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Perverse Incentives in Health Care

By John C. Goodman

Our public-school system and our health-care system may seem as different as night and day. Yet both systems share something in common: Mediocrity is the rule and excellence, where it exists, is distributed randomly.

In both cases the reason is the same. There is no systematic reward for excellence and no penalty for mediocrity. As a result, excellence tends to be the result of the energy and enthusiasm of a few individuals, who usually receive no financial reward for their efforts.

Research by John Wennberg and his colleagues at Dartmouth Medical School suggest that if everyone in America went to the Mayo Clinic, our annual health-care bill would be 25% lower (more than \$500 billion!), and the average quality of care would improve. If everyone got care at Intermountain Healthcare in Salt Lake City, our health-care costs would be lowered by one-third.

Of course, not everyone can get treatment at Mayo or Intermountain. But why are these examples of efficient, high-quality care not being replicated all across the country? The answer is that high-quality, low-cost care is not financially rewarding. Indeed, the opposite is true. Hospitals and doctors can make more money providing inefficient, mediocre care.

In a normal market, entrepreneurs in search of profit would solve this problem by repackaging and repricing their services in order to make customer-pleasing adjustments. Yet in health care, contracts and prices are imposed by large impersonal bureaucracies. The individual physician has virtually no opportunity to offer a different bundle of services for a different price. As a result, very little entrepreneurship is possible.

Sometime in the early 20th century, lawyers, accountants and most other professionals discovered that the telephone was a useful instrument for communicating with clients. Yet even today, consultations with doctors by telephone are quite rare. Sometime in the late 20th century most other professionals discovered email. Yet only 21% of patients exchange email with their physicians; of these, slightly more than 2% do so on a frequent basis.

One would be hard-pressed to find a lawyer in the U.S. today who does not keep client records electronically. Ditto for accountants, architects, engineers and virtually every other profession. Yet although the computer is ubiquitous and studies show that electronic medical record systems have the capacity to improve quality and greatly reduce medical errors, no more than one in five physicians or one in four hospitals have such systems.

Why has the practice of medicine (as opposed to the science of medicine) changed so little in the modern era? The reason is because of the way we pay for medical care, particularly the way we pay doctors. At last count, there were about 7,500 specific tasks Medicare pays for. Telephone consultations are not among them. Nor are email consultations or electronic record keeping. What is true of Medicare is also true of Blue Cross and most employer plans.

Things are made worse by the fact that patients do not usually pay for health care with money; they typically pay with their time instead. As in Canada and most other developed countries, health care in the U.S. is mainly rationed by waiting, not by price.

When the doctor's time is rationed by waiting, the primary care physician's practice is usually fully booked, unless the practice is new or located in a rural area. As a result, there is very little incentive to compete for patients the way other professionals compete for clients. Because time -- not money -- is the currency we use to pay for care, the physician does not benefit very much from patient-pleasing improvements and is not harmed very much by an increase in patient irritations. Bottom line: When doctors and hospitals do not compete on the basis of price, they do not compete at all.

Where third-party payment is the norm, markets tend to be bureaucratic and stifling. But in those health-care sectors where third-party payment is rare or nonexistent, the market is vibrant, entrepreneurial and competitive.

Take cosmetic and Lasik surgery, for example. In both markets, patients pay with their own money. They also

have no trouble finding what is virtually impossible to find for other types of surgery -- a package price covering all aspects of the procedure. People can compare prices, and in some cases quality. Providers are competing on price and quality and competition pays off. Over the past decade and a half, the number of cosmetic procedures grew sixfold along with numerous technological innovations of the type that are blamed for rising costs everywhere else in health care. Yet despite tremendous growth and technological change, the real price of cosmetic surgery declined. Over the past decade the real price of Lasik surgery fell by 30%.

The market for prescription drugs is another area where a great many people are paying out of pocket. In response, Rx.com was the first online outlet that began competing based on price and quality (they make fewer mistakes than local pharmacies). Wal-Mart's new policy of offering a month's supply of generic drugs is yet another example. Can anybody imagine Wal-Mart offering the same deal to Blue Cross?

Perhaps the most spectacular instance of a health-care product developing outside the third-party payment system is the walk-in clinic. These can be found in shopping malls and drug stores in the upper Midwest and they are spreading like wildfire around the country. They post prices. There is very little waiting. They maintain records electronically. The quality of service is comparable to traditional primary care at half the cost.

I know what you're probably thinking. Markets may work for certain specialized services; but can they work for run-of-the-mill hospital surgery? Medical tourism is proving that the answer is yes. If you're willing to leave the country you too can have access to efficient, high-quality health care. In India, Thailand and elsewhere around the world, facilities are offering U.S. citizens virtually every kind of procedure for package prices, covering all the costs of treatment, and sometimes airfare and lodging as well. These prices are often one-fifth to one-third the cost in the U.S. and care is often delivered in high-quality facilities that have electronic medical records and meet American accreditation standards.

One part of our health-care system (the part where third parties are absent) is teeming and bristling with entrepreneurship and innovation. In the other part (where third parties pay the bills), entrepreneurship has been all but extinguished. How can we make the latter more like the former?

Public and private efforts to reform the health-care system have been actively underway for the past two decades. The results have been disappointing, to say the least, and they all have one thing in common: They focus on the demand side of the medical marketplace.

Managed care, practice guidelines, pay-for-performance -- each of these short-lived fads involves buyers of care telling the providers how to practice medicine. Does no one notice how strange this is? In normal markets, buyers do not instruct sellers on how to efficiently produce their products. Even the HMO movement is a demand-side reform in this context. The HMO doctor is just as trapped as the fee-for-service physician and just as unable to rebundle and reprice his services in innovative ways.

Some believe that health savings accounts (HSAs) will radically reform the health-care system. Yet this is also a reform that focuses on demand, not supply. Even with an HSA plan in hand as you approach the doctor's office, you should know that your insurer has already spelled out what services will be paid for, which ones will not and how much will be paid. HSAs, therefore, will not free doctors to take advantage of telephone, email, computerized records or any other truly innovative service. Like school vouchers, HSAs create new freedom on the buyer side without loosening the shackles on those who produce. The reform is commendable. But real innovation must come from the supply side of the market.

One would think that health insurers and employers would find it in their self interest to break the mold. To the extent that entrepreneurs raise quality and lower price, the insurance product itself should become more attractive to potential customers. The trouble is that the entire third-party payment system is completely dominated by government (principally through Medicare and Medicaid). Private insurers tend to pay the way the government pays and providers who break Medicare rules in order to better serve the patient risk being barred from the entire Medicare program.

A possible way out of this morass is to start with government. Under the current system, Medicare and Medicaid stifle entrepreneurial activity and financially punish efforts to lower costs or improve quality. Why can't these agencies reward improvements instead? Suppose an entrepreneur offered to replicate the Mayo Clinic in other parts of the country -- potentially saving Medicare 25% of costs and improving quality of care along the way. Medicare should be willing to pay, say, 12.5% more than its standard rates in order to achieve twice that amount in lower total costs. That would leave the entrepreneur with a 12.5% profit -- an amount that one would hope would encourage other entrepreneurs to enter the market with even better ideas.

Once government agencies jump-start the entrepreneurial process in this way, private insurers are likely to follow suit. In this way, government could promote entrepreneurship, instead of stifling it.

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What's the One Thing Big Business and the Left Have in Common?

By Jonathon Cohn

The struggle to establish universal health insurance, dormant for more than a decade, is back. Should it actually succeed over the next few years, historians may trace that triumph, at least in part, to a news conference on Capitol Hill — and to a most unusual figure who participated in it. The event took place in early December, just after the Democrats won back control of Congress. Its sponsor was Senator Ron Wyden, Democrat of Oregon, who was unveiling what would become the first universal-coverage proposal of the new political alignment. The impending change in Congressional leadership lent the announcement greater significance than usual — Wyden's proposal would actually get a hearing, for one thing.

In many respects, the news conference seemed rather mundane. Universal health care has always been a liberal's cause, after all, and Wyden is one of the Senate's most liberal members, somebody who has long defined universal coverage primarily in terms of fairness and equal opportunity. Among those flanking Wyden onstage were other longtime advocates of universal coverage, including Andy Stern, president of the Service Employees International Union. He, too, paid homage to the traditional rationale, arguing that Wyden's plan "sets down a moral test: Why doesn't every American have the right to the same health care as the president, the vice president, 535 members of Congress and three million federal workers?"

One of the men alongside Wyden and Stern stood out, however, politically if not visually. He was Steve Burd, chairman and C.E.O. of

Safeway supermarkets. Nobody has ever accused Burd of having a bleeding heart: a former management consultant with a graduate degree in economics, he became notorious two years earlier when he helped lead California grocers into battle with their labor unions over employee medical benefits. Burd insisted that the unions accept skimpier insurance to save his company money. In the four-month walkout that ensued, newspapers ran articles about checkout clerks defaulting on their cars and homes. Union supporters blasted Burd as "evil" and "a rat." At one point, a group of clergy members marched on Burd's California estate, holding a prayer vigil and delivering a handwritten plea for him to compromise. He didn't. And eventually he won, forcing major concessions from the union.

Yet here was Burd in Washington, arm in arm with one of labor's most passionate leaders, endorsing a plan in which the government would guarantee affordable, high-quality insurance to every single American. "Our nation is facing a crisis that requires immediate attention," Burd declared. "Working together, business, labor, government, consumer groups and health-care providers can collectively solve this problem." And while the "working together" line had the feel of boilerplate, Burd meant it. In the year that Wyden took constructing his proposal, Burd was quietly advising him; eventually they or their staffs were conferring almost every week.

When Burd wasn't working with Wyden, he was talking about health care with another audience: his

fellow C.E.O.'s, whose support for universal coverage he was trying to secure. Soon that effort may also produce results. When I spoke to Burd recently at Safeway's headquarters in Pleasanton, Calif., just east of San Francisco Bay, he told me that within weeks he expects dozens of companies to join a nonprofit advocacy group he is organizing called the Coalition to Advance Health Care Reform. Burd declined to reveal their names or the exact number of corporations participating. He did say that they represent a broad swath of corporate America and that all will be known when the group goes public later this spring. Burd also confirmed that one of the coalition's officers in Washington will be the longtime Republican Party operative Ed Gillespie — whose presence in an organization explicitly endorsing "universal health coverage," as the coalition's founding principles do, would seem about as likely as the presence of George W. Bush himself, whose disdain for anything resembling "government-run health care" is a matter of public record.

Is all of this indicative of a broader shift in the politics of health care? Perhaps. As health care has become more expensive and even middle-class Americans have become anxious that their hold on employer-sponsored coverage is precarious, politicians have been talking seriously again about making health insurance a birthright, just as it is in every other developed nation. Not long after Wyden unveiled his plan, former Senator John Edwards, who is running for president, offered a detailed universal-coverage proposal of his own. His chief rivals for the Democratic nomination, Senators Hillary Clinton and Barack

Obama, have pledged to insure all Americans. Meanwhile, Mitt Romney of Massachusetts signed a statewide universal law last year before leaving the governor's office; his campaign for the Republican nomination now proclaims it his major policy achievement. Gov. Arnold Schwarzenegger, another Republican, has proposed a similar system for California.

But it is corporate America's interest that is most striking. For many years, the only business leaders openly calling for universal coverage were mavericks like Howard Schultz, the chairman of Starbucks, who has long preached the need for business to show greater social responsibility. The C.E.O.'s rallying to universal coverage now — particularly in the last few months — are acting not so much out of social solidarity as out of financial necessity, as the burden of financing workers' premiums has become ever more onerous.

"The refrain from business was, 'We can't afford to do universal health care,' " says Wyden, whose plan calls for shifting responsibility for buying insurance from employers to individuals. "Now the refrain is, 'We can't afford not to do it.' " The Business Roundtable, one of Washington's most influential business lobbies, now endorses universal coverage, at least in broad principle. And probably no spectacle captured the spirit of the times more than a joint conference held in February by Andy Stern and a man he has spent much of the last few years attacking, Lee Scott, the C.E.O. of Wal-Mart. Together the two pronounced the need for universal coverage by 2012.

Of course, at that news conference, Scott didn't go into great detail about exactly what kind of universal health-care system he would like, just as the Business Roundtable shied away from specifics in its

statement. And that's the rub. In the early phases of the last great debate about health-care reform, during the early 1990s, prominent business leaders sent out strikingly similar signals — suggesting they were ready to embrace universal health care, for the same essential reasons they cite now. At one point, a coalition of business leaders put out a "play or pay" proposal that would have required corporations either to insure their workers or to pay into a common fund for the uninsured. But as President Clinton's health-care plan lost political momentum, the business community's support for universal health care faltered and, eventually, collapsed. Is its support any more reliable now? "This is precisely the political equation the Clintons bet on," says Jonathan Oberlander, a health-policy scholar at the University of North Carolina. "Sorry to say this may turn out to be another mirage."

Burd, who like most successful business leaders does not lack self-confidence, vows to see this campaign through and to bring his fellow C.E.O.'s along with him. Veteran universal-coverage supporters like Stern and Wyden who have worked with Burd say they think it's possible he will do just that. But even they concede that Burd's ideas — and more generally, the ideas of the business community — don't line up perfectly with their own. How far can such a coalition go? And, no less important, where will it go?

The first calls to create what we now know as universal health care date back to the early 20th century. Before then, medical care was generally cheap because it was, for the most part, ineffective. As one scientist put it, "It was around 1910 or 1912 when it became possible to say that a random patient with a random disease consulting a random doctor stood better than a 50-50 chance of benefiting from the encounter." But by the 1920s,

medical advances — in particular, the refinement of anesthesia and the development of sanitary techniques — enabled doctors to cure patients rather than simply comfort them. As medicine grew more sophisticated, however, it became more expensive. Particularly after the Depression set in, large numbers of people could no longer afford to pay for medical care on their own. Many went into debt. Others simply didn't get the care they needed.

Franklin Roosevelt ended up rejecting calls to incorporate health insurance into the New Deal; he is thought to have feared that the opposition of organized medicine might sink his Social Security Act. As a result, the inability of patients to pay for their medical bills remained a problem — not just for the patients but, increasingly, for the providers as well. Having spent the boom years of the 1920s building up their facilities, hospitals faced a serious financial crunch with the onset of the Depression. To improve their prospects of being paid by patients, they created the nation's first group-insurance plans. These plans evolved into the Blue Cross system and eventually became the model upon which all health insurance would be based. Among the most important characteristics of these plans was that they were linked to employment: in order to spread the cost of caring for the sick, hospitals pitched the plans primarily to groups of employees — a method that brought in enough healthy people to subsidize the cost of the sick or injured.

By and large, leaders of the business community in the middle of the century embraced this change. Given their staunch opposition to government interference in the private sector, Blue Cross-style insurance seemed the least-objectionable solution to the medical-cost problem. And during World War II, when the government exempted fringe benefits from its

strict controls on wages, employers started offering ever more generous health benefits in order to attract workers. Another government decision — to exempt group health insurance premiums from personal income taxes — made health insurance an even more attractive option for business to offer. This effectively made a dollar of insurance worth more than a dollar of income, giving companies an easy way to cement worker loyalty.

During the postwar era, with widespread prosperity helping to create relatively good relations between management and labor, C.E.O.'s frequently spoke of themselves as stewards of their employees' well-being — a claim consistent with their role as the country's primary sources of insurance. But by the 1970s, improved technology and increasing demands for it (spurred, in part, by the creation of Medicare) sent the cost of medicine skyrocketing. Meanwhile, America's manufacturing sector faced intense competition from producers abroad who paid considerably less for labor than their American counterparts. As insurance became more expensive, businesses started looking for ways to limit the burden. Often, they succeeded — which is one reason the proportion of Americans without insurance climbed in the late 1980s and early 1990s, setting in motion the Clinton health-care episode.

Though it is not widely remembered, Clinton tried hard to curry favor with business. Ira Magaziner, the chief architect of the administration's plan, met repeatedly with corporate leaders to seek their advice, understand their needs and anxieties and test their tolerance for various provisions. Although the final White House plan included an "employer mandate" — meaning all businesses would be required to pay for a portion of their employees' health-

care costs — Clinton constructed that mandate so that many employers would actually benefit: For example, the automakers and other large employers obligated by union contracts to provide generous benefits would get some financial relief. Even businesses that didn't offer such generous benefits would at least enjoy more predictability, since contributions to a government-administered fund would fluctuate a lot less than existing private-insurance premiums. The mandate would have the hardest impact on the country's small businesses, since so many were not providing any sort of health insurance at all. But the Clinton plan had subsidies for these establishments too. Given all this, why didn't business support the Clinton health plan?

Actually, there was some support — at least initially. Most notably, the U.S. Chamber of Commerce at first embraced the concept of an employer mandate. But when the chamber, which represents both big and small companies, announced its endorsement, it came under attack from the National Federation of Independent Businesses, which represents only small firms. The chamber quickly started to lose members — and to field irate calls from Republican legislators warning against giving any support to the Clinton plan. The chamber and other allies backed off.

Following the plan's demise, the most influential leaders of the business community assumed a strongly oppositional stance to virtually any health-care reform that involved more regulation or spending, no matter how modest. In 1998, when Congress considered passing a law that would regulate the practices of H.M.O.'s, both the Chamber of Commerce and the National Association of Manufacturers joined a coalition that spent \$1 million fighting the measure. One of the coalition's

advertisements featured a Frankenstein figure — and a warning to Congress: "Be careful how you play doctor. You might mandate a monster."

It was during the Clinton-era debate over health-care reform that Burd made his first foray into politics as Safeway's C.E.O. In 1993, well before Clinton unveiled his full plan, Democratic lawmakers interested in building support for universal coverage invited a group of corporate leaders — Burd among them — to visit Washington. During a brief discussion on Capitol Hill, Burd acknowledged that, yes, he thought universal health care was probably a good idea, because his supermarkets spent so much money on their worker benefits and because universal coverage, done right, might bring some relief. As Burd retells the story, no sooner had the C.E.O.'s finished talking than the legislative staff threw open the doors — ushering in a flood of reporters and cameras for a news conference. Apparently the other participants knew this was coming, because they had prepared statements. Burd didn't. So he just spoke extemporaneously when his turn came, saying more or less what he had a few minutes earlier. His comments made the next day's papers, but aside from taking a few follow-up calls, Burd says he didn't play much of a role in the political drama that followed. Instead, he watched the coming political train wreck from afar and concluded that there wasn't much a C.E.O. could do in that political environment.

Within a few years, however, Burd found himself thinking about health care all over again. Like many companies, Safeway received temporary relief from rising insurance costs during the mid- and late 1990s, as insurers began using the techniques of managed care — restricting patients to certain doctors and bargaining harder on prices from hospitals. But those huge

managed-care savings vanished once insurers squeezed out the obvious waste; once consumers rebelled against H.M.O. restrictions; and once doctors and hospitals consolidated into groups with more bargaining leverage. By the late 1990s, premiums started rising at their old rates again. It became all too apparent that if businesses wanted to hold down the cost of employees' health insurance, simply herding everybody into managed care plans wasn't going to do the trick.

Of course, not all businesses faced the same difficulties. Health-care costs had long been an overriding concern for heavily unionized companies obligated to pay lifetime health benefits to generations of retirees. The Big Three automakers liked to say these "legacy costs" added more than a thousand dollars to the cost of every new car, making their products effectively uncompetitive with foreign rivals. And although this was something of an old story — the former Chrysler C.E.O. Lee Iacocca was warning about health care's impact back in the 1980s — the problem had magnified over the years. Uwe Reinhardt, a Princeton economist, has described the Big Three automakers as "a social insurance system that sells cars to finance itself."

Safeway, certainly, had no comparable burden. But as a low-margin business — profits in the grocery industry tend to run between 1 and 3 percent of revenues — it was still very sensitive to rising benefit costs. (Burd likes to refer to the grocery chains as occupying the lowest decks of a leaking ship; as the hull starts to fill with water, they're the first ones to notice.) And while Safeway wasn't directly threatened by competition from abroad, it had become extremely worried about one very big competitor at home: Wal-Mart.

If G.M., with its lavish insurance, represented the quintessential industrial-age employer, Wal-Mart was a prototype for doing business in the postindustrial era. Its work force was nonunionized (thanks in no small part to the company's staunch resistance) and, as such, it could get away with offering less insurance to fewer workers than companies like Safeway. In late 2003, after Wal-Mart announced that it would take its new superstores into California, the big supermarket chains said they had no way to compete with Wal-Mart's bargain-basement prices without heavy concessions from their workers on benefits. Although the union argued that Safeway was merely using Wal-Mart as an excuse to reduce benefits, the eventual settlement of the ensuing strike gave Burd much of what he wanted. In a new, two-tier benefits system, new employees had to wait longer for benefits and, even then, were not promised the same plan as existing employees. In other words, Safeway's insurance would start to look just a little more like Wal-Mart's.

Burd had a freer hand to tinker with the benefits of his nonunion employees — the supervisors and corporate administrative personnel who make up about 15 percent of the company's 200,000-person North American work force. Here he simultaneously adopted two approaches. Instead of offering employees virtually full coverage, Safeway followed the lead of other corporations that were introducing plans with higher deductibles — and lower premiums. By encouraging employees to "put some skin in the game," as the saying went, business hoped workers would become shrewder — and more frugal — consumers of health care.

But that was just Step 1. Step 2 was to develop a comprehensive wellness program for the workers.

Burd, who is 57, is something of a fitness nut, thanks in part to personal circumstances: With a family history of early heart attacks, he ran on a treadmill every day, lifted weights twice a week and meticulously watched his diet. A high-school baseball player, he took special pride in his leadership of the corporate softball team. But he was even more proud that he'd been keeping his cholesterol level below 135.

Burd said he thought that if his employees adopted the same habits, they'd be healthier, too. And healthier employees, he'd come to learn, didn't run up such high medical bills. Burd had never been shy about offering Safeway employees advice about how to behave — in 1998, he famously encouraged his workers to be more cheerful, even setting up a one-day training program that employees mocked as "smile school"; soon he began feeding his employees a steady diet of healthful-living propaganda, through speeches and newsletters. He also introduced screening and counseling for chronic disease, whose treatment inevitably constitutes the bulk of health-care spending. Enrollment in the screening program was strictly voluntary, but those who joined got breaks on their insurance premiums. And just to make sure employees didn't skimp on preventive care in order to save some money — a common hazard of higher-deductible plans — he exempted such treatments from the deductibles and effectively made them free.

Burd says the results were impressive: in 2006, the first year of full implementation, employees who enrolled in the newer plans, with the greater individual cost-sharing, had their personal health-care bills drop by 20 to 30 percent, while the company's health bill for those employees shrank by 11 percent. (It is unclear what

happened to the costs of people who stayed in the old plan.) But Burd soon realized that corporate cost-cutting had its limits. Over the years his interest in wellness had led him to become a major supporter of disease research. In conversations around the Bay Area, he heard over and over from hospital administrators about the financial burden the uninsured were placing on their facilities — a burden that eventually rippled through the insurance system and showed up on Safeway's bottom line as inflated health premiums.

Burd's first effort to trim costs and keep Safeway competitive involved cutting back on health benefits. Then he tried encouraging his workers to be healthier. Could nationwide universal health care simply be the next step? As long as there were large numbers of uninsured, Burd reasoned, there would be no solution to his company's — or the country's — problems with affordable care. And that, he says, is when it finally dawned on him: Maybe this was a problem the company couldn't solve on its own. If he wanted relief from employee health costs, the government would have to help.

It was not an idea that came easily to Burd, a self-described conservative and Republican; in his office, a "Bush 2000" baseball hat sits in a glass display case. But when Burd came to Washington and started talking about his company's problems with health care, it was Wyden, a Democrat, who seemed most interested in working with him.

Ultimately, the bill that Wyden and Burd produced is powerful evidence that an alliance including liberals and conservatives, labor and management, can produce meaningful legislation. According to the Lewin Group, a well-respected health-care consulting firm, the Wyden plan would achieve

universal health insurance in a financially sound way. Families' costs would vary depending on their medical expenses and the insurance plan they chose, but on average those making less than \$40,000 would end up with a little more money than before. Those making more than \$40,000 would end up with a little less money, although they'd also get more choice of plans, better benefits and the knowledge that they could never lose their coverage.

Wyden is quick to share credit for the plan with Burd, particularly when it comes to what is arguably its most significant provision: the severance of the longstanding relationship between where you work and how you're insured. Under the Wyden proposal, most Americans would still use private insurance. But they would not get that coverage through employers anymore. Instead, all employers that offer insurance would "cash out" their benefits — in effect, giving their employees higher wages rather than health benefits. Once that was done, people would be required to buy coverage on their own, directly from insurers. (Wyden's plan leaves enforcement to the states. Some have suggested that schools could require proof of insurance before enrolling children, and uninsured adults could be penalized on their tax returns.) The federal government, in turn, would closely regulate the insurance offerings to make sure all policies provided certain minimum benefits — Wyden has initially set those benefits to match existing Blue Cross-Blue Shield plans. Under Wyden's plan, the federal government would also make sure those benefits were available to everybody at the same rate, regardless of pre-existing medical conditions. Finally, the government would offer subsidies to people too poor to buy insurance on their own, phasing out Medicaid.

Wyden says Burd initially thought that mandating relatively generous benefits was a mistake; it reminded him of those policies he'd replaced at Safeway. But to Wyden's pleasure, Burd didn't insist he strip down his plan. In turn, Burd was pleased to see Wyden promote healthful behavior. In order to finance the subsidies for the poor, Wyden's plan calls for a tax on businesses, pegged to a firm's revenues and size. Companies that now provide relatively generous employee benefits would likely end up paying slightly less under the plan, while companies that don't would likely pay more. And even though employers would no longer be insuring their employees, they would get financial incentives to set up wellness and fitness programs, while employees would get insurance discounts for enrolling in them.

Although Wyden says he thinks there's a chance his bill, or something like it, could pass this Congress, most experts believe a serious effort to achieve universal health care won't take place until after a new president takes office in 2009. Then Wyden's plan could well become a starting point for the discussion, particularly since it represents a variation on the most-talked-about health-care reform idea of the moment: the "individual mandate," so called because it "mandates" that "individuals" buy private insurance just as individuals with cars are mandated to buy private auto insurance. (In some individual-mandate schemes, people can still enroll in public programs like Medicaid if they are eligible.) Mitt Romney and Arnold Schwarzenegger made the individual mandate the foundation of their universal-coverage plans.

It's no great mystery why some businesses might like an individual mandate. It gets them out of the business of insuring their workers while relieving them of most, if not

all, of the financial liabilities associated with health care. In addition, it levels the playing field among companies that have been generous and companies that haven't — in effect, taking away Wal-Mart's ability to undercut Safeway by skimping on worker benefits. No less important, an individual mandate does all of this without asking the government to assume direct responsibility for providing most Americans with health care — which is what would happen if the U.S. instead adopted what is known as a "single payer" system. Indeed, that's usually the punch line of Burd's pitch to corporate audiences: If business doesn't coalesce behind a universal scheme that's based on private insurance, he warns them, frustration with the status quo will produce a backlash that results in single-payer.

Of course, some experts would argue that, strictly on the merits, a single-payer system might actually work better. Unlike plans like Wyden's that rely on private insurers, a single-payer plan substantially reduces the amount of money spent on administration, since insurance companies spend far more on overhead (and marketing, and profits) than public systems. And while the data on medical outcomes are notoriously uneven and hard to interpret, they don't show that the United States provides uniformly better care than single-payer nations like Canada or France. In fact, on measures like "Disability Adjusted Life Expectancy," which social scientists use to measure the performance of national health-care arrangements, single-payer systems actually seem to perform slightly better on the whole.

Insofar as the advocates to Burd's left are eager to achieve universal coverage any way they can — even if it means adopting what they

consider an imperfect model — none of this may matter. "We're ready to have a very bipartisan solution," Andy Stern said. "What you are seeing now that you didn't see in 1994 is that everyone is on the same side saying, 'We want universal coverage.' The only question is, How?" But some of Burd's fellow members of the business community are another matter. Like Burd, they believe forcing workers to take on higher deductibles and more responsibility for their health care decisions is a good strategy for controlling costs. Unlike Burd, they're not necessarily so committed to subsidizing preventive care or providing benefits as generous as Wyden's plan. And they are certainly not that enthusiastic about government doing more — even if it's a plan that preserves a large role for private insurance. "We should not forget there is another way out for companies besides government intervention," says Jonathan Oberlander, the health-policy scholar. "Cut back on coverage, hold down wages and shift costs to workers."

Then again, maybe Burd doesn't have to bring along all of corporate America, with its many and sometimes conflicting interests, in order to make a difference. Maybe it is enough for him simply to give the idea of universal health care greater respectability — to give it the imprimatur of businessmen, who, after all, are typically the kinds of people most suspicious of such grandiose interventions in the first place. And if Burd is acting for reasons that largely reflect his corporate sensibility rather than a sense of social responsibility, even the most passionate advocates for universal coverage say they can live with that. "Unfortunately, simply making this a moral issue hasn't worked," Andy Stern says. "Making it clear that this is a competitiveness and jobs issue, as well—that is what

has propelled the business community into this discussion."

Besides, Safeway's bottom line is not the only thing on Burd's mind these days. As he has gotten more deeply into this campaign, he has talked increasingly about the health-care crisis as a threat to competitiveness — one in which the future of the entire American economy hangs in the balance. At the same time, the health-care problem lately — and unexpectedly — acquired a personal resonance. Burd's own son, a recent college graduate, now runs a small fitness company. Like Burd, he works hard to keep in top physical shape. But because he injured his back a few months ago, and received cortisone treatments for it, insurance carriers have been turning down his insurance applications.

Most likely, Burd's son will be just fine. One of the perks of being a nationally prominent C.E.O. is that you tend to know other C.E.O.'s, including those who run insurance companies. Burd has sent off a few pointed inquiries, and, he told me with a grin, he's pretty sure one company or another will find a way to write a policy for his son. But Burd has also taken note of the experience: it's just one more sign that American health insurance doesn't work the way it should. It may not offend his morality, but it certainly offends his sense of efficiency. If that's what makes him such an influential supporter of universal health care, his newfound allies in the fight aren't going to complain.

Jonathan Cohn is the author of "Sick: The Untold Story of America's Health Care Crisis — and the People Who Pay the Price," to be published next week. He is a senior editor at The New Republic and a senior fellow at Demos.

Health care -- but at what cost?

By Daniel Lee

Christy Tittle now thinks twice before scheduling a doctor's appointment for just any ailment.

After all, unless that visit is for recommended preventative care, she will be footing the entire bill.

The Fishers resident is among a small but growing number of workers to leave traditional health plans for so-called consumer-driven plans. Such plans typically feature low, or even no, premium payments but have high deductibles, or out-of-pocket costs, before coverage kicks in.

The goal: Encourage patients to improve their health, ask their doctors questions and shop around for the best price and quality in care.

"It's made me think more about the costs behind it," Tittle said. "Definitely before they start ordering tests and labs, I would be asking a lot more questions before I would just say 'OK.'"

Tittle, director of benefits for the state of Indiana, said the switch to a high-deductible plan has been an adjustment, even though she studies health plans as part of her job. For instance, she now pays more attention to what each health service might cost and uses a specialized debit card to pay for care.

Doctors also report seeing behavior changes -- some encouraging, others unsettling -- from patients on consumer-driven plans.

Dr. Patrick Rankin of Community Physicians of Indiana has noticed the patients enrolled in consumer-driven plans at his Fishers family practice tend to be well-informed and engaged in their own care.

"It opens up more conversation," he said.

The physicians said they like to see people more engaged in their health care. But some fear that patients, especially those with lower incomes, at times may forego needed care to avoid paying the often-hefty bills from doctor visits.

"The American public in general has trended toward more consumerism, so I think empowering the patient to make their own decisions has the potential to be a good thing," said Dr. Deanna Willis, assistant professor of family medicine at the Indiana University School of Medicine.

Willis said that among her patients, those on consumer-driven plans tend to seek more medical advice by telephone, for which they are not billed, rather than scheduling an office visit.

She added that patients in these plans also sometimes decline getting some lab tests because of costs.

When a patient seeks treatment for certain symptoms, tests may be ordered to rule out that the person is not suffering from a rare but serious condition. In the vast majority of cases, the results for those tests come back negative, but Willis worries about the potential consequence of people regularly declining such screenings.

"Everything in medicine is a percentage," she said. "At some point somebody is going to get burned by that decision."

A recent study by researchers at Harvard Medical School found that patients who switched to high-

deductible health plans went to the emergency department 10 percent less often than people covered by traditional health plans.

Also, those on high-deductible plans had a 25 percent reduction in repeat emergency visits.

"This seems to indicate there's a learning curve," said Dr. Frank Wharam, research fellow in the Department of Ambulatory Care and Prevention at Harvard Medical School and the study's lead author.

Basically, he said, they thought twice about going to the ER again after getting the full bill from the first visit.

Wharam said most of the reduction in emergency visits was for less severe conditions including nausea and headaches -- an indication that high-deductible plans are working as intended to reduce unneeded hospital visits.

But he also warned that more study is needed, especially on the effects high-deductible plans have on those with low incomes or chronic conditions.

The American Academy of Pediatrics shares those concerns.

"We're afraid they might put off something for a day or so, and it gets worse and the child's health is affected," said Dr. Steve Wegner, a pediatrician in North Carolina and an academy member.

In many cases, consumer-driven plans provide patients with full coverage for wellness checks for children, annual physicals for adults and recommended screenings including cholesterol tests or

mammograms for women of certain ages.

The plans have big potential to help control the spiraling cost of health care by giving consumers the power to make more of their own decisions, said Jason Gorevic, chief marketing and product officer for Indianapolis-based insurer WellPoint.

For consumers, that can mean a balancing act between trying to save money while receiving the best care possible.

Tittle, the state employee, said she hopes to save "hundreds or even thousands" of dollars a year by switching to the consumer-driven plan.

Out-of-pocket costs, though, can pop up. She said she spent about

\$150 on two visits when one of her children had an ear infection.

Tittle quickly added that while she might think twice about going to the doctor herself, she is much quicker to seek treatment for her two children.

"That's where I've really have a different mindset about taking them," she said.

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The New CEO--Chief Experience Officer

By Anthony Cirillo

Fast Company released its list of hot jobs for 2007. On the list is a position that might not be familiar to most: experience designer.

Most experience designers can be found in the retail industry, creating the essence and aura of a store. Their work goes far beyond just the look of a place; they make consumer experiences in which shoppers can immerse themselves. The American Girl doll stores in New York, LA and Chicago are obvious examples.

People travel up to six hours to visit the store in Chicago, spend four hours there and spend an average of \$255. American Girl's brand marketer notes that the stores try to deliver seriousness and sophistication that make girls feel respected and grown up.

In comparison, people are not exactly flocking to hospitals to have an experience. (Although I have heard of hospital dining options that were so good people routinely came in off the street for lunch.) As Fred Lee noted in his book *If Disney Ran Your Hospital*, it is all about the experience. Once at your facility, it is the overall experience that will bring consumers back again. And when friends, family or neighbors have healthcare needs, these

consumers will tell them about their experience.

Do it yourself or hire the professionals?

There have been stories in the literature about hospitals addressing the experience component and the steps are well documented:

- Map the experience
- Identify points of interaction
- Conduct in-depth interviews with consumers to fill in experience gaps and understand expectations
- Determine service gaps
- Create work teams to determine how best to deliver the ideal experience

These intentions are good. But the tasks are usually left to work teams and marketing professionals whose jobs don't leave much free time to give this effort enough attention. To change an organization's culture to one that focuses on customer service takes full-time leadership. Further, hospitals work in silos. The consumer might be there for an outpatient test, a physician visit, surgery or as a visitor. All are

separate and probably distinct and disjointed experiences.

The Chief Experience Officer

Every aspect of the organization needs to be graded and awarded based on delivering a great customer experience. Adding a chief experience officer does not diminish this, but rather unifies it to external marketing and brand extensions.

Diagnose the need. Before you call the search agencies, be clear as an organization that the experiential aspect of the business is vitally important and directly ties to the goals and objectives of the organization. If the chief executive is intent on instituting changes and will hold all executives accountable, then an experience officer can help as a change agent. But if the plan is to make the experience officer solely responsible, then reconsider having this position. An experience officer looks at the customer from the enterprise perspective and cannot influence change without participation and commitment from key senior leaders.

Obtain buy-in. If you have been actively fostering a culture of great experience then it will be a smooth transition to look at this as a next

step in the process. As with any new position, it will be viewed as an opportunity by some--but a threat to others.

Look at the big picture. The education and expectations of the consumer are increasing. While considering quality and satisfaction data when making choices, they also look at experiences. They talk to others. And they surf online. Hospital experiences, like Amazon book reviews, will start to be documented in narratives on the Internet. This is the brave new world of hospital selection. All else being equal, it's the experience. Take note of how other industries reacted to consumer information swapping.

Define the position and competencies. There are "gurus" springing up that can actually help you define and hire for this position. Here are a few things to keep in mind:

- This person must be able to work across the enterprise. That means being able to build relationships with the CEO to the maintenance man. Each person in the organization will have different ways of understanding the concept.
- This person must be able to synthesize data across the organization about customers and connect metrics to customer experiences.
- This person must be able to leave their ego at the door and make others own and take credit for the experience that they help guide.

Start small. A commitment to this position means that everything cannot be done in six months, a year or even two years. Working behind the scenes as an experience officer,

you need to understand across the enterprise the key customer service trends and issues. Define specific deliverables for the first three and six months. Be clear. While you may start in one area of operation that could have been determined by having the poorest satisfaction scores, what you do there is an influencer for what is to come. Never lose sight that across the system one experience needs to be defined. When delivered consistently throughout organization, it will become part of a brand that people will talk about. In fact, add to your arsenal an annual plan for the customer and updated it as routinely as your strategic and marketing plans.

While this might be an example you've heard before, NASA had it down to a science (pardon the pun). When visiting dignitaries would tour NASA in the 1960s, they stopped and asked a janitor what his job was. He replied "to put a man on the moon." NASA understood the end goal, the ultimate experience and had everyone talking from the same page. Disparate jobs, guided by a chief experience officer, develop one harmonious chorus over time. Consider how your employees answer the question: What's your job?

Hospital building and expansion

Let's take up the idea of an experience designer a bit more. The shops created by an experience designer are often considered works of art--miniature universes unto themselves. Experience designers are involved in every aspect of creation--from choosing accent colors on walls to slanting the windows in the right direction. If you go into a boutique and you feel as if you've just had a unique "experience"--you have, and

someone went to a lot of trouble to make you feel that way.

Think of what that type of skill set could bring to a hospital that is getting ready to build or expand. Yes, more and more architectural firms and designers are recognizing the experience piece. However, having someone on board to further guide and unite what they do will ensure building projects that are not just aesthetically appealing but which yell "experience" from the moment you walk in the door.

Brand extensions

With services that are now splintering off in new directions--having a presence in malls and airports and other venues--it is equally important to carry the brand experience into off-campus initiatives. A chief experience officer can help guide these efforts especially as you start to merge hospital experiences with retail experiences. After all, that is where we started this discussion.

As noted above, no one is rushing to the hospital for an experience. But consider this: Blue Cross of South Carolina just added Bumrungrad Hospital in Thailand to its network. Blue Cross subscribers can go there as an option, saving 85 percent or more in costs. But there's more! Bumrungrad's facility is like a five-star hotel, offering services and amenities that define an experience. And it all starts with a concierge assigned to you before you enter the country. That makes a statement.

American hospitals need to make a statement too.

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