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Prologue: Repeated efforts to enact public policies that would lead to universal access to medical care have faltered despite the efforts of Democratic and Republican presidents. Now, President Bill Clinton and First Lady Hillary Rodham Clinton have seized the day with expressed determination to introduce a health reform plan by mid-spring. Clinton articulated the broad outlines of his thinking during the campaign; it falls within the framework of this paper by Paul Starr and Walter Zelman, who have become key staff members of the president’s health care reform interdepartmental working group. The authors’ proposal for achieving universal health insurance through managed competition and global budgeting calls for a major restructuring based on the creation of health insurance purchasing cooperatives. It would require unparalleled change, but they assert that nothing less will achieve universality with cost constraint. Starr, a professor of sociology at Princeton University, began to formulate this approach about a year ago, while conducting research on his most recent book, The Logic of Health-Care Reform. In 1982 Starr won acclaim for his Pulitzer Prize-winning book, The Social Transformation of American Medicine. Zelman, special deputy for health issues to California Insurance Commissioner John Garamendi, chaired a task force that developed Garamendi’s bold effort to address health reform at the state level. Zelman, who holds a doctorate in political science from the University of California, Los Angeles, was executive director of California Common Cause from 1978 to 1990. He ran unsuccessfully against Garamendi in 1990 for the state insurance post. After Zelman lost, Garamendi hired him as a deputy. Garamendi’s plan was designed for California, but the proposal’s unique combination of ideas, which the authors draw on liberally, has gained nationwide attention.
Abstract: A new approach to universal health insurance combining managed competition and global budgets promises to break the impasse blocking comprehensive health reform. The central innovation is the development of regional health insurance purchasing cooperatives (HIPCs) as managers and reorganizers of the market and platforms for global budgets. Financing would be based on community-rated premiums, with obligations to employers capped as a percentage of payroll and to individuals as a percentage of family income. Budgets would cap the mandated core of spending and set a target for out-of-pocket expenditures.

In some minds the word compromise raises the specter of compromised principles and corrupt bargains. But in a democracy compromise is not merely unavoidable; it is a source of creative invention, sometimes generating solutions that unexpectedly combine seemingly opposed ideas. The American political process clearly has not worked any such magic in health care reform. Three-quarters of a century after the first proposals for universal health insurance, we are still short some thirty-six million people; more than ever, rising costs strain public budgets and the private economy. Even as political leaders and interest groups have acknowledged the gravity of these problems, they have been unable to bridge their differences. To be sure, we have had compromises in health reform before—generally weak ones that gave each side only a little of what it wanted. The question now is this: Can our politics produce a strong compromise to restructure the system, extend insurance to all, and bring costs under control?

Our purpose is to set forth the outlines of one such strong compromise: universal coverage through insurance purchasing cooperatives, managed competition, and global budgeting. This approach—managed competition under a cap—may not satisfy dedicated free-market or single-payer advocates, yet it should have broad appeal. To conservatives it offers consumer choice and competition among private health plans. To liberals it offers coverage for all at community rates, with comprehensive benefits, and with an emphasis on consumer protection and information. And to the public at large it promises to break the gridlock in health system reform to achieve broad economic and social objectives.

The debate over health policy has been plagued by a misleading polarization between “competition” and “regulation.” Managed competition, we are told, exemplifies a competitive strategy; global budgeting, a regulatory strategy. This antinomy poses a false choice. With new rules and institutions in the market, we can—and almost certainly will—have both. Managed competition does not just “release” the forces of the market; it reconstructs the market. And even without global budgeting, managed competition involves much new insurance market regulation. Moreover, with its emphasis on capitated health plans, managed competition provides a better platform for global budgeting than exists in the current system.
The model we offer is consistent with the principles that President Bill Clinton endorsed during his campaign: “competition within a budget” and “universal coverage . . . privately provided, publicly guaranteed.” In line with his approach, the federal government would require employers to cover their workers, who would also have to share the cost; public financing would help to make coverage affordable for the unemployed and for low-income households as well as for low-wage employers. The specifics in the model presented here are our own. However, the framework and many details reflect an extended conversation over the past year among analysts trying to break through false ideological dichotomies. This paper distills from that dialogue the essential features of reform, as we understand them: the framework of managed competition, the roles of purchasing cooperatives and employers, a method for financing universal coverage, and a national budgeting process.

This approach recognizes that the imperatives of reform are moral and economic in equal degree. The moral imperative is to achieve equal access to care and protection against financial destitution for the millions now uninsured or underinsured. The economic imperative is to slow the rise in health costs, which have consumed an additional 1 percent of gross national product (GNP) every thirty-five months for the past twelve years.

The two sides of the problem are inseparable. Runaway costs put coverage out of reach for more people and make universal insurance seem unaffordable, while the continued exclusion of millions from basic coverage and care makes the system’s failings and excesses morally unacceptable. Cost containment itself has become a moral issue, as ballooning medical costs have crowded out other needs from governmental and household budgets alike. Health care reform used to be a specialized (if not special) interest; now it has become a precondition for America’s economic health-and reputation for decency.

The Framework Of Managed Competition

Managed competition under a cap, as we envision it, involves new relations between the federal government and the states, between the public and private sectors, and between health care finance and health service delivery. The federal government would establish the framework of the new system but allow the states flexibility in implementing it. Under federal law, all American citizens would be guaranteed the right to a comprehensive set of benefits, defined in general terms by legislation and interpreted and adjusted over time by a National Health Board. The federal government would require all individuals and all employers, except perhaps the very smallest, to share the cost of health insurance. All—except, most
likely, employees of large firms would obtain coverage through new regional health insurance purchasing cooperatives (HIPCs).

These purchasing cooperatives—the central innovation in this model—would neither deliver health care nor pay providers. Rather, they would contract with varied private health plans, including health maintenance organizations (HMOs), preferred provider organizations (PPOs), and one free-choice-of-provider option. The plans would be paid by capitation (although many plans would pay their physicians by other methods, including both salary and fee-for-service). Once a year, the HIPC would give every consumer an opportunity to choose a plan under the following principles of managed competition.

(1) **Open enrollment.** Any HMO, insurer, or other plan that wanted to do business with the regional HIPC would have to take all who apply—no medical underwriting or any other device for risk selection would be allowed. To prevent plans from marketing only to the healthy, the purchasing cooperative would conduct the enrollment process.

(2) **Standard, comprehensive benefit package.** The plans would compete on the same benefit package. If allowed to vary the package, the plans might well use those variations for risk selection purposes—limiting benefits, such as alcoholism treatment, that attract high-risk groups and extending benefits that attract low-risk groups. A uniform benefit package will enable consumers to make clear-cut choices based on the price and quality of plans. It also will strengthen the hand of the HIPC in negotiations with plans, since plans will no longer have the excuse of complex benefit variations for higher prices. This standard package must not be minimal or barebones, but a mainstream package broadly acceptable to the public.

(3) **Routine quality measurement.** Federal legislation should specify uniform standards for the plans to report data on quality of care, including outcomes of treatment. The purchasing cooperatives would publish such data to help consumers in their choice of plans. They would regularly survey consumers for satisfaction and complaints, oversampling vulnerable groups, such as people with disabilities and those living in low-income areas, to monitor whether they are receiving the services for which the plans are contractually responsible.

(4) **Contribution pegged to the low-cost benchmark plan.** For any given enrollee, the purchasing cooperative would pay no plan more than it pays the benchmark plan—that is, the plan providing the uniform benefit package at the lowest price and a satisfactory standard of care. Consumers who choose other plans would pay the marginal difference in cost.

(5) **Community-rated premiums charged to the enrollees, risk-adjusted premiums paid to the plans.** The plans would charge consumers the same; premiums would not be higher for those who are older or for people with
disabilities or preexisting conditions. However, the purchasing cooperatives would risk-adjust the overall payments to plans—that is, they would estimate differences in average risk among the plans' enrolled populations, adjusting upward payments to plans attracting higher-risk subscribers and adjusting downward payments to plans enrolling lower-risk subscribers. The techniques for risk adjustment would be prescribed by the National Health Board.

Purpose of the framework. The purpose of this framework is to encourage consumers to make quality-conscious as well as cost-conscious decisions and to encourage plans to serve both high-risk and low-risk populations. The cost of any plan should depend not on the kinds of subscribers it attracts, but on the quality and efficiency of its services. Today, with little information about quality of care, many people judge quality by price—they think a more expensive plan is better. But indicators of quality may well show that less expensive plans have equally good outcomes (perhaps better) and thereby encourage people to respond to price competition. Much the same reasoning is behind the requirement of a uniform benefit package. Such a package is vital to give consumers enough confidence to respond to price and, thereby, to give plans sufficient incentive to compete on price to get more enrollment.

Although the framework of managed competition appears to change only the method for purchasing insurance, it also is designed to encourage the integration of health insurance and health care provision into the same organizations (the health plans). The more integrated the plans, the better able they will be to control cost and quality. Thus, the new system will tend to alter the organization of services, not just the flow of funds. The method here is reform of finance; the true objective is reform of styles of medical practice and structures of management to promote a more conservative, cost- and quality-conscious framework of medical decision making.

HIPCs themselves would have important effects. First, they would reduce sharply the costs of insurance administration in the small-group market (currently twenty-five cents of every premium dollar for firms between twenty-five and forty-nine employees). This would not only permit lower rates for small groups—especially those that have suffered from experience rating—but also would mean more health benefit for every dollar spent.

Moreover, the purchasing cooperatives would open up choices in health plans that many consumers have never had before. Currently, some employers are imposing managed care, often depriving employees of a choice of plan or physician. The purchasing cooperatives, in contrast, can make available a diverse array of plans, thereby restoring a liberty that employer-based insurance is now threatening.

Managed competition, however, does not merely make alternatives
available; it is designed to clarify the true economic consequences of choice at several levels. The system implicitly asks consumers whether plans other than the benchmark plan are worth the extra cost. It confronts the plans with their relative performance within a region. And since regional HIPCs will have separate rates, those HIPCs with higher costs will have an incentive (especially under the pressure of global budgeting) to learn from best-practice regions. In short, this approach to reform creates not only a competitive environment, but a learning environment that links quality and cost-effective performance.

**Balancing federal and state control.** The balance between federal and state control needs to be carefully calibrated to achieve these ends while allowing for diversity and experimentation. On the one hand, the federal government would set the ground rules for the system, establish global budgets, assess new technologies, develop practice guidelines, and have other continuing responsibilities, such as support for training, medical research, and public health. The states, on the other hand, would be given direct authority to supervise the purchasing cooperatives and license health plans. As we conceive them, the HIPCs most likely would be state-chartered public corporations; their boards would be designed to represent the purchasers—that is, consumers and employers in their region.

This approach builds in flexibility because HIPCs could be adapted to different conditions. Yet, states could seek federal approval to opt out of the national program in favor of defined alternatives, including use of the HIPCs as single payers, as long as they met federal budget targets and provided no less than the guaranteed benefits. The expected pattern, however, would be not only to preserve private health plans, but to increase competition among them.

### Some Differences In Approach

Although the approach taken here owes a great deal to earlier managed competition proposals, it also differs significantly from some of them—most notably in its integration of global budgeting and emphasis on the central role of HIPCs. Unlike the Jackson Hole Group, we do not call for federal certification of a new category of “accountable health partnerships.” At least at first, the purchasing cooperatives would allow managed care plans operating in a region to compete; HIPCs might also be specially charged with facilitating the entry of new managed care plans in many areas.

**A free-choice-of-provider option.** We also do not envision restricting the competition to managed care plans. Consumers who want to enroll in a free-choice-of-provider option with fee-for-service payment should be able to do so, as long as they pay the true difference in cost. To minimize that
cost, HIPCs should use periodic competitive bidding to select one insurer to operate that plan. Evidence from the federal employees’ health system and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) suggests that multiple fee-for-service plans raise overall administrative costs and invite risk selection problems. Because the free-choice-of-provider plan under managed competition should be competing only on claims administration (by definition, it has no provider network), there is no reason to have more than one at a time. The competition among fee-for-service insurers can be serial rather than simultaneous.

Competition among managed care plans on the ground rules set by federal law, such as open enrollment and community rating, also will likely produce extensive consolidation. In addition, the purchasing cooperatives should be able to reject plans that do not show the capacity to meet service responsibilities or persistently fail to meet standards. While not opposing federal certification of “accountable health plans” on principle, we think HIPCs and states should be able to develop their own methods for choosing qualified plans. Moreover, implementation of universal coverage and managed competition should not be held up until federal standards are set and individual plans are certified.

**Benchmark plan.** Another difference in our approach is the conception of the benchmark plan. Other proposals have emphasized the low-cost plan as the point of reference. That term gives rise to misunderstanding; most people assume that the low-cost plan would offer less coverage when, in fact, the coverage would be the same. In addition, because people judge quality by price, the term low-cost may carry some stigma; benchmark, on the other hand, avoids that stigma and promotes a concern for quality. Indeed, HIPCs should have authority to evaluate whether a low-cost plan has sufficient capacity and quality to serve as the benchmark in its region.

**Flexible approach to competition.** Unlike some other proponents of managed competition, we do not expect the purchasing cooperatives to rely exclusively on competitive forces. To be sure, where competition exists, the purchasing cooperative should manage it. Where competition can develop, the cooperative should promote it. But where the potential for competition is limited or absent, the states and purchasing cooperatives must be able to use other means to guarantee universal coverage, control costs, and improve quality.

**Global budgets.** Moreover, we see the purchasing cooperatives not only as managers and promoters of competition but as a source of countervailing power and a mechanism for carrying out national spending limits. In these respects, too, we differ from advocates of managed competition who oppose any national budget setting. Some may ask why, if we believe competition will work, we also see a need for global budgets. One might as soon ask the...
designers of a new airplane if their specification of a second engine demonstrates a lack of confidence in the first. Good designs often build in redundancy. If competition is a complete success, the provisions for global budgets will turn out to be superfluous. But, given past experience, a backup system of cost control seems prudent. Moreover, if employers are going to give up control of health benefits, they are going to expect strong guarantees of cost containment. Global budgets are that guarantee.

**Employers And The Purchasing Cooperatives**

Perhaps the single most important choice in the design of managed competition is the role of the purchasing cooperatives. Are HIPCs conceived as a remedy for the small-group market or as a general manager of health plan competition and global budgets? The latter conception would entail mandating all (or all but the largest) employers to participate in the purchasing cooperatives. The higher the proportion of health expenditures passing through the HIPCs, the easier global budgets will be to set and enforce. The principles of managed competition are also more likely to succeed if put into practice by purchasing cooperatives with large populations. The smaller the risk pool, the more likely risk selection is among competing plans. Moreover, even large companies will rarely have the capacity to offer the range of options available through a HIPC.

Wider participation in HIPCs will prevent them from being viewed as residual, second-class pools. It also will facilitate continuity of health care and coordination of coverage, for if large employers are outside the HIPC, they will set up their own provider networks or contract with different managed care plans. Employees will then often face disruption of care and provider relationships when switching jobs between firms in and out of the HIPC. Moreover, families with earners at different firms will often be unable to arrange for care from the same providers if, as seems likely under a reformed system, they are each required to take their own firm’s coverage. Responsibility for coverage of dependents will also be difficult to resolve.

**Large firms.** If participation in the purchasing cooperative is required only for employers with fewer than a given number of employees (100, 250, 500, and 1,000 are the most frequently mentioned levels), two possibilities arise for larger firms. They will either be barred from HIPCs or be offered HIPCs as an option. Barring larger firms would create several problems. First, large firms with high health care costs, such as the auto companies, will argue that a reformed system excluding them fails to address their concerns. Second, even large employers with low costs may worry that if they are unable to get into the HIPC, private health plans will shift costs from the HIPC population to their own employees. The option of entering
the HIPC is the large firm’s protection against cost shifting. Finally, if an absolute bar became policy, small firms would be forced out of the HIPC once they expanded beyond the ceiling, disrupting the health care of many employees. Denying employees access to a system that gives them more choice and a better price seems unlikely to be a highly popular policy.

On the other hand, if larger firms can join HIPCs voluntarily, the firms that do so will tend to have higher-than-average costs. The problem of adverse selection will be especially severe if these firms are offered the purchasing cooperatives’ community rates. Hence, if the purchasing cooperatives are voluntary for some class of employers, any employer from that class that wants to join must be given a risk-adjusted rate.

The more inclusive the HIPC, the greater will be the reduction in administrative complexity. If myriad employer plans continue to operate, providers still may well face much of the current complexity and cost.

Therefore, on grounds of cost containment, portability and seamlessness of coverage, and simplicity of financing and administration, we prefer to see broad, mandatory employer participation in HIPCs. Hence we urge that the mandatory cutoff point be set as high as is politically feasible: a reasonable goal is the level of 1,000 employees in the bill introduced by the Conservative Democratic Forum. Larger employers should also be given the option to join at risk-adjusted rates.

Opting out. If a reformed system is going to assure Americans access to guaranteed benefits (among which we would include choice of a health plan), employers with over 1,000 employees opting out of the HIPC should have to meet the following requirements. (1) Employers opting out should have to offer a benchmark plan to their employees at no greater cost than if they were in the HIPC. In addition to protecting the interests of employees, this rule should restrain employer spending outside the HIPC. (2) All other employer-provided health plans should have to fulfill the same obligations imposed on plans contracting with HIPCs. Self-insurance should not be a route of escape from federal regulations governing the benefit package, uniform data, and other provisions for electronic billing and administrative simplicity. (3) Any employer offering more comprehensive benefits than the standard should be required to offer those benefits in a supplementary package available to all employees whether they subscribe to the benchmark plan or to the employer’s other plans. (4) Any employer opting out of the HIPC should have to conduct an annual enrollment allowing employees to choose among the benchmark plan and other plans it offers, and it should follow federal guidelines for risk-adjusting payments to the plans.

The requirement that employers offer a benchmark plan would replace the unevenly enforced federal regulation that employers offer a qualifying HMO. Other regulations on health coverage outside the HIPC would
replace the provisions of the Employee Retirement Income Security Act (ERISA) regarding health insurance.

A Framework For Finance

Reform will meet fewer objections if its financing resembles the current, employer-based system of insurance premiums. A tax-based system might well be simpler, more efficient, and more progressive. Nevertheless, converting to a tax-financed system inevitably would create large numbers of losers as well as winners—and the losers would be affluent and powerful. Health care reform is hard enough without stirring upper-income taxpayers to opposition.

Under one option that we have proposed, the regional HIPC would annually declare a community-rated premium based on its benchmark plan (or alternatively on a weighted average of the lowest-cost plans making up at least 30 percent of overall enrollment). Employers would be required to pay a minimum share of that premium—say, 75 percent—for employees and their dependents, although they could choose to pay a larger share (even the entire amount). Employees would pay the remaining portion. To ensure that these premiums were affordable for low-wage employers and low-income employees, both employers’ and employees’ obligations for the benchmark premium would be capped. The employer’s 75 percent share could not exceed a given percentage of payroll—say, 7 percent. The employee’s share could not exceed a given percentage of family income—say, 2 percent. Governmental subsidies would kick in at those levels. (The subsidies would not, however, apply to additional premium charges paid for plans more costly than the benchmark plan.) To avoid giving employers an incentive to employ part-time workers, firms would pay a payroll tax on the wages of part-time workers whose premium costs they did not share.

The unemployed, the self-employed, part-time workers, and those out of the labor force would also be required to obtain health coverage through the HIPC. They too would have to pay the community-rated, benchmark premium in their region, but again, governmental subsidies would ease the burden. If their incomes were beneath the poverty level, they would pay nothing. If above poverty, they would pay a fixed percentage—say, 9 percent—of the difference between their income and the poverty line, up to the value of the premium.

To minimize out-of-pocket costs, the federal government could build the subsidies for employees into the tax-withholding mechanism and pay the subsidies for the unemployed and others without jobs directly to the HIPCs. Additional subsidies to the health plans would reduce or eliminate cost sharing at the point of service for subscribers below the poverty level.
In this volume of *Health Affairs*, John Sheils and colleagues report estimates of the public expenditures required under this approach—that is, with premium obligations capped at 7 percent of payroll for all employers, at 2 percent of family income for all employees, and at 9 percent of above-poverty income for all remaining individuals under age sixty-five, including current Medicaid beneficiaries. With low cost sharing and a broad benefit package, the total public subsidies come to $120.3 billion for 1993. Against this cost, however, one must set projected acute care Medicaid spending ($62.6 billion) and the prospective payroll tax on part-time wages ($4.1 billion), leaving approximately $53 billion to be made up in additional revenues. Under a high cost-sharing plan (which we do not favor), the residual revenue needs fall to $42 billion.

Several additional effects of universal coverage would reduce the net cost. Much of the new spending for the uninsured, as well as the higher reimbursement rates for care of current Medicaid beneficiaries, will flow back into the public sector—that is, to public hospitals and clinics now being financed in part by state and local governments. In addition, newly available health insurance benefits at low-wage jobs will encourage movement from welfare to work among many who have remained on welfare because it gives them access to Medicaid. One study suggests that universal coverage could bring about a one-fourth reduction in welfare caseloads. Federal legislation should also encourage the states to achieve economies in the health care component of workers’ compensation by merging it into the general health insurance system.

States and localities thus could benefit financially from the federal program we have described in four ways: (1) Medicaid’s acute care provisions would be folded into universal coverage; (2) “safety-net” spending at public hospitals and clinics for uncompensated care would be sharply reduced; (3) welfare costs would be cut; and (4) substantial savings can be achieved from merging the health care component of workers’ compensation into health insurance. The Lewin-VHI study in this volume of *Health Affairs* considers only the first of these. Unpublished estimates by Lewin-VHI of the impact of Sen. George Mitchell’s (D-ME) HealthAmerica plan put savings in general assistance, public hospital, and other state and local costs at $10 billion. The low cost-sharing package we favor should cut those costs even more. With these other savings to states and localities taken into account, the net costs to the public sector of the program described above might well fall below $25 billion.

In addition, this approach can easily be modified either to reduce needed revenue or to make the plan more attractive. For example, instead of providing subsidies to all firms to keep their premium obligations within 7 percent of payroll, we could limit the subsidies to small employers (or to
those employers who enter the HIPCs. Alternatively, without increasing the subsidies required, we might graduate the cap—say, from 9 percent on larger firms down to 4 or 5 percent on the smallest. And, for small firms only, we might exclude some fixed amount of payroll in calculating the cap—say, $5,000 per employee—thereby reducing premium obligations only for small firms with low average wages.

Yet another possibility would be to exclude entirely the smallest employers—those with five or fewer employees—and treat their owners and workers as if they were part of the self-employed population. (Lewin-VHI estimates the additional public cost of this measure at $2 billion.) There are strong administrative as well as political arguments for this policy. Small businesses start up, close, move, and change names with great frequency. It may be easier for HIPCs to deal with these employees individually. If such a firm bought insurance for its employees, it would have to do so through the HIPC; if it did not, the employees would enter the HIPC individually.

For the additional public revenue required, three possibilities seem to us particularly attractive: a partial reduction in the tax benefits to employer-paid insurance (worth $92 billion in 1993); provider taxes; and the so-called monster cigarette tax of $2 a pack (worth $35 billion a year when fully phased in). While enacting any tax is difficult, each one of these can be designed to improve incentives as well as to raise needed revenue.

Global Budgets Under Managed Competition

The term global budgeting refers to an overall budget limit on health care services, regardless of where the funds originate. In some contexts, global budgeting has come to mean setting a limit on spending by sector—that is, specific allocations for doctors, hospitals, and so on. This kind of global budgeting risks freezing in place the current composition of expenditures and thereby may retard progressive changes, such as the substitution of lower-cost ambulatory care for inpatient care. Moreover, under this kind of budget, individual physicians would still have incentives to increase service volume and intensity. This is an especially serious problem in the United States because of the bias toward high-cost procedures, the oversupply of specialists, and excess hospital capacity. Given balance billing, inadequate state-level data resources, and the lack of enforcement mechanisms, it is also not clear how such a budget would be carried out. All in all, fee-for-service global budgeting seems a fine recipe for blocking structural reform, heightening conflict, and discrediting the concept of a budget.

Global budgeting through capitated payments to health plans does not suffer from these problems. First, the plans can shift expenditures among different categories of service; indeed, they have an incentive to make
exactly the kinds of progressive, cost-saving changes that fee-for-service payment has inhibited. Second, the plans have a strong incentive to enlist their providers in adopting conservative practice patterns to comply with the organizations’ budget limits. It is this link between financing and provision that is missing in the fee-for-service insurance system.

The aim of policy should be to use the capitated health plans at the local level to carry out nationally set targets for health care spending. The purchasing cooperatives are clearly suited for connecting the two. But what exactly is the budget that policy should be trying to control? And how can spending caps be consistent with managed competition and some degree of regional and state flexibility?

The budget for a region could be defined in at least four ways: (1) the benchmark premium times the total number of enrollees; (2) total premiums paid to all plans, including out-of-pocket premium payments for higher-cost plans; (3) total spending on covered benefits for all eligible individuals (that is, premiums plus out-of-pocket payments for services); and (4) total spending on health care for covered and uncovered services. Of these four budget alternatives, the first has a special significance because it identifies government, employer, and individual obligations. All other spending would be with out-of-pocket (preferably after-tax) dollars. Thus, if a global budget cap were interpreted as limiting the growth of benchmark premiums, it would focus policy on the mandated core of health spending.

Ordinarily, such a cap should be sufficient. But the HIPCs and national board should keep an eye on the various forms of out-of-pocket spending that might signal a problem—a shift in the composition of HIPC enrollment toward higher-cost plans; escalation in the premiums of higher-cost plans; and potential inadequacies in the benefit package as services evolve.

Under this approach, which might be called benchmark budgeting, the federal government would determine a maximum allowable rate of increase in benchmark premiums each year and set a target for discretionary, after-tax spending. The cap and the target might be set by the president and Congress on the advice of economic advisers and the National Health Board, which would evaluate demographic and technological factors and recent changes in interpretations of benefits. The board might then translate the overall national spending limits into caps and targets for the states, taking account of changes in population and other variables. With these constraints in mind, the HIPCs would then bargain with the health plans.

HIPCs would have various means at their disposal to bring in plans with sufficient capacity at the allowable rate of growth and to achieve the overall target for out-of-pocket spending. Clearly, by virtue of their dominant role as purchasers, they would be in a position to jawbone the plans and effectively impose a rate. But they would also have other means. They could
work with the plans to reduce the costs of covered benefits by using those with the lowest costs and best results as models for the others. They could “carve out” some high-cost benefits from all of their contracts and seek competitive bids for a single, globally budgeted provider. They could enter into a state-administered arbitration process with the plans.

If local and state remedies were to no avail, a HIPC could seek a finding from the National Health Board that managed competition and bargaining had failed to keep HIPC premium increases within the allowable range. The board could then adopt any of several measures, ranging from advisory recommendations for improved cost containment to imposition of strict regulatory controls. Conceivably, the board might decertify the HIPC if it found the HIPC’s board to be negligent or incompetent. It might also impose onerous controls on provider rates and capital spending. Given the risks to all local parties, HIPCs would have strong incentives to meet the spending cap without calling in federal intervention.

Under an alternative approach, the federal government would merely set targets for HIPC premiums as well as discretionary spending, allowing states and HIPCs to exceed targets but reducing federal subsidies as a penalty. Thus, if states spent above budget goals, premiums would have to rise and states would have to make up the difference between the amount of the guaranteed subsidy and the amount the federal government was paying. Such an approach might seem at first to be much weaker than a strict federal cap on HIPC premium increases. But if the states had to raise new revenue to pay the extra costs, they would, in effect, become the chief enforcers of the cap.

Should the states also be able to reduce the federally mandated benefit package? We favor a relatively comprehensive national standard for the benefit package for several interrelated reasons. Coverage is the key to control; the costs of services not included in the package will be harder to regulate. Also, if limits on high-cost services are imposed, many individuals will turn to government in the end; it is better to require them to carry full insurance in the first place. Moreover, capitated health plans—the linchpins of the new system—work best when they are responsible for providing the full array of medical services. In the capitation context, it makes no sense to exclude routine or preventive medical services or to impose deductibles-techniques of cost control relevant to the conventional fee-for-service model that has, in fact, been unable to control costs. But since fee-for-service will continue, at least for some time, states dependent upon it may need some flexibility on the benefit package, particularly cost sharing.

States may also need contingent authority to regulate rates. As we have suggested, the federal government would establish a set of provider rates
that could be used as a backup to managed competition. The presumption would be that rate setting would be approved only when managed competition failed. But, in areas with little effective competition, states or HIPCs might have greater discretionary authority to employ rate regulation, in part to create pressure on providers to develop new delivery systems that might obviate the need for rate setting.

Rate setting would be available in reserve in all regions for the one fee-for-service option. It is important that there be such a plan, and only one such plan, in every HIPC region. An insurer that won the bidding to run the plan would have two options for paying providers. It could negotiate with provider representatives or invoke a government-mandated rate structure in the event of a failure to come to terms. Balance billing should be banned in this plan as in the managed care options; cost containment with balance billing is like building a dam with a gaping hole in the middle.

**Strategic Challenges**

The introduction of a managed competition system through purchasing cooperatives faces undeniable political and structural impediments. The transitional problems are not primarily, as many believe, the additional public expenditures, which can be held to manageable levels. Rather, the problems stem from the complexity of disentangling present arrangements and the anxieties of so many whose lives and livelihoods are tied to them.

Some of the most legitimate concerns come from groups representing the poor and others dependent on existing programs. Federal legislation should address those concerns by requiring HIPCs to ensure that plans under contract provide accessible services to vulnerable populations. To avoid segregating the poor in the benchmark plan, HIPC could require that all plans with higher charges accept a specified percentage of low-income individuals at the rate paid to the benchmark plan. In some regions, HIPCs might promote plans that would take service to the poor or to language minorities as their special responsibility. Protecting the “floor” will always be an issue (even under national health insurance systems the poor do not, in fact, get the same services as the elite or even the middle class). This approach would provide the poor with a mainstream level of coverage and vest responsibility for assuring care as well as coverage in a new, consumer-oriented institution—the purchasing cooperative.

Even with universal coverage and integration of Medicaid (other than long-term care), “safety-net” needs will persist. Inevitably, some people, such as illegal immigrants, will not be covered; states and counties might use HIPCs to contract for such care. Moreover, some states now provide benefits to the poor (such as transportation, eyeglasses, and, most impor-
tant, care for severe, chronic mental illness) that will not be covered under the uniform benefit package. To maintain such services, states now providing them could create a wraparound benefit package for the poor.

We do not foresee requiring current Medicare beneficiaries to move into the new system. Of all groups, the elderly are most wedded to fee-for-service medicine. Yet they might be offered an annual choice through their regional HIPC as an alternative to fee-for-service Medicare, with the inducement of broader coverage, including prescription drugs. Instead of graduating into Medicare, new cohorts of the elderly might remain in the new system. Traditional Medicare would thereby wither away.

Although the strategic challenges of reform are immense, the risks of failure are even greater. Under the pressure of rising costs, the insurance system is unraveling. Many small businesses and individuals can no longer afford the cost; major corporations are dumping their responsibilities for retirees. People who were once comfortably insured now stare at financial ruin. The prospects facing government are not much better. Under current policies, according to the Congressional Budget Office, health costs will hit 18 percent of GNP by the end of the decade, up from 13.6 percent in 1992, and will represent 30 percent of federal outlays (excluding interest), up from 18 percent today. This is nothing short of an economic catastrophe. A combined strategy of managed competition and global cost controls is the best way to avert that disaster and achieve what other Western countries have long had—an economically sustainable system of universal health insurance.
NOTES

3. For more on these functions, see S. Sofaer, “Informing and Protecting Consumers under Managed Competition;” and A.L. Hillman, W.R. Greer, and N. Goldfarb, “Safeguarding Quality in Managed Competition,” both in this volume of Health Affairs.
5. In separate papers in this volume, we discuss the legal and organizational structure of the purchasing cooperatives and a plan for their national development. W.A. Zelman, “Who Should Govern the Purchasing Cooperative?;” and P. Starr, “Design of Health Insurance Purchasing Cooperatives,” in this volume of Health Affairs.