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## ESSAY

# HEALTH CARE MARKET REFORM: A CORPORATE EMPLOYER'S PERSPECTIVE

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### INTRODUCTION

Since World War II, major U.S. employers have offered health care benefits to their employees.<sup>1</sup> Many employers provide these benefits voluntarily; others negotiate packages with their unions. But what started as a fringe benefit encouraged by government tax incentives<sup>2</sup> has become expected as an entitlement tied to employment. The role of the modern American corporation has been gradually transformed from benevolent provider of insurance to provider of insurance as a required component of employment compensation.

One of the primary issues of the 1992 presidential election was health care reform,<sup>3</sup> and President Clinton campaigned for universal coverage to provide health care for the approximately

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1. See *infra* notes 12-13 and accompanying text.

2. See *infra* notes 19-22 and accompanying text.

3. A poll conducted by the Employee Benefit Research Institute and The Gallup Organization, Inc., asked Americans what issue should be President Clinton's first priority in office. Thirty-seven percent of Americans responded that Clinton should focus on improving the economy, 24% said reducing the federal deficit, and 15% said reforming the health care system. When asked what should be the second priority, 25% indicated reforming the health care system, 24% said improving the economy, and 20% said reducing the budget deficit. Carolyn Piucci, *Public Attitudes on Health Care Reform Results of New EBRI/Gallup Survey*, 14:4 NOTES 6 (Employee Benefit Research Institute ed., Apr. 1993).

thirty-seven million uninsured Americans.<sup>4</sup> He has succeeded in making health care one of the preeminent issues that our society must address over the next several years. However, President Clinton is not alone in his intent to reform the health care system. Multiple health care reform bills are now pending before Congress.<sup>5</sup> Many of these bills propose an employer mandate, requiring all employers to pay for a comprehensive package of health care benefits for their employees. An employer mandate would make these benefits a cost of doing business without regard to whether the employer or the employee believed them to be an essential part of the employment contract.

The initial impact of an employer mandate on large employers who already offer comprehensive health care benefits would likely be negligible, although a few adjustments to coverage would have to be made. On the other hand, the massive restructuring of health care in the private market sector will produce

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4. Emily Friedman, *The Uninsured: From Dilemma to Crisis*, 265 JAMA 2491, 2491 (1991) (citing estimate of 31-36 million uninsured Americans); GAO *Says Universal Access to Health Insurance "Achievable Goal"*, 93 TAX NOTES TODAY 12-70 (Jan. 19, 1993) (estimating 34 million Americans without health insurance); Katharine R. Levit et al., *Americans' Health Insurance Coverage, 1980-91*, 14:1 HEALTH CARE FIN. REV. 31, 33 (1992) (estimating 34.7 million uninsured Americans in 1991, or 14.4% of the U.S. population).

5. See, e.g., the Clinton health plan, H.R. 3600 & S. 1757, 103d Cong., 1st Sess. (1993) [hereinafter Clinton Plan]; the Chafee/Thomas bill, H.R. 3704 & S. 1770, 103d Cong., 1st Sess. (1993) (requiring employers with less than 100 employees to participate in a purchasing cooperative, mandating individuals to have health insurance with a penalty for non-compliance, and eliminating pre-existing condition exclusions); the Cooper/Breaux bill, H.R. 3222 & S. 1579, 103d Cong., 1st Sess. (1993) (promoting a managed competition-type plan by encouraging the formation of health plan purchasing cooperatives to negotiate health plans for coverage on behalf of employers with fewer than 100 employees, establishing a basic benefits package, limiting the deductibility of health plans to the least expensive cost of the package, and encouraging the formation of accountable health plans); the Michel/Lott bill, H.R. 3080 & S. 1533, 103d Cong., 1st Sess. (1993) (implementing small group insurance reforms, expanding the Medicare program, and providing individuals with tax incentives to save for medical expenses through "medical IRAs"); the McDermott/Wellstone bill, H.R. 1200 & S. 491, 103d Cong., 1st Sess. (1993) (establishing a single-payer, Canadian-style government system of health care, replacing Medicare, Medicaid, and most private health insurance with a government-run system administered at the state level, and establishing a national health board to set a national health budget based on annual health costs); the Stark bill, H.R. 200, 103d Cong., 1st Sess. (1993) (establishing annual budgets based on prior year national health expenditures, rates for all personal health services, national standards for health insurance plans, a new federal program to provide health insurance to all children under age 19, and expanded benefits under Medicare and Medicaid); the Nickels/Stearns bill, H.R. 3698 & S. 1743, 103d Cong., 1st Sess. (1993) (establishing medical savings accounts).

an unknown impact on health care cost. And while government participation in the system has its proper applications, many of the proposed interventions are improper. Adoption of any proposal that requires significant restructuring coupled with extensive governmental regulation will create severe market distortions affecting both business and health care environments indefinitely.

It is generally agreed that the health care delivery system in the United States has become somewhat bloated and inefficient. While U.S. consumers have access to the highest quality care in the world, it is also the most expensive. Many parties are to blame. First, federal tax policy promotes generous tax-free medical benefits for employees, the cost of which is tax-deductible to employers.<sup>6</sup> Second, insurance companies generally act as a conduit for funds rather than being concerned with efficiency and quality; when corporate employers self-insure but use insurance companies as claims-processing intermediaries, the insurance company has little interest in managing health care costs.<sup>7</sup> Third, employers have paid for tax-favored coverage without attempting to apply good business principles to reducing insurance costs with the same vigor applied to other cost centers. Fourth, health care providers, and particularly individual physicians, have not focused on health care value. Quality of care has been important to health care providers, but not cost. Under typical fee-for-service arrangements, physicians can determine what services to provide and how much to charge, and thus greatly influence both demand *and* supply of services. These market distortions lead to higher medical costs. Finally, consumers assume that the medical system can cure anything that goes wrong, and fail to recognize their own basic responsibility for their health.

While they have approached a solution to the problems with varying degrees of fervor, each of these five parties recognize that the American health care system must change. Alliances, insurance purchasing cooperatives, and networks are forming to provide leverage to obtain the best value. Insurance companies are forming capitated network arrangements<sup>8</sup> that promote cost

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6. See *infra* notes 19-22 and accompanying text.

7. The incentives for insurance companies to reduce health care costs deteriorate further if the corporate employer pays the insurance company for claims-processing services based on dollar volume of claims processed. Under this common arrangement, it is in the insurance company's best interest for health care costs to escalate.

8. Under capitated network arrangements, insurers pay providers a flat dollar reimbursement per covered employee, regardless of whether services are rendered. This provides an incentive for the provider to better manage health care costs.

saving through managed care. Health care providers are discovering ways to achieve higher quality in partnership with active purchasers. The health care "balloon" is being squeezed from all sides and will have to contract due to heightened competition.

Other countries have reformed their health care systems,<sup>9</sup> but the United States has the chance to be uniquely creative and successful through the use of currently available and pending technology. A great deal of positive reform will be accomplished because of the information that is available through computer-generated data collected by doctors, hospitals, and employers. With better data, doctors will know which hospitals provide the best value and how to adjust their practice to achieve the proper balance between quality and cost. The entire delivery system will begin to take greater advantage of communications through data technology. For example, "best practice" parameters will become increasingly available and aberrations in practice will be subject to peer review on a current time basis.

The result of these advances is that the market will be better able to reward high value medical practice and penalize practices that produce low value. With more information available, purchaser and provider groups will independently continue to establish optimum methods for efficiently selling and buying health care. As the system becomes more integrated, opportunities to carve out pieces of the market will erode. The market may need assistance from government in this process, but the market can and should be allowed to solve the problems. The role of government should be to encourage the market-driven process that already exists.

This Essay considers the response of corporate employers<sup>10</sup> to issues involving the provision of health care benefits to employees, retirees, and dependents in the context of impending reform. Part I discusses the business of health care. Part II describes current practices in corporate employer health care coverage. Part III analyzes three of the health care proposals and their potential impact on business. Part IV discusses the proper role for government in health care reform. The Essay concludes that the basic thrust of health care reform should bring the principles of open economic competition to all levels of the system. The same economic process that makes the United States the most

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9. See generally Leo van der Reis, *Health Care Reform: In Perspective, In Reality*, *infra* this volume, at part II.

10. As used in this Essay, "corporate" employers refers to those companies with more than 100 employees. Many of the proposed reforms, including the Clinton Plan, have special provisions for companies with less than 75 employees. The potential impact on these smaller employers is outside the scope of this Essay.

powerful economy in the world should be employed to make our health care system the world's most efficient and effective.

### I. THE BUSINESS OF HEALTH CARE

Americans may not appreciate the fact that medical care is delivered in a highly competitive economic market place. One-seventh of our economy is related to health care.<sup>11</sup> Like other businesses, most doctors, hospitals, and insurance companies are in business to make a living and earn a profit. All of these entities are in the system to provide a product or service and they expect a financial return. Many do it with a sense of social consciousness. Nevertheless, they are all part of the business of health care, and it is naive to believe that health care is provided by only benevolent care givers.

Like any business, the health care industry must be able to react nimbly to a rapidly changing market place. Technology is progressing at an explosive pace. Data collection and usage is becoming an integral part of all aspects of health care management, and even doctors are finding themselves being pulled into the computer age. Purchaser coalitions and provider alliances are being formed to take advantage of technological advances and to position themselves properly in the market.

The turbulent health care system is responding everywhere to the need for expanded efficiency. It can and will respond and change. This is because the purchasers of health care are beginning to require a better, higher-value product; one that fulfills new needs as they arise. The competitive process is not neat and tidy; some experiments fail. But the new tactics being used by individual businesses, alliances of providers, and coalitions of purchasers are often responsive and innovative. Many bright minds are seeking solutions and will find them.

The government's self-perceived activist role in reform can jeopardize the market's ability to respond to new and better technology, ideas, and designs, and to correct itself when mistakes are made. Business hopes that government will recognize its legitimate role to provide resources for universal coverage, education, and medical research, and to reduce abuse. Government may see its role differently, and attempt to re-engineer the entire health care system. Should this happen, the flexibility and innovation of the private sector will be replaced by a system

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11. In 1991, national health expenditures represented 13.2% of GDP. Suzanne W. Letsch et al., *National Health Expenditures, 1991*, 14:2 HEALTH CARE FIN. REV. 1, 1 (1993). Expenditures are expected to rise to 18.2% of GDP by 2000. Sally T. Burner et al., *National Health Expenditures Projections Through 2030*, 14:1 HEALTH CARE FIN. REV. 1, 2 (1992).

characterized by static programs, massive bureaucracy, and a hampered ability to respond to change.

## II. CORPORATE EMPLOYER HEALTH CARE COVERAGE

### A. *Extent of Coverage*

Most corporate employers offer extensive health care benefits to their employees. Part of the reason is historical. During World War II, Congress passed tax incentives to encourage employers to provide health care benefits.<sup>12</sup> Also, employers circumvented wage freezes by attracting employees through the provision of health care benefits.<sup>13</sup> Since World War II, health care benefits have expanded due to market pressure; employers compete for labor by offering generous benefits, and medical care benefits constitute an important factor in employment decisions. Employers also use benefit programs to retain valued employees and promote loyalty.

Most corporate employers with more than 100 employees provide their employees with some form of health insurance coverage.<sup>14</sup> Typical health care benefits include surgical, doctor visits, and hospital room and board coverage.<sup>15</sup> Health plans may also include coverage for mental and nervous disorders, drug rehabilitation, and pharmaceutical products.<sup>16</sup>

Corporate employers are increasingly offering preventative care and wellness programs.<sup>17</sup> These programs are intended to reduce the demand for health care through education and early intervention. At their best, preventive programs enable employ-

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12. See generally Paul Starr, *Transformation in Defeat: The Changing Objectives of National Health Insurance, 1915-1980*, in COMPULSORY HEALTH INSURANCE 115 (Ronald L. Numbers ed., 1982) (providing historical background of health care reform).

13. U.S. DEP'T OF LABOR, THE TERMINATION REPORT OF THE NATIONAL WAR LABOR BOARD: INDUSTRIAL DISPUTES AND WAGE STABILIZATION IN WARTIME 308-09 & n.3 (1942-45).

14. In a 1993 annual survey of over 1000 major U.S. employers, 100% offered some type of preretirement medical plans. HEWITT ASSOCIATES, SALARIED EMPLOYEE BENEFITS PROVIDED BY MAJOR U.S. EMPLOYERS IN 1993, at 30 (1993) [hereinafter HEWITT SURVEY]. Approximately 82% of the employers offered some type of postretirement medical plan. *Id.* at 52.

15. *Id.* at 34-35.

16. *Id.* at 40-41.

17. For example, 26% of nondurable goods manufacturers that were surveyed provided "well baby" coverage in 1992. WYATT COMPANY, COMPARISON: 1993 STATISTICAL SUPPLEMENT-GROUP BENEFITS 34 (1993). In the 1993 Hewitt Survey, 76% of employers reported some type of initiative to encourage healthy lifestyles. Approximately 74% reported using health risk assessments and screening processes. HEWITT SURVEY, *supra* note 14, at 51.

ees to lead healthier and better lives and cost employers less in health care benefits. Such programs often include smoking cessation, blood pressure and cholesterol screening, weight loss, and mammographies. These programs, without any prompting by the government, have led to improved health status while reducing health care expenses.<sup>18</sup>

### B. Tax Treatment

Congress provides generous tax incentives that allow medical benefits to be given tax-free to employees<sup>19</sup> while being fully

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18. Janet L. Bly et al., *Impact of Worksite Health Promotion on Health Care Costs and Utilization*, 256 JAMA 3235 (1986).

19. Section 213 of the Internal Revenue Code (I.R.C. or the Code) provides:

(a) ALLOWANCE OF DEDUCTION. — There shall be allowed as a deduction the expenses paid during the taxable year, not compensated for by insurance or otherwise, for medical care of the taxpayer, his spouse, or a dependent (as defined in section 152), to the extent that such expenses exceed 7.5 percent of adjusted gross income.

(b) LIMITATION WITH RESPECT TO MEDICINE AND DRUGS — An amount paid during the taxable year for medicine or a drug shall be taken into account under subsection (a) only if such medicine or drug is a prescribed drug or insulin.

I.R.C. § 213. Section 105 of the Code provides in relevant part:

(a) AMOUNTS ATTRIBUTABLE TO EMPLOYER CONTRIBUTIONS. — Except as otherwise provided in this section, amounts received by an employee through accident or health insurance for personal injuries or sickness shall be included in gross income to the extent such amounts (1) are attributable to contributions by the employer which were not includable in the gross income of the employee, or (2) are paid by the employer.

(b) AMOUNTS EXPENDED FOR MEDICAL CARE. — Except in the case of amounts attributable to (and not in excess of) deductions allowed under section 213 (relating to medical, etc., expenses) for any prior taxable year, gross income does not include amounts referred to in subsection (a) if such amounts are paid, directly or indirectly, to the taxpayer to reimburse the taxpayer for expenses incurred by him for the medical care (as defined in section 213(d)) of the taxpayer, his spouse, and his dependents (as defined in section 152). Any child to whom section 152(e) applies shall be treated as a dependent of both parents for purposes of this subsection.

(c) PAYMENTS UNRELATED TO ABSENCE FROM WORK. — Gross income does not include amounts referred to in subsection (a) to the extent such amounts—

(1) constitute payment for the permanent loss or loss of use of a member or function of the body, or the permanent disfigurement, of the taxpayer, his spouse, or a dependent (as defined in section 152), and

(2) are computed with reference to the nature of the injury

deductible to employers as a business expense.<sup>20</sup> Consequently, employers have tended to push as much compensation into this framework as possible. The tax-favored status of health care benefits contribute to their increasing cost. Employers agreed to provide compensation to their employees through the tax-favored medium of health care, and, until recently, failed to monitor closely the value received. Employees came to expect this tax-free benefit from their employers, which, if they bought coverage outside a plan, would be paid with after-tax dollars.<sup>21</sup> In the absence of significant employee co-payments or deductibles that require employees to carefully consider the potential value of the services to be rendered, the federal tax policy promotes the over-consumption of health care services and keeps employees from appreciating the true cost of medical care.<sup>22</sup>

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without regard to the period the employee is absent from work.

(d) [Repealed]

(e) ACCIDENT AND HEALTH PLANS. — For purposes of this section and section 104—

(1) amounts received under an accident or health plan for employees, and

(2) amounts received from a sickness and disability fund for employees maintained under the law of a State or the District of Columbia, shall be treated as amounts received through accident or health insurance.

(f) RULES FOR APPLICATION OF SECTION 213. — For purposes of section 213(a) (relating to medical, dental, etc., expenses) amounts excluded from gross income under subsection (c) or (d) shall not be considered as compensation (by insurance or otherwise) for expenses paid for medical care. . . .

I.R.C. § 105. Section 106 of the Code provides, in its entirety, that “[g]ross income of an employee does not include employer-provided coverage under an accident or health plan.” See also I.R.C. § 125(a); Treas. Reg. § 1.106-1 (1993) (addressing cafeteria plans).

20. I.R.C. § 162(a) (Law. Co-op. 1993); see also Treas. Reg. § 1.162-10(a) (1993).

21. I.R.C. § 213(a). Thus, premium payments and medical expenses paid directly by the individual would be paid with after-tax dollars and would only be deductible to the extent they exceed 7.5% of gross income.

22. One way to limit consumption is to require the employee to make co-payments and to increase deductibles. Most employer plans limit reimbursements to 80% of reasonable and customary charges. For indemnity plans, 67% of employers place an 80% limit on hospital coverage, and 71% of employers place an 80% limit on surgical coverage. HEWITT SURVEY, *supra* note 14, at 34-35. Annual deductibles are required by 16% of HMO plans, 74% of PPO plans, and 97% of indemnity plans. *Id.* at 38.

According to a Rand study, employees who have to pay for part of their coverage use fewer services, and using fewer services does not significantly impact health status. See generally WILLIAM G. MANNING ET AL., HEALTH INSURANCE AND THE DEMAND FOR MEDICAL CARE: EVIDENCE FROM A RANDOMIZED EXPERIMENT (1988).



### C. *Cost Reduction and Quality Enhancement Efforts*

As employee health care benefits expand, so do the costs to the employer. Medical care can easily account for more than ten percent of an employer's payroll when it includes expenditures for retirees.

In recent years, major employers have been successfully pursuing ways to control their health plan costs. Employers use bargaining leverage through networks established by insurance companies or health maintenance organizations (HMOs) to negotiate discounted fee arrangements. Providers are willing to give discounts to large employers or networks in order to boost volume and market share.

The bargaining efforts of employers profoundly affect providers such as hospitals and doctors. If a discount is given to an employer, the provider will attempt to make up the corresponding revenue loss by (1) shifting the cost to other purchasers in the system, (2) lowering costs through increased productivity, and/or (3) increasing the number of services provided.

Discounts given to businesses have rarely been offset by a provider's ability to improve efficiency. Instead, health care providers shift the cost elsewhere, and only the most egregiously inefficient parts of the system are fixed. Those paying higher premiums are typically smaller businesses with weaker bargaining power.

How far can cost-shifting go? Large employers are not the only ones that cause cost-shifting. The federal government creates cost-shifting through Medicare<sup>23</sup> and Medicaid<sup>24</sup> by limiting reimbursements for services provided to the elderly and low-income individuals, forcing providers to charge higher prices to paying consumers and insurers. Small employers also form cooperatives, which lead to additional discounts and more cost-shifting. As more and more purchasers seek volume discounts from providers, there may be no one left to whom the providers can shift and, as a result, the cost-cutting honeymoon that large employers have enjoyed through volume discounts may be coming to an end.

To reduce costs in the future and derive savings other than through cost-shifting, the delivery system must become more efficient. High-value care provided in a timely manner will be

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23. Social Security Amendments of 1965, Pub. L. No. 89-97, tit. I, 79 Stat. 286, 290 (1965) (codified as amended at 42 U.S.C. §§ 1395-1395ccc (1988 & Supp. IV 1992)).

24. Social Security Amendments of 1965, Pub. L. No. 89-97, § 121, 79 Stat. 286, 343 (1965) (codified as amended at 42 U.S.C. §§ 1396-1396u (1988 & Supp. IV 1992)).

expected and required. Along with the changes needed to achieve high value, some form of direct health care rationing will begin to emerge, especially in the case of terminally ill patients.

Perhaps the optimal system would be controlled by primary care doctors who are well paid, responsible for basic patient decisions, and given proper financial incentives to make referral decisions to specialists and hospitals based on value, as determined by factors of cost and quality. If the system makes hospitals and specialists responsible to primary care doctors based on the doctors' perception of cost and quality, the system will be operated by medical people making medical decisions that incorporate value to the patient. Ultimately, hospitals and specialists will be more attentive to how they spend health care resources, or else suffer a competitive disadvantage. Such a system will keep the decisions about care in the medical community and reduce the intervention of non-medical administrators.

### III. PROPOSALS FOR REFORM

#### A. *The Clinton Plan*

The Clinton Plan would impose a joint individual/employer mandate. Individuals would be required to purchase health care coverage either through a regional or a corporate alliance.<sup>25</sup> Employers with more than seventy-five full-time employees would pay eighty percent of the health care premium cost for their employees,<sup>26</sup> and employees would be required to pay the remaining twenty percent.<sup>27</sup>

Under the Clinton Plan, employers with more than 5000 employees, however, may elect to become corporate alliances.<sup>28</sup> As the sponsor of a corporate alliance, the employer must offer its employees a menu of at least three approved health plans.<sup>29</sup>

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25. Clinton Plan, *supra* note 5, § 1002. Medicare-eligible individuals are excluded from the mandate. *Id.*

26. *Id.* § 6121 (for regional alliance employers) and § 6131 (for corporate alliance employers).

27. *Id.* §§ 6101-6103.

28. *Id.* § 1311(b)(1)(A) & (e)(3).

29. *Id.* § 1382. The Clinton Plan would require all insurance plans to provide coverage in accordance with the Comprehensive Benefit Package (CBP). *Id.* § 1101. Proposed § 1101 provides that the "comprehensive benefit package" shall include hospital services, services of health professionals, emergency and ambulatory medical and surgical services, clinical preventive services, mental health and substance abuse services, family planning and pregnancy services, hospice care, home health care, extended care, ambulance services, outpatient laboratory, radiology, diagnostic services, prescription drugs, outpatient rehabilitation services, durable medical equipment and prosthetic and orthotic devices, vision and dental care, health education classes, and investigational treatments. *Id.*

Corporate alliances would negotiate for health care services with the accountable health plans where their employees are located. Employers would have to negotiate for each location, and their employees would not be allowed to purchase coverage through regional alliances. Additionally, corporate alliances would be obliged to offer standard benefits and would have to fulfill burdensome administrative responsibilities.<sup>30</sup>

Except for corporate alliances, premium costs to participate in an accountable health plan would be subject to community rating. Under community rating, the accountable health plan would be required to charge uniform premiums for each individual in a particular community. The only basis for varying premiums would be family status. Corporate alliances, however, will be able to include their own experience as part of their premium determinations.

Employers would continue to deduct all health-related benefit costs. After ten years, costs above the standard benefit package would be taxed to employees.<sup>31</sup> A one percent payroll tax would be applied to corporations that form corporate alliances.<sup>32</sup>

### B. *Other Proposals*

Under the Cooper/Breaux Plan,<sup>33</sup> there would be no employer mandate. However, small employers would be required to enroll in Health Plan Purchasing Cooperatives (HPPCs) and to use HPPCs to contract with health plans.<sup>34</sup> Large employers would be required to offer accountable health plans.<sup>35</sup> Individuals not otherwise eligible for coverage would be permitted to enroll in an HPPC.<sup>36</sup>

The Cooper/Breaux Plan does not specify a standard benefits package, but provides that a package would be determined by the Health Care Standards Commission,<sup>37</sup> which would oversee the health care market.

The employer deduction for health care cost would be capped at the price of the lowest-priced accountable health plan in the local HPPC.<sup>38</sup> Individual premium payments would be deduct-

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30. *Id.* §§ 1386-1388.

31. *Id.* § 7201(a).

32. *Id.* § 7121.

33. H.R. 3222 & S. 1579, 103d Cong., 1st Sess. (1993) [hereinafter Cooper/Breaux Plan].

34. *Id.* § 1005(a).

35. *Id.* § 1005(b).

36. *Id.* § 1104.

37. *Id.* § 1201(1), § 1302(a).

38. Cooper/Breaux Plan, *supra* note 33, § 1001.

ible up to the cost of the lowest-priced accountable health plan.<sup>39</sup> Employer premium payments would still be fully excludable by employees.<sup>40</sup> Like the Clinton Plan's regional alliances, the Cooper/Breaux Plan would require each state to charter at least one HPPC.<sup>41</sup> Only one HPPC would operate in each geographic area.<sup>42</sup>

The McDermott/Wellstone Plan<sup>43</sup> proposes a Canadian-style single-payer system. There would be no employer mandate or purchasing alliances because everyone would be covered<sup>44</sup> through a program operated entirely by the government. An American Health Security Standards Board would be responsible for policies and procedures for the program.<sup>45</sup> Like the Clinton Plan, an extensive list of benefits are included.<sup>46</sup> Employers could, however, provide additional benefits to their employees.<sup>47</sup> Benefits would still be deductible to the employer and excludible from the employee's gross income.

### C. *The Corporate Response*

Employers need to control their own destiny; how they handle benefits given to employees is no exception. Benefits are an important component in developing a positive employer/employee relationship. Legislation that would remove the employer from the equation, other than as a conduit for cost, would impair this mutually beneficial nexus.

A tenet of health care design is that one size does not fit all and if something fits today, it probably will not fit tomorrow. It is essential that plan designs be allowed to change freely as the health system evolves. Static plan design is an impediment to improved efficiency. Further, plan design should be allowed to change at the local level where the health care is actually provided. The idea of having a plan design imposed nationally or even statewide chills innovation and efficiency and should be avoided.

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39. *Id.* § 1003(a).

40. *Id.* § 1001(a) (adding new I.R.C. § 4980C(e)).

41. *Id.* § 1101(b).

42. *Id.*

43. H.R. 1200 & S. 491, 103d Cong., 1st Sess. (1993) [hereinafter McDermott/Wellstone Plan].

44. *Id.* § 102.

45. *Id.* § 401.

46. The benefits would include inpatient and outpatient hospital care, professional services of authorized health care practitioners, community based primary care services, long-term care, home health care, prescription drugs, dental services, mental health and substance abuse treatment. No cost sharing for acute care would be allowed. *Id.* § 201.

47. *Id.* § 201(f).

Both the Clinton Plan and the McDermott/Wellstone Plan would effectively remove the employer from its position as a health care system participant and employee advocate. The availability of "corporate alliances" in the Clinton Plan would appear to give large employers the ability to retain their status as plan sponsors. However, the burdensome requirements placed on corporate alliances make them untenable. The Administration has found to its dismay that few, if any, employers of 5000 or more employees would elect to form their own alliances. This is because the corporate alliances must generally perform all of the functions of a regional alliance, including the communication and administrative work.<sup>48</sup> Also, multi-state employers would not be able to obtain care for employees at outlying locations through existing regional alliances. Rather, the corporate alliances would have to contract directly with providers in the outlying locations as well as fulfill all of the local administrative requirements at that location.

In addition, because the Clinton Plan assumes that employers would only form a corporate alliance if their costs were lower than those of the regional alliance, the Clinton Plan imposes a one percent surtax on an employer's payroll. Finally, with the rich, mandated benefits<sup>49</sup> that are established and required by the Clinton Plan, there is little opportunity to vary design to suit perceived employee needs.

For all of these reasons, corporate alliances under the Clinton Plan are a concession without substance for large employers. The Cooper/Breaux Plan allows for much greater employer involvement because the alliances are not required for employers with 100 or more employees. However, even under the Cooper/Breaux Plan, the requirement to offer plans of a specific benefit level would reduce employers' ability to produce benefits most suited to their individual needs.

In early 1994, several important U.S. business groups, including the Business Roundtable,<sup>50</sup> the U.S. Chamber of Commerce,<sup>51</sup> and the National Association of Manufacturers<sup>52</sup> voiced their opposition to the Clinton Plan. While each of these groups expressed recognition that substantive health care reform is needed, they generally asserted that the Clinton Plan represented

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48. Clinton Plan, *supra* note 5, §§ 1386-1388.

49. *See supra* note 29.

50. Adam Clymer, *Powerful Business Group Backs Rival to President's Health Plan*, N.Y. TIMES, Feb. 3, 1994, at A1.

51. Robert Pear, *Business Groups and Labor Unions Attack Clinton on Health Plan*, N.Y. TIMES, Feb. 4, 1994, at A19.

52. Louis Uchitelle, *Manufacturers Oppose Clinton Plan*, N.Y. TIMES, Feb. 6, 1994, at A26.

excessive government intervention into the health care system. These business groups are clearly reluctant to turn one-seventh of our economy into a highly regulated system run by an extensive new federal and state bureaucracy. Not surprisingly, these groups advocate market-based reform with governmental involvement that extends to implementing a structure for the uninsured and preventing systemic abuse.

Some corporate employers with extensive retiree medical liabilities generally favor portions of the health care reforms that will eliminate their obligation to provide retiree medical benefits. This position comes from their interest in leveling the playing field. Not all corporate employers, and very few small employers, provide retiree medical benefits.<sup>53</sup> Individuals retiring before age sixty-five ("early retirees") that have no postretirement coverage and who are not yet eligible for Medicare do not benefit from an employer mandate — they fall through the cracks. If the government does not provide benefits, or require all employers to provide postretirement coverage, the goals of universal coverage are thwarted. Without this change, corporate employers would be penalized for providing health care benefits to their retirees when retirees of smaller employers would obtain guaranteed coverage through a government program.

#### IV. RECOMMENDATIONS: THE ROLE OF GOVERNMENT

Government has an important role in the health care reform process. Business has long recognized that government should help stimulate a competitive, innovative economic environment by establishing a necessary degree of regulation. In short, government has three roles to fulfill, and none of them are inconsistent with basic business objectives. First, government needs to assure that there are enough resources in the system to provide health care coverage to all citizens. Allowing a large segment of society to exist outside the health care system weighs heavily on all concerned, business and individuals alike. Second, government needs to allocate sufficient resources to ensure that medical research and education continue to be a critical part of the health care system. Third, government needs to assure that abuses that can occur within any economic system are kept to a minimum.

These are difficult roles to fill. The primary questions that the government must confront are: How will we pay for the uninsured? How can we guarantee universal coverage and how

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53. See *supra* note 14. Even fewer small employers offer postretirement medical benefits.

will it be provided? How can abuses in the system be limited without imposing so many regulations that the required flexibility is reduced and the opportunity to innovate and evolve quickly is diminished?

Business leaders generally believe that striking the proper balance in the complex health care delivery system will require incremental change, because no one can say with certainty whether a profound fundamental restructuring will work. The process requires health care purchasers to reasonably adapt to the changing needs of health care providers and vice versa. And in the midst of this turmoil, patients must retain their status as the most important constituent in the system.

As the rough and tumble competition proceeds with its rapid changes and shakeouts, government can provide mechanisms to avoid abuse. These include appropriate antitrust rules tailored to the health care delivery system, and malpractice and medical products liability reform to reduce the unnecessary defensive medicine that is currently practiced. With these governmental actions, the system can become leaner over the next several years. The trick is to find the right balance that includes the proper amount of government participation in the system.

At the other end of the spectrum are those areas in which government should not intrude. These include areas affecting innovation, premium and expenditure caps, financing, and community rating.

#### *A. Areas in which Government Intervention is Appropriate*

##### **1. Antitrust Regulation of Health Care**

The antitrust laws and regulations that have evolved over the years should be generally applicable to the health care system. However, it will be necessary to reformulate the laws to allow local entities to strike a proper balance between competition and protective regulation. Many reform bills provide exceptions for certain segments of health care delivery from antitrust laws.

In September 1993, the U.S. Department of Justice and the Federal Trade Commission issued six policy guidelines regarding mergers and other regulated activities.<sup>54</sup> The policies define the circumstances under which the Agencies will not challenge certain conduct as a matter of procedural discretion. The six areas include: (1) hospital mergers; (2) hospital joint ventures involving

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54. U.S. DEP'T OF JUST. & FED. TRADE COMM'N, STATEMENT OF ANTITRUST ENFORCEMENT POLICY IN THE HEALTH CARE AREA (1993).

high-technology or other expensive medical equipment; (3) physicians' provision of information to purchasers of health care services; (4) hospital participation in exchanges of price and cost information; (5) joint purchasing arrangements among health care providers; and (6) physician network joint ventures. The Agencies recognized that "additional anti-trust guidance may be desirable in the areas covered by these policy statements as well as in other evolving health care contexts."<sup>55</sup>

As the law and regulations evolve to provide appropriate antitrust protections, it is essential that there are not different rules for competing providers. For example, HMOs, integrated service networks (ISNs), and hospital alliances should be subject to the same rules because they typically compete for the same customers in the same marketplace. On the other hand, where there is a single source provider such as a rural hospital, the rules will have to accommodate reasonable consolidation. This may be intrinsically anti-competitive, but is necessary due to local circumstances.

## 2. Medical Malpractice Tort Reform

Medical malpractice litigation is an insidious contributor to the cost of health care in the United States. As jury awards and legal fees increase, so do premiums; doctors and hospitals in turn charge consumers or their insurers more for services.

Excessively large jury awards in malpractice cases are only part of the problem. The larger source of cost escalation is the result of additional and unneeded testing and services ordered by physicians and hospitals practicing defensive medicine in order to insulate themselves against accusations of failure to provide sufficient or correct care. A battery of shotgun tests, which may only marginally improve a diagnosis, often provides little more than a shield to insulate physicians from liability.

Physicians are not necessarily to blame for a system that forces them to use these tactics to protect themselves. This is a flaw in the health care and judicial systems that must be fixed.

Under the Clinton Plan, all medical malpractice claims for services rendered by a regional or corporate alliance must be submitted to an alternative dispute resolution (ADR) mechanism, including arbitration or mediation, prior to commencing litigation.<sup>56</sup> Each alliance must establish an ADR mechanism.<sup>57</sup> If the claim is not resolved through ADR, the plaintiff must submit an affidavit that they have consulted a "qualified medical spe-

55. *Id.* at 3.

56. Clinton Plan, *supra* note 5, § 5302(a).

57. *Id.* § 5302(b).



cialist" who has determined that the action is reasonable and meritorious.<sup>58</sup> Contingency fees are limited to one-third of the recovery amount.<sup>59</sup>

Perhaps a better means of providing malpractice insulation would be physician and hospital adherence to "best practice" parameters established by peer groups coupled with reasonable dollar limits on malpractice recovery. Patients and the community must be protected from malpractice but there also must be a reasonable balance struck between this protection and its cost to society from unneeded services and unrestrained court awards.

## B. *Areas in which Government Intervention is Inappropriate*

### 1. Innovation

Innovation is messy. It creates inequities between those who initially foster and benefit from the innovation and those who do not. It also imposes costs on those who are the subject of innovation that does not succeed.

Governmental regulations that seem to apply to today's market and reflect good-hearted intent can easily become antiquated obstacles to innovation in tomorrow's market. The current set of health providers and researchers, as well as consumer practices, primarily affect the *financing* and *distribution* of health care, not the *quantity* and *quality* of health care goods and services provided. The long-term effect of health care reform will be determined largely by whether new, cost-effective products and practices are encouraged or discouraged. The current market's concern for cost reduction, higher productivity, and value is highly innovative, flexible, and dynamic. Government should not necessarily interfere in this process.

A governmental process set up to define the opportunity for innovation in health care reform would likely be composed of people who are uncomfortable with innovation. The bureaucracies of tomorrow must be able to respond quickly to change. Unfortunately, government is not as concerned about producing innovative solutions. It is more often concerned about retaining and expanding the current system, which will quickly lag behind leading methods. When health care becomes institutionalized and politicized, it will be slow to respond. When policy for tomorrow is determined and set today, it will become a barrier to innovation.

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58. *Id.* § 5303.

59. *Id.* § 5304.

## 2. Premium and Expenditure Caps

Premium caps and expenditure caps have never worked over the long-run, and the health care system should not be designed with these as its underpinning. Over time, caps will tend to focus provider attention on an artificial compression of resources rather than on the market to determine the amount of needed resources by providers actively competing to obtain revenue.

In a government-defined system with an artificially suppressed spending limit, innovation will suffer. New drugs and medical equipment will be developed at a slower pace. Innovation is driven by the development of ideas and the ability of individuals to put those ideas to work, often against vested interests. Expenditure caps tend to remove the incentive to commit sufficient resources to the process of developing new and better alternatives.

The system has plenty of resources to provide the best care. Perhaps the most effective way of reallocating resources is through incentives available to the providers. Doctors should make the medical care decisions based on value that have a cost component attached.

## 3. Financing

Rechanneling the excess resources in the system to pay for coverage of the uninsured will require time. An alternative source of funds would be a tax on the health care providers in an amount sufficient to pay for indigent care. This would help eliminate cost-shifting because every provider would be responsible for paying part of the cost of indigent care even if they had little direct responsibility. A provider tax focuses the expenses of indigent care on the segment of the market that can increase the efficiency of the process. A broad-based tax such as an individual income tax sounds equitable, but providers would view it merely as a source of revenue.

## 4. Community Rating

“Community rating” has been used to describe an array of pricing mechanisms. Insurers typically price insurance coverage based on “experience rating,” which assesses an individual on a wide array of health-related variables to determine the risk that the individual faces. In contrast, community rating assesses the average risk faced by all the individuals within the community.

Community rating in essence compresses the range of variation in individual premiums produced by experience rating. Three forms of rate compression have been proposed: strict (or pure)

community rating,<sup>60</sup> adjusted community rating (or community rating by class),<sup>61</sup> and rating bands.<sup>62</sup> The result under any of these is that the spread between the high and the low ends of risk is greatly reduced while the average cost of insurance is not affected.

There are competing fairness criteria in the debate. The insurance industry asserts that it is only fair to rate according to individual risk. This may confuse actuarial fairness with moral fairness. Isn't society under a moral imperative to care for its underprivileged regardless of financial circumstances or genetic heritage? Only pure community rating, which provides a single rate for each person, spreads the risk of bad health evenly throughout society.

The essence of insurance is to spread risk across a class of people so that the protection can be affordable. By setting up classes of risk pools to group people of like risk into one pool, people of like risk can pay an amount closer to the inherent value of their coverage. Adjusting for risk allows the individual to pay more precisely what the value of the coverage is to the individual.

The pure community rating concept is comprised of two components: the value to the individual and the value to society. In a pure community rating situation, society will pay if the value to an individual is greater than average due to risk factors; the individual will pay if the risk is less. Pure community rating thus results in a transfer of wealth, or implicit tax. The head tax falls most heavily on the younger, less financially secure segment of the population. It is intrinsically regressive.

An additional criticism leveled at pure community rating is that if insurers do not rate according to individual risk, insurers will not be taking into consideration free-riding by those whose voluntary lifestyle behavior imposes costs on the insurance pool — behavior such as smoking, overeating, not wearing seat belts, not exercising, hang gliding, and engaging in unprotected sex. Indeed, community rating may result in higher health costs

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60. Strict community rating allows premiums to vary only according to geographic location, level and type of benefits, and family status. See MARK A. HALL, IS COMMUNITY RATING ESSENTIAL TO MANAGED COMPETITION? 2 (1994).

61. Adjusted community rating allows additional variation according to defined demographic classes, such as age and gender. *Id.*

62. Rating bands are the least demanding means of accomplishing rate compression. Rating bands allow an additional measure of rate variation beyond age- and gender-adjusted community rating, reflecting to some extent individual health risk associated with prior claims experience or with occupational industry classifications. *Id.*

because individuals will have no financial incentive to improve their health and reduce costs if premiums are determined by the actions of the community at large, actions over which the individual has no control.

Should community rating be modified or pure? The system will likely move toward pure because it is administratively simple. On the other hand, community rating, which helps those groups that are at a disadvantage in searching for affordable health care, will provide employers with a disincentive to consider the demand side of the financial equation. Employers will no longer be able to save money by promoting healthy lifestyles among their employees. Without the financial incentives that are taken away by community rating, employers will cease to be concerned with promoting health, because employers will have to pay the same price as every other employer. Only when there is some financial return available will business take the initiative to improve health status.

Government intervention is necessary to provide community rating to employees and citizens who are not able to compete in the marketplace for reasonable health care rates because they are not members of a sufficiently large group. Government regulation must help define the balance between the rights of employees and citizen groups to strive for and achieve healthy outcomes versus those employees and citizens who are not in such groups and must rely on community rating.

#### CONCLUSION

To use the balloon analogy, business and government are both squeezing the balloon, reducing their health care cost while the same cost pops out in another sector. But we have not generally been directly attacking the way that health care is practiced. We have not let much of the air out of the balloon. When we can provide stimulus and incentive to have doctors and hospitals recognize that their product, like every other, must be based on quality and cost, then we will have a market that strives for efficiency. And it is clear that the marketplace is the crucible for developing high-quality health care at low cost. This part of the equation will not come from government regulators. It is not their job. However, purchasers will demand that providers in the marketplace keep costs under control and quality high, and providers will respond. Providers will do it because it is in their best social and economic interest.