

The Future of Employment-Based Health Insurance. (alternatives) *Roger Battistella; David Burchfield.*

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EXECUTIVE SUMMARY

A transformation of employment-connected health insurance from a defined benefit to defined contribution arrangement is projected based on new economic realities affecting the competitiveness of the business environment. This article discusses those new realities along with the **future of employment-based health insurance.**

The business of American business is profits, but, to the detriment of that goal, for the past half century business has also been in the business of providing health insurance for workers. However, in light of previously unencountered pressures on profits, employers are realizing they cannot afford to continue the practice of paying for and overseeing the provision of healthcare benefits to employees amid increasing premiums, state and federal mandates, the overbearing cost of managing healthcare benefits, and the threat of loss of protection under ERISA. Yet, the political and social pressures on businesses to continue to provide health insurance are formidable, perhaps impregnable, barriers to complete withdrawal of what has come to be thought of as a "right" of employees.

Companies are anxious to find alternatives to the status quo, but any feasible alternative must cost less, require less administrative oversight, and ensure that employees still maintain a measure of choice. Two possible solutions for American businesses are adoption of (1) a "medical savings account" system, or (2) a "voucher" system. Either system would result in lower costs and greater fiscal stability for both employers and employees. They would also remove much of the responsibility for healthcare decisions from employers and place it in the hands of the employees. But, perhaps the greatest contribution of either system would be the reduction in moral hazard and its inflationary effect on medical costs.

INTRODUCTION

Job-based health insurance is unlikely to continue in its present form. Events within and beyond management's control are reshaping the way business does business. The reasons for the inevitability of the transformation are numerous and compelling.

First, rising healthcare costs and the increased financial burden of providing health and retirement benefits to a labor force that is aging and simultaneously more transient are altering the social contract whereby employees, in return for loyal service, obtain job security and generous health and retirement income benefits fully funded by employers. Second, the cost-reducing effect of managed care may have reached its peak, and evidence suggests that health premiums will once again substantially outpace inflation. Third, the increased exposure to medical malpractice litigation and an expansion of costly regulations are also seen as impediments to employer-based health insurance. Finally, pressure from formerly passive shareholders who have become more assertive in demanding higher profits and larger returns on investment is inducing businesses to reassess and revise the manner in which fringe benefits are provided (Conte 1998).

The ultimate result of these and related developments will be a transformation of employment-based health insurance. Outlining the pressures behind the transformation and the direction and shape of the ultimate system is the goal of this article.

A BRIEF HISTORY OF EMPLOYMENT-BASED HEALTH INSURANCE

In retrospect, employer responsibility for health insurance provision was a historical aberration brought about by wage and price controls, imposed during the Second World War, that prevented labor from bargaining for higher wages. This prohibition led unions to search for new collective bargaining avenues, which culminated in passage of the Stabilization Act whereby labor obtained governmental approval to pursue gains in health benefit coverage. Employers were allowed to buy health insurance tax free, and employees received a tax-free benefit.

Health insurance growth consequently accelerated. Whereas in 1940 only about 10 percent of the U. S. population was covered by some form of health insurance, those covered increased to over 50 percent by 1950 (Scofea 1994) and the figure now stands at approximately 85 percent. The principal event that solidified the connection between employers and health insurance financing occurred in 1959, when the United Steelworkers settled a labor dispute with steel companies that required the companies to pay 100 percent of employee health insurance premiums (Califano 1986).

Once established in collective bargaining, employment-based coverage not only resulted in a quantum leap in the number of Americans insured, but for persons receiving coverage as a condition of employment it acquired the de facto status of a "right." This sense of entitlement inadvertently contributed to the emergence of an inflationary climate by nourishing a rise in consumer expectations for undisciplined health spending. With its first-dollar feature, health insurance divorced employees from the economic consequences of their consumption decisions. The perception that the money spent was the employer's money and not their own led employees to believe that healthcare was a "free good." This situation leads inexorably to what Fitzgerald (1995) described as a "moral hazard." Moral hazard refers to the additional demand for health services as a result of the existence of health insurance protection.

Employer resistance to increases in health spending was initially minimal for several reasons. First, substantial tax breaks ameliorated any financial discomfort by subsidizing the health insurance benefits provided by employers. Second, outlays for individual and family coverage, until recently, were too small to bother risking confrontations with either workers or health providers. They amounted to an insignificant percentage of payroll. Finally, employers remained indifferent even when health insurance grew to consume a much greater share of payroll, because the ability to trade off fringe benefit increases against wage improvements enabled employers to keep total compensation relatively constant, if not in the immediate future, then over a longer period of time (Fuchs 1996; Pauly 1997). Increases in health costs were paid for by workers in the form of smaller wage gains until equilibrium was restored.

EMPLOYER PRESSURES AND REACTION

But all of that has changed. To be sure, the tax breaks remain, and employers continue to be the primary source of health insurance for most Americans. However, the pressures outlined above, along with the opening of competition to foreign firms unburdened by high labor costs, make the status quo untenable, as does deregulation of formerly protected industries and the near instantaneous flow of information on price changes. In brief, employers have lost much of their former pricing power.

Employers have already made substantial headway in disengaging from the provision and management of health insurance. From 1988 to 1993, the proportion of workers with employer-sponsored health insurance coverage declined from 68.6 percent to 65 percent (Frostin and Snider 1996), and between 1996 and 1998 the number of small businesses offering medical benefits to workers declined from 59 percent to 54 percent (Lagnado 1999). At the extreme, many employers, especially small-sized firms, have opted to eliminate health insurance as a fringe benefit.

First-dollar coverage has become virtually extinct. Workers now pay approximately 25 percent of the cost of premiums formerly paid entirely by their employer. Retirees have been especially hard hit as many firms have ended coverage, just 45 percent of big companies and 17 percent of mid-sized companies now provide any retiree health coverage whatsoever. Among those who continue this benefit, most are seeking to curtail

spending by raising age and eligibility requirements, cost shifting, or putting ceilings on their future benefit obligations (Lippman 1997; Frostin and Snider 1996). Although most of the growth in the number of uninsured workers is a result of external forces, some of it is directly attributable to choices made by these low-income workers. The decline in real wages experienced from the late 1970s through 1996 caused numerous low-income workers to forego participation in employment-based health plans in favor of higher take-home pay. Ironically, rates of rejection have increased at a period when the number of employers offering insurance increased. In 1996 about six million workers who could have been covered by an employer plan turned it down (Cooper and Schone 1997).

Financial Burden on Employers

The cost of healthcare has escalated to the point where outlays for health insurance now make up an alarmingly large and rapidly growing percentage of payroll. Whereas in 1970 health benefits constituted only 2.4 percent of total compensation, by 1989 they had risen to 5.6 percent and by 1995 to 7.6 percent (Custer 1993; U. S. Chamber of Commerce 1997). Total health benefit costs to employers averaged \$4,164 per employee in 1998 (Mercer/Foster Higgins 1999). Employers are being pressed to reconsider the value of what they pay for and to reduce coverage for family members and retirees, mainly because they no longer have the latitude they formerly had in offsetting higher fringe benefit costs. The most often-cited reasons for the decline in a firm's ability to offset higher fringe benefit costs include the taming of inflation, which makes the tradeoff more visible to employees and unions, the stagnation of real wages, global competition, and low service industry operating margins.

Although employers generally are becoming more sensitive to price, among big companies more than half continue the costly practice of subsidizing their more expensive health plans. This practice adds to overall health costs by not giving workers a financial incentive to enroll in lower-priced coverage. One can anticipate that as cost pressures grow, employers will eventually make employees responsible for premium differences (Hunt et al. 1997). The trend, particularly under smaller firms, is to reduce the number of plans workers can choose from to concentrate purchasing power leverage in price and quality negotiations with insurers and providers (Jensen et al. 1997).

Shifting of health benefit costs coincides with and complements the introduction of incentives for employees to select managed care options in place of traditional indemnity insurance. In 1998, among individuals obtaining health insurance through their employer, 87 percent were enrolled in some form of managed care (Mercer/Foster Higgins 1999). Momentum for managed care has all but marginalized traditional indemnity insurance. More than four-fifths of firms no longer include the latter among the choices offered their employees.

To minimize employee resistance to managed care controls, employers commonly provide a menu of plans that vary in the restrictions they place on freedom of choice--traditional indemnity insurance, a health maintenance organization (HMO), a point-of-service plan (POS), and a preferred provider organization (PPO). Although this practice is initially more costly for employers who subsidize the choice of more loosely managed plans, the expectation is that differences in employees' out-of-pocket expenses inexorably will move them into more efficient and higher-value HMOs (Ginsberg, Gabel, and Hunt 1998).

Managed care workplace coverage has grown to the point where employers have recently experienced a respite from the double-digit premium increases of the 1980s and early 1990s, however, the relief now appears ephemeral. Total spending for employer-sponsored health plans rose 6.2 percent in 1998, and employers are predicting their costs will rise even faster in 1999 (Mercer/Foster Higgins 1999). Estimates vary, but even optimists anticipate that costs will grow faster than inflation through the year 2000--and then will accelerate even more.

Several factors are involved in these predictions. First, with so many workers presently enrolled in managed care plans, little room is left to hold down costs by moving employees into lower-cost plans. Second, while

managed care plans are priced lower than traditional insurance (average HMO monthly family premiums are 5.5 percent lower than those of indemnity insurers), the gap is shrinking as traditional insurers respond to competition (Ernst & Young 1996). Third, the fastest-growing managed care companies are those that offer enrollees more choice and fewer controls than HMOs with tight restrictions. This relaxation of utilization controls costs more money by removing the very source of discipline on consumption of unnecessary care that managed care purports to attack. Fourth, in pursuing market sharegrowth strategies, many plans have allowed prices to be set by marketing rather than actuarial considerations, so that contracts signed actually lose money. Finally, underinvestment in information systems to keep track of utilization trends has compounded errors in pricing at the same time that new government regulations are squeezing profit margins (Winslow 1998).

To restore investor confidence, managed care plans are under heavy pressure to raise premium prices. Kaiser-Permanente, the nation's largest and most widely known nonprofit HMO, raised its premiums as much as 20 percent for large employers in 1999 and even more for smaller businesses in an effort to remain financially viable (Rauber 1998). Among employers who had assumed that managed care had succeeded in taming health spending, the anticipated return of inflationary insurance premium pricing is very disconcerting.

The severe financial difficulties afflicting the managed care industry are creating a loss of investor confidence. Publicly traded healthcare service companies averaged only a one percent increase in the value of their stocks in 1996 compared with 26 percent for the Dow Jones Industrial Average. Profit erosion is largely attributable to market share struggles resulting in artificially low prices. Industry consolidation is another substantial factor. Along with heavy debt loads incurred to finance acquisitions and mergers, managed care plans must undertake costly investment in information systems technology to successfully absorb expansion programs. Massive capital outlay requirements are not apt to diminish soon, as the process of rationalization--whereby the highly fragmented insurance industry is becoming consolidated and dominated by a smaller number of large-sized firms--is in its infancy.

Upward pressure on premium prices will persist following completion of the consolidation phase, for there is a limit to how long insurers can continue to generate efficiency savings. As waste is squeezed out of the health sector, additional savings will become progressively more difficult. Also, important changes are evident in the relationship between the buyers and sellers of healthcare regarding the ability to control prices. The advantages now enjoyed by insurance plans and buyers will steadily erode as providers become better organized and more capable of negotiating from positions of strength rather than weakness. If not already the case, the ease with which providers can be bullied into accepting insurer-imposed steep discounts soon will become history.

The Regulatory Environment

Another factor underscoring the inevitable transformation of employment-based health insurance is regulatory expansion. The myriad state and federal regulations dictating the kinds of benefits and coverage that must be provided continue to grow. Whereas in 1965 only seven state-mandated benefits existed and in 1970 only 48 existed, today nearly 1,000 are in existence (National Center for Policy Analysis 1997). As a result, two cost-inflating events occur. First, collectively, state-mandated benefits considerably increase the cost of health insurance to most companies and individuals who do not meet the mandated benefits (Goodman and Musgrave 1994). Secondly, very large firms that have operations in several states may have to offer extra benefits to all employees, even if the benefits are only required in one of the states.

Yet more upward pressures on price and expenditures will result from the growing consumer backlash movement against managed care. Spending will become harder to control as state and federal politicians respond to public perceptions of managed care transgressions--notably that it puts efficiency and profits ahead of compassion and what is best for patients--by introducing regulations that constrict the ability of management to allocate healthcare resources strictly on the basis of cost-effectiveness criteria (Moran 1997). The effect of recently enacted constraints such as those affecting minimum maternity hospital stays and ambulatory mastectomies and the right of plans to exclude physicians with high-cost or medically questionable practice styles seriously hampers management's ability to contain spending. Instead of relying on cost-effective

criteria as originally envisioned, managed care decision making is becoming more politicized, as indicated in the Patients' Bill of Rights movement, which, among other pursuits, aims to restrict managerial controls on medically unnecessary use of emergency rooms and specialist care.

Employers' interest in extricating themselves from the burden of providing and overseeing health insurance is bound to grow as the Employee Retirement Income Security Act's (ERISA) shield of protection against costly malpractice litigation and cumbersome state government regulations deteriorates. The special privileges granted to mainly large corporations for the purpose of allowing multistate employers to offer their workers a uniform benefit package nationwide obstruct the states from addressing many health financing and delivery problems at a time when the federal health reform initiative has stalled. In return for self-insuring and to the consternation of critics, employers are granted exemptions from state efforts to expand access to healthcare, control growth in health spending, and protect workers from plan discrimination (Copeland and Pierron 1998).

State initiatives are laying the groundwork for federal intervention. Some 20 states already have enacted new managed care regulations and consumer protection laws. At the national level, bills have been introduced that, if passed, will enfeeble ERISA and subject self-insured businesses and health insurers to intrusive new standards. Included is a bill that would grant employees the right to sue their employer as well as managed care plans for injuries linked to medical malpractice or denials of care (Christaldi 1997). In point of fact, federal intervention has already begun. Congress recently amended ERISA to impose two new standards--elimination of preexisting-condition exclusion periods and plan applicant health status information (Health Insurance Portability and Accountability Act) and minimum maternity lengths of stay along with limits on coverage differences between mental and physical health services (Polzer and Butler 1997).

Consumer activists are lobbying hard for more radical changes. They allege that ERISA is being used by managed care plans as an instrument for avoiding legal liability for medical malpractice. Should their efforts to hold managed care plans more accountable also encompass employers, many firms may choose to drop health insurance coverage rather than raise the price of products or services to pay for new liability costs.

The actual extent to which employers sponsoring managed care plans will become vulnerable is ambiguous. A number of recent U. S. Supreme Court rulings already enable the states to attack ERISA indirectly through the imposition of surcharges on health plans. Thus, ERISA preemption has become a less formidable obstacle. Future partial or full repeal will add to the already aggravating record-keeping demands introduced in recently enacted federal legislation compelling greater mental health and substance abuse coverage and in the reporting of the health coverage given to former or terminated employees (Coleman 1996).

SHAREHOLDER DISCONTENT

The difficulty of averting shareholder discontent over unsatisfactory earnings leads management to pursue efficiency savings through cost reductions that often target payroll expenditures. Furthermore, the recent taming of inflation makes any substitution of fringe benefits for wages both less opaque and harder to sell to labor. The fact that unemployment is at its lowest levels in decades and that many employers are experiencing a labor shortage puts additional constraints on management's ability to keep labor costs from rising via wage-fringe benefit tradeoff legerdemain. In the case of low-income workers such maneuvers have limited application even under the best of circumstances because wages already are at levels below those which society considers marginal or insufficient. If anything, as evidenced by recently enacted and proposed legislation for raising the minimum wage, the political climate and prevailing social norms effectively require management to resort to other means for controlling labor costs.

A decline in managerial flexibility does much to explain why employers increasingly have moved to shift increases in health expenditures to workers in the form of larger premium-sharing requirements and limitations on family coverage provision. This shift in financial responsibility, together with more drastic initiatives to reduce payroll expenditures (e.g., downsizing, part-time employment, and use of contingency workers), reflects the response of employers to the new economic environment.

The negative consequences to employers of higher production costs from a return of inflationary health insurance expenditures may escalate beyond endurance. As cost-control pressures impel employers to save money by cutting back or eliminating the choice of health plans available to employees, their exposure to medical malpractice litigation will increase and necessitate more complications and expenditures. Good risk-management principles compel employers to monitor and assess the quality as well as price of health services provided to their employees. Although such a practice may be legally advisable and a noteworthy expression of enlightened concern for employee welfare, it ultimately exacerbates the fringe-benefit cost problem.

In addition to the specialized human resources personnel required, the complexities and uncertainties associated with quality of healthcare measurement generate higher amounts of spending. Whereas management has become highly proficient in dealing with price negotiations, it knows comparatively little about the vagaries of good medical care. However, the possibility that an employer may be held liable for corporate negligence relating to the selection of a health plan, regardless of how large or small, is increased if the decision is made solely on the basis of price. Even the current protections afforded by ERISA are not inviolable. To date ERISA has protected both self-funded employers and the MCOs who administer their insurance plans from any malpractice suits; however, that protection is being threatened. The U. S. Supreme Court in a recent case ruled that the scope of ERISA protection is not unlimited (*New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.* 1995). Although this particular decision does not involve malpractice, it does indicate that ERISA will not continue to stand as an invulnerable shield for self-funded employers and their MCO managers. If ERISA protection crumbles, the chain of liability could reach the self-funded employer in the form of lavish awards for punitive damages costing millions of dollars. Rather than continuing to struggle with the difficulties inherent in health insurance provision, business can be expected to limit or discontinue its involvement.

THE FUTURE OF EMPLOYMENT-BASED HEALTH INSURANCE

In examining the future of employer-sponsored health insurance, it is unlikely that the status quo will persist. Given the financial and regulatory pressures on businesses, the central question is not whether but how the change will occur and what the structure of the new system will be. Apart from a continuing but steady cost shifting from employers to employees three alternatives can be imagined: (1) adoption of a national health insurance scheme; (2) a sudden and complete discontinuation of employee health benefits; or (3) the shift from defined benefits to defined contribution, which would entail establishment of either medical savings accounts (MSA) or the introduction of a "voucher" system.

Numerous attempts to install a national health insurance scheme have already failed, and the political climate is hardly receptive to another attempt. And regardless how inviting to employers, a total exit from the provision of health benefits is untenable for two major reasons. First, such withdrawal would generate costly and unproductive labor-management strife. Second, the negative spillovers to society in the form of an increase in the size of the uninsured population most certainly would incur unwelcome governmental intervention including, for example, a revival of interest in mandatory employer coverage and the subjugation of benefit determination to political rather than economic criteria. Therefore, future change predictably will center on MSAs and/or vouchers.

Beginning in the early 1990s many companies started moving in the direction of defined contribution by placing a ceiling on their premium contributions. Many workers, preferring a more expensive plan than offered by the company, now pay for any premium difference out of their own pocket. Although this does much to limit liability and make insurers more responsive to consumer demands, employers generally retain a large and burdensome exposure. Now that the bulk of any savings from shifting costs to employees and moving workers into managed care has been achieved, additional economies entail transferring more control to workers in deciding how best to spend company-provided healthcare dollars (McNeill 1998).

Flexible benefit plans provide a precedent and smooth the way for a defined contribution strategy, except that they keep dollars inside the system instead of allowing benefit dollars to be spent externally. As but one

example, Xerox reportedly is reallocating flex money it gives to workers so that everyone is treated equally instead of continuing to subsidize families and exclude individuals who choose not to participate. Once employees are properly armed with sufficient data to make informed choices, Xerox reportedly expects to get out of the healthcare purchasing business--possibly as early as the year 2005 (Albertson 1997).

In summary, as healthcare costs continue to rise in spite of managed care, as firms evaluate their potential involvement in malpractice litigation and the scope and compliance cost of government regulation spreads, and as investors intensify the pressures on management to generate higher returns, employers will undoubtedly be forced to transform health insurance from a defined-benefit to a defined-contribution system.

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PRACTITIONER APPLICATION

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Today's hospitals rely heavily for payment on both Medicare and employer-based health insurance, and Cayuga Medical Center is no exception. Approximately 40 percent of our services for patients are reimbursed by Medicare, and the remaining are reimbursed by private insurers, individuals, and Medicaid. The majority of the latter comes from insurance firms representing employees of the purchasers of those policies. The ideas presented in Dr. Battistella's and Dr. Burchfield's article regarding the shift from a defined-benefit system to a defined-contribution system should be viewed with both alarm and relief by all healthcare providers, not just by hospitals.

Healthcare providers should be alarmed because such a transition will mean near total reinvention of our present system of information gathering, manipulation, and reporting. On the surface, this may seem a trivial endeavor, however, in reality it can be quite costly and time consuming. However, relief should be felt by all healthcare providers since such a transition would essentially signal the end to the micromanagement of our

service provision by traditional indemnity insurers, managed care firms, and employers. Placing ownership of and responsibility for the basic insurance payment in the hands of the employee/patient will return the healthcare delivery system to at least a semblance of what it was before the advent of managed care. Empowering patients to make decisions in concert with healthcare providers can only enhance the quality of care provided.

The arguments given by the authors for the transition in structure of employer-based health insurance are compelling. Today's healthcare manager must keep abreast of any new information that is likely to affect either their provision of services, their costs of providing those services, or the source and reliability of their revenues if they are to make sound strategic decisions for their firms. If managers are not apprised of what changes are likely in their environment, they will be unable to adequately assess the threats and opportunities presented by those new developments.

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