

rapidly average premiums in a region are allowed to increase.

Unlike the systems of most other countries, however, the Health Security program offers consumers the opportunity to choose among alternative health plans and requires those plans to compete for their enrollment on quality and price. The key institutional innovation expanding choice and restructuring competition is the development of regional health alliances (called "health insurance purchasing cooperatives" in other proposals). Health alliances are not insurers, much less providers of health care. They are purchasers—sponsors—of coverage, responsible for organizing the market and making available to consumers an array of private health plans, each providing a comprehensive benefits package. Except for employees in the very largest companies (those with more than 5,000 employees), the regional purchasing alliances replace employers as the gateways to health insurance, offering most people more alternatives than they now have. Some media reports have said the alliances would offer three plans. In fact, plans offered through the alliances would come in three types: traditional fee-for-service insurance, HMOs, and preferred provider networks. There is no limit on the number of plans.

Based on regular monitoring of the outcomes of care and surveys of consumer satisfaction, an annual report card would provide comparative information on each plan's quality and service as well as price. Consumers would choose a plan during the annual open enrollment run by the alliance. Unless a health plan faced capacity limits because of limited facilities or staff, it would have to take all who signed up; under no circumstances would plans be permitted to screen out the sick.

The alliances would receive funds from employers and

A NEW FRAMEWORK

The previous two chapters have suggested the outlines of an approach to universal coverage that breaks the linkage of health insurance to jobs and enables consumers to choose among private health plans competing under a budget cap. The most comprehensive program embodying that approach is the plan presented by President Clinton in the fall of 1993.

Like universal health insurance in other countries, the Clinton Health Security plan makes coverage a right of citizenship rather than a fringe benefit of employment. It protects Americans from losing their health coverage if their business fails, they lose their job, they get sick, or their life circumstances change because of divorce, the death of a spouse, or a move to another state. The plan guarantees all citizens and legal residents a comprehensive package of health benefits, prohibits the abusive practices and exclusions that make much insurance today inadequate and unreliable, and sets limits on how

Estimated Average Premiums

Policy type	Two-parent family with children		Single-parent family	Couple	Single
	monthly	annual			
Total premium	\$363	\$4,360	\$324	\$322	\$161
Family share*	\$73	\$872	\$65	\$64	\$32
			\$779	\$773	\$386

SOURCE: OFFICE OF THE ACTUARY, HEALTH CARE FINANCE ADMINISTRATION

*"Family share" refers to the 20 percent of average premiums owed by individuals or families that receive the minimum employer contribution and no low-income discount.

Preliminary projections for 1994 premiums under the Clinton plan show an average of \$4,360 for two-parent families and \$1,932 for single individuals.

employees, from others according to their ability to pay, and from government. The funds would flow out to the health plans according to their enrolled population. Employer contributions would pay for a share of the average premium; at a minimum, the employer share would cover 80 percent of the average, though an employer could choose to pay part of the employee share.

Employees would pay the difference between their employer contribution and the premium of their chosen plan. Premiums would vary only according to family status (see chart, above, for projected 1994 average premiums). No consumer would pay more because of any personal characteristic or medical condition. An individual or family that enrolled in an average-cost plan, did not qualify for a low-income discount, and received the minimum 80 percent employer contribution would pay the remaining 20 percent of the premium. For two-

parent families, the average premium for 1994 would be \$73 a month; for individuals, \$32 monthly.

Consumers could, however, pay less by choosing a plan that cost less, and they would pay the extra amount if they preferred a plan that provided the guaranteed benefits package at a higher premium. Consider a hypothetical alliance with five health plans and an average individual premium of \$150 a month (see chart, next page). The employer share would be \$120; on average, an employee receiving the minimum contribution and no low-income discount would pay \$30. However, in this alliance, the employee could pay as little as \$15 or as much as \$45, depending on which plan he or she chose. The plans would all offer the same scope of services and coverage, but they would vary in their mode of organization, choice of providers, quality of service, and other features. Consumers would have to decide whether a more expensive plan was worth the extra cost.

Because consumers reap the savings when premiums are lower, health plans have an incentive to provide the most value at the lowest premium if they want to build up or even retain their enrollment. Where employees have had incentives to make cost-conscious choices because they pay the marginal cost of a plan—for example, at Xerox, Digital, GTE, and the Minnesota public employee system—many employees have switched out of high-cost plans, and overall costs have fallen.

The Health Security plan also includes several key features that help make coverage affordable to employers. First, by spreading the costs of families, the plan avoids requiring *individual* employers to pay 80 percent of the premium for a family. Because many families include more than one worker, alliances would collect too much money if they asked all employers for 80 percent of the premium for each worker with a family. So, to meet the

Hypothetical Alliance	Monthly Premiums (Individual Policy)	
	Total	Employer* Employee
Plan 1	\$135	\$120 \$15
Plan 2	\$145	\$120 \$25
Plan 3 (average cost)	\$150	\$120 \$30
Plan 4	\$155	\$120 \$35
Plan 5	\$165	\$120 \$45

* Refers to credit given to a full-time employee for employer contributions, regardless of whether the employer or employers paid that amount. (Some employers' contributions are capped; also, employees are not held liable for employer delinquencies.)

In this hypothetical alliance, an individual employee receiving the minimum employer contribution and no discount for low income may pay from \$15 to \$45 a month, depending on the plan chosen.

required share, individual employers would pay 80 percent of the family premium *divided by the average number of workers per family in a region*. Nationally, families average 1.4 workers; consequently, the average contribution required of employers would be only 57 percent of the family premium (80 percent divided by 1.4)—or an estimated \$2,479 for a family (see chart, next page).

Second, firms participating in the regional alliances—all those with fewer than 5,000 workers—would pay no more than 7.9 percent of payroll for the required employer share. Businesses with fewer than 75 workers would receive discounts reducing their costs to between 3.5 percent and 7.9 percent of payroll, depending on their size and average wages (see chart, next page). The self-employed would be treated as a small business and enjoy the same discounts; they would also be able to deduct 100 percent of their health insurance costs from taxable income.

Low-income households, the unemployed, and early

Estimated Employer Contributions for 1994

Policy type	Two-parent family	Single-parent family	Couple	Single
EMPLOYER SHARE	\$2,479	\$2,479	\$2,125	\$1,546

Caps on Required Employer Contributions as a Percent of Payroll

Average Wage	Size of Firm			
	Under 25 employees	25-49 employees	50-74 employees	75-5,000 employees
Under \$12,000	3.5%	4.4%	5.3%	7.9%
\$12,000-14,999	4.4%	5.3%	6.2%	7.9%
\$15,000-17,999	5.3%	6.2%	7.1%	7.9%
\$18,000-20,999	6.2%	7.1%	7.9%	7.9%
\$21,000-23,999	7.1%	7.9%	7.9%	7.9%
\$24,000-or more	7.9%	7.9%	7.9%	7.9%

SOURCE: CLINTON ADMINISTRATION

The average required employer contribution for a worker with a family would be \$2,479 in 1994. For all its workers combined, no firm in the regional alliances would pay more than 7.9 percent of payroll. Small firms are capped at lower levels depending on size and average wages.

retirees would also receive discounts to enable them to choose a plan through the alliances at an affordable rate. Medicaid will cease to provide separate coverage for the poor; its funds will pay for welfare beneficiaries and the disabled who receive Supplemental Security Income (SSI) to enroll in any plan in their regional al-

liance with a premium up to the average. Others previously covered by Medicaid, such as the "medically needy" who have exhausted their assets paying for medical care, will have been covered under an alliance plan to begin with.

Medicare would remain a separate program, although at age sixty-five retirees could opt to remain in the alliances and pay the difference between the amount Medicare would pay to the plan and its premium for the elderly. The Clinton plan would expand Medicare to include the same coverage of prescription drugs available to the under-sixty-five population.

The Health Security Act also includes support for home- and community-based long-term care for the disabled of all ages, and it calls for new tax incentives and tighter standards for private long-term care insurance. While veterans would retain existing rights to health services run by the Department of Veterans Affairs, the VA would begin transforming its facilities into integrated health plans that could enroll veterans for comprehensive coverage through the alliances. The Department of Defense health care system would also move in the same direction. Coverage of all federal employees would shift to the health alliances; thus members of Congress would get their coverage through the same alliances and health plans as average citizens.

The transition to a reformed system would take place in stages. The Clinton plan phases in universal coverage, state by state, between 1996 and 1998, and defers some elements of the benefits package, notably broader mental health and adult dental coverage, until 2001. Regional caps on premium increases would not go into effect until 1996. The proposed support for home-based long-term care would be introduced gradually between 1996 and 2000.

While establishing a federal framework for financing, coverage, benefits, and consumer protections, the Health Security plan gives the states authority to set up the regional alliances and to adopt a variety of different approaches to controlling costs and improving the delivery of care. At the federal level, a presidentially appointed National Health Board would interpret rules about coverage and benefits, allocate limits on premium growth among the alliances, and establish a system for monitoring how well plans, providers, and the system as a whole are performing. The states would not only establish the alliances but also retain authority to regulate insurance, certify plans, and license health professionals.

The Health Security plan would affect nearly every aspect of the health care system. Without trying to cover every feature, I want to explore the core elements in more detail in order to help explain how they fit together—and why they work.

The Logic of Comprehensive Coverage

Although hardly anyone opposes universal coverage or comprehensive benefits in principle, many have doubts whether they are workable or affordable in practice. But much as other industrialized countries provide comprehensive coverage for all their citizens, so can the United States—if we use reform to insist on mutual responsibility for payment and clear accountability for the costs.

The Health Security plan requires universal participation in the interest not only of fairness but also of lower cost to the community at large. Lack of coverage doesn't prevent money from being spent on medical care; most of the sick and injured still receive treatment, albeit less adequate care often at a later and more costly stage of illness. If insurance is voluntary, some who are healthy

gamble on their good fortune and then throw themselves on the compassion of others in the hour of their need. A decent society will not leave them to suffer, but a prudent nation will have asked them beforehand to share in the cost. Most of us willingly pay for fire protection even though our house may never burn. Similarly, we must pay for health coverage to support the health care in our communities that may someday save our lives.

Universal participation makes coverage more affordable for three distinct reasons. First, it reduces the number of free riders who force others to pay more in taxes and medical bills for the uncompensated care that they (or their employees) receive. So while universal coverage provides protection to the uninsured, it also protects the rest of the community from hidden cost shifts.

Second, universal coverage reduces the problem of adverse selection that afflicts a voluntary system. If coverage is voluntary, the individuals and small groups that purchase it will include disproportionate numbers of people with high expected costs, and the resulting higher premiums will then deter many other lower-risk people who otherwise might have bought insurance.

Third, a universal system has lower administrative costs. It obviates the need of hospitals for elaborate admitting and eligibility verification procedures to protect against unpaid bills, and it cuts the administrative cost of insurance itself by eliminating functions performed in a voluntary system, such as screening out the sick.

Universal participation also makes it feasible to remove some of the most egregious limitations on coverage in the current system. Under a voluntary system, some people will wait until they get sick to buy insurance; that is one reason why insurers restrict coverage of preexisting conditions. A universal system can fairly

Covered Benefits

- Hospital services, including bed and board, routine care, therapeutics, laboratory and diagnostic and radiology services and professional services
- Emergency services
- Services of health professionals delivered in professional offices, clinics, and other sites
- Clinical preventive services
- Mental health and substance-abuse services: inpatient mental health treatment, up to thirty days per episode and sixty days per year; psychotherapy up to thirty visits per year
- Family planning services
- Pregnancy-related services
- Hospice care during the last six months of life
- Home health care, including skilled nursing care, physical, occupational, and speech therapy, prescribed social services and home-infusion therapy after an acute illness to prevent institutional care
- Extended care services, including inpatient care in a skilled nursing home or rehabilitation center following an acute illness for up to 100 days each year
- Ambulance services
- Outpatient laboratory and diagnostic services
- Outpatient prescription drugs and biologicals, including insulin
- Outpatient rehabilitation services including physical therapy and speech pathology to restore function or minimize limitations as a result of illness or injury

- Durable medical equipment, prosthetic and orthotic devices
- Routine ear and eye examinations every two years
- Eyeglasses for children under age eighteen
- Dental care for children under age eighteen

Additional Benefits in the year 2001

- Preventive dental care for adults
- Orthodontia if necessary to prevent reconstructive surgery for children
- Expanded coverage for mental health and substance abuse treatment

prohibit such limitations because no one can put off paying for insurance until the moment they need it.

Comprehensiveness of health coverage, like universality, reflects an interest in efficiency as well as equity. Benefits packages vary in their scope of coverage and extent of cost-sharing. The scope of benefits covered in the guaranteed package in the Clinton Health Security plan corresponds to the list in good corporate health plans today (see chart, above). The benefits package, however, is especially comprehensive on the "front end" (primary and preventive care) and on the "back end" (there are no lifetime or annual limits on hospital or physician coverage).

Broad benefits in these areas reflect two central objectives of reform: preventive care and security. The plan encourages a shift toward preventive care by guaranteeing coverage of a basic list of clinical preventive services of proven efficacy, such as immunizations and specific

screening tests, without any copayment. And it eliminates the annual and lifetime limitations on hospital and physician coverage as well as other exclusions buried in the "fine print" of insurance contracts that expose many families to catastrophic costs and financial ruin.

Restricting both the "front" and "back" ends of health coverage often produces counterproductive results and savings that prove to be illusory. Limits on primary and preventive care lead to avoidable illness, costly delays in treatment, and greater use of emergency rooms. And when coverage runs out, many people facing catastrophic health costs end up at public hospitals or with unpaid bills, and the taxpayers or privately insured pay for their care anyway.

While its coverage is broad in scope, the Health Security plan does not eliminate all patient cost-sharing. Rather, it provides for three types of cost-sharing that correspond to the principal modes of coverage in the market today. For *fee-for-service coverage*, the cost-sharing would be in the middle range of private plans. There would be deductibles of \$200 per individual and \$400 per family, with 20 percent coinsurance for physician and hospital care, up to a maximum out-of-pocket cost of \$1,500 per individual and \$3,000 per family. Prescription drugs would carry a separate \$250 deductible and 20 percent cost-sharing, up to a maximum out-of-pocket expense of \$1,000.

For *HMO coverage* (the low cost-sharing option), there would be no deductibles, nor would there be any coinsurance on hospital care. The Health Security plan does, however, call for a \$10 copayment per physician visit, which is higher than many HMOs charge today. The HMO copayment for drugs would be \$5 per prescription.

The third type of plan, a *combined structure*, offers

the low HMO cost-sharing when patients use providers within the network but requires the higher fee-for-service cost-sharing level when patients use providers outside the network. This is the arrangement used by preferred provider networks.

The level of benefits in the Health Security plan is squarely in the mainstream; the plan does not ask Americans to accept a lower standard of coverage or offer them only minimal protection if they lose a job or get divorced.

Several other proposals for reform, however, call for only minimal coverage, restricted to catastrophic costs or a mere "barebones" package. Some conservatives believe that Americans are "overinsured" and want to use tax policy and health reform to encourage high deductibles and copayments as a method of cost containment. That approach, however, will not only fail to guarantee security; it is also unlikely to control costs effectively for the most basic of reasons: Most people won't accept it.

If national reform provides only minimal coverage, the great majority of Americans will obtain supplementary insurance. Nine out of ten Medicare beneficiaries today have supplementary coverage either through a private Medigap policy or Medicaid. These supplementary benefits typically reduce patient cost-sharing and generate higher rates of physician and hospital use *under Medicare*. Thus widespread supplementation raises costs in the basic insurance program, defeating the economic rationale of the coverage limits. A new federal program with high cost-sharing and limited benefits for the under-sixty-five population would just repeat the same mistake. Most Americans would get extra coverage from their employers, and the very poor would retain the broader coverage of Medicaid. With only

low-wage workers facing the benefit limits, there would be little effective discipline on costs. A reformed system is far more likely to control costs by making a single health plan accountable for comprehensive coverage than by dividing coverage between a minimal basic package and widespread supplementation.

This is the broader lesson of integrated health plans. Many coverage restrictions that developed under traditional insurance do not make sense as rules for the emerging health care system. Since traditional insurers have not had contracts with providers, much less control over them, they have been unable to allocate resources among different types of services or achieve savings by managing services more efficiently. To control costs, they have often simply excluded services—such as primary and preventive care, outpatient drugs, and home health services—that can reduce overall costs if managed properly. Integrated health plans do precisely that, substituting ambulatory for inpatient care and managing the full range of services to provide broader coverage more economically.

The new paradigm of integrated health care requires a change in thinking about coverage. Under a more integrated system, arbitrary limits on coverage by type of service or provider often get in the way of cost-effective treatment; coverage without those restrictions yields better treatment at lower cost. Genuine savings in health care come not from trying to shift risks to individuals, but from placing those risks on organizations that can manage them and be held clearly accountable for both costs and quality.

A uniform benefits package among competing plans facilitates that clear accountability. If each plan offers a different package, the myriad complex variations make it difficult for consumers to make clear-cut price com-

parisons. A uniform package enables consumers to compare apples with apples and thereby encourages plans to compete on price. Consumers will also feel more confident about choosing a lower-cost plan if they know there are no hidden exclusions.

Requiring plans to offer a uniform package does not prevent them from offering other benefits in supplementary packages (although those must be fully priced to include utilization effects on the basic plan). The required package sets a common reference point that is essential not only for price competition but also for determining rights and obligations. If a national guarantee of universal coverage is to have any meaning, there needs to be a national standard. All parties involved must know what is included in the coverage that citizens have a right to expect, plans have an obligation to provide, and government has a pledge to guarantee.

Some reform proposals accept the need for a standard benefits package but, rather than spell it out in legislation, assign the responsibility to an administrative board. The political appeal of this approach is obvious. Defining a benefits package is inevitably contentious. However, if the American people are to evaluate any proposal, they must know what the benefits are. Moreover, no one will be able to determine how much coverage will cost without knowing what coverage includes. Some critics have charged that the Clinton program vests too much power in government bureaucracies. The National Health Board set up under the Clinton plan, however, would only interpret the benefits package. Other proposals give an administrative board authority to *determine* the standard package, which would make the board far more powerful. In another area as well—the role and power of the purchasing alliances—conservative alternatives ostensibly

aimed at reducing costs and bureaucracy actually increase them.

The Role of the Health Alliances

No aspect of reform is so poorly understood and so critical to its success as the broad-based purchasing alliances of the Health Security plan. Without the alliances, it will not be possible to shift the choice of health plans from employers to consumers, to restore genuine community rating, and to achieve effective reform of the insurance system.

The Clinton plan calls for two types of purchasing alliances. Regional health alliances would cover all employees of firms with fewer than 5,000 workers, public employees, part-time workers, the unemployed, and other individuals outside the labor force—in all, more than 80 percent of the population under age sixty-five. The regional alliances would thus constitute a pool covering the vast majority of Americans at community rates. Corporations with more than 5,000 employees, as well as some multiemployer plans of similar size established through collective bargaining, would be eligible to establish their own corporate health alliances. Corporate alliances would still have to provide their employees at least the guaranteed benefits package and a choice among the three types of plans, but they would not be eligible for any federal subsidies and would pay an assessment equal to 1 percent of payroll. (The assessment goes for medical education and public health and makes up for the cost advantages that companies enjoy in running a self-contained pool without the unemployed, the retired, and the poor.) Large corporations could opt into the regional alliances on an initially risk-adjusted basis, a provision designed to offset the costs of large companies with many older workers. If they came

in, they would become eligible for the 7.9 percent cap on contributions on a graduated basis beginning after four years.

The regional alliances would have the responsibility of ensuring that all eligible people in an area were enrolled in a health plan (people who didn't sign up would be enrolled when they showed up for medical care). The alliances would disseminate information about plans and run the open enrollment, collect funds from employers and individuals and disburse them to plans, and make the risk adjustment in payments to plans according to procedures set down by the National Health Board.

The Clinton plan requires regional alliances to offer at least one traditional fee-for-service plan covering "any willing provider" as well as any other plan that meets the terms of participation. (However, the Health Security Act prohibits states from requiring that *all* plans pay any willing provider, which would make HMOs and provider networks impossible to organize.) The terms include the basic requirements for fair competition: open enrollment, community rating, no preexisting condition exclusions, reporting of data on the quality of care, and no discrimination against consumers on the basis of race, gender, disability, health status, or other characteristics. Alliances could exclude a health plan if it did not observe these practices, failed to provide the benefits, or flunked a state's minimum quality standards. In addition, if a plan's bid exceeded the average premium by more than 20 percent, alliances would not be required to offer it—a provision aimed at giving alliances bargaining leverage with high-cost plans.

With an average of more than 80 percent of the under-sixty-five population in a region, the alliances' in-

clusive membership would enable them to recreate the broad pooling of risk that has been lost in recent decades as the insurance industry has segmented the market, cherry-picked the healthy groups, and denied coverage to many small firms and individuals or charged them unaffordable rates. In addition, the alliances would open up more options to millions of consumers, including many of the insured who have never had access to any plan except the one given them by their employer. And because the alliances would represent so large a pool, few if any health plans or groups of providers would be able to bypass them or offer unfavorable rates. From the plans' standpoint, the alliances would be the point of access to the overwhelming majority of middle-class patients—not just the poor and the unemployed. This is vital to ensuring that the people participating in the alliances get the widest possible options at the best prices.

Health alliances can succeed only if the insurers must go through them to reach the market in the region. If health plans are able to sign up individuals directly, they are as certain to sign up the best risks as water is to roll downhill. And if plans can cut their costs by selectively enrolling healthy people rather than by managing services efficiently, competition will fail to generate real savings. Thus to make competition work, the alliances must conduct the annual open enrollment independent of any plan and risk-adjust payments to insurance plans so that there are no rewards for "cream skimming."

Some critics have charged that the alliances would be a new and unneeded "layer of bureaucracy." The alliances, however, would assume functions now performed by benefits managers, brokers, and other intermediaries. They *subtract* more administrative costs than they add, especially in the individual and small-

group insurance markets, where, as I've indicated, administrative costs currently run as high as 40 cents on the premium dollar.

Ironically, the alternatives advocated by some conservatives—smaller, voluntary alliances with no required employer contributions—will actually raise costs, increase administrative overhead, and permit insurance companies to continue cherry-picking the healthy instead of refocusing their energies on lower cost and better quality. Voluntary alliances would have higher premiums because they would be left with relatively older and less healthy employee groups as well as the unemployed. Voluntary alliances would also cost more to administer because they would have to devote significant resources to marketing and could only spread their fixed costs over a smaller population. And without required employer contributions, premium collections would be less reliable.

Two proposals in Congress that call for voluntary purchasing cooperatives raise these problems. The conservative Democrats' bill, advanced by Representative Jim Cooper, would limit eligibility for its regional purchasing cooperatives to residents of an area otherwise without insurance and to firms with fewer than 100 employees. Another bill backed by Senate Republicans and introduced by Senator John Chafee calls for competing, voluntary purchasing cooperatives, also limited to employers with fewer than 100 workers. Neither proposal requires employers to contribute, though the Chafee plan envisions a mandate on individuals to buy a minimum level of insurance in the year 2005.

Both the Cooper and Chafee proposals threaten to raise premiums in the purchasing cooperatives above the levels for larger firms as a result of adverse selection. Because the proposals do not require participation in the

cooperatives, the most likely to purchase coverage will be individuals or groups with relatively higher risks. And because the cooperatives are restricted to uninsured individuals and employees of small firms, they make up a pool whose costs are higher than the population in larger firms. The relationship between the size of firms in the cooperatives and average premiums is direct: The lower the cut-off point for firms, the higher the average premiums will be.

The likely concentration of high-cost populations in the smaller, voluntary purchasing cooperatives is not only a matter of fairness. If the premiums in the alliances cost more, businesses and unions will seek to get out and the cooperatives will unravel. Small businesses will not want to share in the costs of the unemployed and the poor. Moreover, some health plans may decide not to contract with these high-cost voluntary cooperatives, or the plans will offer only high rates to offset the risks. As a result, voluntary cooperatives may not be able to ensure that their members can obtain affordable coverage. Competition among the cooperatives would only make the problem worse: To reduce risks, cooperatives—like insurers today—would have an incentive to avoid covering high-cost groups.

Some critics suggest that purchasing alliances are unnecessary because their aims can be achieved by insurance market reforms, such as community rating. However, if employers can still self-insure, the "community" being rated will consist of people left out of larger and healthier employee groups, and rates will inevitably be higher. And without the alliances to manage the competition and run the enrollment, insurance plans will continue to compete by dodging high-cost populations. Moreover, this would be a system of employer, not consumer, choice of health plan—with all the attendant

problems of employer-sponsored insurance in an age of managed care (see above, Chapter Five). And with no purchasing alliances, small employers, the self-employed, and other individuals will continue to see a staggering share of the premium dollar eaten up by insurance overhead costs.

By requiring the participation of all employers with fewer than 5,000 employees in a single pool, the Clinton plan creates a broad, stable foundation for the alliances. Rather than being stuck with high costs, Americans who receive coverage through the alliances will benefit from their great combined purchasing power and economies of scale. Small businesses and individuals will be able to obtain health coverage on terms previously available only to the biggest companies. Conservative critics have objected that the alliances will be monopolies (or, to use the exact term, monopsonies) in their regions. However, the ultimate buyers are individual consumers; the alliances organize the competition to reorient health plans from avoiding risk to providing good care at an affordable cost. A structure for the alliances that allows insurers to cherry-pick and guarantee high premiums will raise federal subsidy costs and make it difficult to achieve universal coverage, postponing the real reform we need.

Improving the Quality of Care

In the debate over health care reform, most attention has focused on controlling costs and ensuring security and access to health care. But one of the most distinctive aspects of comprehensive reform today is its potential to improve the quality of care. In the past, health insurance and the delivery of health services were institutionally separate; indeed, public and private insurance programs were often specifically barred from interfering in medical practice.

Today, the consolidation of health insurance and health services into integrated health plans has opened up new possibilities for holding plans and providers accountable for quality and access as well as cost.

There is also growing appreciation that poor quality and high cost are related. Earlier proposals for universal coverage did not build in concern for quality because they generally assumed that spending more money for more services would bring better care. By now we should have learned to stop equating "more" with "better." Much of the excess cost in the U.S. system stems from unneeded and inappropriate care; reform that reduces such excess can raise quality and cut costs simultaneously.

To many people, reducing costs through improved quality sounds like a chimera, but the new forms of quality management in American industry start from exactly that premise. Poor quality is costly; doing things right the first time is cheaper than doing them over. Traditional quality control focuses on picking out defective products and punishing poor performers. That approach not only fails to identify the systemic causes of mistakes and poor quality; it also intimidates and inhibits employees from contributing to improve quality. The new approaches in industry emphasize learning rather than punishment. Instead of relying on surveillance and inspection, they call for close attention to the demands of customers, systematic measurement of outcomes, emulation of "best practice" models, cooperative efforts at quality improvement involving employees at every level of an organization, and continuous monitoring and correcting of performance.

The same movement is stirring in health care, attempting to reform health care from within, and the aim of the Clinton Health Security plan is to create a

broader institutional framework that supports those efforts. The purpose of reform is not to impose a new regime, but to help stimulate and nurture the most auspicious changes already under way. In health care, as in other fields, traditional quality assessment emphasizes case-by-case, punitive regulation. In contrast, the Health Security plan seeks to encourage more systematic measurement of the outcomes of care and an emphasis on correcting the root problems that cause poor quality.

Inadequate knowledge about what works in health care is the critical barrier to improving care. We suffer from two kinds of ignorance, for which we need two kinds of remedy. In some areas, health professionals face uncertainty because scientific knowledge is inadequate. For that problem the only known remedy is research, and the Health Security plan provides funds for that purpose, particularly research on the outcomes of care. In other areas, both providers and consumers face uncertainty because there has been no systematic effort to obtain comparative data about how well plans and providers are performing. In principle, we could know; we just haven't tried to find out. Here we need a commitment to regular monitoring of the various dimensions of performance. The Clinton plan makes that commitment an integral part of national reform.

The Health Security plan calls for attention to six aspects of performance: *access to care*, *the appropriateness of care*, *outcomes of care*, *consumer satisfaction*, *health promotion*, and *disease prevention*. To provide comparative data on these dimensions, there must be commonly agreed upon indicators and methods. The establishment of a National Quality Management Council to choose the quality indicators and methods of collection is one of the responsibilities of the National Health Board. The resulting data will have several uses. They will be com-

ined into an annual public report about how well health plans and providers are performing on key criteria, and the reports will be made available both to consumers to assist them in their choices and to providers to help them do a better job. The data will also be used to guide research priorities and evaluate the performance and impact of the entire reform program in order to make midcourse corrections.

Comparative value information is an idea that has come to health care only recently, but it is familiar to anyone who has opened an issue of *Consumer Reports* and checked the ratings on different products and services. To be sure, most people do not read the ratings, but to generate competition on quality, not everyone has to. Even a minority of quality-sensitive buyers can affect an entire market. Besides, the news media are scarcely likely to ignore assessments of the quality of care, especially when nearly everybody in a community has access to the same list of health plans.

The Health Security plan also calls for technical assistance to plans and providers to help them learn how to correct the causes of poor quality care. The responsibility for that assistance will belong to regional professional foundations, made up of representatives of academic health centers, health plans, health alliances, and practicing physicians and other provider groups.

Several other provisions of the Clinton plan fit into the concern for improving quality and cutting costs. The application of information technology to health care holds enormous promise not just to cut the cost of administrative transactions and eliminate duplicate testing, but to reduce errors in treatment and enable professionals and patients alike to make better decisions. The greater use of electronic information systems will

also help reduce the "cost of quality" by permitting less burdensome tracking of treatments and outcomes. Computerized records, however, raise concerns about confidentiality and security. So while the Clinton plan supports advances in health care information systems, it also calls for the first national standards for confidentiality of medical information and strict penalties for breaches of privacy and security.

Another major concern of the Clinton plan is support for primary and preventive care. The plan proposes a dramatic shift in the priorities of graduate medical education away from specialization toward primary care, and it provides greater support for training of advanced-practice nurses. The plan also seeks to increase rewards for primary care in Medicare's payment system. Inadequate numbers of primary care providers represent an obstacle to providing appropriate care and coordinated services—especially in communities with the greatest needs.

Protecting the Vulnerable

The approach of the Health Security plan to ensuring access for underserved and vulnerable populations is similar to its approach to improving the quality of care. The plan relies on both a general framework for achieving accountability and a series of targeted efforts aimed at overcoming barriers to good health care.

The general framework has been implicit in much of the previous discussion. Both the health alliances and health plans have responsibilities to ensure that underserved communities and vulnerable groups have access. While the alliances must ensure enrollment, the plans must ensure that members receive appropriate services. Access to care and consumer satisfaction are two of the criteria for regular evaluations of health plans, and the

quality management program is specifically responsible for obtaining representative data on populations at risk of inadequate care.

This approach builds in a set of obligations missing from traditional insurance programs like Medicaid. Medicaid provides coverage for many low-income people, but until the recent development of managed care in Medicaid, the program did not vest any health care organization with responsibility for providing access to care. While beneficiaries have had a Medicaid card, many have often been unable to find a doctor because Medicaid payment levels have been so low that no physician will take them, or none is available in their area. Fee-for-service Medicaid could not hold any particular providers accountable for failing to serve the poor or the disabled. In contrast, under the alliances, health plans would be contractually obligated to provide care for all their subscribers. If vulnerable groups did not receive care, they would have not merely a general complaint but specific contractual rights.

Many advocacy groups for the poor are nonetheless skeptical about competition and private health plans. Their experience has taught them that the health care market works poorly for the underserved; this has undoubtedly been true. But in several critical respects, the Health Security plan departs sharply from the status quo. Today, health care services in low-income areas are precariously financed because so many of their patients are uninsured or reimbursed at Medicaid levels. By covering the entire population and integrating Medicaid beneficiaries into private plans, the Clinton plan puts providers in low-income areas on a more stable, secure footing.

The risk-adjustment system provides further benefit to the providers who care for low-income and vulnerable

populations. Today, such providers generally receive lower payment even though they take care of people with some of the most severe problems. After reform, health plans will receive more for enrollees that generate higher costs. To be sure, the methods of risk adjustment are far from perfect. Risk adjustment, however, provides a mechanism for targeting funds where the needs are greatest. It may prove to be far more effective in channeling resources to populations in need than grant programs that depend on discretionary government funding.

Advocacy groups have also worried that under reform the community health centers, public hospitals, and other providers of care in low-income communities might be locked out of private health plans, lose their patients, and face worse financial woes than they do today. The Clinton plan addresses those concerns in several ways. First, for at least a five-year transitional period, the federal government will designate qualifying organizations providing care to vulnerable groups as essential community providers. Health plans will either have to enter into contracts with these providers or pay them on a fee-for-service basis, unless they can demonstrate they have adequate services available in the same communities.

The Health Security plan also offers funds to help community providers establish their own networks and plans as well as to support development of adequate service capacity to provide care in underserved areas. Over the period between 1995 and 2000, the Clinton plan allocates a total of \$15 billion in new federal funds for public health initiatives; many of these initiatives support health care in both rural and urban underserved communities. These include grants to community and migrant health centers, support for school-based health

services, and an expansion of the National Health Service Corps, which awards scholarship aid to medical students in return for later service in designated shortage areas.

In addition, the Health Security plan is the source of an indirect windfall to state and local governments that are now funding public clinics and hospitals. Except for illegal immigrants, the uninsured now receiving those services will gain private coverage. As a result, the Health Security plan will free up approximately \$65 billion in state and local health spending between 1995 and 2000. These funds could be variously used to cut taxes, to provide supplementary services (such as transportation) not covered under the guaranteed benefit package, and to strengthen community health activities.

Keeping Coverage Affordable

Besides ensuring access for the underserved, any health care reform plan has to ensure that health coverage is affordable to low-income Americans and to those who do not receive a full employer contribution because they have lost their jobs, work only part-time, or are retired but not yet eligible for Medicare. Providing for people in each of these situations poses an enormous challenge.

The Clinton plan provides discounts on the family share of the premium to the poor and near-poor—specifically, to people with incomes below 150 percent of the poverty level. In 1993 the poverty line for a family of four was close to \$15,000; thus on a sliding scale, families would be eligible for discounts that phased out just above \$22,000 annual income. No one, poor or otherwise, would pay more than 3.9 percent of income for the family share of the premium.

The Health Security plan also protects the unemployed and part-time workers from unaffordable de-

mands to make up for unpaid employer contributions—that is, the share of the premium no employer ever paid because the head of a family did not work full-time for the entire year. First of all, if a couple or family had one full-time worker, no other family member would need to make up unpaid employer contributions for periods of unemployment or part-time work. One full-time worker per family (or two half-time workers) would earn a family the right to a credit from the regional alliance for a full 80 percent employer contribution toward the family premium.

Second, people who were unemployed or working part-time would be liable for the unpaid employer share only if they had income from interest, dividends, rent, capital gains, and other nonwage sources or made a lot of money when they did work (more than \$5,000 a month). For example, suppose you were single and worked half-time. Under the Clinton plan, employers would pay a pro-rated amount for part-time workers to the regional alliance. As a half-time employee, your firm would pay half the employer contribution for a single worker (an average of \$773 a year or \$64 a month). You would owe the remaining half of the employer share on the basis of a sliding scale to the extent you had unearned income or your wages as a part-time worker exceeded \$5,000 a month. If you were unemployed part of the year, unemployment compensation would not be counted toward this total. Discounts for the 80-percent employer share would phase out at 250 percent of poverty. Responsibility for administering these discounts would belong to the alliances.

Early retirees would derive particular benefit from the Clinton plan. Like everyone else, early retirees between the ages of fifty-five and sixty-five would be eligible to purchase a community-rated premium through the al-

liances; community rating is especially valuable to early retirees because of their age and frequency of chronic medical problems. If they met the requirements for Social Security by working ten years before retiring, the federal subsidy pool would also pick up the 80 percent employer share for retirees until they became eligible for Medicare at age sixty-five. These provisions affecting millions of Americans in the hiatus before Medicare eligibility are especially important today because rising costs and new accounting rules have led many companies to eliminate long-established health benefits for early retirees.

Ultimately, for all Americans, the affordability of coverage will depend not so much on any of these provisions as on our success in controlling the overall cost of health care. For we won't be able to afford helping those least able to pay themselves unless we put the health system on an economically sustainable and fiscally sound basis.