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American industry is faced with an unsustainable financial drain in the form of a health care financing system run amok ---raising the cost of employee insurance programs well beyond what thousands of employers can pay and threatening the insurance coverage of millions of American workers.

The $42 billion in Medicare cuts (to be achieved over the next five years) resulting from the budget agreement for fiscal 1991 were necessary as a short term solution to an immediate budget problem. While the Congress should be given credit for making some very tough choices to reduce Medicare outlays through higher premiums and deductibles, all in all, the cuts barely dent the nation's total bill for health care expenditures. They will increase employers' and workers' share of the costs in the form of higher payroll taxes and Medicare beneficiaries' share through higher premiums and deductibles. The non-Medicare population will also shoulder part of the costs as doctors and hospitals shift charges to private patients as a way to recoup income lost through Medicare payment caps.

Reform of the system itself is our only hope to control or moderate burgeoning healthcare costs. The present situation is intolerable. It is also unsustainable. While in 1960, health care consumed less than 5% of the gross national product, it will approach 12% this year--a rate of increase twice that of

inflation. In 1980, Medicare cost $35 billion. Last year, it cost $107 billion. The estimate for 1995 is $180 billion. Responding to this crisis, health care experts call for solutions ranging from pure rationing (Thou Shalt Not have an organ transplant, ever) to ill-considered calls for outright nationalization of the healthcare system.

There is a way to reform. It is fairly simple in design, and it is working in a number of model projects across the U.S. It is based on competition, the establishment of meaningful competition among medical care providers based on price for a single unit of service or entire array of services.

The fundamental flaw of the Medicare system can best be described in two words: cost-plus. For the past fifty years, the underlying design of the entire U.S. health care system has been to pay physicians and hospitals according to prices set by a monopoly---organized medicine. Only in the last ten years, as a result of the case of Arizona vs. Maricopa County Medical Society (1982), when the U.S. Supreme Court first applied antitrust law to the setting of prices by doctors, has it been thought actually improper for physicians to set prices among themselves. Reinforcing this system, the insurance industry products of the day largely ignored the different prices charged by providers. If one doctor or one hospital was more expensive than another, the insurance company would automatically pay without increased obligation on the part of the patient or employee.

Reimbursements based on cost-plus formulas--in other words payments made without regard to market pricing and arms-length negotiations between insurers, employers and providers---rise from an era when the whole society was geared to the idea of medicine as monopoly. It was a benign monopoly operating unquestioned until the late seventies-- the medical society setting the price for every procedure, while hospitals collaborated on scope of services, accessibility, financing and ultimately price through government sponsored health planning agencies. It was a monopoly that gave us this system of fee schedules and price structures operating independently of the laws of supply and demand, independently of all market disciplines.

The Health Maintenance Organization (HMO) has been a useful first step in creating some price competition among providers---since the HMO is given a fixed amount of dollars to serve a fixed patient population. It is clear the HMO has the incentive to use high priced technology only when the HMO believes it is in the best interests of the patient. Waste comes out of the HMO's bottom line; an HMO physician who prescribes unnecessary CAT scans or the most recent PET scans has just taken money out of his or her own wallet.

Other and more user-friendly, affordable choices for patients must be developed if reform is to become a reality. A nation of fifty laboratories, fifty states travelling down a learning curve--each grappling with the problems and pioneering solutions-

-is the best way to develop working models. Some states, such as New York and Massachusetts, may choose to run their health care system as a public utility, where the state sets hospital rates and revenues, and may move to do the same for physicians with all the attendant regulation and inefficiency. Others, such as Florida and Minnesota, have medical care markets which are experimenting with different ways to negotiate with providers in order to overcome the historical cost-plus mentality. They are creating pressures and incentives for providers to manage more efficient operations and offer market-responsive quality and prices. Over time the most successful models will survive and can be adopted by Medicare and other payors, based on hard results---not good intentions.

Florida is the frontline state in the health care crisis facing America because of our huge elderly population. Our market is the bellwether for the rest of the country. The Miami market for health care services and health insurance is now the most competitive market in Florida. In many government and private insurance programs, Miami could be expected to have medical costs 25% higher than the rest of the state. Yet, the Blue Cross Blue Shield of Florida HMO, a managed care program in Miami which covers some 80,000 people, now has costs equal to or below the state average.

Preferred Provider Organizations (PPO's) are another market-based solution through which subscribers can reduce their out-of-pocket costs by going to a network of providers -- providers

induced to join the organization by the promise of increased volume but selected only after rigorous arms-length negotiations based on quality and price considerations.

Competition among insurers in Florida is part of the state's battle on health care costs. Insurers in Florida are today selected overwhelmingly on the basis of price in highly competitive bidding processes. There are now between 75 and 100 competitors in each segment of the Florida market---and approximately 10 major competitors statewide. To compete for private sector business we have had to invest in people and data processing systems that increase our efficiencies and help us achieve real economies. As Florida's Medicare contractor, we have been able to inject a measure of new competition into the Medicare system nationwide by opening-up a competitive bidding procedure for our Medicare data processing business (a contract in excess of $10 million a year)--a market previously dominated by only one vendor. The new system not only reduces our data processing costs but also saves the taxpayers money as a result of intensified competitive bidding across the nation for these big contracts.

Employers who want to take advantage of the leverage provided through negotiations and competition should run, not walk, to the nearest managed care program that can demonstrate both the quality of care and the savings generated by HMO's, PPO's and other hybrid models insurers are developing. Few, if any, employers have enough bargaining power in their own right to get

as good a deal as those available through these approaches. Except in those states that choose to administer medical services as a public utility, employers should take a hard look at the available plans, compare their costs and advantages, and get into a managed care program. It makes good economic sense. And it is good public policy.

Medicare must keep up with this trend toward managed care. Gail Wilensky head of the Health Care Finance Administration, the federal entity responsible for the Medicare program, embraces the idea of "coordinated care systems" that channel patients to the most cost effective providers. Managing utilization, assuring quality and improving purchasing arrangements are at the heart of this system. Through coordinated care systems, insurance carriers can take advantage of their own knowledge and experience in individual metropolitan markets to negotiate real agreements, reflecting market prices with doctors and hospitals.

The overwhelming majority of the American people think it proper to spend $1 million in a medical intervention for a single patient. But when asked the question, "would you pay for it with a $125 a year increase in taxes?", most Americans say no. The cost and benefit of health care services has become completely disconnected for the American public. Rising consumer expectations for unlimited access to unlimited technology are so strong that many argue quite persuasively that government intervention will be needed to set limits on what kind of medical care will be available.

Before we rely on government arbitrarily to "set limits", employers and insurers should do everything in our power to drive the existing system to perform. Employers, insurers and providers must forge a new alliance dedicated to the idea of keeping costs down---not by government rationing and diktat---but through the application of real market forces on the American health care system.

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