

Cap Globally, Act Locally

The dual reliance on competition and premium caps is the defining feature of the Health Security plan's strategy of cost containment. The strategy's first defense against rising costs is the system of purchasing alliances, incentives for cost-conscious consumer choice, and competing plans paid per capita for their enrollment. The strategy's second line of defense is a cap on the growth of average premiums in the health alliances. Some may ask, "If competition works, why bother with caps?" For the same reason that an engineer designs a plane with a backup engine or a car with an emergency brake: Designing in redundancy helps avoid failure.

Redundancy makes particular sense when there are limits to the principal mechanism of cost containment. Not every region will have vigorously competing plans, and even in areas with the potential for competition, health care providers may successfully thwart it, as they have through much of this century. The purchasing alliances and relevant government agencies might also fall under the control of provider interests; again, a long history suggests "provider capture" is a serious risk. Federally legislated caps on average alliance premiums thus represent a kind of political insurance policy. And in an industry long accustomed to rapidly rising costs, expectations are a force in their own right. The caps announce a new era.

The competitive system and the premium caps also serve another less obvious function: the decentralization of risk. Through the Medicare program, the federal government has effectively assumed the risk for health costs of the elderly. And because it has assumed the risk, it has developed increasingly intrusive microregulations aimed at controlling it. The advent of prospective hospital payment under Medicare in the 1980s was a step toward

FINANCING THE PLAN

The ultimate tests of health care reform will be the quality of health care and the health of the American people. However, the first hurdle any plan must cross is financial: Can it control costs? Does it provide adequate financing for coverage? Does it protect the fiscal integrity of government and economic needs of businesses and families?

The Clinton plan has been developed in extraordinary detail to address many of the specific questions affecting families and businesses in different situations, the array of current government programs, and the transition to new financing arrangements. Behind the multitude of details, however, stand a few central ideas that represent the plan's basic strategy for containing costs and financing coverage. Understanding that strategy is vital to grasping the overall logic of reform.

decentralization because it put hospitals at risk for costs per admission. As providers share more risk, there is less need to regulate them to control costs. The Clinton plan takes the decentralization of risk and decision making much farther. The system of payment places the risk for comprehensive coverage on private health plans, giving the plans full latitude to allocate and manage resources and negotiate prices with providers. If premiums in a region go up faster than an allowed amount, the Health Security plan focuses risk on the plans and the providers that have raised rates the most.

Under the Clinton plan, the caps apply not to the premiums of individual health plans but to an alliance's weighted-average premium (the average of all premiums weighted according to the share of enrollment in the various plans). Federal legislation would set a growth rate for premiums for covered benefits for the country as a whole, and the National Health Board would adjust that rate for specific alliances depending on demographic changes and other factors. Alliances could meet their targets without any enforcement of caps as competition held down premium increases of individual plans or as consumers switched out of high-cost plans, thereby dragging down the average. If, however, health plans' bids threatened to push an alliance's average over the allowable growth, the federal government would deny full rate increases to the plans seeking the biggest jumps and require the plans to pass on those rate reductions to their providers. Thus the premium caps achieve much the same effect as the global budgets for physician spending in the German health care system, except on a more comprehensive level.

The costs of health care vary considerably from one state to another. Some of this variation is due to differences in wage levels and other economic conditions,

some to the level of insurance coverage. Much of it, however, reflects different patterns of health care, such as variations in hospital use that appear to be related to the ratio of hospital beds to people in a region. Under the Health Security plan, the premium caps set at the outset of reform would reflect historic costs in an area. However, the plan calls for a commission to report back to Congress with recommendations for a method for gradually reducing differences in premiums that are due to variations in patterns of practice. Over time, the pressure to control costs should be greatest in areas with the most costly practice patterns.

One little understood function of the caps is to reduce windfall profits to the health care industry from universal coverage. Today, provider rates and insurance premiums reflect the cost of unpaid bills left by the uninsured. After universal coverage, unless rates come down, providers would receive a windfall. In theory, competition should force providers to give up that bonanza, but to count on perfectly efficient markets would be foolhardy. In other countries, the advent of universal insurance has been accompanied by a reduction in payment rates to providers since they no longer bear the costs of charity care. The Health Security plan, however, does not include any general provider price regulation and consequently cannot use that approach. A special tax might recapture windfalls, but many groups are suspicious of the possible long-term use of such a tax. So to avoid windfalls, the method for calculating initial premium caps for the alliances pulls out the current cost of uncompensated care and sets a cap for the first year on the assumption that services for the previously uninsured are paid at average costs. With no premium caps, it is likely that health care reform would begin with a costly expansionary spurt.

Much of the controversy over the caps concerns the desirability of any spending limitation. As one might suppose, providers and insurers alike are strongly opposed to budget limits and have raised public anxieties about the prospect that health plans would run out of money during the year and be unable to provide care—as if plans do not already have to budget their expenditures based on income they receive from premiums set in advance of a year.

A second set of objections has less to do with the caps themselves than with the level of growth projected under the Clinton plan. Some critics have challenged the plan's realism, saying it assumes unrealistic savings. But the plan still assumes significant growth in health expenditures and the targets it sets are, by international standards, scarcely severe.

Until 1996, the Clinton plan assumes that expenditures will rise at currently projected rates. Then, as states carry out reform beginning in 1996, the Clinton plan would have two effects on expenditures working in opposite directions. Expanded coverage would raise spending by about 8 percent, while the purchasing alliances and competition, backed up by regional premiums caps, would cut the rate of increased coverage in per capita costs. Initially, the effect of expanded coverage would predominate; by the year 2000, however, national health expenditures would be about one half of 1 percent of GDP less than under current policies. Thus the plan does not project any reduction in spending from current levels. National health expenditures would rise from 14.3 percent in 1993 to 16.9 percent by the year 2000. Considering that the average in industrialized countries is 7.9 percent and growing much more slowly than in the U.S., 16.9 percent is hardly austere. This is not a rationing plan. We would have "savings" only be-

cause current policies would lead U.S. health spending to rise to 17.5 percent of GDP or more by the year 2000 if we did nothing.

The plan does call for cutting the growth rate in spending for covered benefits from around 9 percent annually at the beginning of the 1990s to about half that level between 1996 and 2000.¹ Under the alliances, two distinct kinds of changes will be at work to achieve that reduction. Besides moderating the underlying growth rate, reform also generates one-time savings from consolidation of the small-group insurance market, consumer switching out of high-cost plans, a uniform claims form, and other changes. It is the combination of ongoing and one-time savings that will permit reducing the growth rate in per capita costs to levels approaching general inflation by late in the 1990s. The Clinton plan also achieves a corresponding slowdown in the growth of Medicare costs through specific reductions in future payment increases.

Some observers have been skeptical that the U.S. could ever undertake any general limitation on health spending because it is such a fundamental departure

1. As of late 1993, the rise of health care prices and insurance premiums seems to have subsided to between 5 and 6 percent, approaching the administration's target for 1996. Thus some say the caps are unnecessary because the "fever" of health care inflation has already broken. However, while price and premium increases have slowed down, overall health care expenditures rose 10.2 percent in 1993 and are projected to grow at double-digit rates in 1994. Previous history suggests the slowdown in prices and premiums is temporary and misleading. The same argument that costs were already slowing—even the same metaphor of a "fever" breaking—was used in the late 1970s, when the industry was haunted by the specter of federal hospital cost containment, and again in the early 1980s, when Margaret Heckler, then Secretary of Health and Human Services, prematurely declared victory over health care inflation. Without a cure for the systemic "infection," the fever will not go away.

from practices in our economy. But government already accounts for four of every ten dollars spent on health care; the lesson of recent history is that the government cannot really control the costs of the care it sponsors without more comprehensive cost containment. Out of concern about the federal deficit, support has grown in Congress for an "entitlement cap" that would limit Medicare spending, and a cap might well pass even in the absence of health care reform. But if there are no corresponding caps on private health spending, the limits on Medicare will likely result in a shift of costs to the same private sector that advocates of entitlement caps are presumably trying to protect from higher taxes. Conservatives who are serious about capping federal health costs cannot escape the logic of comprehensive spending restraint.

Expenditure limits force us to confront how much we spend for health care; that in itself will be a crucial step. A key source of high costs in the United States is their fragmentation and obscurity. Other industrial countries with national health insurance have lower health costs partly because of the higher visibility of their expenditures. To be sure, consolidated financing and global budgets provide the leverage for cost control. But fiscal arrangements not only control money; they also help clarify choices and focus opposition. In the United States, health care reform not only requires a change in incentives and organization; it requires *fiscal clarification* as well.

Reform helps to achieve that clarity in several different ways. At the national level, the federal government would set an overall growth rate for spending on benefits covered in the guaranteed package. (The cap does not, however, affect employer-paid benefits or other private coverage beyond the guaranteed package or other

private spending for health care.) At the individual level, when choosing a plan, consumers would have to decide how much to spend on premiums beyond their employer or government contribution. And in between, at the regional level, the alliances would clarify how much health coverage cost in one area compared to others. The linkage of employer contributions to average alliance premiums creates a direct employer stake in regional costs.

This regional stake in costs is another distinctive feature of the Health Security plan. There is no such regional interest in the costs of the Medicare program. For example, employers and employees in Rochester, New York, do not pay lower Medicare taxes, nor do the elderly in Rochester pay lower Medicare premiums, even though Rochester's health care purchasers and planners have held down medical costs for all residents, including the elderly, far below the national average. Under the Health Security plan, in contrast, average premiums in the Rochester area alliance would be lower, and both families and employers would benefit accordingly. Except for low-income families and employers that hit the cap on their contributions, people and firms in regions with higher premiums would pay more; the alliance approach would literally bring home the cost to the community of excess expansion of hospitals and other health care facilities. If, on the other hand, reform were to nationalize health costs as Medicare does, this regional accountability would be lost, and the federal government would be engaged in a tug of war with local interests, which would continue to have an incentive to overbuild facilities and pass on the costs to the rest of the country.

As the Health Security plan gives states and regions a stake in controlling costs, so it gives them the flexibility

to address the problem according to local preferences and decisions. The plan gives the states the power to determine governance of the alliances, though it requires that the alliance boards represent the purchasers—employers and consumers—rather than providers or insurers. The alliances would have authority to negotiate rate schedules for fee-for-service care with provider representatives, to use financial incentives to encourage plans in underserved areas, and to negotiate with health plans over the quality of service they provide. States would have the option of collapsing fee-for-service coverage in the alliances into a single prospectively budgeted plan. They would also have the latitude to use all-payer rate setting and health planning or to rely on more strictly market-based incentives. And if a state preferred a single-payer system, it could adopt one, as long as it provided universal coverage with the same benefits and kept spending within the budget caps.

Today, the organization of medical practice, hospitals, and other aspects of the health care system is substantially different across the country; the Clinton plan does not require either states or private-sector providers to follow a single model. Indeed, the program gives the states more flexibility than they have now. Many states have been experimenting with policies to control costs and expand access, and all are struggling with out-of-control Medicaid budgets. But federal law has severely restricted the states' ability to make health policy. For important Medicaid innovations, the states generally need a federal waiver; Medicare is virtually off-limits. The Employee Retirement and Income Security Act (ERISA) bars the states from regulating employee health benefit plans, even though the states have authority to regulate health insurance. The courts have interpreted ERISA to mean that state insurance laws

apply only when employers buy coverage from insurance companies, not when they self-fund their benefits. As a result, more employers have self-insured, and the states have lost the capacity to reform health care finance. Curiously enough, therefore, national reform requires, in some respects, that the federal government deregulate the states.

Under the Health Security plan, all but the very largest private employee groups would receive coverage through a state's alliances; so too would current Medicaid recipients. The states would even have the option to integrate Medicare into the alliances as long as they provided beneficiaries with full guarantees of equal or better coverage. So while the Clinton plan creates a national framework for financing and benefits, it involves more authority downward to states and regions in addition to decentralizing risk to private plans and providers. By decentralizing authority, the Health Security plan builds in protections for geographic diversity; by decentralizing risk, it builds in fiscal protections that none of the traditional entitlement programs have had.

Financing the Public Share

Before the public release of the Clinton plan, most Americans expected it would call for a general tax increase. The plan would certainly be far easier to understand if it simply raised taxes to pay for all new expenditures. However, it would also be hard to justify or pass such a program. Instead, the plan finances new federal costs primarily by redirecting funds from growth that would otherwise take place in existing health programs.

The key to the financing of the Clinton plan is a concept familiar mainly to fiscal experts: the baseline. The

baseline is the projection of costs under current law and current trends. For Medicare, Medicaid, and other federal health programs, the baseline is increasing at about three times the rate of inflation. Thus federal spending forecasts already assume sharply higher costs for current programs. Instead of simply accepting these projected increases and then raising more money on top of them, the Clinton plan makes specific changes in federal health programs to reduce their rate of growth. It then uses the money saved to help pay for new initiatives as they are phased in. Overall, reductions in future outlays for current programs account for 57 percent of the sources of funds for new initiatives.

The reductions take several different forms. To bring Medicare's growth in costs down from three times inflation to twice inflation, the plan cuts future payment increases for providers. It also requires that the most affluent elderly—those with incomes over \$100,000—pay a larger share of their premiums for Medicare Part B (primarily coverage of physician services). Both Medicare and Medicaid include "disproportionate share payments" to providers, which were originally supposed to help institutions that bear heavy costs for treating the uninsured. As universal coverage is phased in, the justification for these payments will diminish and, consequently, they can be phased down. And because Medicaid beneficiaries will receive coverage through plans in the alliances (where growth in premiums is capped), Medicaid costs will grow less rapidly after reform than under current projections. Slower growth of premiums will also yield savings in federal employee health benefits.

New revenues supply the remaining federal funds. The plan includes an increase in tobacco taxes (75 cents a pack on cigarettes and an equivalent amount on other

forms of tobacco); the 1 percent of payroll assessment on large corporations that run their own health alliances; and a partial recapture of savings to companies benefiting from lower health insurance costs for early retirees. Each of these levies has a justification in its own right. Higher tobacco taxes discourage smoking, especially among the young, and help pay for the health costs of the cancer, heart disease, and other ill effects generated by smoking. The payroll assessment on corporate alliances falls on companies that will be relieved of the current cost shift from the uninsured as well as the future costs of the unemployed and the poor in the regional health alliances. The recapture tax for early retiree health costs will affect companies receiving substantial, long-term relief from the Clinton plan's retiree coverage. For the first three years after introduction of the early retiree benefit, the plan requires such companies to give back half of their savings to the federal government.

The Clinton plan does not cut back the tax advantages of employer-paid health insurance, as other plans in Congress do. There is no limit on the tax deductibility or exclusion from an employee's taxable income of employer contributions for the guaranteed benefit package. Employer contributions for additional benefits will remain tax-preferred until 2004; by then the guaranteed package will have been expanded, and the impact of the change will be small. Under the Clinton plan, employees would no longer be able to pay medical expenses with before-tax dollars in so-called "cafeteria" plans. On the other hand, the Clinton plan extends new tax benefits to private long-term care insurance.

The new expenditures under the Clinton plan fall into two groups. One set consists of benefits to the elderly and disabled; these consist primarily of the expansion of Medicare to include prescription drug coverage and the

new program to support long-term care in the home. These initiatives are projected to cost \$123 billion over the period between 1996 and the year 2000. Through the year 2000, other provisions of the plan will almost exactly offset those costs by reducing outlays for existing Medicare coverage by \$124 billion.

The second set of initiatives ensures universal coverage and strengthens complementary public health programs. The primary governmental cost for universal coverage consists of the funds for alliances to provide premium discounts to employers, low-income families, and the unemployed. The cost of these discounts will be shared between the federal government and the states. Each state's share will depend on its current cost for the Medicaid program; under the Clinton plan, states would be required to maintain the level of that support, adjusted for the future growth of health costs. Like the federal government, however, the states would see lower obligations because the capped increases in the alliances will be less than under the current Medicaid system. New federal costs will also be offset by reductions in Medicaid costs (\$89 billion)—because the alliances will cover many of Medicaid's current beneficiaries—and by reductions in Medicare costs (\$22 billion)—because alliance plans will become the "primary" payers for Medicare beneficiaries who work full-time.

Over the five years from 1996 to 2000, the net new federal cost for subsidies will be \$151 billion (which includes a cushion of 15 percent of the gross subsidies as a precaution against changes in behavior that are hard to estimate). This is further offset by \$65 billion of Medicaid savings due to reduced disproportionate share payments and slower growth of premiums in the alliances for Medicaid's residual beneficiaries, leaving a net cost of \$86 billion. In addition to the premium subsidies, there are

also new federal costs for tax benefits for the self-employed (\$10 billion) and the public health initiatives, administrative costs, and other measures (\$53 billion). Savings in other federal health programs (\$40 billion) and the new tobacco and other revenues (\$175 billion) more than cover these demands. Through the year 2000, according to administration estimates, the net impact on the Treasury will be to cut the deficit by \$58 billion.

Some critics suggest that before enacting universal coverage, we should wait to see lower costs in existing programs. However, it will be difficult to achieve a slowdown in the costs of those programs without universal coverage. Universal coverage is the justification for eliminating disproportionate share payments. Other savings stem from the enforceable caps backing up the competitive system in the alliances; the caps, as I've indicated, pull out the cost of uncompensated care. That cannot be justified without universal coverage. If millions are still uninsured, intensified competition will lead hospitals and other providers to abandon them because the providers will no longer be able to shift costs as easily to the insured. The political consequence of failing to achieve universal coverage will, therefore, be to inhibit competition. Some of the same critics who are skeptical of the savings also object to the caps and the alliances. They would "wait and see" not just on universal coverage but on cost containment—and then use the failure to contain costs as a reason for further delaying universal coverage. This is what we have been doing for years. It is a recipe for a continuing cycle of failure, which has very large costs of its own.

Financing the Private Share

The conventional view of reform is that it comes at the expense of the private sector because of the mandate on

employers to pay a share of premiums. The Health Security plan, however, has much less of an aggregate impact on employers than is generally supposed. While the plan requires some employers to pay for health benefits for the first time, it enables a lot of firms to pay less than they now do. Today, many employers pay more than 7.9 percent of payroll for more limited coverage; few small firms can obtain good health insurance at anything like the cost under the Health Security plan. Some employers will see an immediate reduction in their benefit costs; others will see lower increases than they would without reform. In no year will the employer sector as a whole pay more than 4 percent more than it otherwise would have paid; by the end of the decade, employers collectively will pay \$27 billion less than they would under current trends.

However, some firms stand to gain and others to lose because the new system will tend to spread costs more evenly among employers. Currently insuring firms—particularly those that cover whole families and have older workers and many retirees—will tend to see lower costs, while those that have provided little or no coverage will, of course, experience increases. For example, manufacturing companies, state governments, and small businesses that now provide good health benefits will generally see reduced costs for their employees. But retail firms and other low-wage service businesses, especially those that rely heavily on part-time workers, will see higher costs. The firms facing the largest increases relative to current labor costs are employers with more than 5,000 workers, such as national retailers, that now offer no insurance and low average wages.

The Clinton plan reduces costs for currently insuring employers not only by capping contributions but also by spreading the cost of families and eliminating the costs

of uncompensated care. Today, firms that pay for health insurance are indirectly covering the health costs of workers at other firms that do not provide insurance. These uninsured workers leave unpaid medical bills, and hospitals and other providers shift the costs to the insured. In addition, firms that cover dependents often pay for spouses employed at other companies. Under reform, an individual employer's contribution for an employee with a family will be reduced by about one fourth because of the contributions of other employers with family workers, and the elimination of uncompensated care will cut on average about 10 percent from current premium levels. These two sources of savings will offset additional costs, such as those for part-time workers not covered by most employers today.

The net impact of these changes on firms that now insure is striking. Without reform, average annual employer premium payments per worker are projected to rise from \$1,923 in 1994 to \$3,086 in the year 2000; with reform, they will increase only to \$2,481—a total saving of \$59 billion to currently insuring employers. As a percentage of payroll, premium payments would grow from 6.8 percent to 8.2 percent without reform by the end of the decade; under reform, they will fall slightly, to 6.6 percent.

The most strenuous opposition to required employer contributions comes from small businesses that do not currently pay anything for health benefits. However, small business owners and their employees are scarcely immune from illness. Under the current insurance system, they typically pay the most for the least adequate insurance coverage because of experience rating and insurers' high administrative costs in the small-group market. The Clinton plan's health alliances give them access to a broad pool, enabling them to purchase coverage at

more favorable rates. Even at full cost, the alliances help them pay less; with the discounts, they come out far ahead compared to either the insurance rates or financial risks that they and their employees now face.

Some small business owners imagine dire consequences because they think not of the comprehensive effects on labor markets and their competitors, nor of the long-run effect on the health system, but of the short-run impact as if their business alone were being asked to pay. Yet small employers survived handily in Hawaii after health benefits were required by the state, and recent studies of federal increases in the minimum wage show little adverse effect.

Moreover, economists generally agree that the costs of health insurance are ultimately borne not by firms but by workers, except for those at the minimum wage. In recent decades, the growing cost of employer-paid health insurance has not pushed up labor's share of national income; the effect, as I noted earlier, has been to depress growth in wages. Sooner or later, workers pay for health insurance even if the employer writes the check.

The ability of employers to shift costs to their workers may explain why business has historically been so ineffective at containing costs. Internationally, there is a direct relationship between the private sector's share of health spending and the level of spending. The relationship is the reverse from what employers may believe: the greater the private share the higher the costs of health care. Most employers in the U.S. have been unable to control health costs over the long term; even today, the majority are paying list price. Our system has been sustained by the illusion on the part of employees that the insurer paid the medical bill while the employer paid the insurance bill; in fact, the workers themselves have been

paying all along. Although the Health Security plan maintains employer contributions, it creates much clearer incentives for cost-conscious decisions by consumers and a framework for holding providers accountable for their full performance—cost, quality, and access. This is reform in the pursuit of responsibility as well as security.