The rationale behind the Clinton health care reform plan

Health Affairs 13, no.1 (1994):9-29
doi: 10.1377/hlthaff.13.1.9

Cite this article as:
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The Clinton administration’s health care reform plan can be described as many different things to the array of individual and institutional interests to which it would apply. Certainly it is a political document, based on a calculus that Congress is most likely to approve a plan of universal insurance coverage if the measure does not impose a broad-based tax to finance it. But it is also the health equivalent of reinventing government, proposing it does the creation of new institutions, new relationships, and new responsibilities for private and public sectors alike. In our Land paper one of the principal architects of this complicated proposal introduced by President Bill Clinton outlines what the author characterizes as “a study in paths taken and not taken” in pursuit of the plan. Walter Zelman is one of a tiny cadre at the White House still working on health policy issues after the dismantlement of the Clintons’ mammoth task force on health care reform. Zelman holds a doctorate in political science from the University of California, Los Angeles, and was instrumental in structuring the concept of a health insurance purchasing alliance. He was executive director of California Common Cause from 1978 to 1990. In 1990 he ran unsuccessfully against John Garamendi for the post of California insurance commissioner. After Zelman lost, Garamendi hired him as his deputy for health issues. Zelman chaired a task force that developed Garamendi’s health care reform proposal, which set out in legislation for the first time the concept of a purchasing cooperative. The California Legislature never approved the measure but did enact legislation that created a state-based voluntary alliance (see page 350 in this issue) and strict, comprehensive, small-group health insurance underwriting reform.
At a recent health reform conference a benefits manager from a major corporation was prepared to unveil nine overhead slides about the Clinton administration’s Health Security Act. Six of the slides offered generally positive comments on key plan elements. The remaining three slides expressed some concerns, none of which went to the heart of the plan’s design. When told her presentation was cut from ten minutes to three minutes, she flashed the first six slides on a screen (“I wish I had the time to discuss these,” she said) and then proceeded to spend her remaining two and a half minutes explaining the second set of three slides.

Her decision illustrates what might be labeled the “glass is 20 percent empty” phenomenon, and when it comes to health care reform, it is a very common phenomenon. It matters little if the observer is an average citizen, a think-tank analyst, a senator, or an interest group. In the debate over health care reform proposals, the tendency is to focus on problems, concerns, and differences, rather than on similarities, areas of agreement, and the potential for coalition building and compromise.

This paper outlines what it is hoped will become an 80 percent phenomenon: the Clinton administration’s health care reform proposal. Since space does not allow for discussion of all aspects of the plan, this paper highlights critical design elements and the rationale behind key decisions. As such, this is a study in paths taken and not taken.

Guiding Principles

**Universality.** The Clinton administration’s health plan begins with the bedrock assumption that all Americans must be guaranteed health coverage that, in President Bill Clinton’s words, “can never be taken away.” Such universality is more than an ethical imperative. It also assumes that coverage for all will produce better health and well-being for society as a whole and will do so more efficiently than the present system.

Universality also serves as a fundamental dividing line between the president’s proposal and those that do not commit to, or do not define the means of, achieving universal coverage. A true commitment to universal coverage entails the responsibility to define exactly who is going to pay, how much, for what, and to what, if any, limit. Plans that fall short of a firm and credible commitment to the goal of universal coverage can ignore, postpone, or leave ill defined some of these difficult reform decisions. In the health care reform debate, that right is an enormous luxury.

To the fundamental guarantee of coverage (not just access) and security for all, President Clinton has added five other principles: savings, choice, quality, simplicity, and responsibility. These can be viewed both as goals of the new system and as failings of the present system. From either viewpoint
they constitute a framework within which present and future systems can be evaluated and against which alternative models can be contrasted.

**Savings.** Savings is clearly a reform imperative. If reform cannot reduce costs-for families, businesses, and government-the current health care crisis will worsen, and universal coverage will prove unaffordable and unattainable. It is hardly surprising, then, that measures that might guarantee, not just promise, cost containment are most prominent in reform proposals that aim at universal coverage. Such proposals often are attacked as “overly regulatory.” But they at least recognize that advocacy of universal coverage may demand guaranteed means of reducing costs.

**Choice.** Choice is critical for two primary reasons. First, it is a right that Americans do not want to, and should not have to, relinquish. Second, the right of individuals (not employers) to choose health plans, providers, and even prices is critical to the success of a competitive, market-based reform such as the Clinton plan.

**Quality.** Quality, too, must be maintained and enhanced where necessary. But this goal also demands that measures of quality be defined, and then more effectively used, by consumers in selecting health plans and providers and by health plans and providers in improving delivery systems.

**Simplicity.** Reform must reduce the complexity and high administrative costs of the current system. Also, a simplified system can help consumers make better choices, driving providers to produce more value for consumers’ dollars.

**Responsibility.** Finally, responsibility is mandatory because the only equitable means to providing coverage for all is to require that all contribute, at least within their capacity to do so.

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**Merging Competing Constructs**

Clearly, while they are helpful in framing the reform debate, there is nothing radical in these principles. In fact, in recent years there has been less debate over the ends the principles embody than over the means of achieving them.

In seeking to define those means, the Health Security Act proposed by the president draws on many competing proposals. But its goal is not to merge them into a lowest-common-denominator political compromise; rather, it is to draw on the best of competing ideas to create a new, higher-level synthesis, and in so doing to overcome the ideological and political deadlock that has marked the reform debate over the past decade. In this way, the Health Security Act attempts to achieve what was labeled in these pages a year ago as a “bridge to compromise.”

Achieving such a policy-driven bridge to compromise entails the proper
positioning of a reform plan on at least three continuums: competition versus regulation; federal versus state authority; and public versus private delivery systems.

**Competition and regulation.** In the recent past, reform proposals that made universal coverage a hallmark have been advocated primarily by Democrats and liberals and generally have invoked heavy doses of government regulation, including substantial rate regulation. Inherent in many of these proposals was deep skepticism regarding the capacity of marketplace competition to achieve reform goals, including universal coverage.

By contrast, proposals featuring market-based reforms, generally advocated more by conservative and Republican reformers, frequently have failed to spell out a viable means to universal coverage. And in contrast with those offered by universal coverage-oriented reformers, these proposals generally have reflected a deep skepticism about potential effects of excessive government intervention in health care delivery.

In reaching beyond this deadlock, the Health Security Act emerges as a blend of means generally associated with conservatives and ends generally associated with liberals. In effect, it outlines a means of employing modest levels of government intervention to make certain that competition works. It clearly favors the market-based approach, one in which private health plans compete for the enrollment of individuals. But it also insists on the guarantee of security for all, at an acceptable cost. Thus, it imposes bookends of government-imposed requirements—a responsibility on all to contribute and a backstop premium cap mechanism to ensure that costs are contained—around a proposal that features marketplace reforms to generate true competition on price, quality, and service among private health plans.

**Federal and state roles.** The act acknowledges that national health care reform, including the guarantee of coverage for all Americans, will require some national rules. These include consistency across states in financing (including obligations of employers, individuals, and governments), establishment of a comprehensive benefit package, insurance reform rules, definitions of which employers may be allowed to operate their own systems (or corporate alliances), and rules regarding controls on health care costs.²

However, the act also recognizes the ongoing needs for innovation and flexibility and the reality that health system delivery, enforcement, and implementation mechanisms are now maintained at the state level. Thus, states are granted considerable leeway to choose alternative delivery systems, define alliance structures and boundaries, and design and administer the long-term care benefit. In this way, the Clinton plan is a blend of federal and state responsibilities, with states having the flexibility to devise and implement proposed reforms, within federally established parameters.
Public accountability, private delivery. Finally, the plan outlines a blend of public accountability and private direction of health care delivery systems. It recognizes that only government can guarantee coverage to all and that government must create new rules by which health care delivery systems provide care. But, unlike many reform proposals that would have the government oversee, and even implement, details of delivery systems—including the imposition of comprehensive rate-setting mechanisms—the Clinton plan prefers to leave the organization and managing of care to the private sector. The underlying assumption here is that the market rather than government will prove more successful in producing high value for the nation’s health care dollar. Thus, the new system combines public accountability and private delivery.

Health Security Act Benefits

Under the Health Security Act all citizens and legal residents would be guaranteed a defined, comprehensive package of health care benefits, comparable to those offered by most major corporations today. The most notable difference between the benefit package proposed and the package most commonly available in today’s marketplace is the act’s heavier emphasis on preventive care. The act also extends the guarantee of coverage to early retirees and establishes two new benefits designed to fill critical gaps in existing public and private insurance plans: a Medicare prescription drug benefit and a new long-term care program for the severely disabled to provide for home and community-based, as opposed to nursing home-delivered, services.

Defined set of benefits. In defining benefits, architects of the act wrestled with several issues: Should a specific set of benefits be defined? If so, how comprehensive should it be? Should it be standardized?

The first issue proved to be no issue at all. While other proposals have left the definition of benefits to future determination, such a procedure would both undermine the president’s promise of security for all and render it impossible to price the new system. So long as any entity—individuals, employers, and/or the government—is required to pay, it seems both irresponsible and impractical to propose a reform the costs and impacts of which cannot be assessed.

Basic or comprehensive benefits. The issue of comprehensiveness was more difficult. Clearly, a nationally guaranteed benefit package could somehow be limited, by covering fewer services, by limiting benefits in terms of days or dollars, or by demanding high cost sharing.

For varying reasons, each of these alternatives was rejected. Eliminating services deemed medically vital is clearly imprudent, from both health and
economic policy viewpoints. Other than preventive care benefits—which the administration and most analysts believe to be cost-effective-any specific reduction in guaranteed services would be too substantial to be good policy, or so small as to be financially insignificant.

Limiting the extent of coverage would do little but shift costs onto some other payer, most likely government. Our society is not prepared to deny coverage to those with the greatest medical needs. Therefore, as long as care is to be provided, we would be wise to pay for it efficiently, and up front.

As for cost sharing, the act seeks a balance between three values: consumer cost-consciousness, flexibility to allow different delivery arrangements to employ different cost-sharing models, and affordability in all circumstances. Thus, the act defines three alternatives, mirroring today’s fee-for-service, preferred provider organization (PPO), and health maintenance organization (HMO) offerings, with the high-cost-sharing option at a $200 deductible ($400 per family) and a 20 percent copayment. Limits ($1,500 individual, $3,000 family) are placed on out-of-pocket costs.

The most extreme alternative to such modest cost sharing is the catastrophic benefit approach, featuring a much higher deductible of $1,000 or more. Such proposals have been promoted as a means of decreasing premiums and/or heightening consumer cost-consciousness. However, the flaws in this approach are glaring. Catastrophic packages deemphasize the values of cost-effective preventive care, are difficult to implement in managed care policies where deductibles are limited or nonexistent, and would require a relatively complicated government subsidy scheme for those who could not afford the out-of-pocket costs. Moreover, health care consumers have demonstrated a considerable desire to avoid risk, suggesting that very high cost sharing—or, for that matter, any tolerance of wide gaps in coverage—would open the door to a booming business in supplemental insurance. Such insurance would lead to higher utilization, as consumers grew less cost-conscious, and would require—as is the case in Medicare-increased regulatory and administrative costs.

Standardizing benefits. The issue of standardization appears to be more complicated. Yet, among those who advocate market-oriented, consumer choice-driven reforms, standardization is widely recommended. Standardization of benefits clarifies options for consumers, reduces the ability of insurers to engage in risk selection, and increases pressures on health plans to compete on price, quality, and service. The administration’s decision to emphasize preventive care and comprehensive benefits makes the case for standardization that much more compelling. Other than cost-sharing alternatives, which the act allows, the differences that might exist between nonstandardized comprehensive packages would be truly minimal indeed and primarily aimed at risk selection efforts. The enhanced choice that
Paying For Universal Coverage

The Health Security Act proposes that all employers and individuals contribute to health insurance costs. Employers of more than 5,000 workers that form their own corporate alliances pay at least 80 percent of the average premium in their alliances to provide the guaranteed benefit package for their employees and dependents of those employees. Other employers, including all public employers, contribute based on 80 percent of the weighted average premium in a regional alliance for each employee (based on the employee’s family status). Individuals and families pay the difference between the 80 percent of the average premium and the cost of the plan they choose. All employers may pay some or all of the employee’s share.

To enhance consumer cost-consciousness, the 80 percent requirement of the employer is pegged to the average alliance premium. Unlike the situation in many current employer plans, in which the employer pays a given percentage of any plan chosen, this design envisions the consumer paying the full costs of selecting a higher-price plan. Pegging the employer share to the average premium also has the value of rendering that contribution more stable and predictable. If the contribution were pegged, for example, to the lowest-price plan, employers (and individuals) would be subject to much more volatile changes in required payments.

Total payments for all employers of fewer than 5,000 employees are capped at a range of 3.5 percent to 7.9 percent of payroll. These caps will limit the burdens of low-wage employers, for whom 80 percent of the per worker premium would amount to a substantial percentage of payroll. The caps do not apply to employers operating corporate alliances.

Employers of fewer than seventy-five workers are eligible, depending on average wage levels, for particularly substantial discounts. The smallest and lowest-wage employers (fewer than twenty-five employees and average payroll of less than $12,000) pay just 3.5 percent of payroll—about $420 per year if average payroll is $12,000, or about twenty-one cents an hour per full-time employee. This would be equivalent to about a 5 percent increase in the minimum wage.

Low-income individuals also are eligible for discounts on their share of premiums, and all individual payments are capped at 3.9 percent of payroll for family share. Many low-income individuals will be eligible for additional help with cost-sharing expenses. Special provisions (based on the principle that all should contribute to the extent they can) are outlined for part-time and seasonal employees, the self-employed, and the unemployed.
Rejecting broad-based taxes and individual mandates. How to finance universal coverage is, without doubt, the toughest of health care reform questions, and architects of the Health Security Act reviewed a variety of options in considerable depth. After extensive analysis, broad-based taxes (including income and value-added taxes) and proposals that called only for an individual mandate to purchase insurance were rejected. (Payroll taxes were considered even more seriously before being dropped in favor of a premium-based system.)

Certainly, a case can be, and has been, made for broad-based taxes. But such taxes, including payroll taxes, would enormously complicate the search for a viable solution, by adding the substantive complexities and controversies of major tax reform to those of health reform. A tax-based system also would result in much greater disruption in current payment patterns, creating far more dramatic “winners” and “losers” than would a system built on existing financing arrangements. The administration’s preference for an employer-based premium mechanism was strengthened by the recognition that protections could be established for businesses and individuals who might not be able to pay their full share. If, as a tax-based system might, the final design does not ask more from those who have more, it does ask less of those who can afford less.

Total reliance on an individual mandate approach also was rejected. Some health economists are drawn to this approach because it maximizes consumer cost-consciousness, forcing individuals to see the full cost of their health care purchases. However, under such an approach, employers would have incentives to drop coverage of lower-wage workers, who might benefit from substantial government subsidies. Thus, costs would be shifted from employers to government, increasing the need for higher taxes-unless, of course, subsidies were minimized and unreasonable burdens placed on low-income families. Suggestions that this cost shift might be mitigated by a maintenance of effort on the part of employers seem wholly unrealistic. Calculations of amounts due, especially over time, would be subject to massive reporting, monitoring, and administrative complexities.

Moreover, most advocates of individual mandates rely almost exclusively on market forces to control costs. While they may support voluntary purchasing cooperatives and/or community rating and other insurance reforms, they tend to reject large-market-share alliances, any caps on premiums, and other nonmarket-driven cost containment mechanisms. Consequently, their models offer few guarantees of cost control. As a result, credible financing of such proposals tends to require one or more of several unattractive features: a less-than-comprehensive benefit package, high deductibles, and/or a substantial dose of government subsidies, raised from higher taxes or the elimination of the current tax advantages now allowed for health
It is no wonder that individual mandate proposals have limited political viability. While offering higher taxes or withdrawals of current tax benefits, no guarantee of cost control, and potentially less comprehensive benefits, these proposals suggest that the coverage now offered by employers may become the employees’ own personal responsibility. An employer may or may not continue to offer coverage. In the end, the individual mandate approach becomes a big promise, but a very small guarantee.

Rejecting the alternatives does not, of course, prove that the remaining option—an employer, backed up by an individual, requirement to contribute—is a viable approach. Nor does it prove that the administration has defined the perfect employer/employee contribution mix (80 percent/20 percent) or the ideal subsidy level. But such an approach has a number of obvious advantages. It builds on the present system, in which at least 85 percent of privately insured Americans currently receive coverage through their employers; it generates far less economic disruption than alternatives; and, as in the administration’s plan, it can be adapted to make the responsibilities of coverage more manageable for employers and individuals who otherwise might be overburdened by a requirement to pay.5

Restructuring The Insurance Marketplace: The Health Alliance

Among those who advocate market-based insurance reforms—and even among many who advocate more regulatory approaches—there is widespread agreement on certain reform goals: (1) replace competition between health plans based on risk selection with competition based on quality, service, and price; (2) equitably spread risk by moving from experience to community rating, thus eliminating differences in premiums based on health status or employment; (3) maximize consumer choice of physicians and plans, in part so that consumers can reward those providers who offer better service and quality at lower prices; (4) strengthen the power of purchasers by consolidating purchasing power and better informing them; (5) simplify and clarify choices for consumers; (6) increase consumers’ cost-consciousness by making them responsible for the differences in cost between less and more expensive plans; (7) reduce high administrative costs of buying, selling, and administering insurance policies, especially for small and mid-size employers; (8) enhance the portability of insurance by enabling workers to change jobs or family circumstances without having to change health plans; and (9) eliminate coverage restrictions such as pre-existing condition exclusions and waiting periods.6

The administration believes that these and other goals are best achieved through the restructuring of the insurance marketplace and the creation of
large community-rated consumer purchasing pools, or health alliances. All
persons except those on Medicare and those in corporate alliances (em-
ployers of more than 5,000 full-time employees) would obtain their insur-
ance through a regional health alliance, the boundaries of which would be
established by the state. The alliance would offer all eligible persons a
choice of all health plans certified by the state at each plan’s chosen price.

All health plans would offer the guaranteed benefits at a clearly stated
price and be paid by the alliance on a risk-adjusted basis. (Reinsurance
mechanisms could be implemented to back up risk adjustment methodolo-
gies.) Several cost-sharing options would be offered. Open enrollment
would take place yearly, with consumers allowed to enroll in any plan
(capacity allowing), at the stated price, with no preexisting condition
exclusions or waiting periods. Choice of plan would be independent of
employment status, and workers would not need to change plans with
changes in job status.7 Most importantly, individuals and families would
enroll through the alliance, not through insurers, minimizing the capacity
of insurers to select or avoid low- or high-risk individuals.8

Given the financing structure outlined above, most individuals and
families would have the cost-conscious choice of purchasing a plan below,
at, or above the average-cost plan. Enrollees would be presented informa-
tion about each plan’s consumer satisfaction levels, about how each plan
fared on nationally approved quality indicators, and about any restrictions
on access to providers. Alliances would be free to provide other informa-
tion, such as numbers of persons disenrolling from each plan and their
expressed reasons for doing so. Alliances also could monitor disenrollment
from plans, to make certain that higher-cost persons were not being im-
properly treated and that plan quality and service were being maintained.
Small and mid-size employers would be contributing to the costs of their
employees’ insurance but would not be burdened with having to purchase
that insurance or operate an insurance plan.

Health alliance options: market share. There are many variations
within the universe of alliance or purchasing cooperative proposals. For
instance, some proposals argue that alliance market shares should be
smaller, including only employers with 100 or fewer workers.9 While there
is nothing magical about the 5,000-employee cutoff proposed by the
Clinton administration, the larger market share should increase competi-
tion in the alliance as more health plans are more dependent on how they
fate in the alliance environment. Moreover, a much lower cutoff could
generate an image, and even a reality, of a two-tier system, with employees
of small employers, the unemployed, and Medicaid-eligible persons in one
pool and everyone else in another. Among other things, this might greatly
increase the opposition of smaller employers now receiving the benefits of
experience rating. As the cutoff number is raised, the image and the reality of equity should increase.

Additionally, a significantly lower cutoff would leave thousands of employers outside the alliance. This would dramatically decrease portability of insurance coverage and increase administrative costs and complexity as individuals and their families and dependents moved between regional alliance and nonalliance circumstances. Moreover, making certain that nonalliance employers were delivering the guaranteed benefits would entail, a major regulatory effort, especially if self-insurance were allowed. Such an apparatus might be a worthwhile investment if there were any evidence that mid-size employers can genuinely reduce health care costs. But little, if any, such evidence exists. In most cases, the best such employers can do to reduce costs is to obtain better risk-based, short-term deals. But over time, all concerned—families especially—are better off if guaranteed more security through maintenance of a fair price guaranteed over the long term.

Finally, a smaller-market-share alliance would greatly compound efforts to guarantee cost containment in the new system, as far more individuals and employers would be outside the premium cap mechanism imposed in the regional alliance. And without effective cost containment there will be no means of guaranteeing employers, individuals, and government that cost increases will be kept to manageable levels.

**Competing alliances.** Others have objected to the Clinton plan’s approach of one alliance per region, preferring the option of multiple competing alliances. But would such additional competition be worth the added complexity for the individual consumer and others? And exactly over what would such alliances compete? It would not be over benefits, which are usually standardized in market-oriented reform plans. Nor would it likely be over health plan selection, as most major plans probably would be offered by any alliance with significant market share. Competition over price is conceivable but fraught with risk selection issues. If employers or other organizations were allowed to form exclusive alliances, barring higher-risk groups, some alliances might get lower rates but by means antithetical to reform precepts. If, on the other hand, all alliances were forced to accept all employers or individuals, competition on price might be short-lived, as individuals would quickly transfer into the alliance offering their plan at the lowest price. After all, it is the health plan, not the alliance, in which consumers will be interested and to which they may maintain any loyalty.

Moreover, while offering only limited value, the multiple-alliance concept may produce considerable additional complexity. Most importantly, risk selection realities would probably require an additional regulatory level. A single-alliance system would require risk adjustment across plans; a multiple-alliance system likely would require a risk adjustment mechanism
across alliances as well.

And if employers or individuals are required to purchase insurance—be it through an individual or an employer mandate—the regulatory complications in the multiple-alliance approach grow even more serious. Once government mandates that individuals and/or employers contribute to insurance costs, it has an obligation to make certain that those contributions are properly safeguarded and managed. The need for effective oversight of multiple alliances, formed and managed by different entities and operating under different rules, raises limitless regulatory complications and concerns. (Witness, for example, the inability of state regulators to protect consumers from failing multiple-employer welfare associations.) It is no wonder, perhaps, that many multiple-alliance proposals do not achieve, or do not fully explain how they would guarantee, security for all.

The power and discretion of alliances. Finally, there is the issue of alliance power and flexibility. Some versions of managed competition, including early models of Alain Enthoven and the Garamendi plan developed by the author, envision much more aggressive sponsors negotiating with health plans over price and having the critical ability to selectively contract with plans. Clearly, one can envision a sponsor performing such a role effectively, thus encouraging competition and reducing costs. On the other hand, there is also reason to fear that even with the best of intentions, such a sponsor might interfere with the market mechanism and restrain rather than encourage competition. This could have a particularly negative impact in a system of only one alliance per region.

The specter of a powerful alliance with a very large market share and an ability to exclude plans may be one of too much authority in one place. In the end, the administration determined that the preferred approach was to create an alliance with large market share and modest powers. The large market share should serve to force all competitors to bid as aggressively as possible, reducing the need for an alliance with a heavier negotiating hand. Limits on alliance discretion should minimize fears of potential alliance or political abuse.

Will Reform Reduce Costs?

The administration believes that its reform plan will reduce health care costs, without the need for broad, government-imposed restraints. This conclusion is based on two realities. First, in addition to focusing on the market-oriented reforms at which the alliance structure is directly targeted, the Clinton plan addresses a variety of other well-documented causes of high health care expenditures, including payment mechanisms that reward
providers for doing more when less might be as or more effective; an
inability to assess and compare health plans and providers on quality
measures; an oversupply of specialists; a limited capacity to accurately assess
and communicate what is or is not working in medical treatment; enormous
administrative complexity in billing and other systems; and state laws that
discourage effective integration in health care delivery systems. If the
diagnoses and cures are even marginally on target, substantial savings
should result.\(^{13}\)

Second, the administration believes that its plan can reduce costs be-
cause similar efforts already are doing so. Much of the successful innovation
in American health care systems today is coming from public and private
employers imposing rules and systems similar to those embraced in the
administration proposal. Innovative plans are operating in public employee
systems in California, Minnesota, and the federal government and in cor-
porations such as Xerox, Digital, and GTE. These plans are forming pur-
chasing cooperatives (alliances), using community rating, raising consumer
cost-consciousness, and assessing quality more aggressively. Overall, these
efforts are producing a new level of value-based competition between
health care delivery systems. This competition, in turn, is lowering costs,
and, in the view of some analysts, ultimately changing the notion of what
delivery systems and managed care are all about.\(^{14}\) None of these systems is
a perfect model, and all function on a smaller scale than the alliances
everisioned in the Clinton plan. But these systems, and their apparent
successes, do suggest that the Clinton plan is building on major and prom-
ising trends.

**Premium Caps And Cost Control**

Still, there are no guarantees. Thus, reform must address the question of
what happens if the plan, in some regions or alliances, does not produce
acceptably lower costs. Who pays, and to what limit? In a system that does
not require all to contribute, this question is moot. But in one that guaran-
tees such coverage and thus requires that it be funded, these questions
cannot be ignored. And it is these questions that demand the existence of
a backstop cost containment mechanism.

In short, the administration finds it unacceptable to require employers
and individuals to contribute unless it is able to place some reasonable limit
on increases in those contributions. It is neither economically appropriate
nor politically viable to require that families or businesses make a substan-
tial contribution for health care and then have to face premium increases of
15 percent or more, as they have so often in recent years.

Nor can we ask government to produce an unlimited and uncapped fund
to pay for the discounts guaranteed to specified employers and individuals. Moreover, government cannot responsibly slow the rate of growth in the Medicaid and Medicare programs unless it can achieve equal reductions in the rate of growth in private-sector spending. The gap between what providers are paid by public and private payers would grow too large, and serious access and quality problems might result in those public programs.

Thus, there is a need for some backstop limit on the rate of growth in private-sector health care spending. The limit selected under the Clinton plan is flexible and enforceable: the rate of increase in the weighted average premium in a regional alliance. It is flexible first because it is based on premiums (a bundle of services) and not prices, and second, because it is based on an average. This approach will allow different plans to raise premiums at different rates so long as the allowable alliancewide average rate of increase is attained. The premium growth limit is enforceable because impending budget problems will be seen before the budget year begins, when premiums are first proposed by plans, and not at the end of the budget year, when adjustments are difficult. Enforcement also is rendered more manageable because the rules of enforcement are set out in federal law and not left to the discretion of the regional alliance.

No one should anticipate that such a backstop cost-control mechanism will be without controversy. But unless we are prepared to tell employers, individuals, and government itself that their liability is unlimited, and unless we are prepared to run the risks of arbitrary cuts in Medicaid and Medicare budgets, such a backstop is even more necessary than it is controversial. Moreover, if the administration plan’s architects are correct, the market and other reforms embodied in the plan will achieve cost reduction goals, rendering the premium cap controversy one more of concept than of practice.

Single-payer alternative. In contrast to the Clinton plan’s emphasis on competition and market-based reforms, backed up by some necessary government interventions, alternative reform approaches advocate either heavier doses of government intervention or greater emphasis on unfettered market forces. At one end of the competition-versus-regulation continuum are advocates of a single-payer system who would prefer, among other things, to discard the alliance and the competition among health plans (at least in terms of price) and substitute direct government payments to providers.

Such an approach might be simpler, at least at the outset. Additionally, it might produce faster reductions in administrative costs, thus generating greater short-term, one-time savings. However, the capacity of such a system to generate long-term and ongoing savings may be far more limited. This is not a matter of “too much government” or even favoring private
over public systems. Rather, single-payer systems as generally advocated have limited capacity to improve productivity, or reward those providers that are more efficient or produce better outcomes. Cost containment becomes synonymous with rate regulation, but as regulators push rates down, the volume of services goes up, producing less efficient and presumably more inappropriate care. The system’s cost containment tools in this sense, however powerful, are inflexible, limited, and likely to produce some undesired results.

Perhaps the difference between single-payer systems and the president’s plan can be best understood by looking at the two systems’ financial focal points. The single-payer approach generally focuses on the price paid to a particular provider for a specific service; the Clinton plan focuses on the premium to be paid to a collection of providers for delivering a package of benefits. In fact, it focuses on what might be labeled an “aggregate premium amount”—the total paid to a delivery system for providing a defined package of benefits to a given population.

Largely because it is more flexible and offers more incentives and capacity to produce greater efficiencies, the competition/premium-oriented approach does more to encourage increased cooperation, integration, and coordination in the delivery of care. If current insurance premiums offer any indication of the potential for savings in more integrated systems, such savings are real and growing. As a number of recent surveys have documented, HMO rates are now ranging between 15 and 25 percent below those of fee-for-service plans, a gap that has been widening in recent years, suggesting that managed care organizations may now be achieving more than one-time savings. These differences, moreover, do not reflect the reality that HMOs, while perhaps benefiting from greater enrollment by lower-risk populations, generally offer broader benefits and lower cost sharing.

In spite of these differences, the Clinton plan is far from hostile to single-payer approaches. It permits states the flexibility to adopt such systems for all or part of a state; it concentrates a large market into one pool; and it includes, as do most single-payer models, a clear method of controlling costs. While the plan, unlike some single-payer models, allows insurance companies to compete, they would do so according to a completely restructured set of rules that fundamentally alter the very nature of the insurance product.

In fact, many American single-payer proposals allow for capitated payments to integrated health plans, as in the Medicare program. Consequently, the most significant difference between these single-payer models and the Clinton plan may be the latter’s acceptance of price competition between such integrated plans. In barring such competition, single-payer
advocates feel that they are preventing tiering and providing one level of care for all.

Clinton plan architects acknowledge this concern but believe that the extent of tiering can be controlled. Moreover, it should be recognized that in the end, a same-price-for-all approach could take two forms, both of which seem inherently flawed. First, everyone could be offered something society could afford, such as an HMO for all. This approach would be unacceptable to many. Alternatively, all could be offered something that more Americans would find acceptable, such as fee-for-service plans for all. But given that many integrated health care systems are now providing equal-quality care for a significantly lower price than fee-for-service plans, offering the latter to all would cost much more than society would need, or should be asked, to pay. The Clinton plan alternative is to guarantee all Americans a solid floor and the same medical benefits, while allowing those who wish to pay more than what is necessary for delivery of high-quality care the right to do so.

Too much government. Advocates from the other end of the regulation/competition continuum assail the Clinton plan as representing too much government. Most of these attacks focus on three elements of the plan: the requirement that everyone contribute; the imposition of caps on alliance premiums; and the creation of a new structure, the health alliance. As alternatives, such critics propose, among other things, “pure managed competition” with smaller-market-share alliances, no limitation on premium increases, and generally no requirement to contribute; individual mandates, with no budgets, vaguely defined benefits, and small and/or voluntary alliances; and other proposals that clearly are more incremental in nature and make little pretense of achieving universal coverage.

In this regard, the “too-much-government” critics serve to remind us of the inherent political, intellectual, and economic requirements of true universal coverage. Their alternative proposals often avoid the toughest, most controversial, and most complex questions of who will pay, and up to what limit. At best, these proposals define sources of funding. However, none comes close to guaranteeing that the burdens on those sources will be kept within reasonable bounds. Above all, most do not outline a concrete path to health security for all.

Many of the “too-much-government” attacks focus on the nature of the health alliance. Here these critics tend to both overstate the regulatory and discretionary powers of the alliance and underestimate the amount of government intervention necessary to render their own proposals functional.

As presented to Congress, the Clinton health alliance is a mechanism that enables the new system as outlined above to achieve reform goals and
needs, many of which are advocated by reformers of varying political stripes. One might assume that an entity able to effect such change would, by definition, have considerable power, discretion, and regulatory authority. But the Clinton plan alliance has very modest amounts of discretion and power, and almost no regulatory authority. And it does not require them. The alliance is, in this way, more important as a construct than as an organization. It is a mechanism by which government changes the rules and allows a new system to operate. While some managed competition proposals have given the alliance considerable discretion and regulatory power, the Clinton plan does not do so. Criticism of the proposed alliance as a new regulatory giant with broad discretionary powers may occasionally prove effective, but it is inaccurate.

Ironically, those who attack the Clinton alliance as “too much government” often propose systems that may, in the end, demand as much or even more government. Virtually all reform models entail major governmental restructuring of the insurance marketplace. Almost all, like the Clinton plan, demand fundamental changes in the rules of selling insurance (for example, guaranteed issue and renewal and community rating), and many call for changes in the rules of buying insurance (for example, creation of purchasing pools) and in the nature of the insurance product itself (for example, standardization of benefits).

The question then becomes how best to implement these kinds of changes. In the Clinton plan the alliance—by controlling open enrollment and offering a selection of plans providing the same benefits at specified premiums—naturally monitors and implements these reforms through largely self-enforcing mechanisms. Without the alliance mechanism, by contrast, monitoring and policing of new insurance laws on community rating, take-all-comers, limits on renewal increases, bars on preexisting condition exclusions, and so on, can become major regulatory endeavors. If the required regulatory tasks are not performed aggressively, health plan administrators will continue to engage in risk selection efforts, and many reform goals—including the critical substitution of competition on price, quality, and service for competition on risk selection—will remain elusive. Indeed, community rating, on which almost all reform plans agree, could increase incentives for insurers to screen risks aggressively. Since plans cannot charge higher-risk groups more, there is more reason than ever to avoid insuring them.

If, by contrast, states or the federal government intend to aggressively monitor and police the new reforms, they will find the need for considerable expansion of regulatory capacity and micromanagement of insurer and employer activities. If universal coverage and a requirement on employers and/or employees to contribute are added in the nonalliance world, regula-
tory requirements multiply. As technicians who assume responsibility for drafting employer mandate plans know all too well, the effort to track and assess payments for different employees and dependents in continually shifting work and family circumstances can become painfully complicated. Administration of subsidy payments adds to the complexity. The alliance mechanism, especially as outlined in the Clinton plan, greatly simplifies these tasks for employers, families, and administrators. In the end, then, one new institution—the alliance—specifically structured to implement insurance reform rules, should produce less government and more impact than reliance on old structures that are ill equipped to monitor or enforce new rules.

**Paying For The New System**

Funds to pay for the guarantees and programs in the Health Security Act will come primarily from employers and families. The government share, required for discounts and some new programs, will come from a variety of sources, including (1) savings in Medicare and Medicaid; (2) savings to the federal government in its own health care programs; (3) new revenues to the federal government as the rate of growth in employer costs slows and taxable wages and/or profits increase; (4) an increase of seventy-five cents a pack in the cigarette tax; (5) a 1 percent payroll assessment on all corporate alliances, so that these alliances contribute their share to academic medical centers and to support more needy and higher-cost individuals insured in regional alliances, and (6) state Medicaid maintenance-of-effort payments.\(^1\)

Other than the employer contribution element, the projected Medicare/Medicaid savings issue has proven to be the most controversial of these sources. Spending reductions in these programs have almost always generated legitimate concerns, first about declining quality and service and second about shifting costs from public to private programs.

However, unlike other proposals to reduce the rate of growth in public programs, the Clinton plan would demand equal-even greater-reductions in private-sector spending. Thus, the gap between what providers are paid for treating public versus private patients should not increase, reducing fears of declining access and quality in these programs. In the case of Medicaid, which is merged into the new system, the Clinton plan would render the “gap” question moot.

**Savings in Medicaid.** Under the Clinton proposal, noncash Medicaid recipients are taken off the Medicaid program. They register through employers or health alliances just as all other individuals do. The remaining Medicaid population—persons receiving Aid to Families with Dependent
Children (AFDC) and Supplemental Security Income (SSI)—is covered through premiums paid to alliances by both state and federal governments. These payments are blended with premiums paid by employers and individuals to determine premiums paid to health plans. Under both payment mechanisms (for cash and noncash Medicaid recipients) the costs for current Medicaid populations will rise no faster than costs for the general population, which, under reform, will be significantly lower than current rates of increase. The result is a decrease in the rate of growth in spending on these persons and savings in federal and state Medicaid programs. Additionally, with universal coverage, the need for Medicaid disproportionate-share payments decreases, saving additional Medicaid funds.

Savings in Medicare. Reduced federal expenditures in the Medicare program will come from a variety of sources, including new proposals to control utilization and an increase in Part B premiums for high-income beneficiaries. Additionally, spending will be reduced through specified reductions in payments to providers. However, since spending in the private sector will also be slowed, the gap between what providers are paid for treating Medicare and private-sector patients will not increase. Thus, as noted above, fears of declining quality or access should be ameliorated. Savings generated are directed toward funding of the new Medicare prescription drug benefit and the new long-term care program.

The tax-cap issue. One revenue source not tapped in the administration’s plan is a significant change in the tax-preferred nature of health care benefits. Such changes have been advocated by many who favor competition-oriented approaches with an emphasis on cost-conscious consumer choice. So long as benefits remain tax free, individuals can buy more expensive plans with pretax dollars and thus may have less incentive to purchase lower-cost plans. A change in the tax-free nature of health benefits could both raise funds to help pay new system costs and render consumers more conscious of the costs of higher-price plans.

Administration planners recognized the value of the tax-cap approach. However, it was also clear that a major change in the tax-free nature of benefits would be viewed as a major middle-class tax increase, with all of the incumbent liabilities of such a tax increase. In the end, it was determined that the revenues to be gained from such a change could be raised equitably from other, less controversial sources. Perhaps even more important was the conclusion that much, albeit not all, of the cost-consciousness value of the tax change could be gained via other means. Specifically, the plan mandates that should employers contribute more than 80 percent of the average premium, persons who enroll in low-cost plans receive the difference between what the employer is required to pay and what the employer is offering, in cash. While the cash is taxable.
income, persons still should see a considerable financial benefit in choosing lower-cost plans, and the goals of tax-cap enthusiasts can in large part be achieved. Also, the plan eliminates health insurance from employer cafeteria plans, making it less likely that employees will make payments for copayments, deductibles, and additional benefits with pretax dollars.

Conclusion

The impending national debate over health care reform will focus on ends and means; on whether or not to achieve universal coverage; and on how best to do it. That debate is likely to be as far-ranging, as detailed, and as crucial to society’s well-being as any in recent memory. Given these realities, and given that we are a nation whose government was structured to move incrementally—with institutions checking and sharing each other’s power—the challenge of health care reform is a daunting one.

But there is reason to believe that the challenge can be met. Beneath the debates over bold steps or caution, and those over more or less reliance on market forces or government intervention, may lie a surprising base of consensus. Few disagree that our health care system is in crisis. Most acknowledge even if they do not yet fully endorse it—that guaranteed, high-quality coverage for all must be the ultimate goal. Large majorities recognize that health care costs for families, businesses, and government must be controlled. And there is a growing recognition that, this time, incrementalism will not produce an adequate solution.

If, as solutions are offered, the focus is mainly on the differences between them, the consensus required to achieve fundamental reform may remain elusive. But if the focus is on the common ground that many proposals and Americans share, the results may be very different. Health care security for all may become reality for all.

NOTES

2. States opting for single-payer systems have some options regarding funding of reform.
4. The general assumption that because employers are paying based on 80 percent of the average premium, employees are therefore responsible for 20 percent of the premium is not wholly accurate. The consumer or family contribution will depend on the plan chosen by that consumer or family. The consumer choosing a lower-than-average-cost plan will pay less than 20 percent. The consumer choosing a higher-than-average-cost plan will pay more than 20 percent.
5. For a fuller discussion of the merits of the employer mandate approach, see Rivlin et
6. The alliance also will simplify the administration of premium payments for employers, make those payments more equitable across employers, and create a means by which one entity efficiently administers both premium collection and subsidy payments for employers and families. These issues are rarely discussed in policy debates, as they are highly technical and not well understood except by those who have actually tried to construct an equitable and workable employer requirement proposal. The alliance mechanism offers a particularly effective means of easing these administrative burdens.
7. Except in the case of an individual or family moving between employers in regional and corporate alliances.
8. This point is one that has not received much emphasis in the reform debate. Many call for community rating, but, absent an alliance structure, making certain that such a system is working as is it supposed to work is not an easy task and would require extensive monitoring by government regulatory agencies. By enrolling individuals directly, the alliance significantly limits plans’ ability to “game” the system and selectively enroll.
10. An employer cutoff of 100 would, for example, leave about 60 percent of the population outside the regional alliances. Based on data supplied by the Employee Benefit Research Institute, Washington, DC.
14. For details on these developments, see R.B. Giffin, “Managed Care Cost Containment: A Review and Reassessment” (Health Care Strategy Associates, commissioned by the AMCRF Foundation of the American Managed Care and Review Association, 1 November 1993); and I.A. Tillman et al., “Market-Based Health Care Reform: Well Beyond the Drafting Table” (Washington: Economic and Social Research Institute, October 1993).
15. See KMPG Peat Marwick, Health Benefits in 1993; Foster Higgins, Health Benefits Survey, 1993; and Giffin, “Managed Care Cost Containment.”
16. For more details on financing, see Rivlin et al., “Financing, Estimation, and Economic Effects.”