Perspectives

Surrounding the discussion of managed competition and its innovative model, health insurance purchasing cooperatives (HIPCs), are a number of issues relating to specific facets of health care financing and delivery. This set of Perspectives examines some of those issues. First, Richard Kronick addresses the division of responsibility between the federal government and states for designing and administering HIPCs. Next, Linda Berghold describes possible benefit packages. Alan Hillman and colleagues discuss quality of care, focusing on the implications for quality if a new delivery model were adopted. Finally, Mark Schlesinger and David Mechanic highlight the needs of the chronically ill, especially those with chronic mental illness, and how best to meet those needs under managed competition. These papers were presented at “Choice Alternatives: Strategies for Universal Health Insurance and Managed Competition,” 20-22 November 1992, in Princeton, New Jersey.

Where Should The Buck Stop: Federal And State Responsibilities In Health Care Financing Reform

by Richard Kronick

There is general agreement that the federal government must establish the basic parameters of the financing system if we are to achieve universal health insurance in the United States. In the absence of federal action, tax competition between states would make many states reluctant either to impose mandates on employers or to enact the taxes that would be required to achieve universal coverage. Further, in the absence of federal revenues, states with large numbers of low-income persons will find it difficult to raise the tax revenues needed to provide subsidies to them. Concerted federal action is needed to guarantee all Americans the right to a comprehensive set of medical benefits. There is, however, less agreement about the desirable extent of federal involvement in achieving a second shared goal: increasing the value produced by the money we spend on health care and limiting the rate of growth in health care expenditures to the rate of growth of value produced by those expenditures for consumers.

In this paper I consider the following questions. First, should state gov-

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ernments be involved in implementing the guarantee that all Americans have the right to a comprehensive set of medical benefits, or should implementation be managed by the federal government with no state involvement? If state governments are involved in implementing this guarantee, how much flexibility should they have in determining how the guarantee is to be implemented? Should the federal government set limits on health spending in each state? What sort of financial responsibility, if any, should state governments have for the level of spending in their state? Should Medicaid and Medicare remain separate programs or be absorbed into a new system? Finally, how quickly can transition to a new set of financing arrangements be accomplished?

Should HIPCs Be Creatures Of The Federal Or State Governments?

Responsibility of states. Because there are substantial variations across the country in the ecology of the medical care delivery system and in the preferences of providers, patients, and politicians, it makes sense to give the states substantial discretion in how HIPCs should be appointed and administered. In some states, primarily rural states such as Iowa or Maine, it does not make sense, nor is it likely to be possible, to have competing groups of providers. In these states residents are likely to be better served if the available providers engage in cooperative health planning efforts. State governments in sparsely settled locales might well decide to create a system of all-payer price controls and public-sector health planning, rather than contracting with competing plans. In these rural states the HIPC might offer only one health plan—the “State Health Plan,” which would look to providers and patients much like Medicare.

In still other states there might be dense enough population concentrations to divide the providers into competing groups, but the preferences of patients, providers, and policymakers might mitigate strongly against a strategy of managed competition. New York State, for example, might prefer to offer a single state health plan to all employees in firms with 1,000 or fewer workers than to contract with a selection of competing provider groups. Although I would be unhappy if New York made a decision to eschew managed competition in favor of a plan that moved in the direction of single-payer price controls of unit prices, I cannot put forth a convincing argument that the federal government should force New York to implement a system of managed competition if that is not the preference of elected officials in the state.

One potential rationale for federal intervention might refer to federal interest in expenditure control; however, expenditure control considerations are largely orthogonal to the managed competition versus price con-
trol debate (as discussed below). A second potential rationale is to argue that because of some (alleged) flaw in the state political system, New York State residents will be prevented from exercising their federally protected rights if important decisions about how to operate the HIPCs are left in state hands. It would be difficult to make such an argument coherently. A similar argument was made to justify federal involvement in enforcing civil rights laws, but the analogy surely does not extend to operation of the HIPC. Further, successful management of competition among health plans will require sustained and intelligent effort from HIPCs. If a state does not want to make a managed competition model work, it is not possible for the federal government to force the state to successfully do so. There are simply too many ways for a HIPC uninterested in promoting competition among health plans to sabotage the plan.

A favorable by-product of allowing variations across states in the functioning of HIPCs is the ability to observe and evaluate the results of alternative modes of operation on the efficiency and quality of the health care delivery system and on the equity (across income classes and race/ethnicity) with which health care is delivered.

**Federal requirements.** Although much discretion can and should be left to the states, there are some minimum federal requirements the states should satisfy. A HIPC should be required to make available at least one “insurance” plan that provides basic benefits. All employers with fewer than 1,000 employees should be required to pay the HIPC 75 percent of the cost of this plan for employees and their dependents. All employees of such employers and all persons not covered through employment would be required to choose a plan offered by the HIPC and pay the difference between the employer contribution (if any) and the premium of the plan they choose. However, I hope that many states would establish HIPCs that would offer a range of health plans and would manage competition among them, rather than offering a single plan.

All health plans under contract to HIPCs would be required to accept, during an annual open enrollment, any person choosing to enroll, without preexisting condition exclusions or waiting periods. All plans would be required to report standardized information on enrollee satisfaction and outcome measures. Premiums would be determined in negotiation with the HIPC and would be the same for all persons purchasing coverage (although, as discussed by James Robinson elsewhere in this volume, the HIPC would pay health plans based on risk-adjusted rates). It is important to allow firms with more than 1,000 employees to decide voluntarily to purchase coverage through the HIPC. To avoid adverse selection, large firms that choose to purchase through the HIPC should make payments based on the demographic characteristics of their work force.
The federal government could persuade states to establish HIPCs by conditioning the availability of Medicaid matching funds on state action to establish HIPCs within a designated time frame. However, since it is difficult to imagine the federal government completely cutting off Medicaid funds to a state that did not establish a functioning HIPC within the appropriate time frame, a more effective inducement would be to provide for a reduction in the federal Medicaid matching rate—for instance, a reduction of one percentage point in the matching rate for each month that a state was out of compliance.

HIPCs As Monopsony Purchasers

In some sparsely populated areas, managed competition is not likely to produce significant improvements in quality and economy; in other more densely populated areas, few organized delivery systems now exist, and it may take more years than politicians, employers, and taxpayers are willing to wait to achieve substantial reduction in the growth rate of expenditures through reliance on incentives created by managed competition. In such markets HIPCs can use their monopsony power to be price makers.

The HIPC as monopsony purchaser has two options for controlling expenditure growth: first, it might regulate the prices of health plans under contract; second, it might regulate the prices that physicians and hospitals are allowed to charge for units of services (for example, visits or hospital admissions). In areas where there are organized delivery systems capable of responding to the regulation of premiums (or the prospect of such systems), the premium regulation approach is far superior. In an environment with regulated health plan premiums, plans will be rewarded with more subscribers if they can figure out how to use the available resources better-for example, by moving resources into primary care, by assuring that patients are informed decisionmakers, and by assuring that the number of specialists is determined by the number needed to keep them busy doing highly valued procedures and not, as is currently the case or as would continue to be the case under price regulation, by the number of residency slots in a particular specialty. In contrast, regulation of the unit prices charged by physicians and hospitals gives no reason to expect that we will receive more value for the money we spend.

HIPCs, as price makers, have the theoretical ability to restrain the rate of growth of health plan expenditures to whatever rate is politically desired. The incentives created by managed competition in some markets may result in a politically acceptable rate of premium growth without any action by HIPCs to restrain health plans' ability to price as they see fit. However, if a HIPC is required by government or decides on its own to restrain
premium increases below the rate that would occur based on market incentives alone, in many markets it will be able to use its monopsony purchasing power to effectively regulate health plan prices. Further, in some markets HIPCs will also regulate the rates that physicians and hospitals are allowed to charge for units of service to achieve expenditure growth targets.

Should The Federal Government Set Spending Limits?

The proposed financing system will create strong pressure on HIPCs and the state governments that create them to control the rate of growth of health plan spending. Employers and employees in firms with fewer than 1,000 employees will be required to make an annual payment to the HIPC for health insurance. The HIPC will announce each year the price of the plan(s) that are available. This required premium payment will feel like a tax to those who are paying it, although the payment will not be counted as part of state general revenue.

Just as state legislators are loath to vote for tax increases, they will, I expect, be careful to construct HIPCs in a way that will allow them to avoid the wrath of angry constituents who might be forced to pay ever-higher health insurance premiums. This new dynamic—that constituents will blame the state government if their health insurance “tax” increases too rapidly—is likely to create a strong backbone in the HIPC when dealing with providers and health plans.

However, it may be the case in many states that neither the market incentives created by managed competition nor the political incentives for state governments and the HIPCs they create to restrain spending growth will be strong enough to result in the “desired” level of expenditure restraint. Intense and well-orchestrated lobbying efforts are always to be expected from providers, and the fact that states can be held responsible for premium increases does not guarantee that HIPCs will act in consumers’ rather than providers’ interest. Although the balance of power between consumers and providers will certainly shift, it may not shift far enough to result in a socially desirable allocation of resources to health care.

Accountability. It makes little sense to create a financing system in which the entity that makes decisions about the volume of funds flowing to health plans is not also financially responsible for the implications of its decisions. HIPCs can allow premiums to increase without requiring state legislators to raise general revenues or cut other state programs; revenue for premium increases will come primarily from employers and workers who pay plan premiums and from the federal government through the subsidization of premiums for low-income persons. Past determination-of-need programs foundered at least in part because those who made decisions to allow
new construction were not responsible for paying for the results of their decisions. Similarly, at least some state hospital rate-setting programs have had less than noteworthy success because those setting the rates are required neither to pay their own money nor to raise taxes and then face the voters if they decide to award generous rate increases.

This problem could be resolved in two ways. First, the federal government could impose spending limits on the states. Second, the financing proposal could be changed to require that states raise additional general revenue if health spending increased faster than some target rate.

Under the first option, Congress, advised by a newly constituted National Health Board, would have the authority to determine a target level of health spending increase for the nation and then determine target levels of increase for each state. HIPCs would be responsible for assuring that spending did not increase by more than the target level.

Under this option, a target could be set for the rate of increase in the premium of the average-priced plan. A HIPC then would be required to assure that the price of the average-priced plan did not increase from year to year by more than a designated rate. In some locales market incentives will cause this result to occur, in some areas HIPC regulation of health plan premiums will be required, and in other areas direct regulation of physician and hospital reimbursement will be needed.

Insisting on the imposition of federally determined targets for expenditure growth may result in welfare losses. If the targets are too high, then they may serve as a floor as well as a ceiling and result in greater expenditure growth than would have occurred without them. If the targets are too low, the result may be fewer resources devoted to health care than might be optimal. Further, an insistence on rigid targets in the short run will lead in many states to the introduction of controls on the unit prices charged by physicians and hospitals; the political, bureaucratic, and provider attention that imposing and implementing these controls will require will inhibit the development of organized delivery systems and result, in the medium run, in a health care system that only slowly, if at all, produces increased value for the money spent.

Enforcement of federally determined expenditure targets is likely to be difficult if HIPCs are creatures of the states. Although the federal government could threaten financial penalties for states that allow overspending to occur or, in the extreme, threaten to take over operation of the HIPCs, either of these sanctions will be difficult and painful to implement.

A second option is to allow states to determine the level of spending increase but to require state general revenues to be used if expenditures increased more quickly than some federally determined target rate. Under this option, the federal government would guarantee employers and em-
ployees that the premiums they would pay for the average-priced plan would not increase by more than a specified rate. If the actual rate of increase was above the target, the state would be required to raise general revenue to pay for the difference between the target and actual performance. Under this option HIPC decisions to allow premium increases in excess of the federal target would require state legislators to make politically painful decisions. Similarly, it would make sense to require states to share with the federal government the burden of making subsidy payments to low-income persons if spending increased faster than the target and to require state governments to pay for the excess revenue loss from tax-free employer health insurance contributions if the target is exceeded. This dynamic should strengthen states’ resolve to moderate spending growth, without the rigidity and enforcement problems that would occur if HIPCs were required to comply with federal directives on expenditure control.

Making states financially responsible for HIPC decisions should satisfy the political needs for federally determined expenditure targets. First, to convince employers and employees to support the mandate to purchase insurance, it will be important to provide some reassurance limiting the amount they will be required to pay. Under this proposal the required payments directly for health insurance would increase by no more than a fixed amount, although other state tax increases (or expenditure cuts) would be required if actual expenditures increased more quickly than the target amount. Second, the federal government has in place the technical levers to reduce the rate of growth of Medicare spending by reducing the volume performance standards (VPS) and reducing the rate of increase in diagnosis-related group (DRG) rates. However, the political difficulty of using these levers is increased if providers are able to form a coalition with employers who are concerned about the additional provider cost shifting that federal Medicare reductions might create and with Medicare recipients who are concerned that some providers might stop serving Medicare patients. Reassurance that the rate of increase in private-sector payments to health plans will be controlled will increase both the political feasibility and substantive desirability of spending restraint in Medicare.

Another concern that arises is the lack of a method for controlling expenditure growth for those large employers who purchase benefits directly rather than through a HIPC. As suggested above, these employers should have the option to purchase benefits through the HIPC; this option will limit the ability of providers and health plans to exploit inelastic demand curves and shift the cost of public program (or HIPC) “underpayments.” If large employers and their employees are asked to pay significantly more outside the HIPC than they would be required to pay inside it, they can simply switch to HIPC-contracted plans.
Medicaid And Medicare

It makes substantive sense to purchase health insurance for Medicare beneficiaries and for Medicaid recipients (at least for acute care) through the HIPCs. In states that want to create an environment that rewards quality and economy, the incentives for providers will be stronger if a larger number of consumers are conscious of quality and (at least for the nonpoor) cost at the time they choose a health plan. In states that want to regulate hospital and physician prices and engage in public-sector health planning, the ability to design and execute plans effectively will be increased if a larger, rather than a smaller, part of the population is included in the population base for the plan. Further, moving the care of Medicaid recipients toward the mainstream will result in most places in significant improvements in access and quality.

However, there are strong political and administrative arguments for maintaining a separate Medicare program and for delaying the folding in of the acute care portion of Medicaid into the HIPC. Although there are many complaints both from beneficiaries and providers about the Medicare program, proposing a massive change would be extremely disruptive and likely would impede passage of a reform program.

The political advantages and disadvantages of proposing to eliminate the acute care portion of Medicaid are more ambiguous, but such a proposal would surely create new opponents to reform among some in the advocacy community without necessarily gaining enough counterbalancing support from providers. More importantly, managing the interactions of existing Medicaid and public welfare bureaucracies with the HIPCs would be a daunting task that would add a new layer of complexity and delay to HIPC implementation. Further, neither Medicaid programs nor provider groups have much experience in providing managed care to severely disabled persons; it is important to develop these capabilities, but this is better done gradually, not in a crisis environment. Perhaps most importantly, the HIPC should not be perceived as (or become) a “poor person’s” program. Thus it makes more sense to plan to delay folding in Medicaid until a specified later date, perhaps two to four years after the implementation of HIPCs.

Implementation And Transition Issues

Some have suggested phasing in an employer mandate and universal access over a fairly long period of time (three to five years) and raising the federal revenue needed to subsidize insurance for low-income persons through generating “savings” (relative to the baseline projections) in the Medicare program. Bolder and more forceful action in achieving universal
coverage is both necessary and appropriate. It is important to establish the
principle that all employers must contribute to health insurance, and there
is little to be gained in waiting many years for implementation. Revenue for
the subsidies that are needed to make insurance affordable for low-income
persons can be raised by limiting the amount of tax-free employer contribu-
tion (thus more equitably distributing federal subsidies for the purchase of
insurance) and by recapturing some of the monies that currently are paid to
providers for care of the uninsured.

An ambitious but reasonable time frame projects the enactment of
federal legislation in fall 1993 that would require states to establish HIPCs
by 1 January 1995. These HIPCs would be required to contract with health
plans and make these plans available by 1 January 1996, at the latest. The
employer mandate and the requirement that all individuals purchase insur-
ance would go into effect on the earlier of 1 January 1996 or the date that a
state's HIPC(s) had contracted with health plans and were ready to accept
enrollees. Universal coverage would be achieved before 1 January 1996 in
many states, and no later than that date in all states.

Interim steps. Some have suggested that it is important to achieve
control of health expenditure growth immediately and that waiting for the
incentives created by managed competition to change provider behavior
will require more time than we can wait without plunging deeper into
financial crisis. The corollary to this suggestion is that, as an interim step,
the federal government should impose price controls on physician and
hospital reimbursement.

A strategy of “interim” federally imposed all-payer price controls would,
in my view, be a mistake. It would not achieve much more by way of price
controls than can be achieved through HIPC implementation. Since
HIPCs have the ability to control health plan premiums, rather than simply
controlling unit prices of physician and hospital services, they could start
regulating health plan premiums 1 January 1996 at the latest, and in many
states before that date. Price controls on hospitals could begin, at the
earliest, 1 January 1994, and developing the information to implement
effective VPS for physician services would take substantially longer.4 There
is not a big time difference between the date on which we could start
regulating health plan premiums and the date on which we could start
regulating unit physician and hospital prices.

Some argue that regulation of physician and hospital prices as an interim
step has few disadvantages and should be used to give more leeway to
implement HIPCs and to foster the development of organized delivery
systems. Administering a system of all-payer price regulation will be a
massive undertaking and will divert political, administrative, and provider
attention from the equally massive undertaking of attempting to restructure
the market to reward quality and economy. There no doubt will be some states that will choose all-payer price regulation, and the federal government should provide technical assistance to these states in implementing this choice, but there is little to be gained and much to lose from imposing this option on all states. As Uwe Reinhardt has suggested, it would be far preferable and much less contentious to require, starting 1 January 1994, all physicians to state their prices using the resource-based relative value scale (RBRVS) (so that physicians simply announce their conversion factors) and to require all hospitals to state their prices based on DRGs.

We would be far better served if, instead of devoting energy to imposing an interim all-payer price control system, we constructed a process to rationalize and create accountability for decisions on the adoption of new technology and to create a sensible and enforceable policy on health work-force needs and development.5

Impact on urban poor. There are three reasons to be optimistic about the effects of the reforms proposed here on health care for the poor. First, the proposed financing reforms will greatly increase the purchasing power of many urban poor persons. A combination of mandated employer contributions and federally provided subsidies will assure that all persons are able to purchase a health plan that provides the standard set of benefits. Increased purchasing power will encourage health plans to place primary care clinics in inner cities, to attract paying patients.

Second, even if health plans do not voluntarily increase primary care services to inner-city residents in response to economic incentives, HIPCs will be able to require health plans to serve the entire HIPC geographic area. A HIPC for Los Angeles, for example, could require that health plans that wanted to serve Beverly Hills also make primary care services available and attractive to the residents of Southeast Los Angeles. Whether the HIPC would actually do so would depend both on the effectiveness of federal and state mandates and on the institutional politics of the HIPC.

Third, at the very worst, the county health departments and other public-sector institutions that currently provide services to inner-city poor persons in some locales will obtain increased revenue for their efforts. Current providers of care to low-income persons will form health plans; to the extent that other health plans neither are interested in nor can be cajoled into providing services to the poor, public providers will benefit from the increased subsidies that will be available to low-income persons.

The problem of increasing the health services available to low-income persons is, fundamentally, a political problem; the advantage of the proposal made here is that it provides an institutional framework in which the political problem is likely to be solved successfully. Consider the alternative in which the HIPC (or the state or federal government), instead of fostering
competition among health plans, engaged in public-sector health planning activities and direct controls on the unit prices of physicians and hospitals. In response to increases in volume of services, the public sector would soon begin to control directly hospital global budgets and aggregate physician reimbursement. Under such a scenario health care resources available for low-income urban dwellers could only be increased if resources available to middle- and upper-income persons were decreased. It is difficult to imagine any governmental (or quasi-governmental) organization aggressively shifting resources from the middle class to the poor, but it is possible to imagine the market facilitating this shift in response to a financing system that puts increased purchasing power into the hands of the poor.

**Conclusion**

During his campaign President Bill Clinton proposed requiring employers to pay for much of the cost of health insurance and providing federal subsidies for the purchase of insurance to low-income persons and to small employers for whom the mandate might be overly burdensome. This framework makes sense, and it is important to proceed expeditiously to achieve universal coverage.

There is less agreement on the question of how providers should be paid and on the roles of the federal and state governments in determining the rules of provider payments. Some argue that the federal government should require all states to engage in managed competition by way of HIPCs. Others argue that the federal government should impose a system of price controls on the unit prices for services delivered by physicians, hospitals, and other health care providers.

Here I have suggested that decisions on methods of provider payment should be left largely in state hands. Each state should be required to establish one or more HIPCs, and to assure that all employees in businesses with 1,000 or fewer workers (as well as all self-employed and unemployed persons) can purchase a health plan offering standard benefits through the HIPC. But beyond fairly minimal requirements, the federal government should allow each state (and the HIPCs they create) to determine whether a system of managed competition, a system of public-sector health planning and administered prices, or some hybrid makes the most sense, given the state’s political and medical care milieu.

On the one hand, it is not possible for the federal government to require states that do not want to manage competition to successfully do so. On the other hand, it is quite undesirable for the federal government to impose a system of hospital and physician price controls throughout the nation. The effort that imposing price controls would require would greatly detract from
the effort needed to build accountable health partnerships. Further, a system of administered prices will do nothing to further the reallocation of resources that is needed in our health care system. In small communities and relatively sparsely settled areas, where multiple competing provider groups are not feasible and where both providers and residents share a greater sense of community than in heterogenous metropolitan areas, public-sector health planning and a system controlling the unit prices of physicians and hospitals can probably be made to work reasonably well. But in major metropolitan areas, competition for cost- and quality-conscious patients among health plans is a much preferable method of improving quality and economy. If the demands of immediate expenditure reduction require such competition to be combined with price controls, the HIPC framework allows these controls to be imposed on per capita premiums rather than on the unit prices charged by physicians and hospitals.

NOTES


3. The average-priced plan refers to the weighted average of all plan premiums, where the weights are proportional to plan enrollment. If people migrate toward less-expensive plans, the average-priced plan’s premium would increase more slowly than the average premium increase of each plan. As an alternative, a target might be set for the rate of increase in the lowest-priced plan. A full discussion of this point is beyond the scope of this paper. However, the California Public Employees Retirement System (CalPERS) experience—in which most of the health plans are priced within 15 percent of each other—suggests that the distinction between controlling rate increases for the lowest-priced plan or the average-priced plan may be more important in theory than in practice.

4. We currently do not have reliable information at either the state or national level on the volume of physician services and cannot implement effective volume performance standards until such information is developed. Further, as discussed by Henry Aaron and William Schwartz, a global budget approach to hospital cost control is much better policy than controls on the unit prices of admissions. Creating well-functioning processes in each state to determine such global budgets would require substantial lead time as well. See H.J. Aaron and W.B. Schwartz, “Managed Competition: Little Cost Containment without Budget Limits,” in this volume of Health Affairs.