The Need For A National Global Budget
by Stuart H. Altman and Alan B. Cohen

A fully implemented managed competition strategy, as described in this volume of Health Affairs, undoubtedly would transform the face of American health care, in terms of the financing, organization, and delivery of services. What remains unclear, however, is whether the financial incentives engendered by managed competition could, by themselves, produce significant systemwide cost savings in a timely way, without the aid of additional cost containment mechanisms.

Managed competition proponents, such as Alain Enthoven, Paul Starr, and the Jackson Hole Group, have argued that such an approach is eminently capable of controlling health care spending. In fact, Enthoven asserts that coupling managed competition with regulatory cost containment mechanisms, such as rate-setting strategies or “top-down” national health care expenditure limits, would be antithetical to a competitive strategy. Advocates, therefore, decry the use of price controls and question the need for global budgets in any reform plan involving managed competition. Skeptics, on the other hand, recognize the potential value of restructuring the financing and delivery systems, but argue that managed competition has never been tried anywhere before, and may not bring sufficient economic discipline into the marketplace to stem the rising tide of health care expenditures.

In the present economic climate, it seems unlikely that Congress or the American people would be willing to commit the tens of billions of dollars needed to make universal coverage a reality without more of an assurance than that afforded by the theoretical construct of managed competition—that the future growth of health care spending will be kept in check. The reform debate is likely to focus on which combination of strategies must be used to achieve the desired outcomes. In this paper we first discuss why cost control is so critical to the long-term health of the American health care

Stuart Altman is dean of the Florence Heller Graduate School at Brandeis University in Waltham, Massachusetts. He was a member of President-elect Clinton’s health policy transition team. Alan Cohen is a research professor at the Heller School and a senior fellow of the Brandeis Institute for Health Policy.
system. Next we outline the major issues and questions that must be addressed in designing and implementing global budgets (or expenditure limits). We conclude with a discussion of how expenditure limits may be used in concert with managed competition models to address the overriding cost issue.

Why cost containment? In our view, the major reason why past cost containment approaches have failed is because both the public and private sectors lack the willingness to accept the degree of change needed to make such efforts effective. Indeed, the 1970s and 1980s were marked by numerous failures of “halfway” competitive market approaches and ineffective regulatory mechanisms. Today the confluence of three powerful forces offers new optimism for controlling costs.

First, recent public opinion polls suggest that Americans may have reached their tolerance limits regarding the high cost of health care. Second, mounting public concern over the federal deficit, coupled with the realization that the nation’s lingering economic woes are partly a function of the high cost of businesses’ providing health insurance benefits to employees, their dependents, and retirees, has further coalesced public opinion in favor of health care reform. Bill Clinton’s December 1992 economic conference in Little Rock, Arkansas, reinforced these perceptions, illustrating for a mass audience how continued health sector growth threatens the competitiveness of American companies in global markets and deprives other socially important economic sectors, especially education, of their fair share of resources. The conference also highlighted the fact that national deficit reduction will likely be achieved only when we have successfully curbed federal spending in key areas, most notably in health care. Finally, the current political climate demands that health care spending be brought under effective control to subsidize efforts to create a universal health insurance system for all Americans. The cost of providing core insurance benefits to those now uninsured or underinsured has been estimated at $30-$50 billion per year.

Why global budgets? Global budgets have been proposed because they are targeted to controlling total health care spending—that is, the product of price and volume of medical services. Previous U.S. cost containment efforts have not addressed total expenditures but have focused instead on constraining prices, constraining service use, or influencing volume indirectly through controls on system capacity. Efforts generally have been implemented in a piecemeal fashion, often affecting only a single payer (such as Medicare) or a single expenditure category (such as hospital spending). Moreover, such strategies have been frustrated by the lack of political will to make them really work.

Examples of price control strategies include Medicare’s resource-based
relative value scale (RBRVS) for physician payment; various state-based rate-setting programs for hospitals and nursing homes; private insurance discounts for hospitals and physicians; physician fee schedules; and wage and price controls under the Economic Stabilization Program (ESP) of 1971–1972. Efforts to control service volume have included federal Professional Standards Review Organization (PSRO)/Peer Review Organization (PRO) programs; private second-opinion review programs for surgical procedures; increased consumer cost-sharing provisions; and utilization review mechanisms, in fee-for-service and managed care environments. Strategies for controlling system capacity (that is, facilities and new technologies) have concentrated on capital expenditure review mechanisms, including state certificate-of-need programs and federal Section 1122 review.

Evidence to date suggests that neither volume controls nor capacity controls are particularly effective tools in containing total health care spending. Experience with price controls, on the other hand, is mixed. Diagnosis-related group (DRG)-based prospective payment in New Jersey, for example, has produced benefits for individual hospitals, strengthening the financial status of some, but has not had the desired systemwide dampening effect on hospital spending. Even the Medicare prospective payment system (PPS), which attempts to control both the prices and volume of services provided per inpatient admission, has failed to constrain total hospital spending. By enabling the federal government to exert monopsonistic purchasing power, PPS has limited program outlays for hospital services, but not without generating severe cost shifting to private payers, sending a ripple effect throughout the system.

While Rochester, New York, and the state of Maryland have each experimented with global budgets for hospital spending, no entity in this country has attempted to establish limits on total health care spending. Experiences with global budgets in other countries, such as Germany, France, and Canada, suggest that expenditure limits may indeed have a restraining effect, keeping spending levels in those nations to less than 9 percent of gross domestic product (GDP). But critics of global budgets argue that the negotiating structures and cultural norms that enable spending limits to work in other countries are absent here, thus rendering such efforts unenforceable and ineffective when applied to the U.S. system.

Framework For A National Global Budget

Assuming that a uniquely American approach is required to establish a workable national health care spending limit, how might such a system look and operate? Key questions include: (1) What services should be included under the spending limit? (2) How should the limit be defined?
(3) What allocation mechanisms should be used across geographic regions, populations, or provider groups? (4) How should governance of the limit be structured? (5) How should spending be monitored? (6) How should the limit be enforced? Each of these questions may be discussed either within the context of the current health care system or that of a reformed system involving managed competition. We believe, however, that implementing a spending limit within the existing health care system will be a far more formidable task than attempting to do so under a reformed system, for several important reasons.

First, private insurers in the current, predominantly fee-for-service environment lack control over service volume, making it virtually impossible for them to develop and adhere to meaningful global budgets. In a managed competition environment, global budgets should actually be easier to construct for the health insurance purchasing cooperatives (HIPCs), which can use them to negotiate effectively with accountable health plans.

Second, the current multitude of individual insurance plans and providers poses an enormous administrative challenge to any national governing body charged with implementing spending limits. Developing credible budgets, monitoring actual spending, and enforcing limits will be difficult in any environment. Managed competition, however, may offer an environment conducive to global budgets that, with appropriately designed data systems for tracking spending, may be comparatively easier to implement.

Third, the current system’s lack of appropriate economic incentives for providers to use resources efficiently, even with a global constraint, probably, would undermine cost containment, leading to potentially harsher inequities in resource allocation among consumers in different groups and geographic regions. A managed competition framework, in contrast, theoretically would encourage more appropriate use of resources, thus undergirding the cost containment potential of health care spending limits. We discuss here how a national spending limit might be designed and implemented under a reformed system, with managed competition at its core.

**Specifying covered services.** A major question in the construction of a national health spending limit is where to draw the boundary between included and excluded services and expenditures. Most health care experts likely would agree that personal health care spending should be the principal target of such a limit. Thus, services that have been traditionally insured, either as core benefits of most plans or as supplemental benefits that are individually purchased, should be included—such as acute hospital and physician care, ancillary services (laboratory and x-ray), and prescription drugs. Less clear cut is spending for services that are often not covered by insurance plans or are covered only in limited amounts—such as long-term care, mental health services, and substance abuse services.
Under a system in which universal insurance coverage would be assured for a core benefit package, core and related supplemental benefits should be subject to the expenditure limit, while noncovered services should be excluded so that individuals may freely purchase such services with their own after-tax incomes. The question remains, though, how restrictive the limit should be regarding covered services. Should all spending for such services be included under the budget, or should limits be placed only on spending for what, in effect, may be the lowest-cost premium or managed care capitation rate? The latter option would use the lowest-cost plan as a “benchmark” premium but would still allow individuals to purchase higher-cost plans available in the marketplace. While this approach is endorsed by some managed competition supporters, we believe that it would create inequities affecting choice of plans, forcing poor and near-poor individuals into the lowest-cost option (subject to the spending limit) but allowing middle- and upper-income individuals to select less constrained plans.

Decisions would also have to be made about how to treat nonpersonal health care spending, such as public health and medical education expenditures. For example, public health expenditures, which now have their own allocation systems, would probably be excluded from the limit. Medical education and capital expenditures, which are now incorporated into most acute care prices, might be budgeted separately and assigned their own national limits.

In the case of capital spending, state and/or local authorities might assist with imposing limits on spending. Under managed competition, marketplace forces and incentives might be expected over the long run to squeeze excess capital expenditures out of the system. However, such an approach would probably take a long time and might easily be thwarted. As a result, state authorities or the new regional purchasing cooperatives might choose to use more direct regulatory methods to impose budget limits on capital spending in their areas. Every country that now uses global budgets also makes restriction of capital spending a key feature of its overall cost containment strategy.

In the case of medical education, a separate limit under the existing system would be difficult to implement and administer across all providers and insurance plans. However, under a managed competition model, a separate limit for medical education spending might provide some relief to teaching hospitals that are concerned that the present system of indirect payment through patient care revenues would cause them to appear non-competitive in a price-conscious environment.\(^\text{13}\)

**Defining a limit.** Economic indicators to track health expenditure growth range from measures of income/output (such as GDP) to measures of consumption/input (such as the Consumer Price Index). Most experts
would opt for income/output measures, with GDP as the preferred indicator, since it reflects domestic national income and is relatively easy to estimate. Definition of a national limit, though, might be most appropriately stated in terms of adjusted annual per capita growth in GDP. This would allow for annual tracking of health care spending, measuring the observed change in terms of spending per individual, with adjustments for the changing U.S. demographic composition.

Assuming that a national spending limit might be translated into state or regional limits, the question then becomes whether and how to adjust for various regional differences. Most analysts would probably advocate, at minimum, adjusting for age differences between populations, since they would likely lead to different rates of service use. Adjustments might also be made to perceived past shortfalls in the rate of spending in certain regions (for instance, due to low resource capacity) or for “revealed preferences” reflecting different spending patterns. Such adjustments could be positive or negative, depending upon whether a state or region needs a boost (such as a resource-poor area requiring additional capital to buy new technology) or deserves a slap (such as an area in which hospital bed supply exceeds some acceptable threshold).

Under a reformed system in which consumers have the option of seeking core services from providers outside the federally mandated system, “revealed preference” behavior can measure the degree of tightness that may exist in the total system. If few consumers appear to be opting out, the control limits may be too loose; if too many are exercising this option, the limits may be too tight.

**Allocating across areas, populations, and providers.** The effective mechanism for imposing the spending limit, either in the current system or in a reformed system, would be through capping insurance premiums for fee-for-service providers and capitated rates for managed care plans. Under a managed competition model, states, HIPC, and approved health plans would all play critical roles in implementing and operating a global budgeting system. States would be responsible for analyzing state spending and for achieving state budget limits. Within states, budget limits would be set for the HIPC, which would manage competition among the health plans on behalf of their members. Through budgeted premiums and capitated rates, health plans would manage health care costs and would be accountable for assuring the health of their service populations. Adjustments in the premium caps and capitated rate limits would be made annually.

A major allocation issue is whether the budgeting system should be structured in “top-down” or “bottom-up” fashion. In either case, a national limit would be set by some federal entity, but the method of developing individual state limits and HIPC budgets would differ. In a top-down
model, the overall limit would be set nationally and allocated to individual states on an adjusted per capita basis, with further allocations made to individual HIPCs. In a bottom-up model, a budget limit for the state would be constructed by first developing a reasonable insurance premium or capitated rate based on a uniform core benefit package and then aggregating over population groups. We believe that a top-down approach must be adopted if the nation is to have truly effective budget limits. However, in developing such budgets, it will be necessary to take into account the various pressures that are likely to “bubble up” from the delivery system.

Another major consideration in setting a national spending limit is whether existing government programs serving special populations (such as Medicare and Medicaid) should be subject to the limit. Inclusion of the Medicaid program appears to make eminent sense, but there surely will be considerable debate over the question of including the Medicare program under the limit. Exclusion of Medicare likely would result in continued cost shifting among payers, thereby undercutting the potential effectiveness of the spending limit. If, on the other hand, Medicare were included, would the program be held to the same payment rates as other payers, or would it be allowed a price differential, at least initially? In the end, whether or not Medicare is formally included under the limit, the challenge will be to integrate the program with other elements of the health care system, whatever form it may take.

**Governance of the spending limit.** It is assumed that a federal board or commission would govern the health care spending limit. The extent of the board’s governing powers will be the focus of a major political debate over who controls the system: the board itself, in a manner similar to the Federal Reserve Board’s control over national monetary supply, or Congress and the president, with the board acting strictly as an advisory body. Most analysts agree that the board’s major responsibilities likely will be to monitor spending levels and to enforce the limits, but it is unclear whether Congress will leave the setting of the budget amounts to the board.

At the state level, great flexibility in implementation is critical. For instance, a state lacking the right conditions for managed competition might opt instead for a state-administered program that combined rate-setting mechanisms with global budgets to control spending. Still another state might choose to adopt a complementary strategy that implemented managed competition in select areas that could support it and rate setting in areas that could not.

**Monitoring health care spending.** An effective global budgeting system must be able to monitor health care spending in a timely and accurate way at national, state, and substate levels. Effective monitoring of spending trends and patterns depends on high-quality data on service prices, service
volume, and per capita spending. Unfortunately, current data systems are incapable of meeting these information needs.

While estimates of national health care spending are generated annually, similar estimates for states are generally unavailable. States may have reasonable estimates of public spending for health care but commonly lack good estimates of private spending. Private insurance data are beset with problems, including nonstandardized claims forms and coding, long delays in processing, and limited availability owing to their proprietary nature. Thus, considerable effort and expense must be invested in the design and implementation of a national data system for tracking health care spending at state and substate levels.

Data on service pricing, volume, and spending at the local level will be necessary for internal use by HIPCs (to make informed purchasing decisions) and by health plans (to manage the costs of health care delivery efficiently). Information on patient outcomes, practice patterns, and quality of care will also need to be developed within these data systems to assist HIPCs in monitoring health plans' compliance with accepted practice standards and in identifying “best” or most cost-effective practices where such standards do not yet exist.

**Enforcing spending limits.** To be effective, a national spending limit must possess the necessary “teeth” to bring health care spending in line. Enforcement of the limit must be backed by the political will to control spending, or the reform effort will suffer the same fate as the failed cost containment strategies of the past two decades. Enforcement also will depend on successful implementation of the data monitoring system for tracking spending. Assuming that major reforms are phased in over several years’, the ability of states and HIPCs to forecast annual spending will be hampered, making enforcement of limits in the short run quite difficult.

On an interim basis it may be necessary to treat annual budgets initially as targets, rather than fixed limits, which then may be used as multiyear trajectories against which to measure cost containment performance. Ultimately, once reform structures are in place and data systems fully implemented, enforcement mechanisms may be employed that target the state, individual HIPCs, or both. Possible mechanisms for enforcing state limits include state liability for repaying or absorbing the cost of any excess spending, federal penalties/incentives for shared risk/reward with states, reduced federal tax exemptions on insurance premiums above a certain level; federally imposed price controls, and federal assumption of control over state limits. Potential actions to enforce HIPC budgets include HIPC liability for repayment of excess spending, adjustments to premiums and capitated rates in future years, state-imposed price controls, and federal/state suspension or revocation of HIPC licensure.
Conclusions

In our view, neither a global budget nor managed competition alone is capable of stemming the meteoric rise in national health care expenditures. In fact, it may be argued that the two strategies require one another in complementary, mutually reinforcing fashion to accomplish their goals. How so? Consider first the case of global budgets in the fee-for-service world as it exists today.

The key in global budgeting is controlling total health spending. Currently, private insurers lack control over service volume. Asking an insurance company to accept a global budget constraint on its premiums may well be akin to inviting it to become insolvent. Short-term cost savings in the present system could likely be achieved only by imposing wage and price controls, an action viewed with great alarm by many. In the longer run, global budgets would need the economic discipline of a managed competition environment to be effective.

Consider now the case of managed competition in the current environment. Public spending, through Medicare and Medicaid, plus potential subsidies for the uninsured, creates artificiality in the health care marketplace, causing us as a nation to spend more than we otherwise would with our own funds. For managed competition to attain the lower spending levels one might expect to see in a near-perfect market, global budgets would be needed to squeeze aberrant spending patterns out of the total system.

Thus, managed competition and global budgets may, in fact, offer promise as symbiotic and complementary strategies for constraining health care spending growth. The challenge lies in crafting a sensible reform plan that incorporates the best elements of both without succumbing to the formidable obstacles of ideology, politics, and imperfect data. Although neither approach has been adequately implemented and assessed either here or abroad, together they warrant future experimentation if true health system reform is to take root and if we are to muster the necessary political will to foster that change.

This work was supported by a grant from The Henry J. Kaiser Family Foundation. The authors gratefully acknowledge the research assistance provided by Cecile Papirno and Beth Kilbreth, as well as the intellectual contributions to earlier working documents offered by Stanley Wallack.
NOTES


