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A Critique of Our Plan

We will inevitably be accused of creating a monstrously complicated proposal, and it will take an enormous effort to communicate the essentials in a simple way.

But the issue is not just communication. There is more regulation in this plan that I expected to see, and I worry about the wisdom of much of it. The spirit and some of the substance contradict the idea of flexibility for states and room for variety, innovation, and competition.

In part, we can answer such criticism by turning proposed rules for the entire national program into rules that states are allowed to adopt, or by indicating that specific details are meant to show how the system might work, not how it would have to work.

However, the most heavy-handed part of the program is the budget, and we may not have any credible way of making it more palatable. It has now become a centerpiece of the new system, not a backup; and yet none of us knows whether we can make it work well or at all, or whether the public would tolerate restrictions on so much private spending.

I can think of parallels in wartime, but I have trouble coming up with a precedent in our peacetime history for such broad and centralized control over a sector of the economy. Is the public really ready for this? The polls all show people think we should be spending more money on health care; of course, people don't see how much health care is costing them. But, whatever the cause, the foundation in public opinion may not exist for as rigid a budget on health expenditures as this would be. And if we are too far out front of public opinion, we won't find support for the rest of our plan. Our opponents will characterize this as rationing--and that charge won't be easy to answer.

My feeling now is that the budget should be a backup, enforceable only if after some period other mechanisms fail. It could be structured like mandatory controls during the phase-in period--with a second trigger.

In other areas, we would benefit by a change in tone as well as substance.

Nowhere in the discussion of regional alliances is there a clear statement that, except in single-payer states, it is the responsibility of the alliances to encourage choice and

competition among plans. (This may be implicit in some of the rules, but it should be explicit.) There is no clear statement that, for a given individual, an alliance pays no plan more than it pays any other plan--to emphasize that it is individual consumers who pay the additional amount if they choose more costly plans.

There appears to be no limit on the ability of alliances to require plans to contract with "designated" providers. This is an open invitation for states to protect hospitals and other providers threatened with closure or merger. Plans need a guarantee that they are not going to be forced to contract with providers that increase their costs and jeopardize their ability to maintain and improve quality.

The broad definition of essential providers raises the same problem. This provision should be narrowly drawn and used only when plans have demonstrably discriminated and provided inadequate access to the poor or minorities. Essential provider rules should stay in effect only if there is a history of discrimination and the National Health Board determines that an alliance requires authority to mandate contracts to provide care for vulnerable populations. Otherwise, they should sunset within some specific time period.

If reform is going to work, it is going to bring about a consolidation of hospitals and reduction in duplicated services. We should not guarantee any provider a permanent stream of revenue. Protectionist regulation will not only prevent reform from working; it will most likely be used to buttress the most powerful providers in the system, not to help the poor.

Consider another regulation now in the proposal: every plan must serve the entire community rating area within five years. I understand the reasoning behind this, but the effect is to undercut the potential for smaller, community-based plans. If New York City is one community rating area, only big plans are going to be able to provide care. This requirement is an example of a provision that might make sense under some circumstances but is unlikely to make sense under all circumstances and shouldn't be a national rule.

The treatment of fee-for-service is going to be a serious political problem for us. As written, the plan provides no guarantee that alliances will offer a conventional (indemnity) insurance plan. There are limits on network providers from providing non-network fee-for-service care. There is only one fee schedule for all fee-for-service plans, and states must create such a schedule.

These provisions will lend credibility to the charge that we aren't really providing people with their current options and

that we're regulating fees permanently across the board. And the charges will be true.

I am not convinced that these restrictions on fee-for-service are necessary to make the plan work. For example, suppose we were to allow an upper-crust, gold-plated fee-for-service plan without a fee schedule. The price would be sky-high, but because only the very affluent would enroll, the plan's "weight" in the weighted-average premium will be limited. This is especially likely to be so in states where development of HMOs and networks is advanced. What if the weight is too great? Then the alliance might need to impose some limit on that plan's fees. But setting a fee schedule in advance for all fee-for-service plans is to say that we know now that such a schedule will be necessary without any exceptions.

Of course, setting a single fee schedule is more egalitarian, if your standard for egalitarianism is preventing the affluent from using their wealth to buy privileged care. I gave up on that a while ago. There is a huge difference between two different kinds of inequality: the first, where the poorest 20%, say, have a lower standard of care; and, a second, which allows the richest 10% to buy more. The American system has followed the first pattern; the German system, the second. If we can move the American pattern to the German one, we will have created a a system of universal insurance that is ethically defensible.

The relation between the short-term control program and the state fee schedule is also worrisome. If mandatory controls are imposed, a national fee schedule (with regional adjustments) goes into effect. Then, when the system gets going, the state is supposed to introduce its own fee schedule--the third price regime in three to four years. Clearly, once we go to mandatory controls, we will have a national fee schedule, and it will be hard for states to do anything but tinker with it. In effect, our "managed competiton" program will become the clothing around an all-payer rate-setting system.

It was one thing to talk about short-term controls until the new system could be created. Some of us argued it would give providers an incentive to help build the new system, since they would escape from price controls. But this program effectively makes price controls permanent.

Gary and Larry would also like to eliminate differences in the average price of plans from one rating area to another by transferring funds within an alliance from low-cost to high-cost areas. This is another provision that might make sense under some conditions, but as a general rule would undermine the effort to contain costs.

We need the public to see where costs are excessive. Otherwise they will never be allies in the effort to control costs. If high-cost areas get more money, people who live in that area have every reason not just to be indifferent to cost control, but to oppose it.

Indeed, under this approach, the entry of a low-cost health plan threatens to reduce the weighted-average premium in the area and thereby the amount of money coming from the alliance to the hospitals and other providers there. So, more than ever, the providers have an incentive to oppose the entry of competitive plans.

The question of whether the benchmark or average premium serves as the basis for calculating the cap on employee contributions raises similar issues. This is partly a matter of revenue--if the cap is pegged to the average, it's going to cost more. But it is also partly a matter of asking individuals to take responsibility for how much they are willing to spend on health care. We are already bringing employees in at a high level--80 percent of the average premium. Making individuals responsible for the remainder of their premium does not seem to me to be a harsh policy. It fosters careful decisions about how much they want to spend--and to that extent, takes the budget out of our hands and puts it in theirs.

We have a clear pattern of differences. Some of us want to see incentives for consumers to choose lower-cost plans and, accordingly, for plans to lower their costs. We are worried about regulations that rigidify the system and could well prevent plans from controlling costs. On the other hand, others see the regulations as necessary to protect the interests of the poor and to fulfill the guarantees of reform, as they understand those guarantees.

We need clarity about where each view is to prevail.

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There are some other areas where I would like to see more specificity.

Some months ago, we talked about providing authority for HHS to issue interim final regulations to carry out the law because of the prospect of delays in implementation. After reading the plan as a whole, I am more convinced that, if enacted, the program could get mired in a regulatory morass. We need an expedited regulatory process, and "interim final" rules seem the best way.

Justice Department officials recommended that any constitutional challenges to the law go directly to an appellate

court. Also, Sallyann Peyton suggested creating a special court to handle litigation over the act. These issues haven't been dealt with anywhere.

Finally, in this same area, the transition group discussed an expedited RFP process, to clear away some of the 23 clearances that now produce year-long delays in getting out RFPs at HCFA.

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The section on the underserved has no articulated relationship with the rest of the proposal. Presumably, the people being served by these grant programs will also be enrolled in health plans. Are we proposing to double-pay for the same services--e.g., preventive services that are covered under the benefit package and under the categorical grant programs? Are plans relieved of responsibilities for care of high-risk pregnant women, for example?

The section does not even mention health plans and alliances. There is a reference at one point (p. 152) to services having a "medical home" but no discussion whether that home might be a health plan.

I do not object to higher funding for these services, but the whole section looks like a long wish list without careful thought about how it fits into a universal insurance program. We need to spell out why these services are not covered elsewhere and need greater direct funding.

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What assurances do employers and consumers have that the alliances will represent their interests?

The proposal does not indicate any specific mechanism of accountability of alliances to purchasers. This is one of the biggest disappointments I have with the proposal. It never shows convincingly why employers and consumers should believe the alliances will represent them.

The specific exclusion of provider representatives on nonprofit alliance boards is good, but it doesn't go far enough (indeed, it doesn't affect alliances run as public agencies at all). The history of such "descriptive" exclusions is discouraging. Barring such categories of people doesn't prevent agency capture. And some consumer groups might choose a doctor as their most effective representative. The issue shouldn't be who the representatives are, but how they are held accountable.

That's why I favor the establishment of statewide councils representing employers and consumers that would choose slates of

nominees, from whom governors would pick. Each alliance board would have a 50/50 split between employer and consumer (including labor) representatives; periodically, these representatives would need to be reconfirmed by the respective councils.

We could make this a "for instance" rather than a rule. But some provision for genuine accountability seems to me essential.

I also support Ralph Nader's idea of a $1 checkoff for advocacy. As consumers fill out an annual enrollment form, they could check off a box to give a dollar of their premium to a consumer advocacy group. As I imagine it, representation on the statewide council would depend on these "votes."

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Finally, we need a check for details of the plan that could blow up unexpectedly. For example, the proposal has open enrollment taking place at the same time for everyone. I have a vision of complete chaos in 1996 as states attempt to carry this out. How can plans--particularly HMOs--accept hundreds of thousands, perhaps millions of people, enrolling simultaneously for the first time? There has to be some way to stagger the enrollment, especially at the opening round.

Too much of this plan has been written to fit with the budget and to satisfy concerns about scoreable savings. Ultimately, the plan will have to make sense to people and work in practice. I'm not sure the budget and some other provisions will do either. And I figure that if I don't think so, a lot of other people are going to have much, much stronger doubts.