Health Reform: The Good, The Bad, And The Bottom Line
by Jack Hadley and Stephen Zuckerman

Abstract: The Health Security Act is a pragmatic plan for achieving universal health insurance coverage for a broad package of benefits at reasonable cost. It proposes necessary and reasonable changes in insurance market practices and administrative structure. It finances the reformed system with a credible combination of achievable cost savings, mandatory private-sector payments, and limited “sin” taxes. Political constraints the inability to tax openly or redistribute tax subsidies—result in weak incentives for consumers to choose low-cost plans and an inefficient scheme for providing subsidies to the poor. The act also unnecessarily restricts and regulates fee-for-service plans and the training of health workers. We propose changes to correct the act’s weaknesses without compromising its basic objectives.

The primary goal of the Health Security Act is clear: health insurance coverage for all Americans, which cannot be affected by changes in health status, employment, place of residence, or family status. To achieve this goal without radically restructuring the U.S. approach to health care delivery, financing, and insurance, the Clinton administration has outlined a pragmatic course of action that embodies elements of several models of health care reform.

The Clinton plan represents the administration’s best guess as to what might be a politically achievable and affordable approach to universal coverage. These judgments have led to many reasonable decisions that, if implemented, would improve the health care system. However, in several areas the proposal sidesteps choices that could strengthen consumers’ incentives to seek efficient health plans and target the subsidies more equitably. There are several other areas in which the plan seems unnecessarily prescriptive when it would be better to let things work themselves out. On balance, though, we feel that the strengths of this plan outweigh its weaknesses and that it is an excellent basis for health care reform. We are particularly encouraged because we feel that its flaws can be corrected without significantly changing its basic structure and substantially increasing its costs.

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In this paper we discuss specific aspects of the plan, starting with those that we generally view favorably. These include insurance market reforms, the financing approach, cost containment goals, and the new administrative structures. We have greater disagreement about the continued tax subsidies for employers and individuals that weaken consumer choice incentives, the targeting of the subsidies, the treatment of the fee-for-service plans, and health labor-force policy. For these areas we propose alternative approaches.

The Good

Coverage, benefits, and insurance market reform. At the heart of the reforms of the health insurance market are the dual requirements that all plans base premiums on a uniform set of comprehensive benefits and that premiums be set by community rating. A drawback of requiring a comprehensive benefit package is that it may force some persons into purchasing more coverage than they otherwise would choose. To some extent, this is unavoidable in an approach that mandates universal coverage. Plans will be prohibited from engaging in medical underwriting and experience rating. Premiums may vary across insurance plans, however, as a function of family type, differences in cost-sharing features, limitations on provider choice, and supplemental benefits.

Many economists argue that community rating in its purest form is undesirable. For instance, if insurance coverage is not mandatory, the result of community rating will be that high-risk people buy too much insurance and low-risk people buy too little. With mandatory insurance, low-risk people will subsidize high-risk people, independent of the individuals' economic status or the causes of their health risks (such as smoking or drug abuse). Community rating also gives health plans strong incentives to seek out preferred risks, as under our current system, albeit for different reasons.

The Clinton proposal tries to address these problems and, in reality, moves away from pure community rating. Although plans would set basic rates for the entire community that vary only with family status, the actual payments they would receive from the regional alliances would be risk-adjusted. To the extent that these risk adjusters are not perfect, some incentive for risk selection would exist. However, the ability of plans to select low-risk persons should be greatly curtailed by the mandate to cover everyone and by the alliance's oversight of the open-enrollment process.

The Clinton plan also addresses the issue of low-risk to high-risk subsidies, although much less directly. The “sin” taxes would force one group of high-risk individuals—smokers—to pay more into the system than is reflected in the community rate. Other activities that increase health risks
also should be assessed. While there are no explicit provisions for lowering the contributions of low-risk individuals, to the extent that the financing plan requires a fixed sum of revenues, increasing sin taxes would reduce revenue requirements from other sources. The subsidies directed to low-income people ameliorate some of the inequity, albeit imperfectly. However, it is reasonable to argue that over a person's lifetime the subsidies paid during the healthy years are somewhat offset by the subsidies received during the sick years.

**Financing.** The largest source of financing for the reform plan would be the private sector: mandatory employer and individual contributions toward the cost of a health plan. The “employer mandate” resembles the Social Security tax more closely than it resembles a true mandate to provide insurance, as, for example, would the “play” component of a “play-or-pay” reform plan. Instead, employers are being asked to finance (80 percent on average) what is essentially an individual mandate to select and enroll in a health plan.

Sources of public-sector funds would include savings from Medicare, Medicaid, and other government health programs; sin taxes, currently proposed only for cigarettes; and a variety of revenue gains expected as a result of the plan's provisions. The projected amount of public funds depends critically on the success of the plan's cost containment strategy.

Critics of using the cost-savings strategy have attacked it on three fronts. First, it is politically impossible to squeeze $189 billion out of Medicare and Medicaid between now and the end of the decade. Second, the private-sector plan will not work, because it is too regulatory and not pure managed competition. Third, and contradictory to the last argument, if the cost control incentives do work, they will cause massive disruptions and lead to government-directed rationing, because providers will not be able to adjust rapidly enough.

Before we address these issues, it is important to put the projected “savings and cost cutting” into perspective. In fact, we believe that the plan's initially stated objective of saving $136 billion annually by the year 2000 is a relatively modest one. The alleged massive cuts and disruptions would come not by reducing current spending but by reducing the rate of spending growth. If the administration's initial plan works as is projected, the health care sector will grow from almost 15 percent of gross domestic product (GDP) now to 17.3 percent, instead of 18.2 percent as projected by the Congressional Budget Office (CBO). Only one other country (Canada) now spends as much as 10 percent of its GDP on health care. Given the decision to begin implementing the plan later than was initially proposed, all of these savings are likely to be lower. However, the principle of using cost savings to achieve universal coverage is still sound.
Slicing $189 billion out of Medicare and Medicaid spending growth is “fantasy,” according to some, in light of the budget battle of summer 1993 that barely managed to cut $56 billion over five years from the two programs. What distinguishes this proposal from past cuts in spending for these programs, however, is that private-sector growth also will be constrained by about the same amount, although the private-sector cuts will be phased in more slowly. Maintaining Medicare beneficiaries’ access to care during the transition should be a high priority. Providers ultimately will have little incentive to dump public program patients in favor of the privately insured. Medicare beneficiaries’ continued good access to care, in spite of payment constraints from the prospective payment system (PPS) and the new Medicare physician fee schedule, illustrates that when managed care plans are blooming, Medicare payments do not look as bad as they might if the private sector were paying providers’ full charges, as it used to do.

**Cost containment objectives.** Since managed competition is a largely untested theory, the Clinton proposal puts teeth into its cost containment goals by setting a ceiling on the allowed premium at 20 percent above the weighted average premium across all plans in an area. The average premium target is set to achieve a desired spending target both within the alliance and nationally. In our view, the plan needs to have this premium target to limit the flow of new money into the health care system. This must happen if spending growth is to be slowed.

The administration could have eliminated current tax subsidies for health insurance payments as the way to change peoples’ incentives. Despite its intellectual appeal to some, however, there is little evidence to show that this approach would succeed. Instead, the Clinton proposal relies on competition among plans but limits the amount of tax-subsidized dollars that can flow into the system and requires the development of a potentially regulatory framework for limiting total spending. If there is a consensus that stronger incentives for consumer choice are unachievable, then there is little choice but to impose some type of spending cap as a way of encouraging providers and health plans to seek efficiencies.

There is little doubt that if faced with constrained revenues, insurance plans will limit their expenses in ways that do not drive away subscribers. One critic characterized this approach as “getting the insurance plans to do the government’s dirty work.” That is exactly right. It seems far preferable to have insurance companies, which are responsible to their subscribers, make these decisions than to have the federal government involved in detailed price negotiations and utilization review procedures with individual hospitals and physicians.

The specter of sick patients being unable to receive care borders on fear-mongering. The U.S. health system is fraught with inefficiencies and
excesses that have no measurable health benefits. Studies of the present system have shown that hospital costs are 10–15 percent higher than they would be if all facilities produced services more efficiently. These estimates suggest that in 1991 inefficiency in hospital production was roughly $30–$45 billion; extrapolating to 2000, hospital inefficiency would be in the range of $50–$70 billion. Imposing financial pressure through caps on premiums means some hospitals will scale back their investments in buildings and equipment, which are often underused, and reorganize their staffs. In the longer run, some services now provided by hospitals may be provided in less costly settings, while others will be provided less often because their current rates of use are not cost-effective. Moreover, these estimates understate the true production inefficiency in hospitals because they are based on the services currently provided and do not question the value or appropriateness of these services. However, there is ample evidence that many hospital services may be unnecessary. One study estimated that between 17 percent and 32 percent of hospital cases for coronary angiography, carotid endarterectomy, and upper gastrointestinal endoscopy represented inappropriate admissions. Another study concluded that 23 percent of hospital admissions were inappropriate and that an additional 17 percent could have been avoided with the use of ambulatory surgery. A third study found that 21.4 percent of pediatric hospital days were inappropriate.

With regard to unnecessarily high payment rates, numerous studies show that the Medicare program pays hospitals and physicians less than private insurers pay. Yet there is little evidence of poor or eroding access to care by Medicare beneficiaries, and research also suggests that as long as private insurance payment rates do not increase faster than Medicare's rates, access to care will remain good. The administration's proposal seeks to constrain payment rates for both Medicare and private insurers through a variety of market and regulatory mechanisms. Providers who currently serve high proportions of uninsured and Medicaid patients generally treat relatively few privately insured patients. Such providers will benefit from the administration's plan. All people will be insured, and payments made for Medicaid beneficiaries will increase, since these persons will become part of the general insurance pool served by the health alliances.

Moreover, Medicare's experience with constraining payment rates hardly suggests that catastrophe lurks around the corner. Implementation of Medicare's prospective payment system (PPS) in 1983 was greeted by dire predictions of massive hospital closings. Yet between 1982 and 1991 the total number of U.S. hospitals fell by only 4.2 percent. Since 1986 hospitals' average total margin has stabilized at approximately 5 percent, and in 1992 the number of hospital closings fell for the fourth consecutive year, reaching a ten-year low of thirty-nine hospitals, out of more than 6,000
institutions. Hospital admissions per 1,000 people have fallen by more than 30 percent since 1982, but Medicare's share of total admissions has been increasing since 1987, in spite of increasingly tighter PPS payment rates. Finally, less generous payments to physicians have not blunted their willingness to accept assignment of benefits for Medicare patients. The assignment rate is at an all-time high, and almost 70 percent of physicians indicated in 1992 that they had signed a Medicare participation agreement, up from 62 percent in 1990.

How quickly can providers respond to changes in their environments? Holding the line on salary increases, letting unfilled positions go vacant, laying off employees, and postponing or eliminating desired capital projects represent unpleasant but essential aspects of health care administration. It is obviously much more pleasant to solve institutional financial problems by bringing in more revenues and saying yes to salary increases and the like. But when the market does not permit revenue-enhancing strategies, institutions do not willingly go belly-up.

As examples, several studies of the hospital sector and one study of physicians' responses suggest both rapid and substantial changes. During the PPS phase-in between 1982 and 1984 hospitals facing the greatest threat of financial loss held their cost growth to 3.2 percent, compared with 10.2 percent for hospitals facing financial gains. In California hospitals that faced both strong competitive pressures and the threat of losses from PPS actually cut their costs by 4.3 percent between 1983 and 1985, compared with cost increases of 2.7 percent for hospitals in noncompetitive markets with little threat of losses from PPS. A national study of hospitals' responses to financial pressure in 1987 found that the 25 percent of hospitals with the lowest profit margins held their total cost growth to 13.3 percent between 1987 and 1989, compared with 27.6 percent for the 25 percent of hospitals with the highest profit margins. Finally, two large studies of hospital costs over several years estimated that the average amount of time for hospitals to adjust their costs to a new set of circumstances was about two years. While there is less evidence regarding physicians' responses, one study found that the annual increase in the volume of so-called overpriced procedures provided to Medicare beneficiaries fell from 9.3 percent to 2.4 percent per year between 1986-1987 and 1988-1989 in response to a fee reduction of 2.4 percent. Given that providers can and do respond quickly, as shown in these studies, the targets proposed by the administration's plan are both feasible and attainable.

Administrative structure. The regional alliances will be at the center of local health insurance markets for all nonelderly persons who are not employed by very large firms that choose to operate a corporate alliance. According to the proposal, the alliances will establish contracts with all
plans in an area that set premiums at or below 120 percent of the premium target, establish enrollment procedures, provide information to facilitate consumer choice, collect data to be used to monitor quality, and generally ensure that the health plan market is functioning. They also will collect and disburse premiums. At no time will the alliances be allowed to function as insurers and bear risk. Once the system is up and running, the alliances' role as the annual negotiators of plan premiums may emerge as their most important function.

The National Health Board will be the policy arm of the health care system. Its major responsibilities will be to monitor the need for changes in the comprehensive benefit package, make recommendations regarding premium growth targets, oversee compliance with congressional decisions, and develop a risk adjustment methodology. In addition, the board will concentrate on data analysis and evaluation of health plans' performance, quality management and improvement, and information dissemination.

Even the largest corporations now have difficulty in comparing the plans they offer to their employees. This is likely to be the case for smaller corporations, health alliances, and even state health departments. We also believe that there are significant economies of scale in these types of research and development activities. Either decentralizing them or not formally incorporating them into the National Health Board probably would lead to inefficient, ineffective, and largely noncomparable efforts to figure out how the system is working, where the problems are, and what to do about them.

The Wall Street Journal, the Heritage Foundation, and other true believers in the market typically describe the proposed administrative structure as the “strong arm of government,” “big brother in the examining room,” or “one-size-fits-all health care.” We disagree with these perceptions. We have no doubt that the actions of the alliances and the board will be visible to both subscribers and health plans. Just as everyone watching a baseball game knows the umpires are on the field, they are rarely the center of attention. Spectators understand that the real game is between the players. The alliances will act as umpires who make sure that everyone who should be on the field is there and that the health plans and consumers are playing according to the rules.

The board will act as a rules committee, setting the parameters and then monitoring how the system is working. Since health care reform is a new and complex game, this rules committee might need to make a wide variety of adjustments in the first few years. The health alliances, in our view, will function like state insurance offices with expanded duties. Rather than just assuring the financial solvency of insurance plans that want to do business in the area, alliances will have to certify that all plans meet the necessary
conditions for qualification, all guided by standards set by the board. If the weighted average premium exceeds the alliance's per capita premium target as established by the board, then the alliance should inform each plan of its relative position on the distribution of premiums and notify those at the high end that they need to bring premium levels down. How individual plans do this, however, should be left entirely to the plans, subject to oversight and monitoring for compliance with the board's rules.

However, there seems to be little need for the alliance to become an integral party to health plan design, within the boundaries set by the basic qualification rules. The alliances could (and should) provide technical assistance to plans if requested, but the final decisions should rest with the plans. The ability of the alliance to control the flow of money in the system and to impose explicit penalties on plans that do not comply with the cost containment objectives of the board ultimately are its most important methods of persuasion.

Although the drafters of the Health Security Act may have a clear idea of what the board and the alliances should look like and how they will function, no one has ever seen a real health board or alliance, and there are likely to be variations that no one can now predict. In making these concepts into concrete entities, both Congress and the states will have a great deal of administrative discretion regarding how to discharge their responsibilities. There also will be differences created by staff decisions at all levels. Despite these unknowns, we see the board and the regional alliances as important strengths of the Clinton plan. They are specifically intended to be far removed from provider/patient relationships. Their functions are designed to address some of the most serious deficiencies of health insurance markets: risk selection, inadequate consumer information, the link between employment and health coverage, and the lack of control over costs.

Two aspects of the alliances are particularly well designed. The first is their size. They are intended to be quite large. Most people will select their health plan through the alliance. This reduces the likelihood that the alliance, as a whole, will suffer from adverse risk selection. Allowing more firms to self-insure (by allowing firms with fewer than 5,000 workers to be corporate alliances) would shrink the alliance and expose it to greater risk-selection problems. Smaller alliances also might be perceived as "primarily for poor people" and thus risk losing political support from a broad cross-section of Americans.

As we see it, an alliance's large size should not create diseconomies of scale. In fact, to the extent that there are start-up costs, being large would allow these costs to be spread over more enrollees. A large alliance also would allow the policies of the board and Congress to apply to the health
plans of more persons, strengthening the equity and cost controls in the system.

The second feature of the alliance that we applaud is its lack of policy-making authority. Policies would be made by the National Health Board with congressional approval. This is especially important with respect to premium caps. The board would be in a much better position than any alliance to consider issues of geographic equity. The board also would be much less susceptible to regulatory capture by the health plans than the alliances would be. Obviously, the board could be so detached from the health plans that it sets caps that are too low for all plans in an alliance. This seems highly unlikely to happen for many years. However, if it did, the alliance could negotiate with the board for a more generous cap. If this were a widespread or persistent problem, it should signal to the board that its caps are not allowing for an appropriate level of care or that providers (and plans) were unable to achieve the efficiencies that the board was expecting. In either case, it opens up a reassessment of the policy choices that drive the premium caps.

The Bad

Weak consumer choice incentives. Health care reform based on managed competition gives consumers a strong incentive to choose a low-cost plan by eliminating the tax exemption now provided to employers’ health insurance contributions. Removing or reducing this tax exemption would correctly be seen as a tax increase imposed on workers, particularly those in the middle and upper income brackets, who benefit most from the current tax policy. The administration has chosen not to confront this politically difficult issue and, as a result, has conceded an important element of consumer choice.

They have, however, not completely ignored the need to improve consumer choice incentives. Employers who agree to contribute more than the required 80 percent of the average plan must make the same dollar contribution for all employees. Persons who select a lower-cost plan would receive the difference between their required contribution and the employer’s contribution as a taxable rebate. Those who choose a low-cost plan should be indifferent to this approach over one in which the employer increases wages rather than making the extra contribution.

By institutionalizing the rebate, the administration has made clear the benefits of choosing a low-cost plan. Economists would argue, however, that workers choosing a health plan requiring a lower total contribution from employers and employees would receive higher money wages, without the same dollar contribution and rebate rules. To an economist, this repre-
sents almost no improvement in consumer choice incentives. However, in a world where many people do not recognize the trade-off between wages and fringe benefits, this policy probably will make some people choose a lower-cost plan than they otherwise would choose.

Keeping consumer choice incentives weak by maintaining the tax exemption for employer contributions makes the inclusion of alternative cost containment policies all the more critical. The alternative that this plan puts forward is the premium cap—a control on the rate of growth in health plan revenues. In light of the uncertainties concerning how consumers would respond to price differences among plans under managed competition, a premium cap may be a necessary backup to achieve meaningful cost containment, under any circumstances.

In our view, the premium cap is the major policy tool for slowing health spending growth. It is designed to force health plans and providers to keep spending growth at or below rates deemed desirable by the political process. If the political process is unwilling to rely on the principles of consumer choice to achieve savings, then the premium cap is both a necessary and reasonable stand-in.

**Structure of subsidies.** A basic issue with the mandatory employer contribution is that the employer would want to reduce wages or wage growth to “pay” for this contribution but may be constrained by minimum wage laws. This would increase total compensation for low-wage workers and could lead to layoffs. Alternatively, firms may try to pass these extra labor costs on to consumers in the form of higher prices or may accept lower profits, but these options are not feasible in highly competitive markets. Economic studies of other mandates (such as minimum wages or Social Security taxes) suggest that job loss is not likely to be a major issue. Put differently, wages or other factors adjust so that an employer is able to shift most of the cost of the mandate onto workers or customers.

If most of the costs of the mandatory employer contribution are shifted back onto the worker, then any subsidies instituted to offset the burden of these contributions should be provided to the worker. From a public policy perspective, workers with low incomes should be of greatest concern. Here again, though, the administration’s proposal opts for political pragmatism. The argument seems to be that if the employer is required to make the contribution, the employer must get the subsidy. As such, the distribution of the subsidies is based on the characteristics of firms.

Historically, most of the grumbling about mandates has come from small firms. Their concerns also must be based on the misperception that the employer will bear the costs. Nevertheless, the Clinton plan makes subsidies available only to small firms (those with seventy-five or fewer workers). Because many small firms employ fairly high-income workers, only small
firms in which the average annual earnings are below $24,000 could receive some subsidy.

There are two basic flaws with this subsidy structure. First, it will end up subsidizing some high earners who work in small firms that happen to have low average earnings. Second, it ignores potential problems that the mandated contributions could create for low-wage workers in firms with more than seventy-five workers. If the plan tied subsidies to the characteristics of the worker, more low-wage workers could be protected for the same total cost. Although we realize that it might be too costly to extend subsidies to all workers with a potential need, it seems inappropriate to allocate available subsidy dollars to higher earners in small firms.

Linking the subsidies to firm size also creates incentives that may distort how firms are organized. For instance, firms may create small independent firms that employ their low-wage workers on a contract basis to provide the same services or products that these workers provided as employees. In fact, this type of gaming of the subsidy structure may introduce organizational inefficiencies into some firms. At a minimum, the uncertainty about the extent of this activity makes estimating subsidies more difficult. However, the growth in “contracting out” in recent years suggests that firms already are doing this to control labor costs and that providing financial incentives may accelerate this trend.

One argument to attenuate these concerns is that most larger firms already provide comparable health insurance benefits to both low- and high-wage workers without any special allowances, resulting in an implicit cross-subsidy. By not providing subsidies for low-wage workers in large firms, the Clinton plan must be assuming that these cross-subsidies will continue. However, the incentives to restructure firms combined with the government’s commitment to guaranteed universal coverage may open these arrangements to renegotiation. By offering fundamental reform of the health insurance system and orienting the choice of a plan toward the individual as opposed to the firm, the Clinton plan makes the relationship among workers at the same firm much looser. As such, current cross-subsidies may break down, creating a need for explicit government subsidies for more workers.

A fairer and more efficient approach would be to get business out of the picture altogether, at least with regard to the tax-deductibility of the premium and subsidies. Employees need to be informed that they already pay essentially the full cost of health insurance premiums in the form of lower money wages. The fact that the employer transfers the money to the insurance firm does not make it a free good to the employee. Although large firms still should be allowed to organize their employees’ health plan options as a service to their employees if desired, getting the employer out
of the way would simplify the process of identifying and subsidizing low-income workers. Small firms are not necessarily unprofitable firms. Small firms that are unprofitable may not deserve to be subsidized; and low-wage workers do not necessarily have low family incomes.

Since family income determination is difficult at best, we suggest tying the process to the income tax system, to identify who is eligible for a subsidy, to determine the size of the subsidy, and to collect premiums as withholdings from income. We recognize that a potentially hidden cost of piggybacking the health insurance financing system onto the income tax system is that it will create an incentive to understate income, especially for lower-income families near the subsidy threshold. We believe that these costs could be reduced by increased enforcement efforts and that whatever costs remain are more than offset by the gains from eliminating inefficiencies due to the current employer-based approach to health insurance financing.

The primary barrier, we believe, to moving from an employer to an individual mandate is the other dreaded R-word: redistribution. Work done by The Urban Institute shows that families in the top two deciles of the income distribution received nearly 40 percent of the $44 billion in federal tax subsidies in 1989. The families in the lowest two deciles received only 2 percent of the total tax subsidies. Given the growth in private health insurance premiums, these federal subsidies currently amount to almost $65 billion. That's a lot of money to move around. Instead of giving up altogether, this may be an area where a long phase-in, such as the one granted to employers and unions that now have excessively generous benefit packages, should be proposed.

With this clear body of economic logic stacked against both the current tax subsidies and the desirability of a mandatory employer contribution (even with targeted subsidies), why do these ideas persist in the political arena? The costs of providing coverage for those without the means to pay for it themselves could be financed through the tax system and be at least as progressive as income taxes—or, accepting some regressiveness, through a simpler payroll tax. Seeing these options as politically unattainable, the administration's planners (and others who have advocated mandates before) are seeking to keep as much of the new costs “off the books” as possible. This is the only logic for incorporating an employer mandate. The administration has decided to live with the regressiveness of the tax treatment of employer contributions, the potential for job loss, and the complexity of the targeted subsidies in exchange for achieving the objective of universal coverage.

In trying to achieve universal coverage and correct some of the accepted flaws of employer mandates, the administration may be attempting to build
a house of cards on a weak foundation. As economists, we cannot condone this. As observers of the policy process, we can understand why they feel driven toward this approach. Without the political ability to tax, other sources of monies must be tapped.

**Provider payment under the fee-for-service plan.** We are concerned that the fee-for-service sector designed in the plan is too restrictive. Health alliances will negotiate a fee schedule with providers, presumably modeled after Medicare's PPS and resource-based relative value scale (RBRVS). This part is fine. But then all qualified fee-for-service plans must use the same fee schedule as a ceiling in setting actual payments to individual providers, and providers must be prohibited from balance billing.

This design does not even try to allow market forces to operate. Reducing price variation to zero within the fee-for-service sector of an alliance, as the plan proposes, seems to be an extreme approach. The basic issue is that by requiring all plans to use the same fee schedule and by prohibiting balance billing, fee-for-service plans will lose their ability to compete along the potentially important dimension of price. Moreover, forcing everyone to pay the same price has been shown to lower quality of care.

Fee-for-service plans should be required to use the same relative values (such as diagnosis-related groups and the RBRVS). The choice of a conversion factor to translate relative values into payment rates should be left to the plans. As long as a higher conversion factor can be provided within the premium caps that are tax-subsidized, there seems to be little justification for requiring a single fee schedule. Subscribers should be made aware of these differences during open enrollment so that they can weigh these extra costs against other features of the plan.

The issue of balance billing is more complex. Some might want it prohibited as a means of consumer protection. Others might see its ban as a necessary element in the overall control of health spending. However, to achieve these goals, the plan aims to protect us from spending our own money. Limiting the cost-sharing obligations of the poor is clearly appropriate. This can be done both by assuring that a plan with low cost sharing is available and (although this is more complex) by building in an income-related limit on out-of-pocket spending. Preventing higher-income people from spending their own money, out of pocket and without any subsidy, seems both unnecessary and politically damaging, since it may galvanize opposition from organized medicine.

Balance billing should be treated as any other extra benefit that people choose to purchase. From the perspective of national accounting, spending above the fee schedule should not be in the national health care budget but should be treated as consumption spending. More importantly, balance billing provides a crucial safety valve for gauging the appropriateness of the
fee schedule. If more people are willing to pay charges in excess of the basic fee schedule over time, it will tell plan managers that the fee schedule is not buying a level of service that people want. This is important information for periodic fee schedule renegotiations.

Without balance billing, providers who are not satisfied with the prospectively budgeted fee schedule and patients who are willing to pay for these services are likely to seek alternative arrangements. Under the plan, these arrangements need not constitute an illegal black market. Providers who feel that they can command higher fees may join to form a qualified preferred provider organization (PPO) in a combination plan. Instead of choosing these providers because their costs are low, as is now the case in PPOs, patients would choose these providers on the basis of perceived quality and service. Under this scenario, the combination plan likely would have much higher premiums than the fee-for-service plan, perhaps reflecting the full 20 percent differential allowed. This high-cost combination plan might be the approach used by faculty practice plans and teaching hospitals to assure a mixture of both average and critically ill patients. Without this mechanism, these providers might see themselves cut off from patients other than those seen on a referral basis.

Proponents of the balance-billing prohibition and strict budgeting of fee-for-service plans might argue that without these constraints, the rich will be able to use the fee-for-service system as a means of purchasing "Cadillac-quality" care by luring all of the best doctors and best hospitals into the fee-for-service plan, to the exclusion of everyone else. This strikes us as an unreasonable concern because, as far as we know, there is no objective evidence that the most expensive doctors and hospitals are the best-quality providers. Moreover, Medicare's experience under its new physician fee schedule clearly suggests that the great majority of physicians—not nearly 70 percent in 1992, according to the American Medical Association (AMA)—will voluntarily accept the fee schedule amount as payment in full, up from 62 percent in 1990.¹⁴

Providers who balance bill may offer more convenience and greater amenities. If people want to pay for those, then there is no reason for the reform plan to prohibit such behavior. The plan should, however, require that providers inform patients prior to providing the service that balance billing will occur. It is more important that the reform plan guarantee that the low-cost plans, which are likely to enroll the majority of low-income people (and probably many middle- and higher-income people as well), provide the same quality of care, based on objective measures of health outcomes, as do the high-cost plans.

Health labor-force policy. The reform plan proposes that at least half of all graduate medical education training positions be devoted to primary
care specialties. It also sets up a mechanism for allocating approved slots among regions of the country and among training programs. In addition, the plan includes incentives for increasing the training of nurse practitioners and physician assistants.

Although only a very small part of the overall proposal, these regulations are both superfluous and cumbersome. While we favor primary care, regulation of graduate medical education is not going to have any impact on the proportion of primary care physicians for a long time. Given the supply of practicing physicians relative to the flow of new physicians from training into practice, it will take roughly thirty years before the mix of primary care specialists reaches 50 percent of all practicing physicians.

Aside from being ineffective, this approach is unwise. If the health plans and fee schedules emphasize primary care, then the flow of services will follow reimbursement, regardless of the specialty designations and formal training of the providers. One of the key lessons of Medicare's experience with PPS is that it does not make sense for payers to get involved with labor-force hiring decisions. Instead, payers should negotiate or set the prices they are willing to pay and then let providers figure out the most efficient mix of inputs to produce them.

Past experience with government intervention in training programs for physicians and nurses also suggests that another foray into regulating training would not be prudent. Training programs and people seeking training can adapt quickly. Subsidy programs, once established, are unwieldy and difficult to reorient or eliminate. In the case of health labor policy, it is best for the government simply to get out of the way and not create any artificial labor-market distortions.

The Bottom Line

The strengths of the Health Security Act are that it corrects many of the deficiencies in the market for health insurance that have led to inadequate and unstable coverage and that it provides a mechanism for controlling the rate of increase in spending. These insurance reforms and achievable cost controls bode well for universal coverage.

In a number of areas, however, we believe that political pressures have resulted in unfortunate concessions. These include the failure to enhance consumer choice incentives by eliminating or reducing tax subsidies for health insurance, and the decision to target subsidies toward firms in the face of evidence that workers will bear the costs of the mandated employer contributions. If these choices are politically necessary in the short run, stronger consumer choice incentives and individually targeted subsidies should be phased in over time.
In two other areas—the rigidity of the fee-for-service sector and the regulation of health labor-force training—the Clinton proposal is unnecessarily prescriptive and potentially harmful. As long as the plan controls costs and expands coverage, there is no need to prohibit people from exercising their preferences in a market setting. In addition, controlling the composition of the health labor force may distort health plans' ability to meet patients' demands at the least cost.

All in all, the Clinton proposal is a remarkable document with many positive features. It is unlikely to be nearly as disruptive and bureaucratic as many would have us believe; it will bring genuine health security to all Americans; and whatever it does not get right on the first pass can be adjusted over time. The plan that passes this year is not necessarily the system we will have ten years from now. The Clinton plan will establish a framework for monitoring, influencing, and, if necessary, controlling the health system to better meet the health needs of all Americans.

NOTES


