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Commentary

Budget Limits And Managed Competition: Allies, Not Antagonists
by Henry J. Aaron

Budget limits or managed competition? Wrong. Budget limits and managed competition! Far from being at war with one another, these two approaches to controlling the growth of health care spending should be used in combination to reinforce one another.

This natural affinity is strongest in the case of hospital spending. Hospital costs have been growing each year at a rate of about 11 percent and now average more than $1,300 per person annually. Confronting such high and rapidly growing hospital spending, advocates of managed competition and budget limits give conflicting prescriptions for cost control. As explained in this Commentary, appropriately defined hospital budget limits provide a natural bridge to managed competition and simultaneously assure that hospital spending will fall within specified limits.

Advocates of managed competition note the lower rates of hospitalization and somewhat lower overall costs among prepaid group practices. They argue that in the current system, people are sheltered from a full awareness of these costs by a combination of employer financing of insurance premiums and the unlimited exclusion of these premiums from personal income taxes. They observe that people are unable to compare prices of alternative plans effectively because plans vary in the services they offer. If health plans provided identical benefits, and if the amounts that employers or governments paid for health care were uniform across health plans, people would be forced to face the full costs of choosing plans that cost more than some baseline plan. The result, advocates of managed competition hold, would be competition among plans to achieve the mix of low cost and high quality that patients want. People would choose the plans that offered the best value. Costs would be reduced, and spending growth probably would be slowed as competition led plan managers to scrutinize which services were worthwhile and how health plans were managed. To the extent that spending continued to rise, such growth would reflect the informed, cost-
conscious decisions of households and would be no cause for concern.

Not so, say the advocates of budget limits; a whole host of problems would prevent managed competition from realizing the hopes of its advocates. People would not shift to low-cost providers quickly and perhaps not at all. Health plans would have strong incentives to try to “cherry-pick,” enrolling only low-risk, low-cost patients; efforts to defeat these incentives would require intrusive regulations. The medical “arms race,” in which each hospital is driven to buy every new gadget in order to attract the best physicians, would continue to drive up costs. Even if managed competition eventually slows the growth of health care spending, it is unlikely to do so quickly enough to relieve the budgetary woes of federal and state governments, for which rising Medicare and Medicaid costs spell fiscal ruination—not in the distant future, but by the mid-1990s. Remorseless control of fee schedules under Medicare and Medicaid may delay this inevitability slightly. But such reimbursement controls have shifted costs to private business and individuals and, if intensified, would only exacerbate the problems facing private payers. The answer to rising costs, say advocates of health care budgets, is an absolute limit on the growth of total health care spending. One cannot bank on the untried theory of managed competition, say its critics. Stick to budget limits. They work abroad to control health care spending; they will work here too.

In fact, budget limits for hospitals are not at war with managed competition; these limits can be constructed to strengthen and channel the incentives of managed competition. Here is how.

Consider a hypothetical community of a million people with four thousand hospital beds distributed among twelve hospitals. As in most U.S. hospitals, the average daily census in this hypothetical community is well below capacity. Moreover, the average occupancy rate varies widely across the various hospitals, as do average costs for typical procedures.

Following the declared intent of the Clinton administration, Congress would create health alliances that offer a number of approved health plans to all businesses with fewer than a stipulated number of workers, to individuals, and to selected others. Medicaid and Medicare would continue to operate independently. Approved health plans, as a practical matter, would purchase hospital services from one or more of the twelve area hospitals. The plans could negotiate fees hospital by hospital, but such negotiations would create opportunities for hospitals to engage in discriminatory pricing to extract the maximum potential income from the various plans. If instead the plans paid hospitals a pro rata share of fixed budgets, discriminatory pricing would be eliminated. Furthermore, each region would be assured that total hospital spending would not exceed a specified maximum.

A health alliance, an independent health board, or some other entity
would determine each hospital’s budget for a previous period. It then would project a budget for each hospital based on the hospital’s historical average budget and a projected rate of growth that incorporates inflation, new technology, and projected caseloads. The resulting total would be the hospital’s budget for a stipulated period. The budget may be increased in the short run, but only if admissions significantly exceed the assumed census.

The budget for each hospital would equal or exceed the total charges that the hospital could charge the various payers from which it receives reimbursement. Charges would be calculated by assigning a weight to each admission based on a scale similar to that used for reimbursement under the Medicare diagnosis-related group (DRG) system. For example, the Health Care Financing Administration (HCFA) pays hospitals 4.48 times as much for performing craniotomies on patients with multiple and severe trauma (DRG 484) as for treating patients with viral meningitis (DRG 21). The charge for a particular admission would be equal to the total budget of the hospital divided by the sum of the weights for all admissions multiplied by the weight for the specific admission. For example, suppose that a 200-bed hospital has a 60 percent average occupancy rate, an average length-of-stay of five days, and a budget of $100 million for one calendar year. It will have 8,760 admissions per year. For an admission with an average weight, the hospital would be required to charge all payers no more than $11,141. For a more complicated case with a weight twice the average, the charge would be $22,282, and so on. The hospital would be permitted to charge less than this amount, but it would have to provide the same percentage discount on behalf of all patients to all payers.

Setting budgets for each hospital in this fashion would confront approved health plans with a menu of widely varying charges for admissions to various hospitals. Hospitals with a history of high costs per admission would temporarily carry those costs forward and have relatively high charges per admission, unless the hospitals exercised their option to charge less than their allowed maximum. If a hospital’s charges were above average and the quality of its service was below par, approved health plans would have a powerful incentive to direct patients to lower-cost or higher-quality facilities. As this shifting of patients occurred, the hospital’s census would decline. The budget it initially was given would be divided among a reduced number of patients. As a result, the amount that the hospital can charge would rise.

If a hospital is losing patients because of high prices or inferior quality, it faces some difficult managerial choices. First, it may elect to charge less than the maximum it is permitted to charge, thereby directly reducing or removing any price disadvantage. This strategy can work only in the short run unless the hospital succeeds in a second strategy: cutting costs or
improving quality. If it cuts costs or enhances quality and its success is recognized by health plans, its share of the community's patient caseload should increase. This success would be self-reinforcing, as a rising caseload would permit the hospital to recover its entire budget but at a reduced charge per patient to each health plan, thereby further increasing the hospital's attractiveness to health plans. If the hospital fails to pursue either of these strategies successfully and remains a high-cost or low-quality institution, it will continue to lose patients.

The rules under which the health authority operates should require it to reduce the budgets of persistently low-census hospitals. In this fashion, hospitals must either bring operations up to standard or face the prospect of declining censuses and falling budgets. The cost of continued managerial failure would be closure. This approach would delay rewards for high-quality and low-cost hospitals and punishments for low-quality and high-cost hospitals relative to a system that links total hospital revenues directly to caseload. This sacrifice in the promptness of market signals to hospitals would be compensated by assured budget control for the community.

In short, the existence of a hospital budget establishes a fixed maximum above which the outlays of hospitals, individually and collectively, cannot rise. This advantage, which no pure managed competition plan can claim, is an important assurance to governments and private payers alike. At the same time, it provides a framework within which the processes of managed competition can work unhindered. Indeed, the forces of managed competition would be reinforced, because the framework within which hospitals' rates are set would be transparent and uniform across all payers. Hospitals would be prohibited from discriminating among payers in the charges they set—a process that adroit managers could use to exploit plans with immobile patients, thereby boosting their total revenues. In particular, hospitals would not be permitted to charge free-choice-of-provider plans any more (or less) than they charge health maintenance organizations (HMOs) or other managed care plans. Hospitals owned and operated by a single approved plan would not be required to accept patients from other plans unless the managers of the hospital conclude that it should do so.

The system described here could be applied to Medicare and Medicaid or could be blended with distinct systems of reimbursement under those programs. It could accommodate separate payments for graduate medical education or other subventions to assist teaching hospitals. It could be applied to large urban areas and to small communities. Isolated hospitals would not be subject to competitive pressures any more than they would be under other forms of managed competition. Nothing in the description of this plan should be taken to minimize the enormous technical difficulties in appraising hospital quality in an analytically defensible way. Nor does this
approach to cost control address whether and how to regulate new investments in buildings, renovation, and equipment.

Unlike other systems of budget control, this system does not encourage hospitals to offload services to freestanding clinics, nursing homes, or other providers. Buyers of hospital services, assumed to be approved health plans, would have to pay for diagnostic radiology, laboratory services, convalescent care, and various other services and most likely would purchase those services wherever the best mix of cost and quality could be found. Thus, hospitals would not have incentives to shed these services. The budgets of hospitals that take on or shed services should be adjusted accordingly.

This method of combining budget limits and managed competition assures prompt cost control. This is important for government planners who cannot delay budget savings until such time as managed competition succeeds. Many other transitional cost control mechanisms sometimes suggested to bridge the interim between enactment and full effectiveness of managed competition simply substitute for managed competition and thus threaten its ultimate implementation. For example, fee limits on all payers (universal DRGs) hold out the potential of controlling the price (but not the quality) of services, but only by completely short-circuiting the principal mechanism of competition at the provider-level price. Premium limits carry the risk that they may fall short of the cost of services that plans are actually obliged by contract to deliver, thus carrying the risk of bankruptcy and disruption, but with no guarantee that actual costs will be controlled.

The essential point of this approach to cost control is that the hostility between advocates of managed competition and supporters of budget limits is entirely misplaced. I suspect that this hostility derives from the ideologies of the people on either side. Many advocates of managed competition simply do not trust government regulation of almost anything. Many supporters of budget limits do not trust markets, at least not for health care services. In fact, the certainty that budget limits promise in no way hinders achievement of the objectives of managed competition. The mixture of budget limits and managed competition described here would regularize the payment system for reimbursing hospitals, thereby achieving for approved health plans some of the advantages that advocates of managed competition claim will follow from the establishment of uniform benefit packages—transparency for affected parties who will be enabled to evaluate alternatives more effectively.

NOTES

1. In symbols, let B be the hospital budget and Wi be the weight assigned to admission i. Then the charge for a particular admission Cj, is Cj = Wj [B / \( \Sigma_i W_i \)].

2. In terms of the equation in Note 1, Cj will rise as \( \Sigma_i W_i \) declines.