Implementing Health Care Reform with All-Payer Regulation, Private Insurers, and a Voluntary Public Insurance Plan

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Executive Summary

This paper is a companion to the author's paper on Cost Control and Health Care Reform: The Case for All-Payer Regulation, which is being released on the same date.

The Cost Control paper argues that health care reform proposals without serious cost controls will fail both as policy and politically. Most of the agenda being discussed in current debate has already been judged by the Congressional Budget Office (CBO 2008) as unlikely to yield significant savings within the necessary time frame. That paper reviews both the compelling reasons for doubt about relying on measures such as cost-effectiveness research and "pay for performance" in the short-term, and the even more compelling reasons for better control of the prices paid for services both in the short- and long-term. In response to the liberal/conservative dispute over whether a "public plan" would have "unfair" advantages over private insurers, which is based on belief by both advocates of the public and private sectors that the public plan could do a better job of limiting prices, I argue that the logical solution is to combine the efforts of public and private insurers to create an overall system of standard and coherent prices for medical services – what in other countries is known as all-payer rate-setting. This is a compromise that would be better than either doing without the public plan or having the public plan simply in competition with the private plans.

This companion paper addresses implementation issues about such a system of all-payer regulation with both a public and private plans. The first section summarizes the basic advantages of all-payer regulation; readers should consult the first paper for evidence. The second section explains why the combination of a public plan with private plans is particularly attractive. The third section discusses basic issues of subsidies and regulation on insurer competition that would have to be addressed in any system. The fourth section provides an overview of issues about rate-setting, as a guide to the choices that policy-makers will confront if they seek to create such a system.

Health care reform involves many choices about values. No system treats all citizens the same, and all systems cost more than the citizens want to pay. Any reform in the U.S. will still be imperfect, and reformers must know that as they begin the effort. Choices about implementation will surely be controversial, and require compromising some values. Yet, if followed, the approach proposed here will lead to much better control of costs and a far more equitable system.

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Implementing Health Care Reform with All-Payer Regulation, Private Insurers, and a Voluntary Public Insurance Plan [1]

Introduction

Successful health care reform requires effective cost control. One of the major divisions within the current health care reform debate is over President Obama's campaign proposal that a voluntary, publicly-sponsored insurance plan be made available to the non-Medicare population. As John Holahan and Linda Blumberg (2008: 1) summarized:

> "The intent of the competing public plan is to use the administrative efficiencies of government-run insurance plans, as well as the purchasing power of

> government to control costs. The underlying argument is that individual insurers do not have (or are unwilling to use) the market power to counter the pricing power of many hospital systems or physician specialties. This seems likely to remain true even if reforms lead to more aggressive competition in insurance/managed care markets. Thus the power of a larger purchaser motivated to contain costs is needed to control rising health care expenditures."

The proposal is controversial, however, precisely because it could be effective. Insurers and conservatives fear that the argument for the public plan is accurate, and that the public plan therefore would drive the private insurers out of the market (Abelson 2009a, Nichols and Bertko 2009, Sirota 2009).

In a companion paper (Cost Control and Health Care Reform: The Case for All-Payer Regulation) I have proposed a logical solution to the supposedly "unlevel playing field": sharing the ability of the public plan to achieve lower prices. In short, public and private insurance should be part of an ***all-payer cost control system***.

In all modern health care systems other than the United States, care for the vast majority of citizens is paid for by the same rules to most if not all providers. This happens automatically in the Canadian "single payer" system. Yet even if there are multiple insurers, as in France or Germany or the Netherlands or Japan, there are standard fee schedules by which hospitals, physicians, or pharmaceutical companies bill the insurers.

Standard fee schedules may be created through direct government regulation, as in the Netherlands or Japan. Or, they may be created through systems of coordinated bargaining between all (or almost all) payers and providers, as in German physician payment. In either case, bargaining power on the payer side is concentrated in a way that simply is not seen in the United States. Such coordinated payment rules have a series of major advantages:

1) Because payers have more power in the rate-setting, prices are systematically lower in all-payer systems than in the United States (Anderson et al. 2003). This directly lowers total costs.

2) Standardization leads to two kinds of administrative savings. Compared to in the United States, insurers save from not having to negotiate and then keep track of many different prices from many different plans negotiated with different providers; caregivers do not need to maintain elaborate billing operations to deal with inconsistent insurer payment rules.

3) All-payer systems are much more transparent for both caregivers and consumers. If there is cost-sharing, the prices paid by the insurers are not trade secrets, so consumers know if the insurers are charging the correct amounts (an unfortunate concern in the U.S., as discussed below).

4) The standard payments can also substantially standardize medical record-keeping. It becomes possible, for example, to combine files to review practice patterns – or even to coordinate billing through a central clearinghouse, and analyze patterns through that database.

5) In an all-payer system, the different payers see themselves as having a shared interest in cost control. This is very different from in the United States, where fears of cost-shifting mean that employers, for example, are not a lobby in support of better cost control for Medicare.

All-payer rate regulation does not prevent all variation. As will be discussed below, there may be small portions of the population or providers who are not part of the system, and some payers may pay a bit more. Yet these systems over time always reduce administrative costs and enable lower prices than would occur in a system of uncoordinated payment.[2]

This paper discusses how such a reform might be implemented in the United States. It begins from President Obama's campaign proposal. I will therefore assume a system in which private insurers and a new public insurance plan are available to most citizens through some sort of Health Insurance Exchange that performs a range of functions to both administer subsidies and manage the marketing of the insurance. I will also assume that Medicare and Medicaid will continue as separate plans.

This analysis adds to the Obama campaign proposal by including all-payer regulation. The issues that follow then are related both to the competition among insurers and the implementation of the cost controls. The first section following explains how the public plan and private insurers could complement and check each other to provide a superior system, especially as compared to one with only private insurers. The second section considers the challenges of administering subsidies and preventing insurers from competing in ways that damage the system. The third section addresses how to set the rates in an all-payer system.

I. Advantages of Having Both Private Insurers and a Public Plan

Combining a Medicare-like public plan with competition from private insurers within a system of coordinated payment rates would have many advantages. First, the public

plan would maximize choice of provider, as well as certainty about which providers are covered, for citizens who choose that plan. Second, competition from the public plan adds an extra dimension to regulation as a check on behavior of private insurers. Third, the private plans would provide some constraint against politicians perhaps underfunding customer service in the public plan. Fourth, the combination would pressure both the public and private plans to innovate by increasing value, rather than the dysfunctional competition that characterizes the current U.S. health insurance market.

The case for all-payer regulation in a system of multiple insurers is supported both by the importance of prices and administrative costs in cost control (see the companion paper), and the fact that a number of other countries have such systems. The advantages of coordinated payment, however, do not in and of themselves call for having a government-sponsored public plan in competition with nonprofit and/or for-profit insurers. Maryland currently sets hospital charges for all payers without having a public plan competing with private insurers. In Maryland and any other American state, of course, there are large public plans (Medicare and Medicaid) already. Yet that in itself does not provide an example of a public plan competing with private plans.[3]

There is a strong case, nevertheless, for creating a public plan to compete with private insurers as part of expanding guaranteed health insurance beyond the Medicaid and Medicare populations. It would both expand real choices available to enrollees and greatly assist in ensuring that insurers compete in ways that focus on value rather than on attempts to avoid beneficiaries who might get sick.

Advantages of a public plan. Having a Medicare-linked public plan would improve any system of multiple insurers by providing an insurance option with maximum choice of caregivers. From the average citizen's perspective, one of the great disadvantages of our current health care system is the fact that the vast majority of plans have restricted networks. Citizens choose a plan, and then find out later, when they get sick with some unexpected problem, whether the network fits their needs. Many of us have horror stories of a friend or relative who suffered from such constraints.

In spite of its failings, selective contracting with restricted networks is, in the current system, the only way private insurers can control costs. They need to be able to choose among providers in order to force providers to bargain about contract terms. Even though, given current market conditions, selective contracting does not do much to constrain prices, it's better than nothing.

The public plan in a reformed system would be extremely likely to, like Medicare, have

to offer free choice of providers in any area. The government faces different constraints than apply to private parties, and it would be quite difficult to justify discriminating against providers once governments have licensed them as competent to practice (Fox 1997).[4] If there are good quality measures the public plan could publish them, but it would still need to let citizens choose among all possible caregivers, without the confusing set of exclusions and differential cost-sharing that characterizes current insurance options. This kind of choice is highly valued by citizens.

Some analysts believe that a system of regulation would be sufficient to ensure that competition among private insurers pursues and achieves the goals of a fair and high-value health care system. Even those analysts, however, acknowledge that experience is one reason for skepticism as to whether “new insurance market rules will prevent private insurers from putting their own bottom line ahead of quality care and patient safety” (Nichols and Bertko 2009: 5). Public plans could have their own management issues, but the incentives for public plan managers will be different enough from those for private plan managers so that the public plan should provide some competitive check on private plan behavior.

One example of this benefit is how having a public plan might limit or at least help identify manipulation of any premium-setting process. In any system that combines government subsidies with multiple plans, there has to be some way to set the size of the subsidy, and it can’t be just based on whatever each plan decides to charge. Instead, many designs, such as those proposed during the Clinton effort to reform health insurance, base subsidies on a benchmark created by a formula, with the formula based on some combination of the bids submitted by insurers. Unfortunately, in such a system insurers have many incentives to distort the process with bids that attempt to manipulate the benchmark. It was easy to identify ways this could have happened with both the Clinton and other plans proposed in 1993-94 (White 1995: 303-08).

In the reform discussed here, however, the public plan would not be a profit-maximizing entity with incentives to game the system. Its behavior therefore could help identify questionable behavior by the other participants, making it more likely that the other insurers will submit more credible bids. In Australia, which has a system of both gap and parallel private insurance that supplements the main public insurance scheme, one of the private insurers is actually a government corporation (Medibank Private). Some Australia provides an example of a public insurance plan appearing to have this positive effect on the behavior of private insurers.[5]

Contributions from the private plans. Having private plans competing with the public plan has two logical advantages. First, in countries with fairly standard benefits but all-

payer regulation, plans compete in part by offering marginal extra benefits and through customer service. We tend in the United States not to talk much about the simple things, like quick and friendly interactions with our insurer over questions of benefits and billings. But they matter to people, and this is one concern for which competition seems like a good thing. I would be concerned especially that a public plan, subject to some pressures from budget-focused policy-makers who would surely be providing it with some taxpayer subsidies, might not receive quite the administrative funding it could use. Competition from private plans that could gain business by spending a small amount extra (relative to total costs) on service would be a useful discipline on the public plan.[6]

Second, precisely because the public plan would need to have free choice of caregiver, there would be room for value-improving innovation by the private plans. A standard fee schedule can leave room for a series of non-standard alternatives. For example, a traditional group-practice HMO, which pays its caregivers by salary and has exclusive relationships with its physicians, would be able to prosper if it did a better job of "managing care."

Instead of trying to get advantages over each other in fee negotiations, individual caregivers as well as insurers would have incentives to innovate and increase value by providing other delivery arrangements. Those incentives would be increased by the regulations described in the next section. In the present system, insurers have no incentive to offer particularly high-quality, or even lower cost, care for expensive conditions, because they do not want to attract sicker patients. It is better to have fewer diabetics, for example, than to deliver care to diabetics more efficiently. In a reformed system, data from diabetes patient costs for the rest of patients could be used to work out a risk-adjustment so that insurers would receive higher premiums for diabetics. Then an insurer that attracted a disproportionate number of diabetics and received the standard extra payment, but developed a model of chronic care case management that gave better quality at equal or lower cost, would actually profit from doing so. Similarly, a medical practice that developed such a model could market it to insurers.

In these and other possible cases, if a health plan actually found a way to improve delivery, such that both caregivers and patients would choose to contract with it, this improvement would be better for everyone.

This is not to suggest that the public plan should be prevented from innovating. It makes a great deal of sense, for example, for a public plan (or Medicare at present) to look for ways to structure and pay for case management, or have pilots on "paying for performance." But these are very hard things to get right (which is why it hasn't happened), and when it comes to innovation, it makes sense to let a hundred seeds be

planted and see if anything blooms. At the same time, if all plans are “innovating,” citizens can just get confused, and so some stability in a plan available to all is highly desirable.

II. Subsidies and Regulation of Competition

The competition between the public plan and the private plans within a system of coordinated payment of providers would need to be regulated, but no more than any competition among health insurers in a system that serves social goals of cost control and fairness. All Americans must be included in the system. There must be a good standard benefit package, and insurance with lesser coverage should not be allowed. Subsidies must allow families to contribute in proportion to their ability to pay, while measures such as community-rating, guaranteed issue, and both prospective and retrospective risk-adjustments should limit insurers’ ability to engage in risk-selection. Marketing should be regulated through a health insurance exchange or similar structure, though I would recommend that insurers be allowed to market directly to some large employers.

Any health care finance system, in addition to controlling costs, has to organize subsidies from the currently healthy to the currently sick, and from people with more resources to people with less. The U.S. system currently fails badly on all grounds: costs are extremely high, many less healthy people have difficulty gaining insurance and excessive out-of-pocket costs even when insured, and lower income individuals also have worse access than in other systems.

All-payer payment regulation can provide significantly better cost control than in the U.S. status quo. But it does not in itself provide answers to the two most basic problems in health insurance design.

Two challenges. The first challenge is how to ensure that, in any system with multiple insurers, some don’t attract a disproportionate share of the less risky enrollees, leaving the rest to other insurers. In such a system, the less fortunate pools of beneficiaries could have such high average costs as to be unaffordable. This can be called the *risk distribution problem*. The challenge is how to limit two kinds of behavior. The first, *adverse selection*, is most severe if individuals only choose to buy insurance if they feel especially likely to need it. If young and healthy people avoid insurance, it becomes less affordable for everyone else. That is why all other countries have some sort of mandatory participation in the national health care/insurance system. The second problem, *risk selection*, occurs when insurers compete by “cherry picking” healthier enrollees, or even by trying to convince sick existing enrollees to disenroll.

The second challenge is how to arrange subsidies for people who could not afford even the average cost of insurance coverage. In the United States this challenge is far more severe than in any other country, because average insurance costs are a much larger share of national income.[7] The *income subsidy* challenge is directly related to the risk distribution challenge, because there is a danger that the people who need the most help both because of low incomes and high risk might end up in pools that have to be heavily subsidized, while other insurers (and their enrollees) exploit the system.

While these are difficult problems, two things should be remembered. First, there are many countries that handle them reasonably well. Second, we have to deal with these problems anyway, absent an exceedingly unlikely single-payer system. They are unrelated to, and probably even made easier to handle by, all-payer rate regulation and the existence of a publicly sponsored plan that is available to all: if for no other reason than that better cost control reduces the subsidy challenge.[8]

The benefit package. In order to limit the income subsidy and risk distribution challenges, one of the most popular ideas among conservatives and some insurers should be rejected up front. Allowing plans with much-reduced benefits – such as high-deductible health plans – is a bad idea on many counts (Jost 2007). This is especially true if the high-deductible insurance is accompanied by Health Savings Accounts that get special tax breaks. First, this design clearly leads to anywhere from modest to substantial risk-selection (Barry et al 2008). Second, it directly favors people with higher incomes. If they are healthy they get an extra subsidy for savings they would have had anyway, which is an extra cost to the health care system that has nothing to do with protecting people against illness. If high-income people do have to spend up to the deductible, they have the cash available to do so, while low-income people may not. So this approach subsidizes the wrong people. Third, it risks people (especially those with lower incomes) foregoing necessary services (Dixon et al. 2008).[9] *Any system with multiple insurers should start with a benefit package that is clearly adequate to eliminate fear of health care costs for most citizens, so comparable to more extensive private employer coverage today.*[10] All multi-payer systems with all-payer cost control have broad benefit packages.

That does not, however, mean that the basic benefit package must be so generous as to be fully adequate for the poor. In a number of countries the guaranteed system does not include all desirable coverage. Then there is supplementary coverage that can be bought from private insurers but is specially subsidized for the poor (as with coverage for cost-sharing in France), or special rules for certain populations, as with Japan's lower cost-sharing for the elderly. Similarly, the new U.S. system could have separate

public support for extra benefits for people who cannot afford, for example even low cost-sharing. That is not all that different from the fact that Medicaid benefits in many states now are ostensibly more generous than most insurance packages, or the fact that in Canada's "single-payer" systems, drug benefits are separate and provided by provincial governments mainly to the elderly and low-income citizens.

Relating contributions to income, not risk Although it may be viewed as a radical reform by American insurers, simple community rating – charging premiums unrelated to health status or demographic attributes – does not address the income problem and therefore has not been the core of premium payment except in Switzerland (where it also is associated with substantial inequalities in premiums; see Leu et al 2009).[11] Therefore, until recently, the norm outside of the U.S. has been for insurers in multi-payer systems to receive revenues not as flat cash premiums but as percentages of some portion of their enrollees' income (e.g. about the first 43,000 Euros in wages in Germany in 2008). This allows no price discrimination by health status, while higher incomes subsidize lower. Percentage of payroll contributions are, in essence, what Medicare Part A does, though across the life-cycle rather than in a given year. People who earn more over their lifetimes pay more than people who earn less, and contributions are unrelated to projected costs.

Collecting as a share of income does not eliminate all inequalities because, especially in a system in which there are legal or historic factors that sort people into funds related to geography or occupation, some insurers will end up with higher-income members or healthier members than others. Beginning in 1992, the German system has undergone a series of reforms designed to reduce inequalities in contribution rates that were created by the original geographic and occupational basis of the system. On balance, these measures have made contribution rates more equal (Worz and Busse 2005; Cheng and Reinhardt 2008). In essence, the Germans have used a mix of regulations to make "competition" increase the form of equity that Europeans call solidarity. By solidarity they mean the members of a society supporting each other to build a stronger whole.

If different funds require unacceptably unequal contribution rates, one solution in all-payer systems involves government subsidies to funds. The contribution rate can be set at a level that works for the more fortunate groups, and then the government uses general revenues to pay the extra amounts needed to cover further costs within the less fortunate groups. This is essentially how the system subsidizes health care in low-income or high-risk municipalities in Japan. Another approach is to mandate transfers from some funds to others, based on obvious differences in membership. Such transfers based on proportion of the members who are elderly are common.

A third approach is for the government to collect the funds and then pay each plan based on some formula of the projected costs per enrollee – a *risk-adjusted contribution*. The Dutch are furthest along this road of risk adjustment, and their experience shows that risk adjustment must include a wide range of measures based on actual sickness experience of the members. Even then it is not perfect, but it does dampen the incentives for and consequences of risk selection. German reforms being implemented in 2009 also include extensive diagnosis-based risk-adjustment. A fourth approach involves what in U.S. debate is called *reinsurance*: in essence insurance for the insurers. In a reinsurance system, insurers are protected against costs above some level (e.g., $50,000) for any individual enrollee; all insurers might be required to contribute a premium for each of their members, and the insurers who have more high-cost beneficiaries are the net winners from this second level of insurance. Government might also subsidize this pool.

Financing arrangements can get quite complex, and the current Dutch system appears to combine most imaginable measures (Leu 2009; Van de Ven and Schut 2008). There is a percentage of payroll premiumfor part of expenses. There is also a flat premium (to give individuals an incentive to shop around and insurers an incentive to control costs, though the latter have little ability to do so); but in order to make this more affordable, the government subsidizes about 40 percent of households for portions of the flat premium. The payroll contributions are collected in a common pool and then allocated to insurers according to a risk-adjustment formula. The risk adjustment is then both prospective, according to a formula with factors like age and previous medical experience, and retrospective, such that "annual costs for the highest-cost patients above a threshold are shared, with the plan paying 10 percent and pooled funds across carriers paying 90 percent" (Leu et al. 15). And a portion of costs, particularly hospitalizations for more than one year, other long-term care, and some mental illness, is covered with separate, tax-funded insurance.

Any U.S. system will involve a complex mix of measures. My own preference is to have at least a substantial share of contributions defined not in cash terms but as a percentage of income. Subsidies for flat cash premia are an inferior method that requires precise calculations of income-based subsidies for every enrollee, which is complex and expensive. At a minimum, however, any system must require insurers (and the public plan!) to charge flat community rates regardless of health status and to have open enrollment. Then the system must be structured in a way that allows both prospective risk-adjustment and retrospective experience-adjustment, so that insurers benefit minimally from selecting healthier members.

President Obama's campaign proposal for a Health Insurance Exchange could serve not only to implement the cross-subsidies but to reduce risk-selection by regulating marketing. For example, plans must be required not to discriminate in prices by health status, to provide guaranteed issue to applicants, and to market within the broad framework of the exchange, so that their product is offered to the entire community.

Experience shows that insurers (both inside and outside the United States) may also try to cherry pick good risks by marketing in ways that address those customers but not others – such as through dances for the Medicare population or, as one private insurance executive in Australia told me years ago, having "your office on the second floor of a building without a lift." Therefore marketing regulations should include some limits on marketing outside the exchange. These restrictions should not, however, in my opinion, include preventing insurers from marketing directly to pre-existing pools such as employers that offer coverage directly to their employees – so long as both the insurers and employers are required to match or exceed the standard benefit package, and to participate in whatever cross-subsidy schemes are legislated.

Self-insured employers. Self-insured employers can fairly easily fit into such a system of regulations designed to provide sufficient subsidies and equitable risk-sharing. Self-insurance, in the sense of an employer choosing to bear the risk of medical costs for its employees, has been a common feature of the systems in both Germany and Japan. The employers that choose self-insurance simply are treated as insurers for purposes of the regulatory system.

Companies have chosen this approach if they could benefit from doing so: which means if their employees were a large enough group to spread risk; if they were projected to be less risky than the norm; or if their incomes were above average so the contribution rate could therefore be below average. Although this evidently favors large employers (and their employees), inequality of contributions is moderated by measures such as the cross-subsidies among funds in Germany; and by the fact that in Japan there are public subsidies to other funds but not the individual employer funds, while transfers are made based on the number of elderly in each fund.[12]

The most important difference between American self-insured companies and self-insured companies in Germany and Japan is that in the U.S., companies are left to fend for themselves to control costs. In Germany and Japan, their costs are reduced by the same overall system that requires they participate in some cross-subsidies. On the whole, that appears to be a better deal for German and Japanese companies than the one American large employers receive. Given the choice between working through current private insurers or the new public plan, with the new benefits of all-payer rate-

setting, self-insured American employers also should be better off than they are today.

III. Politics and Payment Policies

Implementing all-payer regulation raises a series of choices. These include, first, whether the current public plans for elderly and low-income populations should pay the same rates as do the plans for the balance of the population; whether any further variation should be allowed; how to achieve a reasonable balance of the competing interests in health care rates; how to cope with geographic differences in input costs, medical need, and practice styles; and how to implement a new system with as little difficulty from the transition as possible. There are many possible answers to these questions, but some principles should be followed. First, "fairness" includes consideration of both payers for and providers of care. Second, "fairness" among providers is largely a matter of relative incomes, so does not call for precisely "right" prices for all services. Third, totally standard rates are impossible in the short run and may not be desirable in the long run; but should include a phased transition with some increase in payments for the Medicaid population and decline in rates for the current privately-insured populations. Fourth, regional variations should be addressed, but slowly and carefully; and the answers to questions of federal vs. state authority are political calls. Fifth, the process of rate-setting should require that payers be aware of consequences for providers and providers be aware of consequences for payers.

An all-payer reform with a voluntary public plan, a good minimum benefit package, substantial and prudential regulation of health insurance marketing, the strongest possible risk adjustment among insurers, and standard provider payments across all payers would be a great improvement. Other countries have implemented such systems successfully, and even some American states have had successful versions for the hospital sector. Yet there would certainly be contentious issues in any system of this type.[13]

Components of fee schedules. The core choices about any set of payment rates involve setting relative values (the relationship of fees to each other); *conversion factors* (how those relative values are translated into prices, on average) and *geographic adjustments*(any variation in fees among local markets or political jurisdictions).

Fees for hospital or physician services within Medicare, for example, can be viewed as beginning with relative values. So two diagnoses in the hospital prospective payment system, or two physician services in the RBRVS (Resource-Based Relative Value

Scale) system, have a standard proportional relationship. Each year the actual price is adjusted by an “update” applied across the board to either hospital or physician services, which either raises or lowers the conversion factor. But the relative values are only rarely changed.[14]

Relative values and conversion factors create the basic fees. But, within Medicare, fees also vary from county to county, and in some cases from institution (e.g. hospital) to institution. The basic argument for geographic variation is that input costs are different in different markets. For example, a physician is likely to pay much higher rent for an office in Manhattan, New York City than in Manhattan, Kansas. Medicare seeks to recognize such difference by calculating average practice costs and varying fees accordingly. The perhaps insufficiently explicit goal of such adjustments is actually to equalize net incomes for similar baskets of services across regions or markets.

For political purposes, it is important to remember that relative values largely affect the distribution of income across providers of care. Providers care a lot about relative incomes; payers for care generally care less. Therefore payers tend to be more interested in the conversion factor, which is the lever payers would prefer to manipulate in order to control total costs. The major exception to this rule is if the volume of particular services provided by certain providers grows especially quickly. Then it may make most sense to adjust the relative value of that service downward.[15]

Variations among payment levels. In existing all-payer systems there can be some variations in fees, even as there is a basic fee schedule. Yet in all cases the largest part of care is paid for by the standard rules, and the effects, compared to current arrangements in the United States, are essentially the same.[16]

One issue sure to be posed is whether physicians and hospitals should be allowed to bill extra above the amount in any fee schedule. This is not the same as cost-sharing within an insurance plan. For example, if a fee were $150, and there were a $20 co-pay, in a system that allowed *extra-billing* the physician might charge $200; and the patient would pay both the $20 co-pay and the extra $50. On the whole, this is a bad idea; unrestricted extra billing can make insurance and the fee schedule meaningless. At a minimum, extra billing should be quite restricted.[17]

A second issue is how a good all-payer system would interact with the existing public programs. In some areas, for some services, the difference between Medicare and current private payer rates is so great that a quick move of the higher payments to the Medicare rates would be too large a shock to the provider community. At the start of the system, rates for the non-Medicaid and non-Medicare populations might be set at the

Medicare rates plus some surcharge (e.g. 10 percent more). The rates could then be brought closer together, over time, in phases.[18] In the case of Medicaid the problem is a bit different, because Medicaid generally pays particularly low rates now. All rates should not be lowered to the Medicaid level, as that would be draconian and unfair (though not all Medicaid rates are clearly too low – hospitals in some markets appear to seek Medicaid obstetric patients). Ideally, Medicaid rates therefore would have to be increased, but that would be a shock to state budgets. More likely, there would have to be some phase-in, with Medicaid rates being raised slowly towards the new standard. This is not a new concern; as two senior health policy scholars put the case years ago, "While the ultimate goal might be an identical payment schedule for Medicare, Medicaid, and all private payers, a lengthy transition may be required" (Ginsburg and Thorpe 1992: 76).

"Fairness" in rate-setting.[19] Nothing is more certain than that any set of prices will be called "unfair" by anyone who wants to be paid more. Defining "fairness," "equity" or "justice" is an activity for political philosophers, and there will never be agreement either among philosophers or politicians or citizens. *The challenge is made especially great by the importance of adequately compensating the training, work, and dedication of medical professionals in whom patients place their very lives.*

We might, however, be able to define some rough guidelines for addressing claims about fairness.

First, *fairness of prices and overall payments must mean fairness to both the sellers and buyers of medical care*. The most basic inequity in the U.S. health care system is that Americans pay a far larger share of national wealth for medical care than do the citizens of any other country in the world. Total payments in the U.S. redistribute far more income from everyone else to the health care sector, and there is very little reason to believe the rest of us get much extra value for the five percent more of our economy (about $700 billion dollars at this writing) we pay compared to any other country. Perhaps we should be two percent more expensive, but the current level of costs is totally unjustified. Therefore *a reasonable standard, for many years to come, would be to set prices in a way that would stabilize the share of national income going to medical care.*[20]

Second, *the key issue for physicians, hospitals, drug companies and other sellers of medical services is not specific prices but their overall incomes*. In practice it is these incomes – in total and relative to other participants in the medical economy – that are the real focus of rate-setting conflicts in any country. This does not solve the fairness problem, but it does make it a lot easier to think about – prices can be set based on

their effects on incomes for a limited number of categories of providers of care, rather than in an effort to be absolutely fair about thousands of activities.

Third, *providers will never believe their payments are fair*. Physicians, for example, can always identify someone else in society whose income is harder to justify – say, partners in large law firms, or mediocre shortstops. They do not compare themselves to firefighters or police officers or public prosecutors or teachers. Trying to satisfy everyone is hopeless. Instead, it makes sense to target an average income for physicians which is well above the national norm – and compare them to that average, rather than to small groups that may be particularly over- (or under-) paid. There will be great controversy about any overall standard for any type of provider, but in addition to a multiple of average incomes for physicians, I can suggest two logical standards. First, hospitals should earn enough to cover their costs with a prudential margin – there is no justification in principle for profit. Second, drug companies should not be expected to have larger returns on capital or operating margins than is the norm for large corporations. In the case of pharmaceutical manufacturers, in fact, it might make more sense to aim for the profit levels of a traditional regulated industry, such as public utilities. Both hospitals and drug companies are essentially supported by income largely collected according to requirements set by law (even in the U.S. at present, through both public programs and subsidies through the tax code); they are also providing a service that we wish to see available to all citizens. They should not be allowed to maximize earnings at the expense of taxpayers.

Fourth, *fair prices are prices that provide the target incomes for **efficient** care*. Prices should cover necessary costs, not unnecessary costs. For example, the price paid for an MRI scan should be enough to cover costs if the machine is used quite heavily, rather than enough to make it profitable to buy a machine and have it idle half of the time. Otherwise, the price will overpay institutions that use the machine efficiently while also causing excessive purchase of equipment that, in turn, will lead to excessive volume of services. Similarly, fees for physicians should not be so high as to cover the costs of the level of office staff that are needed for the extremely complicated billing operations under our current insurance system; in a system that simplifies billing by standardizing rates, it should be possible to pay physicians less yet leave them with comparable net incomes. A related point is that incomes which actually contribute to medical care should be favored in the fee-setting schedule, and incomes that don't – excess administration, profits for investors in some institutions, and high pay for administrators – should not.

Fifth, *prices should be based on costs of care, not of other activities. Other activities should be paid for separately.* Trying to compensate for activities such as medical

education within the rate structure is just asking for extra complexity. If there is a national interest in funding medical education or medical research, that should be paid for separately and visibly on the appropriate government budget, rather than hidden in the fees paid for medical services.

Sixth, *prices should be adjusted in a timely manner to reflect changes in productivity and profitability; to ensure that productivity increases, as in normal markets, are distributed mainly to customers; and to maintain the target distribution of incomes.*[21] At present neither Medicare nor private payers appear to have been adjusting relative values in a way that reflects the original goals of the Medicare RBRVS reform in 1989, which intended to provide greater incentives for primary care practice as opposed to specialization (See Ginsburg and Grossman 2005; also see data in Dyckman & Associates 2003).

Seventh, relative fairness among providers is best assessed by looking at the current distribution of income, deciding if some changes are called for, and then adjusting fees to create that change. In short, it should be done incrementally, based on the status quo, rather than pretending there is some clearly correct figures that could be figured out as a matter of principle. More generally, *almost all changes in relative incomes should be phased in and incremental, because sharp changes in relative income may require wrenching adjustments for those who relatively lose, and anger the losers more than they please the winners.*

Last but not least, *any fair process must represent both payers for and providers of care.* The payers must ultimately have the stronger voice. Yet there should be organized representation for providers; physicians especially should have a strong voice on relative values; and there should be strong, neutrally competent analytic bodies that have the ability and independence to validate claims that payment constraint is becoming too strict.

Geographic adjustments. One of the most difficult challenges is how to address the arguments that (a) payments should be higher in some areas than in others, yet (b) costs are much higher in some areas of the country than in others, for no evident good reason. This is both an analytic challenge and a governance challenge.

There should not be a single national price schedule, because there are major variations in input costs. The rates have to be set for smaller units: states and, in the case of larger states, units within the state. This is how it works in Canada or Germany already. The governance question then is whether to set up separate bargaining structures at those geographic levels (as in Canada and Germany), or to have some set

of national rules and then a whole lot of formula adjustments based on some combination of history and measured costs (as in Medicare).

Logically, the answer to that question depends on the sources of variation and on how the funds for care are collected. For example, medical education in one area (say, Boston or New York) may ultimately serve patients in another area. The same is true of research done in any given hospital. Variation for these reasons should not be handled locally but instead funded separately from the fee schedules, with national funds.

If some areas of the country are poorer than others, so require greater subsidies, which also should be based on a national formula for adjustments. Consider, for example, parts of the country to which a disproportionate share of seniors retire. It would be unfair to burden workers in those areas with all the costs of extra care for this relatively elderly population. So cross-subsidies based on the number of elderly, or of the poor, should be collected and distributed on a largely national basis, as is the case today.[22]

What about the fact that there are higher input costs in some areas, such as the Manhattan, New York City vs. Manhattan, Kansas comparison? To some extent, costs such as real estate are higher in areas where wages also are higher. Similarly, if a hospital in one area pays higher wages than a hospital in another, this often will also mean that the general income level is higher in the first area. So higher labor, real estate, and perhaps other input costs should be associated with higher incomes from which to collect contributions. This might seem to be an argument for collecting funds and setting rates at the local level. Yet if input costs were entirely proportional to income, then a standard proportion of income premium would relate costs to incomes automatically across the country. People in Manhattan, Kansas, would pay less on average than people in New York's Manhattan; but their care would also cost less.

The most difficult challenge follows from the fact that total costs may vary from area to area for reasons separate from inputs like real estate and wages and the need for subsidies. As is well known, both fees and the volume of services vary greatly across the country, based on a combination of local market conditions (in essence the relative market power of payers and providers) and local medical practice norms. As many critics have argued, it seems unfair for taxpayers in low-consumption states, such as Minnesota and Oregon, to pay for an average level of costs that includes high-consumption states, such as Florida. More precisely, it is unfair for them to pay for differences in services that are not caused by differences in medical need.

Reallocations of national funds among political jurisdictions are extremely difficult in any political system. This is not simply a function of the U.S. Senate – though that may not

help the situation in the United States.[23] The variation within the U.S. suggests that it would make sense for a significant portion of the funds that pay for medical care within any area to be raised within that area, and to create a system that sets fees to control costs within that area. If Miami-Dade County has much higher costs than Minneapolis-St. Paul, the federal government may reasonably be expected to cover the portion of those costs that is caused by a particularly high proportion of the elderly or of poor people within the former metropolitan area. But, to the extent these costs are caused by unusually high volumes of services, the people who actually receive those services should have some reason to worry about the costs, and to support adjusting the fee schedules to reduce the costs. This could mean a lower conversion factor in the more expensive regions or even somewhat different relative values, if costs are driven by particularly high volume for only some forms of care.

On balance, therefore, geographic adjustments should include national decisions for some purposes, such as to correct inequities caused by systematic risk and income factors; but more local decisions based on local variations in medical practice. The latter decisions could include either stronger price controls or higher contribution rates – depending on what the local rate-setting process chooses. Perhaps voters in some regions will be glad to pay more for what might be considered more extensive service. But perhaps not.

Caregivers and cost control. In the design of any system, all measures should consider the legitimate interests of the medical caregiving community. Cost control is not an absolute value. Unfortunately, the costs of the U.S. system are so far out of control that even physicians and hospital administrators should worry that the system could collapse under the burden, which would be good for no one. But any rate-setting approach should pay close attention to the adequacy of compensation for the people who deliver care, and to equity among providers. It should allow caregivers who do not want to receive payment from insurance to charge what they wish.[24] A reform should reduce or eliminate the debt burden from medical education.[25] Yet it is vital to remember that all-payer regulation, by reducing administrative costs and hassles, can direct a larger share of medical care expense to those who provide the care, and to concentrate more on providing that care.

Conclusion

The health care system in the United States has shameful access and cost failings. Better control of costs is necessary to pay for improved access. In a companion paper, I have shown how international comparisons, comparisons of Medicare to U.S. private insurance, and even cost control over time within the U.S. private insurance system, all demonstrate that the most important tool to control costs is to gain better control of

payments per service, however those services are defined. This is a politically challenging task, but in practice is more likely to yield successful policy than are any of the currently widely publicized alternatives.

A system of all-payer rate regulation can provide significant savings while encouraging competition between a public plan and private insurers for the patronage of the portion of the U.S. population not covered by the current public programs. It thus provides a superior way to implement the approach proposed by President Obama in his campaign.

The analysis in this paper has provided a guide to implementation issues such as how having both the public plan and private plans could improve performance compared to having only one or the other; how to manage competition among insurers so as to deal effectively with the risk distribution and income subsidy challenges; and how to conceive of and work to achieve reasonably fair results from rate regulation. I do not pretend that any system can be ideal. Yet the approaches described here could be the basis of a much, better system than the one we have in the U.S. today: a system that gave Americans the kind of health care they deserve, at a price they could afford.

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Endnotes

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[2] There was a brief period of time in the mid-1990s when competition among insurers through selective contracting led to particularly good restraint on prices in the United States. The dynamic, however, quickly reversed. See White (1999, 2007) for further information.

[3] Within Medicare itself there is such a competition, but it is currently intentionally rigged to favor the private plans, paying them more than the costs of traditional Medicare for the populations they enroll. That is not a model that should be replicated in the rest of the U.S. health care system. In Japan, each community does have a community-sponsored plan, which covers individuals who are not covered under the alternative plans. But that is not in competition for members with other plans. In Germany there is also, in each region, a regional plan; but it is not exactly government-sponsored. In the Netherlands, there is a public plan to cover "extraordinary medical expenses" such as long-term care, but mainline insurance is provided entirely by separate insurers. In Switzerland, all insurers are private.

[4] The argument here may be controversial with advocates who believe a new public plan, or Medicare itself, could lead a process in which "low-quality" providers were excluded. But the arguments made in Fox (1997) seem much more realistic. Having a maximum-choice plan also is simply desirable in its own right, for the reasons given. Again, this does not exclude providing information to inform choice.

[5] As Tim Jost summarizes, Medibank Private – which is, again, a government corporation selling insurance on the marketplace – "has, according to some commentators, served as a social conscience for the private insurance industry, supporting a complementary role for private insurance and community rating. It is also believed that its existence has discouraged collusion among private insurers… The Australian experience demonstrates that it is possible to have a public plan that runs efficiently, pays providers competitive rates, and competes successfully with private insurers without driving them out of the market" (Jost 2009).

[6] I do not mean to imply that private plans always give good service, especially when they can save money with bad service. For example, the CMS on January 12 suspended enrollment of Medicare beneficiaries in a series of WellPoint Medicare Advantage and Part D plans, as well as suspending all marketing for those plans, due to a series of what appear to be egregious failures (CMS 2009).

[7] The much higher share of GDP spent on health care in the United States – over 16 percent vs. a maximum of around 11 percent in other countries – might make this subsidy problem seem obvious. In practice, a substantial portion of subsidy costs is removed from U.S. health insurance premiums by having the separate, tax-supported, Medicare and Medicaid programs. Nevertheless, the average health insurance premium for an American family insured through an employer in 2008 was $12,680 in 2008 (Health Research and Educational Trust 2008), which is well above average effective premia in other countries.

[8] The discussion that follows is based largely on White 1995 and 2001, plus a review of more recent developments, such as Van de Ven and Schut 2008. A good further source with discussions of many countries is the special issue of Health Economics in 2005. The World Health Organization's European Health Observatory provides a range of studies, with occasional updates on particular countries, at http://www.euro.who.int/observatory

[9] One study does report that members of high-deductible plans used as many preventive services as members of PPOs, but that was not much of a test because in that case the preventive services were free in the high-deductible plan (Rowe et al 2008)!

[10] Some of the most eminent American health economists refer to current employer-based coverage with adjectives such as "lavish." They provide no empirical basis for this argument-by-adjective. Even high-end U.S. coverage would not look "lavish" in Germany or the Netherlands, yet those countries have much lower costs.

[11] I interpret "community rating" as charging the same rate to all individuals within a community, except possibly for separate categories for single and family. Others would say more detailed family categories (e.g. couple with and without children) and some age categories would still count as "community rating." In any event, it is not sufficient.

[12] For further explanation on Japan see Campbell and Ikegami (2008); on Germany, Worz and Busse (2005) and Cheng and Reinhardt (2008).

[13] Many of the possible concerns were addressed during the last round of serious health care reform, in a thoughtful paper by Paul Ginsburg and Ken Thorpe (1992).

[14] Which is not to say, at all, that they should be changed so infrequently; failure to properly change relative values is a serious failure, as discussed in the companion paper.

[15] For discussion of this issue, see the companion *Cost Control* paper.

[16] In addition to geographic variation, as in Medicare other sources of variation include (a) having a standard set of fees paid by insurance, but allowing some extra billing above the schedule; this can create equity issues, but their seriousness depends on the size of the extra charges; (c) having some small group of "boutique" providers who are not part of the basic insurance system – e.g. some cosmetic surgeons, or orthopedic surgeons to the stars; (d) some insurers paying a percentage above the standard price, in return for which their customers hope the hospitals and doctors will provide special convenience or amenities; (e) in some countries, hospitals may be essentially budgeted rather than paid fees per service. In that situation, payments averaged across services might differ among hospitals.

[17] For example, it could be restricted to a small extra percentage, as is the case in Medicare at present; or as in Australia there could be a ban on supplementary insurance coverage of any fees above the fee schedule.

[18] A further issue, with or without the all-payer regulation, is whether the Medicare benefit package should also be expanded (Schoen, Davis and Collins 2008); if so that also would best be phased in over time.

[19] This section is based on my assessment of how other countries' systems work, as well as of the consequences of some current practices in the United States. Nevertheless, even more than the rest of this paper, it should only be viewed as a starting point for discussion. I have drafted a longer, though equally provisional, assessment that I can provide to readers on request.

[20] Naturally I do not expect all to agree. But, as a matter of fairness to payers, it is hard to see how continued increases would be justified. Especially since some of the efficiencies of an all-payer system can be used to reduce spending without reducing physician and nurse net income.

[21] See the discussion in the companion *Cost Control* paper. Here, my point is that adjustments are necessary not only to control costs but to maintain equity between payers and providers and among providers.

[22] The national subsidy structure is direct through Medicare's funding through general revenues and a nationally collected payroll tax; and a bit less direct through the

Medicaid provisions that provide a larger federal matching amount in states with greater need.

[23] A Senate in which obstructive tactics are normal is not a promising institution in which to try to reallocate from some states to others. But health policy analysts in the United Kingdom argued for decades that London had too many hospital beds and the rest of the country too few, with little effect. It's just politically hard.

[24] In Canada, physicians do not need to accept the provincial rates – so long as they do not want the provincially insured patients.

[25] I would be glad to have the federal government just pay the costs directly. That is, of course, a controversial position, especially among economists who believe medical education is an investment that yields a high return for the student. True enough, but large debts appear to be viewed as a great burden by physicians who then behave in ways, such as avoiding primary care, that are not good for society. Economists who feel that paying for medical education would make the return to specialty training too high should recognize that lowering fees paid for some specialties solves that "problem."