

Healthy Compromise

Universal Coverage and Managed Competition Under a Cap

Paul Starr

T*his is how the system might work:* You would get your health insurance through a new, regional health insurance purchasing cooperative. The purchasing cooperative, bargaining on behalf of large blocks of subscribers, would contract with a variety of private health plans, including health maintenance organizations (HMOs), preferred provider plans, and one conventional free-choice-of-provider option. Each plan would have to offer a standard, mainstream benefit package to every prospective enrollee. Once a year the purchasing cooperative would ask you to choose among the health plans (or “networks,”

as Bill Clinton calls them) and inform you about their monthly charge and quality of care, including consumer satisfaction.

Money would flow into the cooperatives from employers and employees, from other people according to their ability to pay, and from government. Money would flow out to the health plans according to their enrollment: The purchasing cooperative would pay each plan a standard rate tied to the plan with the lowest premium. If you wanted a health plan with a higher premium, you would have to pay the extra amount. The purchasing cooperative would also adjust the overall payments to plans in line with the average “risk” of their enrollees (for example, it would pay more to plans with older subscribers); the rates charged to enrollees, however, would be the same. Government subsidies would enable all those who are not employed also to choose a health plan through the purchasing cooperatives—no one would be excluded. (Medicare, however, would continue for some time as a separate program.) While

responsibility for appointing the boards of the purchasing cooperatives would belong to the states, a federal health board would set standards for coverage, monitor outcomes of treatment, and regulate the flow of funds into the purchasing cooperatives and out to the health plans.

This is “managed competition” under a spending cap—a proposal for universal health insurance, quality improvement, and cost containment that cuts across conventional ideological lines. With the moment of decision about reform drawing near, there is deepening interest in an approach that can appeal to a wide coalition. Indeed, the range of support and increased political centrality of these ideas since early 1992 have been astonishing—an abrupt turn toward a new policy paradigm that brings together new allies and divides old ones, and that raises new hopes of breaking the impasse blocking national reform.

Managed competition has conservative appeal because it relies on choice and competition among private health plans. It has

liberal appeal because it calls for a comprehensive standard of coverage, insurance for all, and community-wide pooling of risk (everyone would get the same rates). It also creates new mechanisms to hold health plans accountable for their performance and introduces a potentially powerful new force—the purchasing cooperatives—to defend consumer interests. Perhaps most important, health insurance would no longer be tied to jobs. And in the version I support, the federal government would use the purchasing cooperatives to cap the growth of health spending.

But there are other versions of managed competition, too, without the same provisions for universal coverage and global cost controls. Indeed, ever since September 24, when Clinton endorsed “competition within a budget” and “universal coverage ... privately provided, publicly guaranteed,” managed competition has attracted varied interpretations as well as growing interest. During the first presidential debate, when Clinton responded to a question about health care by immediately referring to his “managed competition plan,” I wondered how many Americans caught what he said. Many people (even experts in health policy!) are unsure exactly what managed competition means and how it relates to universal insurance and a national health care budget. And many are skeptical that universal coverage under any system can be financed without large tax increases. Clearly, for those who favor this approach, dispelling those doubts is a top priority.

The Emerging Debate

A year ago, managed competition did not even figure in most public discussion of health care reform. As the news media presented it, the menu of reform had three major alternatives: a Canadian-style, single-payer system of national health insurance; Bush's plan to reform the current insurance market and give tax credits for limited coverage to the poor; and “play-or-pay,” the proposal embraced by the Senate Democratic leadership to require employ-

ers to insure their workers or pay into a public insurance program.

Of these three, only play-or-pay is a live option today. The election deprived the tax-credit approach of presidential sponsorship, and the single-payer approach has no prospect of winning it. The decisive obstacle to a single-payer plan remains fiscal—not just the initial tax increase required for

An abrupt turn in the strategy of health care reform raises hopes of breaking the political impasse

public financing of a comprehensive program, but the added revenue that would be needed each year to pay for the bulk of a system now costing over \$800 billion a year and growing 10 percent annually. Even if a single-payer program cut growth sharply, its annual budgetary demands would likely be enormous. A Clinton administration with lots of other commitments besides universal health insurance cannot risk the damage to its overall program.

But neither can the new administration risk the damage from the weak cost controls in the present system or in the kind of approach supported by Bush. Under current policies, according to the Congressional Budget Office (CBO), health spending during the 1990s will jump from 18 to 30 percent of federal outlays (excluding interest). As a proportion of gross national product, health expenditures hit an estimated 14 percent in 1992, up from 9.1 percent in 1980—an additional one percent of GNP *every 35 months*. While the average in industrialized countries is under 8 percent and growing slowly, CBO projects health care's share of GNP in the United States at 18 percent by decade's end. Higher costs will put health insurance out of the reach of more people, cause further problems for businesses now groaning under the burden, erode increases in real wages produced by economic growth, crowd out other programs from

public budgets—in short, imperil the promise of the Clinton presidency. So, while its final shape is still uncertain, fundamental reform is no longer optional, and the new President, the Congress, and even the major interest groups clearly understand that.

The emergence of managed competition as a leading framework for health reform under Clinton took many people by surprise, particularly because it has been identified—wrongly—with free-market views. While some editorialists have portrayed the current debate as another battle in the epic struggle of regulators versus marketeers, the truth (I am almost hesitant to reveal) is that managed competition, even without a global budget, involves plenty of regulation. It is best conceived, not as a pure market solution, but as a reconstruction of both market and regulatory institutions, aimed at enabling consumers to make informed, cost-conscious choices among alternative health plans with population-based budgets.

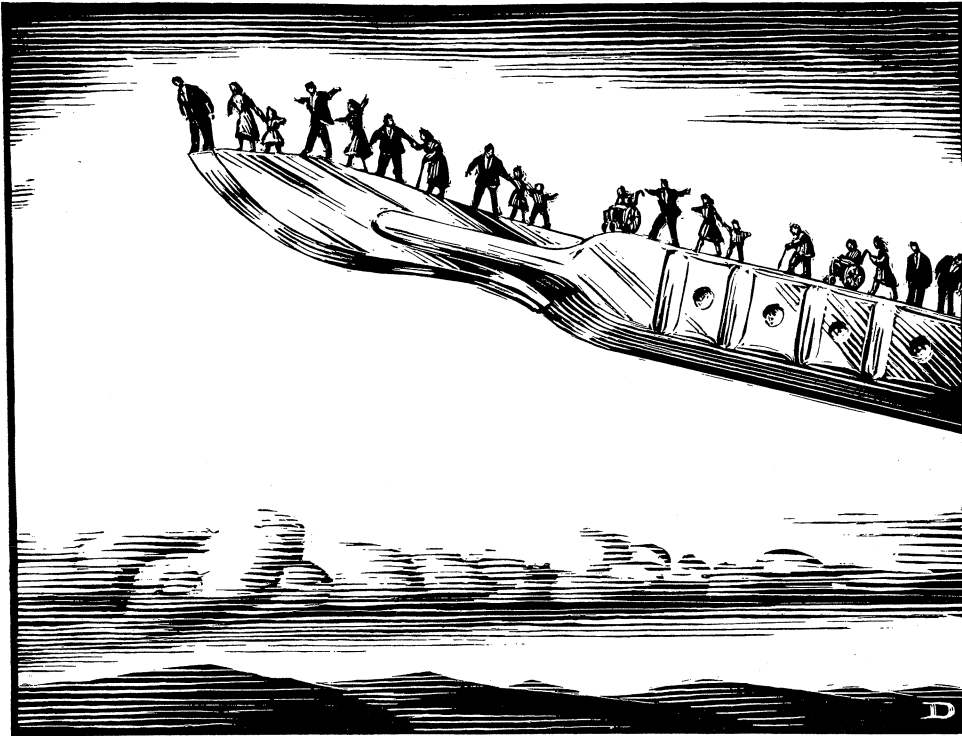
The basic concepts have been around for about fifteen years, ever since the Stanford economist Alain Enthoven first developed a “consumer choice” option for national health insurance at the request of the Carter administration. Enthoven subsequently adapted his approach to the employment-based system and emphasized the need for an active “sponsor” of consumer choice—that is, an employer, purchasing group, or public authority that would “manage” the competition to clarify the true costs of alternatives and prevent any plan from manipulating the market. Although not all supporters of managed competition have shared his commitment, Enthoven has always called for universal coverage and stressed that while advocating competition in the delivery of care, he favors a “social insurance” framework for the financing. As in Social Security, participation in universal health insurance cannot be voluntary.

In recent years, Enthoven has teamed up with Paul Ellwood, the physician who pioneered the concept of health maintenance

organizations, and Lynn Etheredge, a policy analyst who served in Carter’s Office of Management and Budget, to formulate a broad, managed-competition initiative. Known as the Jackson Hole proposal (because the group holds meetings at Ellwood’s home in Jackson Hole, Wyoming), the initiative calls for universal coverage through “accountable health partnerships.” These are health plans that would provide a federally mandated standard benefit package, offer open enrollment and community rating (that is, equal rates to all), and produce routine data on their quality of care, including outcomes of treatment. Under the proposal, all employers would be mandated to provide coverage; employers with fewer than 100 workers would obtain that coverage through health insurance purchasing cooperatives or HIPCs (pronounced “hippics” by the hip).

Two other initiatives in the past year have helped put managed competition on the national agenda. In February 1992, John Garamendi, California’s insurance commissioner, called for a system of regional HIPCs, embracing all employee groups and individuals, financed by a state payroll tax (an average of 6.75 percent on employers, 1 percent on employees). An innovative feature of the proposal is that it would merge the health care component of workers’ compensation and auto insurance into one comprehensive health insurance system. At least two health plans in every region would be available with no out-of-pocket premium; consumers could pay more for other plans, but within a cap. By combining managed competition, public financing, and a global budget, the Garamendi proposal reframed the debate. Garamendi’s proposal has the unified financing of single-payer plans (all the money through one spigot), but it also has competing delivery systems—hence it is a “single-sponsor” approach to managed competition.

At the national level, managed competition itself has acquired new sponsors. In the House of Representatives, the Conservative Democratic Forum (CDF)—a group of



mostly Southern Democrats—introduced a managed competition proposal last spring that would require states to set up purchasing cooperatives and make the cooperatives the exclusive channel for all tax-advantaged health insurance for firms with up to 1,000 employees. The bill generally follows the Jackson Hole model, except in one crucial respect: It does not require employers to offer insurance, only to use the purchasing cooperatives if they expect to get full tax benefits. (The bill does include more than \$30 billion in subsidies to enable those with incomes below 200 percent of the poverty level to enroll.) While falling short of universal coverage, the CDF bill would transform health care by making the purchasing cooperatives the central institutions of health care finance.

Meanwhile, on the Senate side, support for a comprehensive, universal insurance program through purchasing cooperatives has come from Democrats with a more liberal cast, notably Jeff Bingaman, Tom Daschle, Bob Kerrey, and Harris Wofford. They would allow states and regions to modify the structure to suit local circumstances. For

example, in rural areas where there is no prospect of effective competition, the purchasing cooperatives might adopt other arrangements, including a single-payer plan.

Under Majority Leader George Mitchell, Senate Democrats have also been moving to achieve a consensus between supporters of play-or-pay and advocates of managed competition. The differences between the two approaches are substantial, but negotiable. Play-or-pay offers a choice of plans to employers; managed competition gives the choice to consumers. But if the public program under pay-or-play is converted into a purchasing cooperative, the gap between the two narrows. Furthermore, because small businesses cannot buy insurance efficiently themselves, many play-or-pay advocates are prepared to mandate participation in the purchasing cooperatives for small and perhaps mid-size firms, while leaving it optional for larger ones.

This, in fact, is one direction of compromise proposals, but several questions then arise. First, where should legislation draw the cut-off for mandatory participation in the purchasing cooperatives—at 100

employees, 1,000 employees, or some other level? The advocates of play-or-pay have tried to minimize the "pay" alternative for fear of creating a huge government program; most managed-competition advocates, by contrast, want the purchasing cooperatives to become the primary way to arrange for health insurance.

The issue here is not only which is more likely to control costs, but which allows more freedom. When employers separately adopt managed care, they restrict their employees' freedom to choose their doctors. That raises a question: Why should my employer limit my choice of doctor? Through the purchasing cooperative, on the other hand, consumers will have a wider range of plans to choose from. In my view, there is a world of difference between a managed care plan imposed by an employer and a managed care plan offered as a choice by a purchasing cooperative that has other options; and it is ironic, if not positively perverse, for the play-or-pay Democrats to favor the employer-based alternative, which increasingly limits the rights of consumers. (Moreover, employers that offer choice do not have the capacity to "risk-adjust" premium payments to plans or to impose other rules and incentives needed to manage health plan competition appropriately.) So, the more inclusive the purchasing cooperatives, the better.

Yet if, in the interests of compromise, participation in the purchasing cooperatives is mandated only for small and mid-size firms, on what terms should larger firms be able to join? Making participation voluntary inevitably creates a problem of "adverse selection" (that is, those with higher risks will take the offer): Employers with higher health costs will join the purchasing cooperatives and, if they get the same rates as other employers, the cooperatives will become more costly. The answer here, unfortunately, is that if some category of employers is permitted to opt out, the purchasing cooperative must be able to charge a risk-adjusted rate to any employers from that group that sign up.

Allowing large employers to opt out raises another serious problem. If the purchasing cooperatives only have partial coverage of the market, they can no longer impose a global budget. To be sure, if the cooperatives embraced all firms below 1,000 employees, they would have nearly two thirds of the employed population and could effectively regulate total spending (although Medicare is a complicating factor). But the less inclusive the purchasing cooperatives, the greater is the need to find some other way to set spending limits—most likely direct controls on hospital revenues and physician fees.

Some reformers believe controls on revenues and rates are inevitable, especially in states where fee-for-service remains dominant. But such controls won't necessarily work (consultants stand ready and willing, for a fee, to undo and subvert them), and it may not be easy for the Clinton administration to accept controls on one seventh of the economy or to get Congress to adopt them. Such an effort would require the administration to expend a lot of political capital; and if controls passed, the federal government would become even more deeply involved in the "micro-regulation" of health care that Clinton has said he wants to avoid.

Those difficulties argue in favor of a Garamendi-style strategy of comprehensive budgeting through the purchasing cooperatives, which can "cap through capitation"—that is, cap growth in spending by limiting the per capita payments to plans. For example, the new national health board might set a permissible index for growth in the base payments by purchasing cooperatives to their plans and a spending target for the added dollars consumers spend for higher-cost options. If out-of-pocket premiums exceeded the target, it could trigger a series of measures by federal and state authorities, ranging from advisory recommendations to strict regulatory controls, or even decertification of the purchasing cooperative's board, depending on the cause and severity of the problem.

Of course, channelling all employer-

paid insurance through the cooperatives would be a radical break from employer-provided insurance. While many employers are ready to give up control of health benefits, others are still convinced—despite years of failure—that they can hold down costs. Moreover, although there is much opposition to price controls, there is also a lot of skepticism among policy experts about whether managed competition can actually deliver the savings it promises.

Savings from Managed Competition

The term “managed competition” is easily misunderstood because of its similarity to “managed care.” A managed care plan is a health insurance plan that attempts to control cost or improve quality through some selection of providers or regulation of treatment decisions. In its current use, managed care embraces HMOs and fee-for-service arrangements. (Most people in managed care today are, in fact, in the latter.)

Managed competition, by contrast, refers to a framework of consumer choice among alternative health plans, not all of which need be managed care. To be sure, managed competition would promote managed care, but it would also change it and, perhaps more important, managed competition would change the environment in which managed care develops.

The confusion of managed competition and managed care is evident in efforts to evaluate the future impact of managed competition by estimating the past effects of managed care. Some forms of managed care—HMOs based on group practice—have proven economies, but the evidence on other managed care plans is inconclusive about whether there are real economies (or just less access). Hence, some say, managed care alone will not adequately control costs—and they may well be right.

Managed competition’s impact on costs, however, derives from several distinct elements. To be sure, managed competition would require consumers to pay extra for more expensive health plans. Advocates would also limit the exclusion from taxable

income of employers’ health insurance contributions to an amount no greater than the premium of the low-cost plan. As a result, consumers would have to use after-tax dollars to purchase plans with higher premiums. That should make consumers more cost-conscious and more likely to choose a less costly, managed care alternative.

Furthermore, the purchasing cooperatives will open up HMOs to new enrollees and alter the incentives facing the health plans. Under the current employment-based system, millions of potential subscribers to HMOs are effectively bottled up in employee groups that do not have such options. Even employers that offer alternative plans today virtually never require the plans to offer the same benefit package, nor do they limit their contributions to the low-cost plan or risk-adjust premium payments. Employers’ current policies encourage plans to try to enroll the most favorable risks, to expand benefits rather than cut premiums, and to keep their premium rates right behind the high-cost options. Managed competition would drastically alter these incentives, simultaneously focusing consumer attention on relative prices and measures of performance like satisfaction and health care outcomes.

But, unlike some other advocates of this approach, I do not see individual cost- and quality-consciousness as the decisive element. By combining individuals and employee groups into large purchasing cooperatives, managed competition creates a powerful, knowledgeable countervailing force on the demand side of the market. Health care has historically been characterized by strong providers and weak purchasers. Managed competition equalizes the relationship—indeed, the purchasing cooperatives will have an unprecedented capacity to restrain costs.

Moreover, the system will not only concentrate buying power, but also produce a rapid consolidation of the insurance industry. For while the purchasing cooperatives increase the array of choices available to most consumers, they will reduce the total

number of health insurance plans operating in a region. The federal requirements that the plans offer open enrollment and community rating will make survival difficult for small insurers that have flourished by "cherry-picking" healthy subscriber groups. In addition, the purchasing cooperatives should consolidate fee-for-service into a single, competitively bid insurance plan. Under these policies, a mature market in a metropolitan area will be unlikely to have more than a dozen plans.

Currently, there are over 1,000 health insurance companies, some of which offer thousands of different plans. The result is a bureaucratic nightmare, not just for patients befuddled by complex forms, but for doctors and hospitals that must deal with myriad different policies and coverage limitations. The purchasing cooperative will drastically reduce this administrative complexity and thereby cut paperwork for providers. The same effect will follow from managed competition's standard benefit package and from the ability of the purchasing cooperative to impose other standardization requirements facilitating electronic claims and payment systems.

Besides cutting overhead for providers, the purchasing cooperatives will reduce the administrative costs of insurance itself. A large proportion of insurance premiums now goes to insurance administration, particularly for small groups—40 cents of every premium dollar for the individually insured and groups with fewer than five workers; 25 cents of every premium dollar paid by firms with 25 to 49 workers. That amount falls to below 5 cents for the largest firms. With their large economies of scale, the cooperatives will sharply cut overhead in the small-group market.

Like other plans for universal coverage, managed competition generates other savings, too. Today, many on welfare are reluctant to take the low-wage jobs available to them because they have no health insurance benefits; one study from the National Bureau of Economic Research estimates a one-fourth reduction in welfare caseloads

from universal health coverage. In recent surveys, three out of ten adults say someone in their household has not moved jobs because a pre-existing medical condition might jeopardize health coverage at a new firm. By eliminating such restrictions, universal insurance encourages job mobility and greater productivity.

I mention these indirect as well as direct benefits of universal coverage in part because there is a tendency to think only of the costs of covering the uninsured and, therefore, to believe that postponing reform saves money. But delay also means prolonging the inefficiencies of the current system and its harm to the economy. A complete accounting of reform would, I believe, show the balance to be strongly positive.

Financing Universal Coverage

But, surely, even if reform produces broad economic benefits, won't it demand large increases in government spending on health care? The answer, I believe, is not necessarily—not in relation to the more than \$800 billion in current national health expenditures. How much a new program adds to that spending depends in part on whether we are able to recapture the savings from reform and apply them to expanded coverage.

One advantage of managed competition is that it does not require the federal government to raise most of the revenue for health care. Reform, after all, should not try to make health insurance free; it should make it affordable. The purchasing cooperatives can set a community-rated premium for their region; the role of the federal government (and the states) can then be limited to subsidizing the participation of low-income people and low-wage employers. The cost of these subsidies can be offset by other measures, such as changes in the tax treatment of employer premium contributions.

Consider the following possibility. Employers would pay a minimum of 75 percent of the purchasing cooperative's standard premium (based on the low-cost plan), up to a limit of 7 percent of payroll.

Employees would pay the remaining 25 percent of the premium, up to a limit of 2 percent of family income. The self-employed, unemployed, and others outside the labor force would pay little or nothing if their incomes were below poverty, but otherwise they would be responsible for paying the premium up to 9 percent of their income over the poverty line. (Today the poverty line is about \$14,000 a year for a family of four. Hence a family with \$20,000 in income but no employer contribution would pay 9 percent on \$6,000, or \$540, which works out to \$45 a month.) Part-time workers would be treated as self-employed, except that employers would have to pay a 7 percent payroll tax on part-time wages to avoid creating any bias toward part-time work.

Lewin-VHI, a consulting firm that has provided major national organizations with estimates of the costs of health care reform proposals, has estimated that if we were to cap premium obligations as I've described, new government revenues required for universal coverage would be approximately \$53 billion in 1993. (This assumes a somewhat broader benefit package than a federally qualified HMO, no deductible, and a \$10 copay on physician visits; the required subsidies would fall to \$42 billion with the less generous package in the Senate leadership's play-or-pay proposal.) Of this amount, however, \$13 billion would consist of payments to hospitals for services to the uninsured that are now covered by shifting the costs to privately insured patients; \$25.7 billion would consist of higher reimbursement rates for services now being given to Medicaid beneficiaries.

Remember also that the purchasing cooperatives will cut overhead for providers and insurers. (Lewin-VHI puts the savings to insurers at \$11.2 billion.) Thus, absent other measures, providers and insurers would reap windfall gains from reform. Competition should force providers and insurers to return those windfalls to consumers. But Congress could justifiably recapture some of those savings through

taxes on providers and insurance transactions and apply them to coverage of the uninsured. Along with the limit on the tax exclusion of employers' contributions—worth between \$10 billion and \$25 billion, depending on where it is set—the package as a whole can be constructed to impose minimal demands on the federal budget.

This is not to say there would be no new costs to anyone: Both employers who do not offer health benefits and individuals who now have no coverage would be required to pay for health insurance. The value of the tax exclusion of employer-paid premiums would fall. Small insurers would leave the market. But premiums would go down for employers who now pay more than 7 percent of payroll and for the individually insured who pay more than 9 percent of over-poverty income. While currently uninsured small employers will undoubtedly resist a mandate, many other employers stand to gain from a 7 (or even 8) percent limit and from federal controls over the rate of spending growth. Properly constructed, a managed-competition program will enjoy a lot of business support.

Making the System Progressive

Yet there are dangers. Some proposals for reform being described today as managed competition are actually proposals for managed care with no management of competition. Typically, these proposals do not call for an independent body like the purchasing cooperative to conduct the enrollment process, negotiate and enforce the contracts, risk-adjust payments to plans, or inform consumers and serve as their advocate. Yet without these (and other) protections, health plans will sign up the healthy and shun the sick, and the market, far from producing more efficient care, will generate less care for those who need it most.

Consumer and labor organizations, as well as many others, ought to find such proposals unacceptable. But rather than oppose managed competition altogether, they could help make it serve progressive purposes. In addition to global caps and

universal coverage, they should insist on a strong consumer-oriented role for the purchasing cooperatives, including a special emphasis on their responsibility for assuring care to the most vulnerable populations. In their contracts with health plans, for example, the cooperatives may need to include requirements that they establish clinics or affiliate with providers in low-income areas. For poverty-level enrollees in the purchasing cooperatives, the price differentials among plans should be reduced to enable them to choose alternatives beyond the low-cost plan. In addition to its general surveys of consumer opinion, the purchasing cooperative should specifically survey people who switch plans to identify sources of dissatisfaction as well as patients with chronic and high-cost conditions to determine whether they are being adequately served. The results should be published to help consumers choose plans and should be used to force plans to improve their performance and to guide future contract negotiations. The purchasing cooperatives themselves should be evaluated for their performance in responding to consumer complaints and making sure consumers, particularly the poor, have access to the services that they are entitled to receive.

Another key issue for consumer groups should be the standard benefit package. If health plans can vary the benefit package, they will avoid including benefits that are known to attract higher-than-average cost subscribers. This is particularly a problem for mental health services and treatment for alcoholism and drug dependency. A major complaint about managed care today is inadequate mental health coverage. Those inadequacies arise not just because plans resist paying for mental health services, but because they know that good mental health coverage will attract bad health risks. (People who use mental health services use other medical services more, too.) The only way to avoid this problem is to make sure that all health plans are required to maintain the same level of coverage and are evaluated for their quality of service.

Some policy makers talk about a "basic" or "minimum" package as a standard. But what plan will provide extra coverage of services known to attract high-cost groups? Comprehensiveness of coverage is essential to achieve comprehensiveness of cost control; genuine cost containment comes not from excluding benefits and cost-shifting back to patients, but from requiring health plans to produce services more efficiently. To be sure, by "comprehensive" I don't mean covering everything, but the package must be a mainstream standard, acceptable to the great majority, not a step down for those currently insured.

As consumer and labor groups recognize, the transition to a universal system cannot happen overnight, but they should resist any effort to postpone committing the nation to a schedule for introducing universal coverage. Concern about rising costs has so intensified that some who otherwise would support universal coverage now say, "Cost containment first, expanded coverage later." That has been the refrain for the past twenty years. But if not universal coverage now, when?

Of course, a universal insurance program that merely expands the present system will add to costs. But a universal program can also provide the institutional mechanisms and—perhaps more important—the moral foundation to bring spending under control. This is partly a matter of moral and political psychology. Relieving the public insecurity about health coverage is essential to gaining the confidence and support necessary for reforms not all of which can be entirely popular. Everyone recognizes cost containment is essential; nonetheless, it will win few friends and, at the end of the day, little applause. The friends to be won with universal coverage, on the other hand, are many—and their commitment is passionate. Spending control, therefore, lies on the other side of the gate of universal insurance. And, unexpectedly, managed competition under a cap is emerging as the most likely way to get us there. ♦