverse selection, and high administrative costs. There is “job lock,” people unwilling or unable to migrate to a better job because of unavailability of health insurance. Worse yet, in a model that combines employment-based eligibility with effective managed care, people are often forced to change doctors when they change jobs because the new employer does not offer their previous carrier. People lose their health insurance when they lose their job or their continuation coverage runs out, arguably when they need it most. Large-scale regional exchanges could help mitigate some of these problems.

■ **Specific roles for employers.** I have discussed these issues with hundreds of benefit managers. Every employer has its own history and its own health benefits issues. Health benefits are a part of a complex package of total compensation whose parts are interrelated and are often negotiated. Employers understandably see health benefits primarily as a tool in the labor market, not an instrument of health policy. I am convinced that employers will never change in sufficient numbers without very strong business leadership and support from public policy. What form might this support take?

Large employers in several market areas could join together to create their own exchanges and demonstrate the advantages. After the start-up phase, this could

yield economies of scale in administration. Instead of each doing a marginal job of managing health benefits, they could pool resources into one exchange that could do an excellent job. It would then be in their interest to expand the membership to more and more employers, to enlarge the competitive market.

Each employer would have to agree to undergo the costs of the transition to fixed-dollar contributions. Each employer would have to sacrifice having its own distinctive design. Then the exchange could reach out to actual or potential effective delivery systems such as multispecialty group practices. (In the United States there are more than 980 such practices with twenty-five or more doctors. Many of them would form a promising base for effective delivery systems.) At a minimum, they could direct some carriers to develop truly selective networks. Midsize employers might seek out or demand exchanges from their brokers. Government might subsidize the costs of people who lack access through exchanges. States should start and, this time, adequately fund small-employer exchanges like the Health Insurance Plan of California. States or the federal government would have to take into account that the start-up costs for such an exchange are substantial, mainly for educating employers.

■ **Role of government.** Business leaders should advocate policies that support this transformation. Congress could enact strong incentives for employers to create and join multiemployer, multicarrier exchanges, such as making the tax exclusion for employer-paid health benefits conditional on participation in such an exchange. Congress could grant an ERISA-like exemption from state benefit mandates to risk-bearing insurance plans offered through federally qualified exchanges, and it could offer temporary tax credits to first movers to motivate change. Congress could create a regulatory body to be sure that exchanges actually promote competition and expand the competitive market.

■ **Limited employer contribution.** It also would be desirable to limit the amount of the employer premium contribution that would be tax-free to the employee, to enhance cost-conscious choice at the margin. (These limits could be adjusted for variations in regional costs.) Savings could be applied to subsidizing access for low-income people. If this is not politically feasible, Congress might at least require that tax-exempt contributions be in level, fixed-dollar amounts.

Expanding The Numbers Of Insured Americans

Regional exchanges could serve as a base for extending the number of people with health insurance. For example, they could administer COBRA continuity. There is now bipartisan interest in tax credit proposals to subsidize health insurance purchases for the low-income uninsured.²⁴ One problem with such proposals is that they leave the market without a source of guaranteed-issue health insurance for recipients. Large regional exchanges could serve as such a source.

People who are not part of any group could get the benefits of group purchases. These steps might be combined with an individual mandate or free-rider tax on

people who have the means but do not choose to buy insurance.²⁵ Such a tax would not be acceptable unless people had assured access to a guaranteed-issue source of reasonably priced health insurance.

If these policies were successful, the savings in administrative costs could be large, as this would permit a drastic simplification of the entire health insurance process. People would not have to change insurance plans when they changed jobs. Providers would know that the great majority of their patients were covered and could pay. Personal medical bankruptcies would be reduced.

The transition to efficient, effective delivery systems would not be quick or easy. It would take decades to complete. The whole orientation of the medical profession would eventually have to change. But what I am proposing would be voluntary for both doctors and patients. Nobody would be forced into an HMO. Substantial progress toward this goal could come reasonably soon because there is so much waste in the system now and because there exist successful models of delivery systems and exchanges on which to build.

EMPLOYERS ARE NOW TRAPPED by the health care cost spiral. Health care cost increases will soon absorb all of the affordable annual increases in total compensation, if they haven't already. Employers need a way of distancing themselves from health care without irresponsibly abandoning their employees. A system of exchanges, multiple choice at the employee level, and fixed-dollar contributions keyed toward the least inflationary part of the health care system could accomplish this goal.

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NOTES

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18. By "critical mass," I mean enough that each of several competitors could grow to a point at which they achieved economies of scale. This might be on the order of one million people in a metropolitan area.
19. Office of Personnel Management, "Federal Employees Health Benefits Program," www.opm.gov/insure/health, and "Links to Plan Brochures for 2003," www.opm.gov/insure/03/html/blinks.asp (21 May 2003). The FEHBP needs a "tune-up," including diagnosis-based risk adjustment, a true fixed-dollar employer contribution, regional pricing, and minimum standard for benefit packages.
20. California Public Employees Retirement System, "Monthly Enrollment Summary," 1 April 2003, www.calpers.ca.gov/health/program/enrollbyplan.htm (30 April 2003). CalPERS also needs a "tune-up," including diagnosis-based risk adjustment, a true fixed-dollar employer contribution for all participants, regional pricing, and RACS/RAPPS (see Note 23 below).
21. California Choice offers a choice of six carriers and nine plan designs. See the California Choice Web site, www.calchoice.com/default.asp.
22. For general information, visit the BENU Web site, www.benu.com.
23. A leading provider of software for such transactions, eBenX (www.ebenx.com), has a model called Risk Adjusted Contribution System/Risk Adjusted Premium Payment System (RACS/RAPPS) in which each employer pays the expected costs of its own employees and each carrier is paid for the risks it actually enrolls. Risk-adjustment software is provided by DxCG (www.dxcg.com), the supplier to Medicare for management of its HMOs.
24. R. Cunningham, "Joint Custody: Bipartisan Interest Expands Scope of Tax-Credit Proposals," 18 September 2002, www.healthaffairs.org/WebExclusives/Cunningham_Web_Excl_091802 (30 April 2003).
25. About twelve million uninsured Americans are in households with incomes above \$50,000. See U.S. Census Bureau, *Health Insurance Coverage: 2001* (Washington: U.S. Department of Commerce, September 2002). See also J. Breaux, "The Breaux Plan: A Radically Centrist Approach to a New Health Care System," www.healthaffairs.org/WebExclusives/Breaux_Web_Excl_030503.htm (13 May 2003).