

The Private-Sector Health Care Revolution: How It's Controlling Costs Across Florida and America

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EXECUTIVE SUMMARY

- Although the major government health care programs, Medicaid and Medicare, are riddled with problems Florida Governor Lawton Chiles and U.S. President Bill Clinton continue to promote plans that will force more and more people into government-intermediated health care programs. In Florida, Governor Chiles' "Florida Health Security" plan would dramatically expand the scope of the state's 11 new regional purchasing alliances by having them sell government-subsidized health plans to low- and middle-income residents.

- Eighty-five percent of Americans have health insurance. In order to facilitate health coverage for the other 15 percent, the key issues facing Florida and the nation are: access and affordability. Rather than “universal coverage”—coverage that requires large, expensive, taxpayer-financed programs or mandates on business—Floridians and Americans would be best served by reforms that *facilitate* universal access and universal affordability in the *private* marketplace for health insurance.

- The good news is that a private-sector revolution in health care is taking place in cities across Florida and America, where companies are developing a nearly endless variety of methods to make health care more accessible and more affordable. These include *privately*-sponsored (not government-run) purchasing alliances, the use of “Medical Savings Accounts” (MSAs) in tandem with low-cost catastrophic health policies, the development of databases and financial incentives to help employees comparison shop among competing medical providers, and other mechanisms.

- The bad news is that the plans promoted by Governor Chiles and President Clinton will needlessly channel more taxpayer dollars into flawed, government-run schemes like Florida Health Security—schemes that contribute to rising medical costs by perpetuating the “third-party payer problem”—rather than seek solutions in the further expansion of today’s myriad of private-sector, no-cost-to-the-taxpayer innovations for making health care more affordable.

- Florida legislators should draw a line against the expansion of Florida’s new health care bureaucracy, the Community Health Purchasing Alliances (CHPAs), and pursue measures to encourage the further development of private-sector reform. A seven-point plan for doing so is presented here. It includes requiring the CHPAs to compete head-on with private insurers by repealing the CHPAs’ annualized \$3.1 million in state subsidies, the enactment of tax-law changes at the federal and state level to provide tax-treatment equity among conventional insurance plans and programs using Medical Savings Accounts, and other measures.

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Today, we literally have thousands of innovative systems evolving—where groups of companies have gotten together and come up with new, innovative ways to control costs. President Clinton talks about this innovation all the time, but his proposal would kill it and have the government try its hand. Instead, we should be encouraging innovation.

—*U.S. Sen. Phil Gramm*¹

I believe that managed competition can and should be the answer, but if it's not, it will be the bridge to a single-payer system.

—*Doug Cook, Florida's top
health care official*²

Eighty-five percent of Americans have health insurance but, in order to help the remaining 15 percent afford coverage, Florida Governor Lawton Chiles and President Bill Clinton continue to promote plans that would steer more and more people into government-intermediated, managed care health plans. Governor Chiles proposes to expand the scope of the state's 11 regional purchasing alliances established by a 1993 law. His "Florida Health Security" (FHS) plan would provide taxpayer-subsidized health insurance to Florida residents with incomes at or below 250 percent of the federal poverty level. He was not able to get the state legislature to enact FHS during 1994, when the House passed it but the Senate did not. During the 1995 legislative session, Chiles again put forward the FHS proposal for consideration by state lawmakers.

Governor Chiles' proposal for another taxpayer-subsidized program—and President Clinton's similar approach at the federal level—ignore the lessons of America's experience with government-sponsored health care. The nation's major government health care programs, Medicaid and Medicare, are riddled with problems—skyrocketing costs to taxpayers, bureaucratic red tape, rampant fraud, and the growing refusal

of physicians to treat patients under those programs. Among other problems, these government programs are inherently flawed by contributing to the "third-party payer" problem that drives up health care costs. In the U.S. health care system that has evolved in recent years, a third party—the government through Medicaid or Medicare, or a private insurance or managed care company—pays most doctor and hospital bills. The consumer of health care, then, does not face any incentive to control costs, as they do when shopping for other goods and services. Economists today widely acknowledge this third-party payer problem to be one of the most significant factors in the rising costs of health care. Instead of channeling more taxpayer dollars into taxpayer-subsidized health care programs that will share this inherent flaw with government programs that have come before them, Florida's leaders should seek to facilitate the growing *private-sector* revolution in health care that is spreading across Florida and the nation and enact the tax law changes necessary to encourage these efforts.

This background: 1) examines today's private-sector revolution in health care, 2) outlines the similarly flawed foundations of the health plans promoted by Governor Chiles and President Clinton, and 3) puts forward a seven-point program for how Florida lawmakers can draw the line on the expansion of Florida's new health care bureaucracy and encourage instead the spread of today's growing number of no-cost-to-the-taxpayer initiatives.

THE PRIVATE-SECTOR REVOLUTION IN HEALTH CARE SERVICES

During the 1980s and early 1990s, American employers watched the cost of the health care benefits they provided to employees increase by 10 to 25 percent annually. In response, many employers throughout Florida and the nation began devising methods, alone or in concert with other employers, to introduce marketplace discipline into their health plan equation. In just a few short years, employers have woven a tapestry of creative solutions that already have proved successful in controlling costs. The result: a true free-market in health care is evolving—a free market that has not existed in recent decades because approximately 40 percent of expenditures have been accounted for by the government Medicare and Medicaid programs.

The main types of reforms developed or initiated by employers include:

- Privately-sponsored employer purchasing alliances—as opposed to the 11 Community Health Purchasing Alliances (CHPAs) set up by the state of Florida;
- Joint efforts between employers and medical care providers to identify and end the systematic overuse of some medical procedures;
- Employer provision of a “Medical Savings Account” (MSA) in tandem with a low-cost catastrophic health insurance policy, which puts control over health care choices (and costs) back into the hands of consumers;
- Employer-sponsored access to data bases that help employees comparison shop among competing medical providers in their area; and
- Employer-generated financial incentives for employees to pay small claims directly rather than clog claims offices with paperwork.

Those examples of injecting “competition” into America’s marketplace for health care have nothing to do with the “managed competition” promoted in recent years by politicians nationally and in Florida. The solutions noted above are elements of a bottom-up competition—that is, by consumers of health care services (individuals and firms) looking out for their pocketbooks (i.e., for good quality at low cost). The employer initiatives generally take one of two forms: 1) programs structured around the employer as the cost-cutting agent, or 2) programs structured around the employee/patient as the cost-cutting agent. Examples of both of these types of initiatives follow.

THE EMPLOYER AS THE COST-CUTTING AGENT

Private sector buying coalitions. Local businesses in over 150 American cities have formed non-

profit coalitions to negotiate with medical provider groups for a better value for their health care dollars. The programs that these coalitions’ member firms jointly undertake typically include:

- volume purchasing of health plans;
- ongoing dialogues on quality improvement with provider groups (groups that often include hospitals, physicians, and other medical professionals); and
- the publication of a consumer’s guide to encourage individuals to ask about different treatment options available before obtaining health care services.

Employer coalition brings down hospital costs in Orlando. The average cost of treating patients at Orlando’s two largest hospitals actually declined in 1992, after steep annual increases over the previous five years. This resulted from those hospitals’ adoption of a program of analyzing how patients are treated, and sharing data on treatments vs. outcomes with all of their physicians. In this manner, a doctor can look at the data associated with his/her colleagues. If he sees that his patients are averaging hospital stays a day longer for the same ailment as another doctor, he can study that physician’s method of treatment and consider adopting it. For example, one Orlando cardiologist was shown data that revealed that every time he treated a patient with acute chest pain, he prescribed a “clot-busting” drug, TPA. Another cardiologist, with equally successful results, used a drug that cost \$2,000 less per application. On his own initiative, the first physician switched to the cheaper drug.

The Orlando hospitals instituted that program of producing and analyzing patient “outcomes data” at the insistence of the Central Florida Health Care Coalition, a group of Central Florida employers founded in 1984. The Coalition convinced most of the Orlando-area hospitals to institute a software-based monitoring program licensed by MediQual Systems, Inc., of Westborough, Massachusetts.³ The employers in that private coalition, in turn, use the outcomes data to negotiate health plans among competing provider groups not only on the basis of price, but also on the quality of medical

outcomes that patients are getting for their (that is, the employers') medical dollar. The data collection program has helped the Orlando-area hospitals to cut costs markedly.

Orlando Regional Medical Center, part of Central Florida's second largest hospital group, reduced costs per patient by 2 percent in 1992, after increases of 12 percent in 1988, 20 percent in 1989, and 9 percent in 1990. Even more dramatic was the decline in the hospital group's use of ancillary services, such as electrocardiograms and physical therapy. In several such areas, utilization declined between 2 and 40 percent. Over a four-year period, the rate of Caesarean section deliveries at Orlando Regional fell from 32 percent to 23 percent. As a result of changes instituted after reviewing the outcomes data, Orlando Regional went from losing \$12 million annually on its treatment of Medicare patients to actually earning \$500,000—with a consequent reduction in cost-shifting to other purchasers.⁴ Similarly, Florida Hospital, owned by the region's largest hospital group, saw its per-patient costs drop 4.2 percent in 1992, after a 5.4 percent increase the year before. Over a four-year period, Florida Hospital's Caesarean rate fell from 25 percent to 21 percent. Drug costs at the hospital declined 1.7 percent in 1992, after rising 43 percent in 1990 and 29 percent in 1991.⁵

The Central Florida Health Care Coalition now has over 100 member employers that account for approximately 175,000 employees and 400,000 covered lives. These employers include Walt Disney World, Lockheed Martin, Harris Corporation, McDonnell Douglas, Rockwell International, Johnson Controls, United Telephone, General Mills Restaurants, the Orange County School System, and the City of Longwood. In 1993, the per-employee health care benefit expense for General Mills Restaurants' 4,000 employees in Central Florida was down 27 percent over 1986.⁶ The Orange County School System saved \$1 million in employee hospital costs in 1992 (an 11 percent savings), while observing improved medical outcomes of its employees receiving care under its health plans.⁷

Coalitions across Florida unite. In 1990, the Orlando-based Central Florida Health Care Coalition and a Tampa-based employer group formed an umbrella association in order to jointly pursue "value-based purchasing," which they define as "volume purchasing leveraged for quality and price." From 1986 to 1990, the

Orlando coalition had focused on quality—through an extended dialogue with area hospitals to convince them to install the outcomes tracking system outlined above. Over that same period, the Tampa-based employers had been concentrating on group-purchasing based primarily on price. With the creation of the Employer's Purchasing Alliance (EPA), the two groups linked their quality- and price-oriented initiatives and began tailormaking and negotiating managed care products with provider groups that agreed to institute the computerized system of tracking patient outcomes and share the results with employers. The EPA also recruited employer coalitions from elsewhere in Florida and beyond. This allows EPA to negotiate contracts that are national in scope, and thereby serve member-firms that have employees (and covered retirees) located both in Florida and elsewhere.

The EPA comprises employer groups in Tampa, Orlando, Miami and cities in several other states. In all, the EPA covers over 430 businesses with 850,000 employees and a potential covered population (once dependents are included) of 2.5 million. EPA member companies enjoy the same product prices no matter what their size. In order to pursue volume purchasing on behalf of both small, fully-insured employers as well as large self-insured firms, the alliance's solution is to "unbundle" the products and negotiate them on a wholesale basis. "This puts our small employers in the driver's seat," explains EPA president Frank Brocato. "They can swap third-party administrators and insurance carriers—without changing provider networks—as often as they want. This prevents the 'lowballing' by insurers that underprice their rates and then jack them up in year two or three, knowing employers will not want to move their workers to a new provider network." The EPA reports that as a result of its volume-purchasing, its members save between 10 and 40 percent on their health care costs.⁸

Privately-run group purchasing successes elsewhere in the U.S. As noted above, over 150 privately-run business coalitions have been formed throughout the nation to jointly negotiate and purchase health care services. In **Memphis**, a coalition of leading employers, including Federal Express, collected comparative cost information among local hospitals in 1986. The employers found variances as wide as 80 percent for some services and began putting their business out for competitive bid. The coalition estimates it

has since saved its employers tens of millions of dollars, and it recently established comparative measures of quality to enable purchasers to select providers based upon quality, not just price. In **Denver**, the Colorado Health Care Purchasing Alliance has over 170 member businesses. Coors Brewing Co., with 8,000 employees, is the largest member, but about half of the group's members have 100 employees or less. The alliance has negotiated discounts of up to 15 percent on members' health plans. It uses the system licensed by MediQual Systems, Inc., to make quality comparisons among providers. In **Madison**, Wisconsin, the Employers Health Care Alliance Cooperative has 50 large employers (with 50,000 insured lives) and 9 provider organizations that represent about 12 percent of the local private health care market. In 1993, the Madison alliance's large employers acknowledged the potential for local health care companies to cost-shift to the small employer market and so the alliance began a small employer initiative. Their small business product—a fully-insured fee-for-service plan—carries premiums 12 to 15 percent lower than the normal rates in the small employer market.

Chambers of Commerce facilitate affordable plans for small employers. Several of Florida's largest chambers of commerce also have stepped into the private-sector health care reform game, with the interests of their smallest member firms particularly in mind. In August 1992, PCA Family Health Plan, Inc., began offering plans to the **Miami Chamber of Commerce's** small-employer members. Today, PCA is covering approximately 20,000 individuals (employees and their dependents) through the 13 different benefit design options it offers in association with the Miami chamber. The plans are sold to firms with 1 to 50 employees; also, individual insurance is offered for part-time workers in firms with more than 50 employees. Rhodele Holzberg, executive vice president of the Miami Chamber of Commerce explains: "These plans offer more coverage, with cheaper rates, than the standard and basic plans offered through the CHPA. We know our activity in this area is helping to bring rates down because we have companies tell us that merely by noting that the [Miami] chamber is offering a given plan cheaper, they can negotiate lower rates with the insurance companies."⁹

In 1992, the **Greater Orlando Chamber of Commerce** began offering a group-purchasing arrange-

ment to assist its member companies with 3 to 25 employees in obtaining affordable health insurance. It contracted with the Prudential Health Care System of Orlando to offer two types of plans to these members. The Orlando chamber's Walter Nason explains:

Despite a good response from Orlando employers, we quit selling those plans in December 1993, in anticipation of the spring 1994 start-up of the CHPAs—which would be marketing similar plans to small employers in Central Florida. But continued demand from member companies that preferred not to contract for health care through the CHPA led the chamber to re-launch the offering of small employer health plans in June of 1994.¹⁰

Today, the **Greater Orlando Chamber of Commerce** offers its small- and medium-size members three health plans written by two insurers, Prudential Health Plans (for firms with up to 50 employees) and PCA Family Health Plan, Inc. (for firms with up to 75 employees). The plans are quite affordable; one of them typically carries a premium of \$97/month for individuals and \$341/month for a family of four—less than the Florida Health Security's projected total rates of \$116/month (individuals) and \$348/month (families). PCA Family Health Plan's Orlando office reports that it has signed up 150 firms (1,200 covered lives) since it began selling in association with the Orlando chamber in October of 1994. PCA offers a similar health plan through the Orlando-area (Region 7) CHPA, but has signed up only one employer account through that channel since the CHPA's May 1994 start-up. "We would certainly like to have more business come to us through the (Region 7) CHPA," PCA Commercial Marketing Manager Tim Freeland explains, "but the one account written in May of 1994 is all we have received."¹¹

Orlando chamber members have also been solicited by Prudential Health Plans which has signed up 54 small businesses (626 covered lives) since June, 1994.

It is particularly notable that the Orlando chamber is marketing these plans to the same small employer market that the Central Florida-area CHPA is targeting. This demonstrates that the Central Florida (Re-

gion 7) CHPA is not fulfilling a need that is not being addressed by private insurers in the area. That the Orlando chamber is providing these affordable plans to small employers is promising for the prospect of private-sector health care initiatives in Central Florida, particularly given the unfortunate development that the Central Florida Health Care Coalition stopped selling small group plans (50 employees and under) after the Orlando-area CHPA began operation. (This is a classic example of how government's entry into the provision of a service provided by the private sector often results in government displacing and supplanting private initiative.)

In 1993, AvMed Health Plan was approached by both the **Jacksonville Chamber of Commerce** and the Northeast Florida Builders Association about those associations' desire to offer affordable health plans to the smaller employers among their membership. Since AvMed started marketing two plans for the two associations in June of 1993, it has signed up over 875 companies (accounting for about 3,000 covered lives).¹²

In-house doctors—dusting off an old-time, cost-effective approach. In 1991, Orlando hotelier Harris Rosen, the owner of the Tamar Inns discount hotel chain (five hotels, 1,500 employees) got fed up with his company's rising health care costs. He had tried to control costs by adding an optional managed care plan to his indemnity plan, only to find that his rates kept going up despite that his company's wellness programs were keeping his workers well. Through repeated inquiries to his carrier, Rosen finally discovered that his insurer was making a \$250,000 annual profit on Tamar Inns' \$400,000 in premiums, while continuing to assign Tamar double-digit annual rate hikes because of the sickness record of other members of the insurance pool. In effect, Rosen was paying to cover the high claims rate of companies that had not instituted the creative wellness programs he had developed.

Rosen canceled his old plan, designed a new plan around an in-house doctor and an emphasis on preventive care, and slashed his company's health care costs 66 percent. The doctor is paid \$50,000 to see patients 20 hours/week at an on-site clinic. Rosen's self-insurance plan also involves 1) direct purchasing of acute-care hospital services from Orlando-based Florida Hospital Corp. on a capitated basis, and 2) a contract with Walgreen Drug Stores for the provision of prescription drugs at a discount. The company's employees get free

doctor visits with no deductibles or copayments, annual physical examinations and preventive, prenatal and well-baby care, including immunizations, preventive dental care at 100 percent coverage, specialist referrals, generic drug prescriptions at 100 percent coverage, brand name drugs not available in generic form for a \$3 co-payment, and other services. Through the new program, Tamar Inns' health care costs declined from \$2,223 per year per covered employee in 1991 to \$745 in 1992 (with a rise to approximately \$850 in 1993 due primarily to an increased use of medical specialists and prescription drugs and a \$125,000 liver transplant).

Sandra Johnson, vice president for Florida Hospital, explains: "Tamar saves money because it controls its demand for medical services [through] promoting a lot of prevention and a lot of health as well as treatment of disease."¹³ As Rosen reported to *Florida Trend*, his health plan cost his company approximately \$960,000 in 1993—fully \$398,000 less than the \$1,358,000 that he calculated the Clinton Plan would cost him.¹⁴

Bradenton hospital develops affordable health plans for the indigent. Manatee Memorial Hospital in Bradenton, Florida, used to be known as "the hospital of choice for Manatee County's uninsured." After it performed \$12.8 million in uncompensated care in 1992, the hospital's director of financial services sought to address the problem of the county's uninsured by developing an affordable health plan for low-income residents. The Access to Healthcare Plan that resulted is available to individuals and small businesses that have been without health insurance for a minimum of six months. It offers comprehensive coverage at a price 40 percent below the retail market. How is this possible? The hospital convinced its physicians that providing the uninsured access to health care meant they would be paying *something*, instead of nothing. The hospital and its physicians agreed to accept reimbursement at rates tied to Medicaid rate formulas, and agents agreed to cut commissions by 50 percent. Because the plan insures people who typically have little understanding of how insurance works, customer support includes "welcome" calls to each new insured's home. Over 31,000 individuals have been insured through the Access to Healthcare Plan since its launch in June of 1993. Most policies are being sold as individual plans, rather than through employers. The Access Plan clearly is not an initiative that aims to harness the incentives of

the free market to moderate health care costs, and its success is linked to providers' acceptance of reimbursement rates established within the flawed Medicaid system; however, the Access to Healthcare Plan is mentioned here because it demonstrates one hospital's earnest effort to design a discounted health plan for the indigent that would be administered with no government subsidies.¹⁵

THE EMPLOYEE AS THE COST-CUTTING AGENT

Corporations bring down health care costs by changing employee behavior. With employees' average annual deductible under the nation's corporate health plans at \$205 (for an individual plan), the 139 million employees covered by corporate plans in America have not generally been motivated to engage in comparison shopping for health care services. But with company health bills jumping by double-digits annually during the 1980s and early 1990s, many U.S. corporations began to give their employees the tools and financial incentives to become discriminating purchasers of health services.

At American Telephone and Telegraph Company's **NCR Corp.** unit, a fee schedule outlines what the company will pay for 11,000 separate procedures, so that employees can verify—and if need be, negotiate—prices with doctors before treatment begins.¹⁶ At **International Paper**, after health care bills increased 20 percent annually throughout the 1980s, the company developed a data bank and a set of financial incentives to get its employees to comparison shop. First, it raised the annual out-of-pocket maximum (paid under the deductible and copayment rules) for salaried employees making between \$25,000 and \$50,000/year with family coverage to \$4,600, from \$2,000; and to \$6,500 for those making over \$50,000. Secondly, the company began encouraging employees to check its files to compare the company reimbursement rate for a given procedure with rates charged by local physicians. For example, an International Paper employee who lives in Greenville, S.C., and is facing a gallbladder operation can learn that the company will pay a maximum of \$1,219 to the surgeon, \$257/day for a semi-private hospital room, and \$178/day for nursing care. The company files then inform the employee of the rates charged by 19 surgeons in the area—which range from \$958 to \$1,900—and list each physician's name, office address, age, sex, office hours, where they went to medical

school, where they did their residency, whether they are board certified, which hospitals they work in, and whether they will discuss fees. The company also makes available to employees a video with tips on how to negotiate a fee with a doctor. The objective, of course, is to keep employees from exhausting their out-of-pocket maximums.¹⁷

Medirisk helps patients “shop around.”

Medirisk, a health care consulting firm founded in Atlanta in 1983, has developed a cost comparison database that is, effectively, a medical version of *Consumer Reports*. The service, Mediguardsm, allows consumers across the country to comparison shop for the cost of medical procedures and use that information to negotiate doctor's fees. (The database was developed by culling information from more than 450 million claims.) Subscribers pay a fee of \$69/year for a nearly unlimited number of calls to a toll-free 800 number. Representatives who handle subscribers' calls provide the following types of information:

- Pricing information for premium, typical, and discounted local costs, and the Medicare costs (in the caller's local area) for 7,500 specific medical procedures;
- Counseling on how to negotiate with physicians to obtain the best pricing;
- An explanation of the possible health care services the subscriber may expect their physician to recommend; and
- Advice that helps the consumer determine if recommended testing is necessary and avoid unnecessary duplication of services.

Medirisk also markets this service to self-insured employers through “Mediguard for Employers.” Companies subscribing to that service can have their employees call the toll-free 800 number prior to a visit to a doctor. The incentive for employees to use the service is provided by Medirisk-designed plans through which employers share with employees the savings obtained when workers successfully negotiate or shop around for a fee lower than the highest applicable fee for a spe-

cific procedure.

Dun & Bradstreet's "Consumer Hospital Guides" help Floridians shop for care. During 1994, Dun & Bradstreet and EDS, self-described as the world's two largest providers of information to businesses, formed a partnership to provide comprehensive, comparative information to the health care sector on the treatment effectiveness and cost of providers. One D&B/EDS product, developed for Florida consumers, is a set of easy-to-read pamphlets resembling hospital "report cards"—one for each of the state's five main health care markets of Jacksonville, Orlando, Tampa/St. Petersburg, Fort Myers/Sarasota, and Miami/Ft. Lauderdale. First released in June, 1994, each regional guide presents a table with comparative information for each of five common hospital treatments: baby delivery, heart (coronary bypass) surgery, heart attack, stroke, and hip/knee replacement. The table for each treatment lists acute care hospitals in that region and allows the reader to compare hospitals by four measures: number of patients on which that treatment is performed, mortality rate, medical complication rate, and cost. (Consumers can obtain one of the guides by phoning 1-800-888-8628.)

Forbes rewards employees for paying routine medical expenses themselves. In January 1992, *Forbes* magazine launched a program to reward its employees who stayed healthy and avoided filing claims for routine medical expenses *by paying such expenses themselves* (directly to the provider). Under *Forbes'* program, if an employee's claims for a calendar year are under \$500, the company pays that employee double the difference between that total and \$500 (on an after-tax basis). As editor Malcolm S. Forbes, Jr., explains: "People here quickly recognized that each dollar of claims costs them \$2 and that they win if total submissions are under \$1,000 (if your expenses are \$800 and you don't submit them to the insurer, you will receive that \$1,000 and come out ahead by \$200)."¹⁸ *Forbes'* innovative program has been quite successful. As a result of the diminished number of claims submitted to the company's insurer, when *Forbes'* insurance was up for renewal in 1993, its rate declined by almost 10 percent—enough to cover the low-claims bonuses it paid to employees in 1992.

Richmond utility company also pays employees to stay healthy. In 1989 Dominion Resources, an electric utility holding company in Richmond, Virginia,

instituted a cash incentive program to encourage employees to adopt and maintain healthy lifestyles. Since that time, the company has seen rises in its health care costs of only 1 percent annually. As benefits manager Ken Davis explained in the *Wall Street Journal*:

In a typical working-age population, about one-third of medical costs arise from five risk factors that can be largely controlled by personal behavior—weight, blood pressure, cholesterol, smoking, and seat-belt use. The company offers employees wellness incentives of up to \$600/year if their five risk factors can be rated as "low" using traditional insurance industry rating tables. More than 60 percent of the company's employees participate in the voluntary program, under which an outside contractor keeps strictly confidential the medical data used to assess risk.¹⁹

The other half of Dominion Resource's cost-containment strategy is its decision to treat its health insurance program like true insurance (as opposed to pre-paid managed care). The company offers employees a medical insurance plan with an annual deductible of \$1,500 for individual coverage and \$3,000 for family coverage (at about one-third the cost of a standard family plan with a \$500 deductible). For each employee who opts for that plan, the company establishes a payroll deduction savings account at a local bank to accumulate money that would otherwise be spent on medical premiums for a higher-cost plan. Seventy-five percent of employees selected the high-deductible, low-premium plan that costs about \$110/month for family coverage.

Employees make withdrawals from their "Medical Savings Accounts" (MSAs) in order to directly pay small medical bills—that is, those incurred prior to reaching their catastrophic plan's annual deductible of \$1,500 (individual) or \$3,000 (family). The MSAs earn interest, and funds not spent in a given year remain in the account and are carried forward to be available for medical expenses in future years. Finally, to impress upon its employees that medical benefits are merely one form of compensation and not an entitlement, Dominion Resources provides "total compensation statements" to employees each year which show how much

they were paid in cash and how much in company expenditures for their benefits.²⁰

WHY MSAs WILL PROVE EVEN MORE EFFECTIVE IN REDUCING COSTS THAN PRIVATE EMPLOYER COALITIONS: ADDRESSING THE THIRD-PARTY PAYER PROBLEM

One essential feature that the Medical Savings Accounts (MSAs) have over joint purchasing and medical outcomes-measurement programs of private employer coalitions is MSAs' ability to reinsert consumer diligence and discretion into the purchase of health care services by removing the third-party administrator. As noted above, one of the central causes of rising health care costs in recent years is the nation's third-party payment system. Ninety-five percent of the money Americans now spend in hospitals is someone else's money at the time they spend it; and four-fifths of all physicians' payments are now made with other people's money.²¹ This encourages patients to ignore the costs and appropriateness of the services they receive. In short, the patient lacks the market incentives to control costs and, because consumers lack market incentives to control costs, doctors and hospitals do not compete to reduce costs. Since someone else is paying the bills, patients simply seek to maximize quality without regard to cost.²² In recent years, studies by the Cato Institute, RAND Corporation, and others have clearly showed that third-party payment is the main factor behind rapidly rising health care costs.²³

Medical Savings Accounts address the third-party payment problem head on. They allow individuals to save money in tax-exempt accounts each year—similar to the way in which people can now contribute to individual retirement accounts (IRAs). People use the funds in their MSA to cover routine medical expenses. Instead of expensive, “first-dollar” insurance policies, they buy a far cheaper catastrophic policy to cover them against major medical expenses. For example, as attorney and health care analyst Peter Ferrara writes:

Today it costs an employer more than \$4,800 to provide health insurance for a typical American worker, a spouse, and two children. Would it not be better if, instead, the employer bought a catastrophic policy (with, say, a \$3,000 de-

ductible) for approximately \$1,800 and pay the worker the \$3,000 difference? The worker could then put that money in an MSA. Any unspent money would roll over to the next year. Since 90 percent of Americans spend less than \$3,000 annually on health care, in a very short time a worker would have a tidy pool of money available to use in the future. When the balance reached a certain level, the worker could transfer the funds to an IRA or other retirement fund. With MSAs, workers effectively would be spending their own funds for noncatastrophic health care. As a result, they would have full market incentives to control the costs of such care.²⁴

Golden Rule Insurance offers a catastrophic policy combined with a Medical Savings Account—designed especially for small employers. Indianapolis-based Golden Rule Insurance Company is, in 19 states, marketing a program that combines a catastrophic coverage policy with a Medical Savings Account (MSA). While the joint coverage program can be instituted by a company of any size, Golden Rule's program is particularly designed for the small employer market of 1 to 30 employees. It is based on a fee-for-service insurance structure, and the employer can either administer the plan directly or enlist a third-party administrator. The insurance plan carries a \$2,000 deductible for individuals and a \$3,000 deductible for families. Golden Rule reports that employers that switched to its catastrophic coverage plans have, on average, seen a premium savings that is more than enough to fund deposits to employees' Medical Savings Accounts that equal the higher annual deductibles of \$2,000 (individuals) and \$3,000 (families).²⁵

Jersey City government moves to catastrophic coverage and MSAs. The Jersey City administration of Mayor Bret Schundler recently responded to the rising cost of its employee health plan by switching to a catastrophic insurance policy combined with a Medical Savings Account. The city's premiums under the State Health Benefits Plan—the plan used by most of the state's municipalities, including Jersey City—had reached \$6,800/year for family coverage, despite a \$200 deductible and a 20 percent co-payment requirement.

The new policy the city is negotiating with Golden Rule Insurance Company is highly innovative. From Mayor Schundler's description of it in the *Wall Street Journal*:

Family coverage for our 2,500 municipal employees will cost approximately \$4,700 for a catastrophic policy that covers 100 percent of costs above a \$2,000 deductible. The city will then place an additional \$2,000 into a Medical Savings Account in the employee's name. The employee's first \$2,000 of family medical expenses will be paid out of the MSA. Above \$2,000 in medical expenses, the insurance policy will kick in and cover 100 percent of costs. Added together, this means that employees will no longer have any health care deductibles or out-of-pocket expenses for covered procedures. . . . If the employee's total health care costs for one year fall below \$2,000, and there is money left in the savings account, that money will be returned to the employee at year's end. . . . There will be no incentives for fraud and cost-shifting. Employees don't make fraudulent claims when they know that MSA dollars not spent will be returned to them in cash, and doctors are less likely to shift costs onto patients when they know those patients will be personally affected by a padded bill.²⁶

A study released by the Cato Institute in March 1995, "More than a Theory: Medical Savings Accounts at Work," outlines the experiences of numerous companies with using MSAs as part of an employee health care package, and is highly recommended.²⁷ For example, the Washington, D.C.-based Rubber Manufacturers Association pays about 25 percent of its health funds (for its 30 employees and 20 retirees) to an insurer for a catastrophic policy, and the remainder into an MSA-type health fund reserve. The reserve is building so fast that last year employees were able to withdraw \$12,000 from it as a result of lower costs. Windham Hospital, in Williamantic, Connecticut, with 1,000 employees, switched its employees from a pure first-dollar coverage plan in 1993 to a plan with a \$500 deductible and company contributions to each employee's MSA. Projected health care costs for the

hospital's employees have been reduced by about 50 percent.

CHILES' MISGUIDED AGENDA TO EXPAND THE CHPAs AND GOVERNMENT-SUBSIDIZED HEALTH CARE *Governor Chiles' Florida Health Security Program*

On April 3, 1993, the Florida legislature passed the Health Care and Insurance Reform Act of 1993, which authorized the state to set up 11 Community Health Purchasing Alliances (CHPAs) as state-chartered, non-profit organizations that would pool small employers together to purchase health plans. The act included a one-time appropriation of \$3.1 million (\$275,000 per CHPA) to provide start-up costs, and it specified that the CHPAs were designed to become self-supporting after that initial year of subsidized operations.

In January 1994, Governor Chiles sent the Florida legislature a set of proposals to expand the 11 CHPAs. His 300-plus page *Final Florida Health Plan* contained three essential elements: 1) the addition of new constituencies to CHPA membership; 2) the blending of the health plan markets for publicly-insured and privately-insured individuals by having the CHPAs offer low- and middle-income people a government-subsidized plan called Florida Health Security; and 3) the transformation of CHPAs from the "information gatherers and disseminators" envisioned in the April 1993 law to entities with broad powers to shape and administer health plans, such as through "re-bidding" the quotes that insurers submit to the CHPAs.

Various elements of Chiles' plan were incorporated in more than a dozen bills that were debated in the Florida House and Senate during the 1994 regular and special legislative sessions. Although the House passed Chiles' Florida Health Security (FHS) program, the Senate deadlocked over it and the program did not become law. In January, 1995, Chiles submitted to legislators a substantially streamlined version of the proposals he had submitted a year earlier—a 35-page draft bill as opposed to a 300-plus page plan. In turn, Rep. Elaine Bloom (D-Miami Beach) formally introduced Chiles' draft FHS bill—which, once formatted as HB 1459, numbers 61 pages in contrast to the 500-plus page FHS bill passed by the House in 1994. Chiles' intent in 1995 appears to be the passage of a streamlined FHS bill that will enact into law all the *essential* fea-

tures of his original FHS program. However, the other proposals for expanding the scope and power of the CHPAs that Governor Chiles has floated over the past two years are important for Floridians to keep in mind. They attest to the full scope of the governor's agenda for health care legislation, and they can resurface at any time. The essential features of the Florida Health Security bill introduced in the House are reviewed below, followed by a recap of other key proposals for expanding the scope of the CHPAs the governor has floated within the last two years.

Florida Health Security: Outline of the proposed program. Under Chiles' proposed Florida Health Security program, an estimated 1.1 Floridians with incomes at or below 250 percent of the federal poverty level (\$18,000 for individuals and \$37,000 for a family of four) will be eligible for taxpayer-subsidized health plans. The CHPAs will receive exclusive authority to offer the new, subsidized FHS plans. Eligible persons must 1) be a Florida resident and a U.S. citizen or resident alien, 2) have a gross family income equal to or less than 250 percent of the federal poverty level, and 3) have at least one member of their family that has been uninsured for at least 12 months. (Exempt from this last requirement are individuals receiving Medicaid, veterans' benefits, or other publicly-funded health care benefits for low-income persons, as well as employers and employees who were uninsured for 12 months prior to purchasing coverage through a CHPA.) Application for an FHS plan may be made by an individual, a family, or an employer on behalf of his employees; and employers or individuals purchase coverage through the CHPAs.

FHS enrollees will be guaranteed a benefit package that includes broad inpatient care, outpatient services, primary and preventive care, prescribed drugs, mental health services, and some long-term care and community-based services. FHS benefits will be provided by private provider groups approved by the CHPAs (termed accountable health partnerships), as well as agencies of a county government or local tax district approved by the CHPAs (termed community health partnerships). Every 12 months, FHS enrollees can select the plan of their choice from a variety of health plans offered through the CHPAs.

The FHS benchmark premium is set at \$116 per individual and \$348 per family per month, regardless of family size. An estimated 55 percent of the pre-

mium is to be paid with federal tax dollars, 30 percent with state tax dollars, and the remaining 15 percent paid by the individuals and/or their employers. The precise share of the premium that the enrollee and/or his employer is required to pay will vary according to which of five income categories the individual falls in. Individuals' employers are not required to contribute, but may if they so choose.

The federal and state portions of the premiums are to be paid for with existing state and federal funds—Medicaid savings accrued from mandating managed care for all Medicaid recipients (\$547 million in savings projected by FY97/98), tightening Medicaid reimbursement policies (\$457 million in projected savings by FY97/98), reallocating funds from a program that compensates hospitals that treat a “disproportionate share” of indigent patients (\$162 million in projected savings by FY97/98), and eliminating most of the Medically Needy program (\$433 million in projected savings by FY97/98).²⁸ That reassignment of federal health care dollars requires that a waiver of several provisions of the Social Security Act be granted by the federal Health and Human Services Department (HHS) for a five-year period in which to try out a Medicaid “demonstration” reform. This waiver was granted by HHS in September 1994.

Budgetary impact of Florida Health Security uncertain. Since the December 1993 release of his Florida Health Security proposal, Governor Chiles repeatedly has promoted it as a budget-neutral program requiring no new state or federal tax dollars. For example, a September 1994 FHS document released by his office notes:

FHS will not require any new federal or state funds or taxes. Premium discounts will be funded with federal and state savings already building up as traditional Medicaid recipients enroll in more efficient health plans.²⁹

However, Governor Chiles' proposed FY 1995-96 budget, released in January 1995, includes a \$427.9 million line item for FHS “premium.” The Governor's Office of Planning and Budgeting reports that after backing out Medicaid managed care “savings,” the FHS budget line item drops to \$334.6 million. The budget also contains a \$34.2 million line item for the 7.5 percent FHS reserve some lawmakers proposed during the

1994 debate on FHS. Chiles' references to budget neutrality aside then, it appears that his Florida Health Security program would cost \$368.8 million in new state funds during its first year alone.³⁰

FHS: Medicaid with a "private" label. Several reasons have been offered by Gov. Chiles for setting the eligibility level for FHS at 250 percent of the federal poverty level, but one particularly clear explanation comes from Chiles' top health care official, Doug Cook, director of the Agency for Health Care Administration. In a letter of May 1994 to then State Senator Ander Crenshaw, Cook explained that the 250 percent ceiling would "lower the premium level by blending a lower-risk population with low-income participants who are perceived as high risk and utilizing more services." Cook's explanation belied the central feature of FHS—it is designed to effect the socialization of private health plans. "Blending" people who otherwise would face differing health premiums into an arrangement where their premiums will be equalized is socialized medicine—complete with all the accompanying rewards for individuals who do little or nothing to maintain good health, and all the accompanying penalties for those who maintain a healthy diet, do not smoke, or undertake other preventive health measures. As Sen. Crenshaw wrote in the newsletter, *Healthtrac*, after receiving Cook's letter: "This means that the higher income, or middle class, people will be subsidizing the lower income participants, at least to the extent of the premium differential. The question then becomes: is the premium subsidy from the state to the middle class *greater* than the direct subsidy by the middle class (in terms of paying higher premiums) to the lower income participants? If not, then the middle class working person will actually be paying *more* for insurance than he or she otherwise could if left alone."³¹ In the latter case, of course, individuals would not opt to buy an FHS plan, but would choose a cheaper plan offered outside the program.

The Florida Health Security program is simply an expanded version of Medicaid with a "private," managed-care face. Under the name Florida Health Security, Medicaid would be reborn as a government-subsidized health plan administered by the CHPAs—the same agencies Chiles' described to Floridians in 1993 as designed to act as a facilitator of *private* health plans. The CHPA-administered FHS plans will serve to blur the distinction between government-run health insurance and private health insurance, and the full extent of

taxpayer-provided health benefits will no longer be easily identified, quantified, and scrutinized by analysts, auditors, and interested citizens alike.

Under Chiles' FHS Plan, the premiums paid by private individuals and firms for the "private" health plans now sold through the CHPAs (the government does not subsidize the premiums of those plans directly, although it substantially subsidizes the operations of the CHPAs) would be channeled into the same CHPAs administering this reborn Medicaid program to an estimated 1.1 million Floridians. Although the FHS bill pending in the House provides that CHPAs must maintain separate risk pools for FHS and the non-FHS plans they sell, the potential for cross-subsidization remains—e.g., through the per-member fees the CHPAs add on top of the private insurers' rate quotes. Florida's citizens and employers paying premiums on the non-FHS plans purchased through the CHPAs likely would be to some degree cross-subsidizing those citizens covered by the FHS plans. In addition, it is important to recall that the first publicly-disseminated version of Governor Chiles' FHS plan, released in December 1993, recommended that Florida legislators "revise current law to permit employers participating in Florida Health Security to be in the same risk pools as other employers purchasing coverage through the CHPAs."³² Given that the governor's original intent was to have the CHPAs mingle the FHS plans with the non-FHS plans in the same risk pools, the possibility remains that the governor could push for that legislative change later, once a less controversial version of FHS is enacted.

Further, the FHS plan itself contains no vision or program for eventually transitioning its enrollees off of this taxpayer-subsidized health care plan. In short, FHS looks set to become another big-government, addict-creating welfare program, like Medicaid before it. And what's worse, because employers can apply for FHS plans to cover their employees—and employers' contribution toward the cost of the premium is entirely optional—FHS provides to low-wage employers a strong financial incentive to drop their private health plans in order to qualify workers for FHS after the 12-month period.

Fattening up the CHPAs with new member groups. In addition to the FHS bill's provision that the CHPAs will have exclusive authority to offer the FHS plans, over the last two years Governor Chiles has identified several other groups that he proposed be directed

by law to obtain their health insurance through the CHPAs: state employees, county and municipal employees, school board employees, and Medicaid recipients.³³ In addition, during 1994 the governor recommended that CHPA eligibility be expanded to include employers with up to 150 employees (up from employers with 1 to 50 employees under the 1993 law)³⁴; and Chiles also directed the Department of Elder Affairs to examine whether the CHPAs should be assigned a role as intermediary for long-term care plans for the elderly.³⁵ It is important to recall these other groups that the governor has sought to steer into the CHPAs, because it is indicative of his full agenda for expanding the role of the government purchasing alliances through the addition of more and more member groups.

Expanding the power of the CHPAs with new legislative authority. Finally, also over the past two years Governor Chiles has proposed several new powers for the CHPAs. His 1994 *Final Florida Health Plan* contained several provisions that would dilute the “facilitator” role assigned to the CHPAs by the 1993 law, such as granting the CHPAs the power to negotiate premiums through re-bidding. Current law requires that CHPAs advertise all plans submitted by the associated health partnerships (AHPs) that meet the requirements of the CHPAs’ RFPs, regardless of the plans’ rates. However, Chiles has proposed that the CHPAs be empowered to weed out the higher-priced plans by granting them the power to negotiate premiums through re-bidding. This would end the CHPAs’ role as a clearinghouse for small employers that want to compare the prices of small group health plans offered by private insurers, and transform the CHPAs into an information booth for only those plans that meet the state government’s definition of “acceptable” with regard to price and/or design.

Another proposal Governor Chiles floated in his 1994 *Final Florida Health Plan* is mandating physicians’ use of government-set practice parameters. Chiles would require physicians in the AHPs to abide by state-approved practice parameters, or face the possibility of having the state Agency for Health Care Administration deny them membership in AHPs. Additionally, the state could deny AHP certification to insurers or HMOs that do not adhere to state practice parameters.³⁶ The establishment of state-determined and coercively-enforced medical practice parameters would be most detrimental to the progress of private-

sector innovation in the health care sector in Florida. It is one matter for private provider groups to use medical outcomes data to cooperate on the identification and promotion of “best practices” or “most cost-effective practices” so that medical providers and provider groups may *voluntarily* choose to adopt practice parameters identified by some as efficacious.

It is quite another thing to have government bureaucrats and lawmakers determine one set of practice parameters for a whole variety of medical conditions and to legislate that these must be followed—either by all medical providers in the state, or by those insurers and provider groups desiring to bid on plans offered through the government-run purchasing alliances. Government-mandated medical practice parameters would substantially politicize the process by which private providers, insurers and consumer groups are trying to identify cost-effective treatment practices. They would result in a substantial loss of autonomy for physicians to follow their own best judgments, and to an eventual decline in the quality of care in response to one-size-fits-all treatment parameters.

Continued state funding of the CHPAs. Finally, it must also be mentioned that during 1994 Florida legislators did not adhere to the provision of the Health Care and Insurance Reform Act of 1993 that specifies that each CHPA should receive a one-time only subsidy of \$275,000 for start-up costs (\$3.1 million total), after which they were to be self-supporting through premium revenues. The 1993 act specified that “each contract for start-up funds is limited to \$275,000 (Florida Statutes, sec. 408.704(2) (emphasis added)). The 1993 act further specified that “each alliance shall set reasonable fees for membership in the alliance which will finance all reasonable and necessary costs incurred in administering the alliance” (Florida Statutes, sec. 408.702(7) (emphasis added)).

During 1994, legislators quietly annualized the \$3.1 million appropriation in the state’s 1994-95 budget. This means that the subsidy will carry over into each future budget unless specifically eliminated by law.³⁷ At a recent Senate subcommittee hearing, the Agency for Health Care Administration’s Chief of Managed Competition, Sharon Jacobs, testified that further funding was needed because the CHPAs still have not become self-supporting.³⁸ In fact, the Orlando-area (Region 7) CHPA, which has signed up more enrollees than any other CHPA, reports that it does not expect to break

even until February 1997.³⁹ As of February, 1995, the state's 11 CHPAs have enrolled approximately 26,000 Floridians. At this point in time, then, the annual \$3.1 million state subsidy to the CHPAs amounts to \$119 per enrollee. It should be kept in mind, too, that figures kept by the state's Agency for Health Care Administration show that slightly over 50 percent of CHPA enrollees previously had health insurance.⁴⁰

Florida legislators should remove the continued annual appropriation of \$3.1 million in operating subsidies to the CHPAs and once again direct them to achieve self-sufficiency in a year, as the original law intended. If the CHPAs cannot achieve self-sufficiency in a year, this costly experiment in taxpayer-subsidized purchasing alliances should be closed down.

HOW GOVERNMENT PROGRAMS UNDERCUT PRIVATE SOLUTIONS AND ACCESS TO QUALITY CARE

Despite the cost-cutting innovations of employers in Florida and throughout the nation that have proven quite effective, Governor Chiles continues to promote "reforms" that would undercut such initiatives and instead steer ever larger groups of citizens into government-run alliances or other taxpayer-subsidized programs. There, employers and individual consumers will not have any direct financial incentive to hold down their use of health care services. The officials running government purchasing alliances, in turn, will have no incentive to look for creative ways to cut costs. They will only be required to identify those plans that meet the benefit packages outlined in government-announced RFPs (and possibly also government-set ranges of "acceptable" premiums); and insurance companies, in turn, will dictate to participating groups of medical providers the resulting fee schedules afforded by the government premium rates.

Top-down vs. bottom-up reform. Gov. Chiles' agenda for "managed competition," as represented by the state's 11 CHPAs (and his proposed Florida Health Security plan) and President Clinton's federal-level proposals share the same essential difference with the private-sector innovations outlined in this paper: a *top-down* approach versus a *bottom-up* approach to reform. With the Chiles and Clinton top-down approach, one level or another of government controls the health care products (coverage plans) offered for sale. With the private-sector health care revolution's bottom-up ap-

proach, employers and consumers control the monies spent and the products purchased. Cost control is achieved by employers and consumers looking out for their bottom line—their health care bills. We see this happening in the workplace more and more today, wherever employers institute programs to make employees and health care providers more accountable for a prudent use of their employer's health care dollars.

In addition, the Chiles and Clinton plans would move Florida and America toward a legal environment in which insurance companies would be able to offer nothing less than a government-defined policy with minimum benefits. Over time, the government-designed benefit plans, which would be subsidized for many enrollee groups, likely will become the choice of a growing number of employers seeking the cheapest, legal path to providing insurance to their workers. As a result, employers would be relegated to merely identifying the lowest-priced government-set benefits package and covering their employees with it. They would no longer have any incentive to pursue a proactive role with insurers or providers about the quality of care they obtain for their health care dollar.

These Plans Would Prepare the Way For a Single-payer System. Under a single-payer system, such as Canada's national health program, the government makes all payments to health care providers directly—with no insurance firms or other entities assuming any risk. Although it was little noticed, the September 1993 Clinton Plan would have given individual states, from the very outset, the authority to establish a single-payer system. Any system of state-wide government-sponsored purchasing alliances later could serve as the infrastructure through which a state introduces a single-payer system. A June 1993 comment by Doug Cook, Gov. Chiles' top health care official, is instructive: "I believe that managed competition can and should be the answer, but if it's not, it will be the bridge to a single-payer system."⁴¹ (Other nations' experiences with single-payer systems are fraught with problems. Under Canada's single-payer system, waiting lists grow longer—resulting in increasing reports of unnecessary deaths and growing numbers of Canadians crossing the border to obtain medical care in the U.S.⁴²) Indeed, the Health Care Reform Act of 1992, which the Florida legislature passed in March of that year, provides that "by December 31, 1994, employees and their dependents have, at a level acceptable to the Legislature, cov-

erage of the basic health care benefit package or employers shall be mandated to provide such coverage.” (Florida Statutes, sec. 408.0061 (1)(b) 2). Some, including Governor Chiles, have interpreted that provision as giving the state authority to implement either a single-payer system or a “play-or-pay” system of mandates on business.

If Governor Chiles continues to get his health care agenda legislated incrementally, at some point Florida’s 11 state-run CHPAs will be serving as a health plan intermediary for a substantial portion of Floridians; and very possibly acting as the sole receiver of premiums and the sole payer of premium monies for those plans. It would then be a relatively small further step for government to simply take insurers out of the loop altogether and pay providers directly—i.e., a single-payer system. As noted above, under a single-payer system, the quality of health care is certain to deteriorate, and Floridians can expect eventually to face waiting lists for care (i.e., rationing) as has resulted in Canada and elsewhere.

HOW TO DRAW THE LINE ON THE EXPANSION OF FLORIDA’S NEW HEALTH CARE BUREAUCRACY (THE CHPAs) AND LET THEM COMPETE WITH THE STATE’S PRIVATELY-SPONSORED ALLIANCES AND OTHER INNOVATIONS

The steps necessary to halt the expansion of Florida’s CHPA system and ensure that it continues to have to compete head on with the state’s privately-sponsored, no-cost-to-the-taxpayer alliances and other private innovations are quite few. A simple, seven-point plan for Florida includes:

- 1) **Revise Florida law** to end the state's ability to mandate employer participation in CHPAs or institute a single-payer system.
- 2) **Maintain the current legal provision** that membership in CHPAs be *voluntary*.
- 3) **Don’t institute the Florida Health Security program** which would represent a new, taxpayer-financed, Medicaid-type entitlement for the middle-class administered through CHPAs. Similarly, the

state should continue to implement any government-subsidized health program (Medicaid and others) separately from alliances or other channels that administer *private* health plans, so as not to undermine the private health care marketplace by blending (however indirectly) fully private plans with government-subsidized “private” plans through CHPAs.

4) **Do not expand the membership, scope, or power of CHPAs** by adopting any of the various proposals recently put forward such as, for example, authorizing CHPAs to negotiate health plans through “re-bidding.”

5) **End the authority of CHPAs to collect and distribute premiums**; limit them to being “information gatherers and disseminators.”

6) **Discontinue taxpayer subsidies of the state’s 11 CHPAs.** The CHPAs were designed to be a facilitator for *private* health plans, and the viability of the CHPA experiment must be allowed to be tested through the provision of no more taxpayer subsidies.

7) **Promote tax law changes** at the federal and state level, that would: a) provide tax-treatment equity so that self-employed and individual purchasers of health plans are put on an equal footing with citizens who receive coverage through their employer, and b) provide tax-treatment equity among conventional insurance programs and programs that include the use of Medical Savings Accounts (MSAs) by allowing contributions to MSAs to be made with *pre-tax*, rather than after-tax, dollars.

Conclusion. Governor Chiles, Florida’s state legislators, President Clinton, and the Congress should approach health care reform proposals keeping in mind that most Americans have health insurance and are

happy with the quality of health care they are receiving. The public's interest would be poorly served if improving the health care coverage of the 15 percent of Americans without insurance came at the expense of lowering the quality of health care for most Americans. Health care reform should facilitate (not restrict) employers' ability to experiment with the design of the health plans they offer to their employees. New government initiatives are not needed in order to encourage the spread of *private* coalitions, where large employers invite small employers to join their group-purchasing and quality assurance efforts. Not only are *government*-run purchasing alliances not necessary, if left unchecked they will undermine the continued success and expansion of the private coalitions. Let the public arrangements compete with the private arrangements, and let employers and covered employees reap the benefits of competition between the two for the provision of a superior level of service.

The "managed competition" health reform that has been introduced in Florida, with the CHPAs at the core, may well prove unable to stand on its own, without continued taxpayer subsidies. It is therefore important that membership in Florida's CHPAs continues to be voluntary, and that Florida's private businesses continue to pursue and expand their alliances and other

initiatives. Elected officials in Tallahassee and Washington should not pursue any health policy reform that diminishes private employers' and insurers' incentive to be part of the solution *in their own way*—at no cost to taxpayers. A free market in health care services has not failed America or Florida, because a true free market in health care has not been allowed to operate in America in recent years—where large government programs have accounted for over 40 percent of health care spending. Today, however, a free-market revolution in health care is taking place in cities across Florida and America, as companies develop a nearly endless variety of innovative health plans—including *privately*-sponsored purchasing alliances, the use of Medical Savings Accounts, and many other mechanisms. These private-sector innovations are making health care more accessible and more affordable to more people every day. Rather than stifling private solutions through the introduction of new government programs, lawmakers instead should encourage them through tax-law revisions and other enabling reforms.

END NOTES

1. U.S. Senator Phil Gramm (Texas). Remarks at a September 27, 1993 forum at the Cato Institute, Washington, D.C.
2. From an interview with Creston Nelson-Morrill that was referenced in "Intelligence Report," *HealthTrac*, June 29, 1993, p. 158.
3. An informative, detailed review of the process of progressively more sophisticated data collection efforts undertaken by the Coalition in cooperation with Orlando-area hospitals and MediQual Systems can be found in: Marilyn H. Bell and Jon R. Reiker, "Florida Employers' Efforts to Measure Health-Care Quality and Value," *Medical Interface*, November 1992, pp. 92-95.
4. Mike Oliver, "Employer-Hospital Coalition Manages to Cut Health Costs," *Orlando Sentinel*, February 15, 1993, p. CFB-14.
5. *Ibid.*
6. Remarks by Jon Reiker, Vice President, Benefits, General Mills Restaurants, Inc., at a conference entitled, "Health Care Reform: Private Voluntary Initiative vs. Government Mandate," September 30, 1993, Orlando, Florida.
7. Comment to the author by John Hanson, director of insurance for the Orange County school system, at the conference noted in *ibid.*
8. Interview with Frank Brocato in Tampa, October 7, 1993.
9. Rhodelle Holzberg, executive vice president and chief executive officer, Miami Chamber of Commerce, in a telephone interview of December 1, 1994.
10. Walter Nason, Greater Orlando Chamber of Commerce, telephone interview, October 3, 1994.
11. Tim Freeland, commercial marketing manager in PCA Health Plan's Orlando office, telephone interview, November 30, 1994; this information was reconfirmed on March 30, 1995.
12. Roy Boone, AvMed Health Plans, Jacksonville office, telephone interview, March 23, 1995.
13. Rosalind Resnick, "The Rosen Health Plan," *Florida Trend*, December, 1993, p. 33.
14. *Ibid.*, p. 30. (Calculated by multiplying his total payroll by the 7.9 percent small business payroll cap.)
15. Interview with Mike Dwyer, of Mike Dwyer Associates, an insurance agent in Altamonte Springs, Florida, that markets the Access to Healthcare Plan, October 1994.
16. Glenn Ruffenach, "Firms Use Financial Incentives to Make Employees Seek Lower Health-Care Fees," *The Wall Street Journal*, February 9, 1993, p. B1.
17. *Ibid.*

18. Malcolm S. Forbes, Jr., "Fact and Comment" editorials, *Forbes*, January 18, 1993, p. 25, and April 26, 1993, p. 23.
19. Ken Davis, "Now the Good News on Health Care," *The Wall Street Journal*, September 20, 1993, p. A14.
20. Ibid.
21. John C. Goodman and Gerald L. Musgrave, *Patient Power: The Free Enterprise Alternative to Clinton's Health Plan* (abridged version of *Patient Power: Solving America's Health Care Crisis*), Cato Institute, 1994, pp. 75-76.
22. Peter J. Ferrara, "More than a Theory: Medical Savings Accounts at Work," Cato Institute Policy Analysis no. 220, March 14, 1995, p. 3.
23. These studies are summarized in Ferrara, op. cit., pp. 4-6.
24. Ibid., p. 7.
25. Phone interview with Brian McManus, Golden Rule Insurance Company, September 10, 1993.
26. Bret Schundler, "Let's Talk Health Reform" *The Wall Street Journal*, August 1, 1994, p. A14.
27. Peter J. Ferrara, "More than a Theory: Medical Savings Accounts at Work," Cato Institute Policy Analysis No. 220, March 14, 1995.
28. Executive Office of the Governor, State of Florida, "Florida Health Security: Everybody Wins," September 14, 1994, pp. 9-13.
29. Ibid., p. 9. See also "The Florida Health Security Plan: Healthy Homes 1994," December 1993, distributed by the state Agency for Health Care Administration, p. 69: "All of this can be accomplished without requiring any new federal or state dollars."
30. "FHS Highlighted in Gov. Chiles' No-New-Tax Budget," *Healthtrac*, February 1995, p. 10.
31. Ander Crenshaw, "A 'Top Ten' List of Fallacies with the Governor's Health Care Plan," *Healthtrac*, June 6, 1994, p. 164.
32. "The Florida Health Security Plan: Healthy Homes 1994," December 1993, distributed by the state Agency for Health Care Administration, p. 35.
33. *The Florida House Republican "Consumer Choice in Health Care" Proposals for 1994*, mimeo dated March 22, 1994 and distributed by House Republicans, p. 13.
34. "The Florida Health Security Plan: Healthy Homes 1994," December 1993, distributed by the state Agency for Health Care Administration, p. 35.
35. "Briefcase," *Healthtrac*, June 6, 1994, p. 167.

36. Christine Jordan Sexton, "Chiles, Cook Unveil Florida Health Security," *Healthtrac*, January 13, 1994, p. 4.
37. Christine Jordan Sexton, "Intelligence Report," *Healthtrac*, March 1995, p. 1.
38. *Ibid.*, p. 2.
39. A comment by Terry McCorvie, executive director of the Region 7 CHPA, cited in *ibid.*
40. Cited in *Healthtrac*, December 1994, p. 7.
41. From an interview with Creston Nelson-Morrill that was referenced in "Intelligence Report," *HealthTrac*, June 29, 1993, p. 158.
42. John C. Goodman and Gerald L. Musgrave, *Patient Power: Solving America's Health Care Crisis* (Washington, D.C: Cato Institute), 1992, p. 253