MANAGED COMPETITION II: A PROPOSAL

*JACKSON HOLE GROUP**

INTRODUCTION

The managed competition proposals presented by the Jackson Hole Group in September 1991[1] have contributed signifi-

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 This Article presents a plan for reform of public and private health policy in the United States. These proposals are based on the deliberations of the Jackson Hole Group (JHG), an ad hoc and changing collection of health executives, leaders, and experts who have been meeting over the last twenty years to discuss and address the most serious deficiencies of the health system. The only consistent participants in the process have been Dr. Paul M. Ellwood, M.D., President of the Jackson Hole Group, and Alain C. Enthoven, Ph.D., Marriner S. Eccles Professor of Public and Private Management, Graduate School of Business, Stanford University.

These policy proposals include recommendations for major reform and are the result of JHG participants' operational experience with the system's problems and their collective sense of what might be accomplished through aggressive joint public/private efforts spanning the next decade. The reforms would establish a system of managed competition between accountable health plans, with government setting the ground rules for competition. Tax exclusions for health benefits are proposed to shape the capabilities of organizations delivering medical care, and as a mechanism for curtailing health services cost inflation.

An expanding group of participants in the JHG critically review these proposals continually, and gather comments from other interested parties. The objective is to reach consensus among key providers, insurers, purchasers, and policy makers, establishing common policies to be implemented within their own organizations. Private sector cooperation and reform is critical to advancement of the JHG proposals in the public sector. These ideas now enjoy wide political support as comprehensive, moderate, market-based health care reforms.

There is no membership in the JHG, only participation by invitation, as agenda items for the JHG Health Forums are developed. Members of the press are excluded from the forums as a matter of policy to protect the participants and to allow free and open discussion.

1. JACKSON HOLE GROUP, THE 21ST CENTURY AMERICAN HEALTH SYSTEM (1991) [hereinafter MANAGED COMPETITION I] (on file with the *Washington University Journal of Urban & Contemporary Law*).

cantly to the current debate on American health care reform. Critical elements of our earlier work — purchasing cooperatives, accountable health plans, outcomes information — are instrumental to most current state initiatives[2] and many proposals for national legislation.[3]

While these ideas have formed the basis of mainstream thinking about health care delivery, Congress and the President have not yet been able to formulate a consensus strategy for ensuring universal coverage and effective cost containment.[4] Each proposal for federal legislation seems stymied by its

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2. Several states have enacted variations of the managed competition proposals. These states include Florida, *see, e.g.*, Lawrence D. Brown, *Commissions, Clubs, and Consensus: Reform in Florida*, 12:2 HEALTH AFF. 7 (1993) (describing Health Care and Insurance Reform Act of 1993); Hawaii, *see, e.g.*, Deane Neubauer, *Hawaii: A Pioneer in Health Systems Reform*, 12:2 HEALTH AFF. 31 (1993) (describing State Health Insurance Program of Hawaii); Minnesota, *see, e.g.*, Howard M. Leichter, *Minnesota: The Trip from Acrimony to Accommodation*, 12:2 HEALTH AFF. 48 (1993) (describing the HealthRight and Minnesota Care programs); Oregon, *see, e.g.*, Daniel M. Fox & Howard M. Leichter, *Oregon: The Ups and Downs of Oregon's Rationing Plan*, 12:2 HEALTH AFF. 66 (1993); Vermont, *see, e.g.*, Howard M. Leichter, *Health Care Reform in Vermont: A Work in Progress*, 12:2 HEALTH AFF. 71 (1993) (describing Vermont's Health Care Act of 1992); and Washington, *see, e.g.*, Robert A. Crittendon, *Managed Competition and Premium Caps in Washington State*, 12:2 HEALTH AFF. 82 (1993) (describing the Washington Health Services Act of 1993).

3. *See, e.g.*, the Clinton health plan, H.R. 3600 & S. 1757, 103d Cong., 1st Sess. (1993) (adopting many proposals contained in MANAGED COMPETITION I); the Chafee/Thomas bill, H.R. 3704 & S. 1770, 103d Cong., 1st Sess. (1993) (requiring employers with less than 100 employees to participate in a purchasing cooperative, and mandating individuals to have health insurance with a penalty for non-compliance); the Cooper/Breaux bill, H.R. 3222 & S. 1579, 103d Cong., 1st Sess. (1993) (promoting a managed competition-type plan by encouraging the formation of health plan purchasing cooperatives to negotiate health plans for coverage on behalf of employers with fewer than 100 employees, establishing a basic benefits package, limiting the deductibility of health plans to the least expensive cost of the package, and encouraging the formation of accountable health plans); the Michel/Lott bill, H.R. 3080 & S. 1533, 103d Cong., 1st Sess. (1993) (implementing small group insurance reforms, expanding the Medicare program, and providing individuals with tax incentives to save for medical expenses through "medical IRAs"); the Stark bill, H.R. 200, 103d Cong., 1st Sess. (1993) (establishing annual budgets based on prior year national health expenditures, rates for all personal health services, national standards for health insurance plans, a new federal program to provide health insurance to all children under age 19, and expanded benefits under Medicare and Medicaid); the Nickels/Stearns bill, H.R. 3698 & S. 1743, 103d Cong., 1st Sess. (1993) (establishing medical savings accounts).

4. *See* Gail R. Wilensky, *Health Care Reform: Is 1994 the Year?*, *supra* this volume, part IV.

inability to predict the economic consequences of its implementation.[5]

Changes of the magnitude envisaged under leading reform proposals have never been tried before, creating tremendous uncertainty that threatens to undermine reform. No one can confidently estimate the costs associated with various proposals, how effectively different mandates will achieve universal coverage, the results of price controls or global budgets and whether they can be enforced, the lack of capacity that may result from a continued shortage of primary care practitioners or delays in accountable health plan (AHP)[6] formation, how employers will use savings, the effects of increased consumer involvement in the decision-making processes, or the magnitude of savings that may be achieved by reducing the amount of ineffective care.

This level of uncertainty poses a serious risk to implementing effective reform. That risk, along with other lessons learned in actually applying managed competition, has caused us to revise selected parts of the original managed competition proposals. The underlying premise of Managed Competition II is that reform should adapt to observations and experience. This is exemplified by a common sense approach in which government health care financing is always in balance, and is coupled with a step-by-step approach to reaching universal coverage. The original managed care proposals continue to provide the basic framework for health care reform as summarized in Table 1.

Managed Competition II presents three technical improvements to the managed competition model, including refinements in the design of Health Plan Stores (HelPS), incentives for cost consciousness and healthy behavior, and increased protection for consumer choice of provider. It also adds two critical policy initiatives to the original model: a balanced health security budget and a universal coverage program.

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5. *Id.* at part III.D.

6. An Accountable Health Plan (AHP) is a health care delivery organization that combines the services of health insurance with provision of medical care to patients. AHPs can take several forms and are sometimes called integrated care organizations. They will compete with one another on the basis of quality and cost.

TABLE 1

Core Elements of Managed Competition that Remain Unchanged from Managed Competition I

ACCOUNTABLE HEALTH PLANS (AHPs) - "The Providers"

AHPs are the "engines of reform" and would shift the emphasis in health care from disease and intervention to prevention and wellness. AHPs are organizations that:

- Both finance and deliver the standard benefits.
- Are accountable to the public for member satisfaction and the effect of their services on members' health.
- Comply with solvency and insurance standards, including community rating and guaranteed issue and renewal provisions.
- Offer doctor choice in at least one AHP per region.

SPONSORS - "The Health Plan Store"

Large employers, government, and Health Plan Stores (HelPS - formerly known as HPPCs, Health Alliances) would act as sponsors in enabling a choice of health plans. Additionally, there would be more than one Health Plan Store permitted in a region. In general the role of the sponsor is to:

- Provide information and incentives for individuals to choose among competing AHPs.
- Pool risk and achieve economies of scale in purchasing.
- Set rules to assure equitable coverage of all members of the sponsored group.
- Collect and pay premiums to Accountable Health Plans.

STANDARD BENEFITS - "The Measure of Universal Coverage"

A standard benefit package would:

- Be the services made universally available to all Americans.
- Be continuously amended by the Health Security Commission and approved by Congress through a process insulated from inordinate political interference.
- Be based on scientific documentation of efficacy, including cost-effectiveness.

THE HEALTH SECURITY COMMISSION (HSC) - "The Referee"

The HSC would be an independent federal agency to guide, oversee, and facilitate a transition to a new health system. HSC powers and responsibility would be explicitly limited in legislation to:

- Recommending a standard benefits package to Congress.
- Recommend measures to balance the health security budget.
- Coordinating a standardized data reporting system.
- Setting standards for and registering AHPs and HelPS.
- Disseminating information and making recommendations on risk adjustment.

I. Refinements to the Managed Competition Model

A. *More and Smaller Health Plan Stores (HelPS)*

As introduced in the original managed competition proposals,[7] HelPS in a reformed system would act as sponsors for individuals and small employers, giving them the ability to pool risk, achieve economies of scale, and drive the competitive process through informed individual choice. HelPS should not be regulatory or price-setting agencies, and should not negotiate or limit choice of AHPs. Rather, they should offer an informed set of choices to help individuals weigh personal priorities in health plan selection. If HelPS were allowed to negotiate (*i.e.*, refuse to offer plans whose prices are too high), individual choice would be limited. In addition, an effectively functioning and competitive market would be undermined by concentrating too much purchasing power in a single entity.

While many private sector initiatives are proving effective in holding down health costs, especially purchasing efforts of large employers, the problems associated with the small group and individual markets have not improved and the need for HelPS remains. We initially proposed creation of a single exclusive HelPS in each geographic area to address the needs of the small group market.[8] Recently, however, we have seen that concentration of purchasing power in monopoly HelPS provides a structural device that can be easily applied to constrain — rather than support — competitive markets.

We now propose a system of competing Health Plan Stores. States would be required to create a state-sponsored Health Plan Store for pooling consumer purchasing power, but multiple stores could be created to compete, provided that each meets the standards outlined below.

We appreciate the value of HelPS where participation would be voluntary, and have considered greater reliance on such structures. Experience has shown, however, that the small group market is easily fragmented into small, expensive groups that insurers avoid and small, low cost groups that are easily insured. Such risk selection, and the associated cost shifts, remains the central problem which purchasing pools are intended to overcome and which will not be addressed by voluntary HelPS.

It therefore seems prudent to start with a system in which HelPS are the mandatory sponsors for the small group and

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7. *See* Managed Competition I, *supra* note 1, at 15-19 (describing Health Plan Stores under the rubric of health plan purchasing cooperatives).

8. *Id.* at 17-18.

individual markets, in that preferential tax treatment of health expenditures would be conditional on purchase of coverage through a licensed HelPS. This competing HelPS structure would still require special measures to ensure that the market is not undermined by adverse risk selection. Private sector organizations or associations could become licensed as HelPS if they agreed to open enroll, offer all AHPs, cover entire HelPS regions, meet solvency standards, and conform to other HelPS standards including a prohibition against conflict of interest. AHPs would offer the same base community rate to all HelPS serving designated regions. HelPS would compete only on their administrative overhead (the cost of which would be added to premiums) and their customer service. Competing HelPS that negotiate premiums would undermine community rating in the small group market. In a system of competing HelPS, states would have to take on the additional responsibilities of dividing their territory into HelPS regions, and coordinating risk adjustment and standardized data collection. With this design, competing HelPS can still achieve the original HelPS goals, yet satisfy those that contend a need for significant reform of the small group and individual markets exists.

B. *Rewards for Cost-Conscious Consumers*

Recent purchaser initiatives and state reforms have recognized the central role of consumer behavior (demand) in shaping successful reform. Any successful reform must include mechanisms for encouraging cost-sensitive utilization of health care services and healthy lifestyle. A limit on the tax deductibility of health benefits remains the best way to instill cost-consciousness in health plan selection, control government expenditures, and raise revenue for low-income subsidies without increasing marginal tax rates. A revised tax code that addresses the concerns of the public while preserving cost-conscious incentives would include:

- Extending full preferential health insurance tax treatment to all consumers that purchase coverage through an appropriate sponsor (*i.e.*, a large employer or Health Plan Store). A requirement to use the appropriate group sponsor would ensure that the risk of costly illness is spread fairly.
- Capping tax deductions and exclusions at the average of competitive AHP prices in the lowest quartile (25 percent) of AHP prices in an area (instead of at the level of the lowest-cost AHP).
- Allowing those who choose an AHP priced below the tax incentive to keep the difference in a tax-

free health bonus account to be used to defray the costs of copayments, deductibles, and benefits not included in the standard benefits package or to supplement an individual retirement account.

- Allowing health plans to reward health lifestyles and behaviors with contributions to members' health bonus accounts.

C. *Assuring Choice of Providers (Doctor of Choice-DOC)*

The original managed competition proposals did not limit the type of health care delivery organizations that would compete in a reformed market. While we continue to support a marketplace which offers a wide variety of insurance and delivery models, we acknowledge public concern that consumer choice should not be restricted. For this reason, every sponsor should be required to offer at least one AHP with an out-of-plan (*e.g.*, point-of-service or doctor of choice (DOC)) option, which allows enrollees to use non-AHP providers at increased cost. In the event that no AHP within a sponsor's region offers an out-of-plan option, all AHPs in that region would be required to do so.

II. Universal Coverage Under Managed Competition

A. *Balanced Health Security Budget*

The original managed competition proposals focused on structural reforms and did not propose any specific strategy for financing universal coverage. However, as various financing schemes have been proposed in legislation, it has become clear that the financing of health reform has implications for how structural aspects will interact. A managed competition approach to *structural reform* requires a managed competition approach to *financing*.

The United States needs to achieve a predictable and acceptable level of health care spending. In the current environment, spending cannot be allowed to exceed available funding. A balanced health security budget would instill fiscal discipline into the health care system by guaranteeing that federal health expenditures do not grow faster than revenue and promoting an honest and explicit debate regarding these expenditures.

The balanced health security budget can be regarded as a ledger that (1) continuously matches federal revenues to expenses, (2) relates the benefits package to available financial resources, and (3) relates the benefits package to providers' demonstrated ability to improve function and well-being. Fed-

eral health spending covered by the balanced health security budget would include low-income subsidies (referred to as EquiP 1 and 2),[9] Medicare, and the Federal Employee Health Benefits Program (FEHBP). The increases in lost tax revenue (tax expenditures) to the federal government, due to the preferential tax treatment of health expenditures, would also be counted as part of the balanced health security budget, thus helping to contain the growth in mandated private health security costs.

Under such a system, government health expenditures would be disbursed on a pay-as-you-go basis, and the health system would move toward universal coverage in carefully monitored stages. Each year, Congress and the Health Security Commission (HSC)[10] would adjust three elements of the health care financing system in order to achieve an annual health budget target. If projected expenditures exceed the rate of increase in the health budget target, the HSC would recommend to Congress either (1) an adjustment to the benefits package[11] or (2) a slowdown of the expansion in low-income subsidies. If Congress opted not to accept these recommendations, it would have to appropriate more money to achieve fiscal balance. While it might be preferable to have an explicitly earmarked health tax as the funding source for the balanced health security budget, it may be best to begin with existing sources of public health care funding. Ultimately, Congress must know what it is spending, who is covered for which services, and the impacts of benefits on the health of Americans.

B. *Universal Access as a First Step Toward Universal Coverage*

The best way to achieve universal coverage is through a competitive, premium-based system with adequate public subsidies for low-income consumers, financed through progressive taxes. Such a system will require several years to be fully implemented and effective. Providers will need time to build high quality health plans, the government will need time to measure and evaluate progress and accumulate real savings for public programs from managed competition, and individuals will need time to understand and avail themselves of the reformed system. If we wish to build a national system that is sustainable, affordable, and integrated, then we must intro-

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9. *See infra* part II.B.

10. *See supra* Table 1.

11. The benefits package would be voted on in a manner similar to the military base closing procedure.

duce significant policy elements carefully, in a way which permits us to fully understand their effects.

We must first establish a system in which all individuals have access to affordable coverage — universal access — as a first step towards universal coverage. Such a system would help those who need it most (*i.e.*, the poorest individuals through subsidies, and individuals and small employers through purchasing cooperatives and insurance reform), allow establishment of a truly competitive system, and permit a smooth transition to universal coverage by, say, 2002 if Congress passes comprehensive health reform in 1994.

Achieving universal coverage in a fiscally realistic manner will require that public programs are incorporated into a managed competition system and that a true universal access system is in place. The remainder of this section discusses a staging process.

Stage 1 - Equity Program Part 1 (EquiP 1): A government subsidy program for the current categorically needy acute care portion of the Medicaid program (those receiving AFDC and SSI benefits)[12] that "equips" them to obtain coverage.

Perhaps the greatest and most consistent challenge faced by state governments in recent years has been the dramatic increase in and unpredictability of costs in their Medicaid programs. While more states, like the private sector, now look to managed care as a means of tackling cost and quality problems, little more than ten percent of Medicaid beneficiaries are in true managed care programs like health maintenance organizations (HMOs). Reform must accelerate this process to instill financial discipline and to realize predictability of costs and accountability for quality where neither have existed for some time. Furthermore, EquiP beneficiaries should have access to the same AHPs and standard benefits as the general population to eliminate inequities in the health care system.

States would be responsible for the administration of their respective EquiP 1 programs, which would be fully funded as of the first year of reform and designed as follows:

- Because together they are generally regarded as above-average risk and should be explicitly financed to ensure their costs are spread equally,

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12. Aid to Families with Dependent Children (AFDC) is part of the Social Security program providing grants to states for aid and services to needy families with children. 42 U.S.C. §§ 601-617 (1988 & Supp. IV 1992). Supplemental Security Income for the Aged, Blind, and Disabled (SSI) is another part of the Social Security umbrella. 42 U.S.C. §§ 1381-1383d (1988 & Supp. IV 1992).

the AFDC and SSI population would be maintained, at least initially, as a separate risk pool that is covered by AHPs.

- Each state, or contracted sponsor acting on behalf of the state, would base capitation rates for the EquiP 1 population on actuarially sound estimates of the average reasonable costs across AHPs of delivering a standard benefit package adjusted to the special needs of the AFDC and SSI population.
- The federal and state governments would jointly contribute 100 percent of the price of benefits for EquiP 1 beneficiaries. States would be required to maintain their current level of financial commitment to acute Medicaid and uncompensated care.[13] Thus, they would be at a relatively greater risk for their AFDC and SSI populations.
- Using a one-year voucher, the EquiP 1 eligible population could choose from among participating plans through their own EquiP 1 HelPS during the annual open enrollment period. For individuals who fail to select a health plan, the EquiP 1 HelPS would choose one for them.
- Once the EquiP 1 population had experience in AHPs and its risk could be predicted and adjusted with relative accuracy, it would be served by the local community HelPS, where the government would pay a competitive health status-adjusted community rate on their behalf. Additional benefits that were not part of the initial standard benefits package available to the general population would be added as needed, funded jointly by states and the federal government and provided by AHPs.
- While personal costs for Equip 1 beneficiaries should be mitigated so coverage is within their reach, they, like everyone else, should pay some portion of their care to instill a degree of cost-consciousness.

Stage 2 - Equity Program, Part 2 (EquiP 2): A government subsidy program for individuals below 200% of the poverty line, and those ineligible for EquiP 1, that "equips" them to obtain coverage.

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13. Current expenditures would be trended forward according to EquiP 1 experience.

The below-poverty uninsured population consists of 10.8 million individuals (28.1 percent of the uninsured), while the 100-200 percent of poverty uninsured population represents an additional 12.5 million individuals (32.5 percent of the uninsured).[14] In addition to the subsidy available to everyone through the tax treatment of benefits and the contribution to health insurance by some employers, this population needs further subsidies to have meaningful access to the health system. EquiP 2 eligible individuals would receive subsidies in the form of vouchers, and would select their coverage through their local HelPS or large employer, depending upon employment status, thus minimizing the government's role in the program. EquiP 2 funding would be phased in as funds accrue to the government. The initial subsidization targets would be full subsidization into the low-cost plan for EquiP 2 eligible individuals below 100 percent of the poverty line, and a sliding scale of subsidies for beneficiaries between 100 percent and 200 percent of the poverty line.

Congress should appropriate sufficient funds to subsidize everyone in EquiP 2 by the year 2002. If these subsidies are effective, at least ninety-five percent of this population should be covered by then. If ninety-five percent of this population is not covered, Congress would need to expand the EquiP 2 subsidy program or proceed with some form of coverage mandate.

The present Medicaid program creates substantial disincentives for returning to work, since beneficiaries lose coverage after they cross the eligibility threshold. Combined with the loss of other low-income benefits such as the earned income tax credit, food stamps, and housing subsidies, this threshold represents a significant disincentive to earn more. While any scaling of health care subsidies would be an improvement over the current system, the pressing need to tackle welfare reform in conjunction with or soon after health care reform, is apparent. To increase incentives for work, the increase in cost of health insurance associated with moving to a higher income bracket should be minimized. This can best be assured by phasing out public assistance for EquiP 2, at a gradual rate as income increases, and may require expansion of EquiP 2 beyond 200 percent of the poverty line.

Stage 3 - Guaranteeing Sustainable Universal Health Care Coverage

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14. EMPLOYEE BENEFITS RESEARCH INSTITUTE, SPECIAL REPORT AND ISSUE BRIEF 145: SOURCES OF HEALTH INSURANCE AND CHARACTERISTICS OF THE UNINSURED 33, tbl. 14 (1994) (on file with the *Washington University Journal of Urban & Contemporary Law*).

No system which provides for responsible financing can guarantee identical coverage for every U.S. resident. Just as definitions of "full employment" accommodate known structural deficiencies of the employment market, any working definition of "universal coverage" should allow for known political constraints (*e.g.*, resistance to mandates) as well as unknown behavioral responses to reform (*e.g.*, possible reluctance of the wealthy to purchase insurance). Universal coverage might be defined as the point at which it can be verified that, say, ninety-five percent of the population is covered.[15] As reform proceeds, the target percentage could be adjusted to reflect the point at which the additional cost of bringing individuals into the health security system through government means, such as a mandate or increased outreach, is too great for the public to accept. At some point it may make sense to adopt a policy that uniquely targets care for the residual percentage of uninsured, rather than devoting limited resources to the difficult and expensive task of pulling every individual into the general system of universal coverage.

To ensure that universal coverage is achieved within a reasonable timeframe, legislation should include a mandate (compulsory coverage) for the year 2002. If universal coverage, as defined by Congress, has not been achieved by 2002, this measure would automatically force Congress to implement a mandate unless it took proactive measures to attain universal coverage by other means, such as increasing the scope of the Equity Program.

Congress should defer a decision on the nature of the mandate until 2002 to ensure that it is the appropriate measure. By then, much will have been gained from experience with a reformed system. Broad low-income subsidies would be at or near full phase-in; competing AHPs would be functioning; group purchasing and health insurance reforms would have been in place for some time; and the residual uninsured population would likely be less significant in number and different in character than the presently uninsured population. Only with accurate information regarding the number and percentage of uninsured by employment status, income and demographic groups, geographic location, and health status can an informed decision be made regarding what type of compulsion, if necessary, would best lead to universal coverage. For example, if it is primarily low-income, unemployed individuals that remain uninsured, it is unlikely that any form

15. We are currently conducting some analysis that may allow us to be more precise in defining universal coverage.

of mandate would be effective; instead, changes to the EquiP program would be required. On the other hand, if mostly wealthy, non-working individuals were uninsured, a free-rider tax would probably be the most effective way to achieve universal coverage. Finally, if large numbers of employed individuals were uninsured, an employer mandate might be the most appropriate alternative.[16]

Medicare

Medicare recipients should have the opportunity to receive the same universal standard benefits as the general population, with the same choice of providers and health plans. Equally, beneficiaries should be motivated to save money and pursue prevention and health maintenance measures. While reform of Medicare cannot be immediate because many beneficiaries value the present program, Medicare should ultimately resemble the rest of the health care system. The standard benefits package will be more comprehensive than current Medicare benefits and will potentially eliminate the need for medigap[17] policies. While AHPs should be paid on a capitated basis for providing this enhanced benefits package to Medicare beneficiaries, cost-cutting measures proposed by Congress and implemented by HCFA[18] could continue to control traditional Medicare expenditures. Medicare would start to be integrated into a managed competition environment as follows:

- The Medicare population would be maintained as a separate higher risk and cost group. During an annual open enrollment period, regional Medicare HelPS would allow current Medicare beneficiaries to choose between traditional HCFA-administered Medicare with the present Medicare benefits, and competing AHPs offering the more comprehensive standard package, including prescription drugs. Beneficiaries would have a greater choice of AHPs than present law permits, including AHPs that offer an out-of-plan provider option.
- For beneficiaries who choose an AHP, the federal government would make a defined contribution toward premiums. Under present law, Medicare risk-contracting HMOs are paid ninety-five per-

16. See *infra* Appendix for further discussion of mandates.

17. Medigap policies are insurance policies which may be purchased by individuals to supplement Medicare benefits. VERGIL N. SLEE & DEBORA A. SLEE, HEALTH CARE REFORM TERMS 53 (1993).

18. The Health Care Financing Administration (HCFA) administers the Medicare and Medicaid programs.

cent of what HCFA estimates it would have paid for Medicare-covered services had beneficiaries remained in the fee-for-service sector. This system is fraught with problems, including ties to fee-for-service medicine and the geographic inequities in the distribution of Medicare reimbursement that penalizes regions of the country where health care expenditures are lower and better managed. Whatever future payment methodology is used, it should allow for a transition toward a system in which Medicare reimbursement is determined by competitive bidding and consumer cost sensitivity (as in the private sector), and low cost regions are rewarded for their effectiveness. One such system would tie the government contribution to the average of competitive AHP bids in the lowest quartile of AHP prices in a Medicare HelPS region, or the adjusted average per capita cost (AAPCC), whichever is lowest. Once the penetration of AHPs into the Medicare market exceeded a certain percentage, say, fifty percent, the tie to the AAPCC would be removed.

- Beneficiaries who choose an AHP would be responsible for paying the difference between the government contribution and the premium cost of their plan of choice. Present employer-sponsored retiree health benefits that pay for wrap-around coverage could be redirected to defray the difference between the government's defined contribution and an AHP's premium. Also, employers and retirees might agree to reconfigure retiree health benefits into a defined contribution, added to the government contribution, so that those who join AHPs receive the savings derived from their purchasing decisions.
- Beneficiaries that age into the Medicare program would be encouraged to continue obtaining standard coverage from AHPs.
- Eligible low-income Medicare beneficiaries would continue to receive premium and cost-sharing assistance through EquiP 1 or 2.
- The present policies that impede HMOs from participation in the Medicare risk contracting program would be aggressively reduced with a significant shift toward policies that develop Medicare-oriented AHPs and encourage them to compete to serve beneficiaries.

As AHPs find ways to improve efficiency, they should be able to offer rates that are at or below the contribution set by government, even though they offer a richer standard benefits package. The opportunity to obtain more benefits at no additional, or only slightly higher cost, as well as continuity of care though primary care physicians, reduced paperwork, and the elimination of the need to purchase a Medigap policy, should motivate Medicare beneficiaries to join AHPs. However, present Medicare beneficiaries who place more value on the fee-for-service alternative could retain the opportunity to stay in the current system.

As AHPs succeed in lowering their costs below fee-for-service Medicare program costs, and more Medicare beneficiaries choose to enroll in AHPs, the federal government would achieve significant savings.

Conclusion

We can only achieve the required broad-based support for health care reform if we avoid rash, complex, and untested strategies. Federal reform measures must be sufficiently flexible to adapt to whatever new behaviors emerge in response to the changed health care environment. They must not preempt our ability to adjust key elements of the financing system as we learn more about what works. It would be foolhardy to guarantee universal delivery of a rich package of benefits only to find ourselves bankrupt before the decade expires, thereby undermining every American's ability to receive needed health care.

Managed Competition II is offered as a pragmatic approach to achieving universal coverage. If its concepts are ultimately selected as a template for reform, then several key elements of Managed Competition II are necessary if the integrity and effectiveness of the proposal are to be preserved:

1. Staging of health care reform with the attainment of universal coverage by a specific date that allows a sufficient time interval for the development of a lasting health care system.
2. Establishment of a health system based on consumers choosing between accountable health plans which compete on both price and quality.
3. Promotion of cost, quality, and health-conscious decisions by consumers.
4. Obligatory purchasing of health plans through group sponsors including Health Plan Stores and large employers.
5. A public program of equitable health care with the same incentives and benefit choices as the private sector.

6. A balanced health security budget with pay-as-you-go financing of public health expenditures that prevents unfunded health care entitlements and instills fiscal responsibility.

It is our desire that Managed Competition II will expose to public and political scrutiny the interplay between funding, benefit levels, and health care effectiveness. It is designed to expedite access to affordable insurance coverage to every American, and provide a mechanism for sustaining universal coverage far into the future, regardless of shifts in the political mood, advances in technology, or changes in public needs. National health care reform cannot hope to fix on a perfect financing formula in 1994; it must put in place, instead, prudent mechanisms for experimenting with, learning from, and responsibly managing our health care economy in the long term.

APPENDIX: DISCUSSION OF MANDATES

I. Combination of Mandates

A combination of employer and individual mandates, as outlined in Table A-1, best builds on the current employment-based system, ensuring that the 99 percent of companies above the 100-person threshold currently offering coverage to their employees would continue to do so.

Table A-1

Description of Combination of Mandates

EMPLOYER MANDATE FOR LARGE EMPLOYERS
• All employers with more than 100 employees would have to offer a choice of AHPs offering the standard health benefits package to employees who work more than 30 hours per week and their dependents. Employers would be required to make a defined contribution of a minimum of, say, 50% of the price of the low cost plan to health care premiums of their employees. To minimize employment effects, the prorated contribution requirement would be phased in over a period of time. A prorated contribution would be required for part-time workers who worked more than 1,000 hours per year and a payroll tax of X% would be paid for workers who work 1,000 or less.
• To assuage effects on employers near the HelPS threshold size, there would be a gradation of their financial obligation in accordance with firm size. These employers would not be relieved of their obligation to offer standard health care benefits.
INDIVIDUAL MANDATE FOR INDIVIDUALS AND SMALL EMPLOYERS
• Part-time workers (not otherwise covered) working 1,000 hours or less per annum for an employer with more than 100 employees, and all individuals (not otherwise covered) not employed or those employed by firms with less than 100 employees, would be obliged to purchase coverage through their local HelPS.
• At the direction of their employees, small employers would be required to make a monthly payroll deduction and send the amount to the appropriate HelPS.

To the extent that large businesses compete with small businesses in the same industry, employee compensation packages would differ, but since a mandate would exist in both

sectors, total compensation in any individual firm should not be different. However, if employees do not recognize the trade-off between wages and benefits, small employers would have a hiring advantage. A combination of employer and individual mandates would increase the incentives for firms to game the threshold by engaging in such actions as hiring temporary personnel and splitting companies into separate entities. However, this may be mitigated by phasing in the percentage requirement with firm size.

Income is the major determinant in access to health insurance, not size of firm in which one is employed. Therefore, for a combination approach to be equitable and efficient, the subsidization formula used must be consistent across mandate environments, and tied to income level (as in the EquiP program),[19] not employment status. Individuals eligible for EquiP subsidization would use their vouchers either through their large employer or their HelPS[20] to defray the cost of coverage. If, on the other hand, subsidies under the employer mandate were targeted at employers, as opposed to individuals, the employer mandate portion of the combined mandate would represent an inequitable and inefficient financing mechanism, and would result in the reallocation of labor on the basis of the subsidies available (so-called *sorting*).

The most expedient, efficient, and politically viable way to enforce the individual portion of the mandate would be through a free-rider tax. Individuals choosing not to purchase coverage would be required to pay a tax. Advantages of a free-rider tax are that it could be progressive and enforced by the IRS. The free-rider tax would be equal to a fixed amount plus a penalty that would be directly proportional to income. While such an enforcement strategy would not perfectly attain universal coverage, it would go a long way toward ending the free-rider problem while minimizing societal and economic dislocation.

Some proposals have embraced employer mandates and subsidies targeted at firms because they allow the government to shift some of the burden of public programs onto employers and create the perception that no one is paying the price. While fiscally attractive to the government, this type of mandate perpetuates cost-shifting, and causes the most economic dislocation because it effectively raises the minimum wage in many firms. To the extent that employers were unable to take the additional costs of health premiums out of wages, an

19. *See supra* part II.B.
20. *See supra* part I.A.

employer mandate would cause some unemployment, especially in firms not currently offering coverage and in firms with low-wage workers.

II. Individual Mandate

If individuals are targeted to receive low-income subsidies to make those subsidies more explicit, efficient, and equitable, a mandate targeted at individuals makes sense as well (see Table A-2). An individual mandate could be implemented easily and quickly without disrupting present purchasing arrangements. It would satisfy those who believe the ultimate obligation to purchase health care should be on the individual, not the employer, and that health care coverage should be divorced from employment status.

Table A-2

Description of Individual Mandate

- All individuals would be required to purchase coverage as of the date of implementation or pay a free-rider tax.
- All employers, while not required to finance coverage, would be required to offer coverage, either through the HelPS if they have fewer than 100 employees, or directly for large employers.
- Voucher eligibility and preferential tax treatment would be contingent upon purchasing coverage through the appropriate sponsor.

The greatest potential disadvantage of an individual mandate is the risk that companies that are currently active, value-based health purchasers will cease these activities, and will perform the minimum duties necessary to fulfill the obligation to offer coverage. It is not possible to predict the extent of this behavior. However, business leaders suggest that competitive forces in the labor market may be sufficiently strong to maintain an active employer role, especially if there is a stipulation that predicates tax-preferred treatment of health expenditures on purchasing through the appropriate sponsor (the large employer for its employees). In addition, in a mandated environment, employees will value health purchasing that maximizes the wage portion of their compensation and secures quality health care. Employees of large firms without access to HelPS will look to their employers for purchasing expertise, since most employers purchase coverage for employees today. If large employers prove to be inefficient purchasers, it would be possible for employees to pressure their employers to go to secondary purchasers, such as purchasing coalitions, to purchase coverage.

Another potential serious disadvantage of an individual mandate is that upon passage, all individuals might demand access to HelPS. It is unlikely that Congress would have the political will to deny this. If the public then demanded that HelPS exercise greater control over the cost of health care, the result could be a slow, but steady progression toward covering a great majority of the population through HelPS — leading to regulation and possibly a single-payer system. To some extent, competing HelPS should mitigate this danger.