The Failed Clinton Health Reforms: Is Managed Competition A Viable Policy Paradigm?

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The collapse of the Clinton health reforms has produced a thousand autopsies, and enough tactical second-guessing to keep a generation of doctoral students busy. For those whose interest in the issue transcends the fate of a particular President or Congress, however, a larger concern is the viability of the intellectual foundation of those reforms, namely the idea of "managed competition".

The concept of managed competition has been in the public domain for at least sixteen years, since the publication of Enthoven's proposal for a "Consumer Choice Health Plan" in the New England Journal of Medicine in 1978. It is the only intellectual cohesive alternative to government-sponsored health insurance in the present policy landscape, and has had international influence on health reform efforts.

However, the two year health reform debate provided the first "reality check" on the feasibility of managed competition as an American health policy framework. At least in this author's judgment, managed competition was damaged as a policy construct by the miscarriage of health reform, and may need to be re-engineered to serve as a viable platform for future reform efforts. The following paper examines the vulnerability of the idea to partisan debate, and proposes a modified form of the model given current political realities.

Complexity and the Problem of "Choice"

However the Clintons may have modified the original idea, managed competition proved exceptionally difficult to "manage" in a polarized and partisan political climate. During the debate, this author participated in a wide variety of forums about the health reform issue. To each audience, the question was posed: "How many of you understand the basic idea of managed competition well enough to explain it to your Mom?" Even in audiences of a thousand, only a handful of hands were raised.

Physicians, healthcare executives, trustees, businesspeople, medical school faculty, bankers and accountants, and ordinary citizens were uniformly baffled by managed competition, not only by the arcane vocabulary, but the conceptual framework. Lack of understanding breeds mistrust, particularly in a climate hostile to government initiatives. If one must teach voters and policymakers a private language to explain a political idea, odds are high that the idea won't sell.

However, managed competition's greatest vulnerability was its easy and inaccurate association with the limitation of choice of physician or healthplan. The potent political image of an obscure government bureaucracy assigning individuals to a physician or health plan (as in Britain, for example) made a major contribution to derailing the initiative. The Clintons were unable to detach this negative valence from their proposal, which, in reality, would have substantially expanded consumer choice of health plans. A hasty Clinton tactical response to the choice problem - requiring all health plans to offer open panel, "point of service" options- did not succeed in dispelling the image of loyal patients being forcibly separated from their doctors.

The prospect of expanded influence of HMO's also created a potent counterrevolution of interest groups who felt threatened by the HMO's ability to limit referrals or shrink participating

physician panels. By the conclusion of the reform effort, an improbable coalition of consumer activists like Ralph Nader and the American Medical Association, orthopedic surgeons and their arch enemies, the chiropractors, supported legislation that would have constrained the ability of HMO's to limit choice of physicians. State medical lobbyists went further, enacting in several states so-called "any willing provider" legislation, which compels health plans to include any physician who agreed to accept its payment schedules.

How much influence this coalition will be able to exert on future reform efforts remains to be seen. But the health reform debate succeeded in coalescing opposition from both ends of the political spectrum to managed care, as well as damaging managed care's public image. The very existence of an anti-managed care coalition will complicate future health reform, and may leave a legal residue which will prevent health plans from achieving economic discipline. Consumer sacrifice under managed competition is not a loss of choice per se, but a loss of tax-subsidized choice. What managed competition seeks to do is force consumers to choose a system of care which is self-regulating economically. Consumers who choose an open-ended non-system will, through the withdrawal of tax subsidies, be paying for the privilege of self-directed or physician-directed care with their grocery money. To an electorate which expected health reform either to reduce their out-of-pocket expenses or bring them new benefits without them having to pay for it, this message would have been unwelcome, if anyone had actually delivered it.

The message is not notably more appetizing if people have a dozen choices, particularly if they lack the disposable income to opt out of tightly managed, closed panel "low cost" health plans. Explaining that choice is indirectly constrained, and that people will bear the marginal cost of expensive health plans, proved virtually impossible, given the complexity of the issue and the din of political combat.

Taxes and Entitlements-the Democratic Problem

Any Democrat would have faced two major problems in implementing a managed competition strategy: financing the subsidies to businesses and uninsured individuals in a hostile, anti-tax climate, and hedging the existing rich health benefits entitlements of core Democratic constituencies.

The failure to present a believable financing plan for his program damaged the President's plan from its introduction. After its fall, 1993 rollout, an unnamed Administration source characterized the financing plan for the Clinton reforms as: "a walk in space", and Senator Moynihan, in a exquisitely timed outburst, a "believable fantasy". Sensitized by campaign charges of being a "tax and spend" Democrat, the Clintons proposed only one visible tax in their plan - on tobacco products. Broader, tax-based funding for the health plan, such as a national value-added tax, was quickly rejected as politically infeasible. The result was a plan financed by in major part by a pseudo-tax- the employer mandate-and the dark, swirling waters of huge regional alliance funding pools.

The obvious funding source for managed competition-based health reform is the $60 billion tax subsidy provided by the federal tax code for employer-provided health insurance. Tapping this source, however, was politically complex, since it would have meant invading the lavish, union-won health benefits of core Democratic constituents - the autoworkers, the teachers, and municipal employees.

Coming on the heels of a bitterly unpopular right with union leadership over NAFTA, Clinton adherence to managed competition dogma would have been viewed as the ultimate betrayal, a White House-sanctioned giveback of a near-religious artifact. This risk the Clintons were unwilling to take. Tax subsidies were to be withdrawn only after ten years, long after existing union contracts expired (and the President was out of office). This delay made it impossible to fund coverage for the unemployed uninsured with this potential revenue source.

Instead, to secure their support, the Clintons lavished new entitlements on core Democratic constituents. Unionized workers got guaranteed, federalized retirement benefits after age 55, financed 20% by employer contributions and 80% by the rest of us. The elderly got a new entitlement to prescription drug coverage and, eventually, long term care. The helping professions got a new program for home and community based care to the disabled. The mental health lobby got mental health benefits written into the basic benefits package. Medical schools got a huge new subsidy to assist in the conversion to managed care and a primary care based training program. No obvious sacrifice was asked of any major Democratic constituent group.

The idea of curing the nation's health cost problem with a huge new entitlement program was classic, old Democratic thinking. Throwing new dollars at those who already had the richest healthcare coverage only increased the cost of the plan, and frightened many moderate Democrats concerned about its fiscal consequences. Funding this expensive plan without obvious public revenue sources was simply not credible in a deficit-sensitive political climate. It was not Republican intransigence which killed Clinton's plan, but his failure to engage and mobilize (or even to listen to) the moderates in his own party.

Libertarianism and Compulsion -- the Republican Dilemma

Republicans faced a complex political challenge in the face of a Democratic managed competition plan. If they accepted the premise of a managed care-based reform strategy and the goal of universal coverage, they needed a credible alternative financing vehicle. The Democratic funding wheelhorse - the employer mandate - was flatly unacceptable, both philosophically and politically.

Clinton's proposed employer mandate placed the burden of funding health reform squarely on the shoulders of small businessmen and service firms with large numbers of uncovered workers - a core Republican constituency. During the 1980's, Republicans fought all political initiatives that imposed costs on employers - minimum wage increases, mandated parental leave, etc.- as disguised tax increases. The health reform employer mandate was, as the Congressional Budget Office inconveniently told the country, really a payroll tax collected and dispersed by an agent of the federal government.

The key to the Clinton political strategy was to split the business community, and secure support from Fortune 500 firms with expensive health benefits to pressure Republican and moderate Democratic lawmakers to support the employer mandate. Large employers who joined the Clinton alliances would have seen their health cost liability capped at 7.9% of payroll, and those with union-won retirement health guarantees would have had them 80% federalized. These blandishments proved insufficient to mobilize big business support against small business. Clinton's plan was effectively dead in February, 1994 when the Business Roundtable refused to endorse the employer mandate.

The Republican moderates countered Clinton's plan with the Dole/Packwood proposal, resembling the Heritage Foundation plan, which would have required individuals to purchase health coverage, with those with lower incomes subsidized via a refundable tax credit. This plan was effectively dead when Dole realized that the bumper sticker would read: "Democrats want your Employer to Pay for your Health Insurance - Republicans want YOU to pay for it."

As the health reform debate moved into the fall, the Republican "center" moved to the right. And Dole encountered fierce resistance from the libertarian wing of his party, which opposed any form of state compulsion as a vehicle for achieving health reform. The Republicans never found an acceptable funding alternative to the employer mandate, and essentially dived under the carpeting as the Clinton plan foundered (correctly sensing the loss of public urgency by mid-1994 about Congressional action on health reform).

If the employer mandate is a non-starter for business-oriented moderates of both parties, then the inability of either party to embrace tax-based financing bodes ill for achieving health reform. The new Republican majority in Congress has a perceived mandate to cut taxes, not to devise new ones.

Regulating Health Insurance - A Bipartisan Problem

If it was impossible to achieve bipartisan consensus on issues of coverage and financing within the managed competition framework, in the area of health insurance reform, consensus seemed at least possible. Both parties seemed to agree that certain health insurance practices should be forbidden, including discrimination against those with pre-existing conditions and against groups with above normal health risks. Both parties also favored achieving portability of benefits, enabling individuals to move from job to job or from employment to unemployment without giving up their healthplans or physicians.

The messy issue of how to do this never arose because these issues were held hostage to the larger, unresolved issues of coverage and financing. The vehicle Clinton chose to reform health insurance provision was an orphan from birth: large regional alliances which collected premiums from employers and individuals and dispersed them to healthplans. The Alliances frightened everyone as large, quasi-government bureaucracies, and became the symbol of an extension of government power which helped contribute to the plan's demise.

Yet, how does one actually achieve portability, community rating, nondiscrimination against the high risk and those with pre-existing conditions without expanding federal or state oversight over health insurance provision? Community rating requires regulation: assuring non-discrimination requires either regulatory oversight over policy design, marketing and underwriting practices, or else statutory guarantees enforced (like tort liability) by the courts.

Enthoven's original approach was highly regulatory, and relied on expanding federal authority to restructure the private health insurance market. The politics of this expansion is a proverbial can of worms. Most large and medium sized employers today self-fund their health insurance coverage, and are exempt from state regulations governing health insurance by the 1974 ERISA Act.

If one adopts a federalist health reform agenda, and relies upon states to implement health reform, ERISA ties their hands by keeping states from including self-funded employers in funding or basic benefit package provisions. ERISA basically tells the states to keep their hands

off self-funded plans, but provides no federal standards on plan design, administration or consumer protection. States which desire to reform health financing on their own are forbidden by federal law to standardize, tax or otherwise regulate self-funded health plans.

State regulation of health insurance has been notoriously variable in quality. And state legislatures have been chronically unable to prevent healthcare financing programs they administer from becoming political Christmas trees for providers and attorneys (e.g. Workers Compensation). Waiving the FRISA pre-emption could expose self-funded employers to a new wave of mandated costs or taxes.

Whether states or the federal government does it, the superficially popular idea of community rating of health insurance premiums is a political minefield. Strict community rating of health insurance premiums sharply increases the cost of health insurance for young people, further increasing the already substantial intergenerational transfer of wealth embodied in Social Security and Medicare.

The practical realities of health insurance regulation are much messier on the ground than from the air-conditioned cabin of the health policy airliner. In the absence of federal action, the new Congress will find it difficult not to let states forge ahead into the swamp by amending ERISA. Business leaders as well as consumer advocates have reason to be concerned about the consequences. And yet those who seek a federal platform for health insurance regulation will face the same concerns about centralizing control over health insurance provision which helped derail Clinton's plan.

Is Managed Competition Feasible as a Policy Framework?

It is clear from last year's health policy debacle that the managed competition framework does not easily map onto the current partisan landscape. Yet managed care continues expanding rapidly, and is the default option for solving the Medicaid fiscal problem. It seems entirely possible that with no federal action, HMO enrollment could reach 80-90 million by the end of the decade.

If the relatively limited use of federal power to reform group insurance and subsidize care to the uninsured was unpalatable to the American voter, electoral support for federalizing health insurance provision seems completely unattainable. California's citizens voted overwhelmingly against a single-payer ballot initiative in 1994, while across the nation, moderate and liberal Democrats sustained a resounding clobbering at the polls. The legitimacy of government as a vehicle for solving major national problems seems likely to continue its nearly two decade long plummet. National health insurance along the Canadian path is simply not going to happen in the United States.

Thus, policy makers must be willing to take up and wield the available weapon for achieving economic discipline in health services. That weapon is a private health insurance system increasingly organized into resource managing economic entities called HMO's.

Private Sector Market Reform is the Urgent Priority

The most serious risk of renewed healthcare inflation resides in the private sector. The inflationary engine in American healthcare financing is the small group and individual health

insurance market. It is to small businesses and individuals (insured and uninsured) that providers and insurers alike shift their costs.

Not only is health insurance far more costly for individuals and small groups, but it is where most of the profits in health insurance (and healthcare delivery) are to be found. Caps on public healthcare spending programs, a likely response of the new Republican Congress, will only inflame this inflationary nexus of private healthcare payment by initiating another round of cost-shifting.

Thus, the single most urgent task of health reforms post-Clinton is not to achieve universal coverage, but to restructure small group and individual health insurance purchasing, not only to eliminate the costs imposed by middlemen such as insurance brokers , but to mass the purchasing power of individuals and small groups to make expanding insurance availability to these groups more affordable. Aggregating the purchasing power of individuals and small businesses into purchasing entities would close off the "open end" of the American healthcare financing system.

If the costs of insuring individuals and employees of small firms take a further sickening upward lurch, the cost of achieving universal coverage will vault into the realm of the completely unaffordable, regardless of what funding strategy is chosen. The policy opportunity is to sharply reduce the cost of individual and small group insurance while health insurance premiums in many communities are already falling for larger employers and purchasing groups.

There are multiple ways to achieve the massing of purchasing power required to do this. One potential approach is to extend present state and federal purchasing systems to individuals and small groups. The California Public Employee Retirement System (CALPERS) is the most powerful actor in California's health insurance market, and has been able to roll back health premiums for their members in the past year. Why not encourage other states to follow California's example, and mass the public employee groups in their states as CALPERS has, and enable individuals and small groups to buy in to these systems at group rates? In states where this cannot be achieved because of collective bargaining constraints, the Federal Employees Health Benefits Plan could be broadened to include individual and group enrollees.

At the same time, business coalitions are gaining momentum in many American communities. The San Francisco Bay Area Business Group on Health was able to achieve a 15% rollback in premiums for their members during 1994. Mass purchasers have discovered a remarkable truth about health insurance premiums: they not only need not rise inexorably, but they can actually be made to fall! The more lives these coalitions represent, the more power they will have to command reduced health insurance premiums. Small businesses and individuals could provide the quantum increase in mass many coalitions need to achieve market leverage.

There is no need for a single massive coalition if multiple large purchasers exist in markets and the number of unaffiliated covered lives can be sharply reduced. Public and private purchasing co-operatives could compete with one another to see who can offer the lowest rates and the broadest array of health insurance choices. The key is to reduce the "unaligned" portion of the health insurance market to less than 5% of the employed population. It is not clear how policy makers can best encourage this to happen, but the key is for public and municipal employee groups to exert mass purchasing power in the managed care market.

The impact of closing off the inflationary spigot of individual or small group health insurance on providers would be stunning. Policy planners do not understand how fragile the economic structure of health services markets are, and how sensitive they are to modest increases in health plan enrollment. With the closing off of the small group and individual health insurance market, providers would find that the payers who pay them billed charges, and accounted for most of their operating profits, would suddenly be bargaining with them through health plan negotiations. Provider margins and incomes would be placed at risk, and capacity would come tumbling out of over-bedded hospital markets and over doctored specialty communities.

Individual, not Corporate, Mandate

If the cost of individual and small group health insurance can be sharply reduced, then the debate shifts logically to the method of achieving universal coverage. With the Republican takeover of Congress, and a pronounced rightward shift in public sentiment, mandating that employers offer health insurance to their workers is simply not going to happen.

Even politically liberal states like Massachusetts and Oregon have been unable to implement an employer mandate. Hawaii's economic record in the two decades its employer mandate has been in effect is hardly an advertisement for the strategy. Hawaii has among the most hostile business climates in the entire Pacific Rim, and the result has been a stagnant, banana republic economy. The employer mandate, a core idea in Enthoven's original vision of managed competition, is no longer politically or economically viable.

Employers do not offer health insurance to their workers out of altruism. They do so in order to compete for workers in tightening labor markets, and to bind their employees to the firm. As the economy continues expanding, and smaller cohorts of workers enter the labor market, tightening labor market conditions will compel more firms to offer coverage to their workers, providing that it is affordable. Affordability of coverage becomes the key to broadening coverage. If individuals and small groups could purchase health insurance 30-40% cheaper than they can now, at rates comparable to those obtained by large corporations, it is not clear that an employer mandate would be required to substantially reduced the uninsured population.

Against this background, the policy debate should shift from corporate to an individual mandate, along the lines of the Heritage Foundation proposal. Individuals who do not receive insurance from their employers should be required by law to purchase their insurance through a private or public purchasing co-operative. This purchase should be subsidized on an income-related basis through a refundable tax credit on their federal income tax. Everyone should be required to pay a portion of the premium out of their household budgets, up to a fixed percentage of their gross income (say 4%).

The debate over health coverage should shift from group entitlement to individual responsibility. Almost 30% of the uninsured have household incomes over $30 thousand annually, and have made voluntary decisions to spend their money in other ways. Millions of Americans are eligible for Medicaid but do not enroll because of its welfare connotations or lack of trust in government. When these individuals have major health problems, they shift the cost onto the rest of us. For those with resources or eligibility to obtain coverage, free-riding is irresponsible behavior. The reason we have tolerated it is that, unlike passive smoking or auto accidents, the victims are not identifiable, and we have been able to socialize the cost of these individual decisions to the vanishing point.

The price we have paid is an explosively inflationary healthcare payment system which exploits the unaffiliated individuals, families and small groups. The case for requiring individuals to purchase health coverage is just as compelling as that they purchase auto coverage. Universal coverage eliminates cost shifting and is vital to stabilizing health costs, and sealing off the health financing system from further inflationary outbursts.

What was missing from the Heritage Foundation proposal was the vehicle for massing the purchasing power represented in the vouchers. Requiring that the vouchers only be "cashed" via a purchasing alliance closes an important gap in an otherwise sound proposal, and assures some measure of control over the cost of the subsidies. Using the Internal Revenue Service to calculate the federal subsidy and issue the vouchers will raise some concerns. But the individual mandate has far fewer moving parts than the Clinton plan and, critically, does not create a whole new class of entitlements (e.g. corporate health insurance subsidies).

Replace the Casualty Model of Health Insurance with a Shared Responsibility Model.

The present health insurance system is built around a casualty model which assumes that health costs are the inexorable result of Acts of God and nature and that individuals are passive, helpless victims. While this may be true of diseases like influenza or Alzheimers disease, human agency and personal choices play a major mediating role in health status. The present health insurance system socializes the cost of irresponsible personal choices as well as the cost of unavoidable illness.

A major flaw in the original concept of managed competition was the limited role of the individual consumer. Virtually the sole role of the consumer was to pay the marginal cost of expensive health plans, or select the "self-limiting" plans such as HMO's. The assumption that shifting risk to providers via HMO's can by itself contain the rise in healthcare spending assumes that individuals exert no control over the primary demand for care. This assumption clearly is wrong. Consumers must share economic risk and responsibility for maintaining their own health if health status is actually to improve.

The conception that Americans have a "right" to healthcare is fundamentally unbalanced, since it does not carry with it a collateral obligation of citizens to behave in a healthy fashion. Since we cannot, with rare exceptions, dictate to individuals how they behave, we must rely, rather, on economic risk sharing as a vehicle for implicating citizens in managing their own health. A right to healthcare cannot mean a right to free care unimpaired by personal, health determining choices.

Health insurance contracts represent a matrix of incentives that signal not only to providers but to individuals and families how they should behave. These signals must change to encourage individuals to behave responsibly. Families which avoid consuming the average health costs in their group should receive a tax-free rebate of a portion of the savings. High risk maternity patients should receive incentives to encourage compliance with prenatal care. Addicted pregnant women should receive bonuses for staying clean through the term of their pregnancy and delivering a "clean" baby.

Conversely, we should not continue socializing the costs of patently irresponsible personal conduct. The individual who incurs a head injury while driving without seatbelts or helmet should pay a significant fraction of the cost of their trauma care out of pocket. Those who fail to have their children immunized should be fined, and should also pay a significant fraction of the costs of caring for the diseases which result. Health insurance contracts should convey some minimum expectations of the individual's responsibility to maintain their own health, and signal through both rewards and shared risk appropriate conduct.

Changing Federal Tax Policy is Essential

The difficult public policy decision is how to finance the vouchers provided to individuals to purchase insurance. There is one obvious and one less obvious source of funding: capping the individual tax deduction for employer provided insurance and imposing a federal insurance premium tax applicable to all health insurance premiums (whether purchased by insured corporations or self-funded plans).

Excusing from federal taxes the cost of first dollar health coverage (such as the autoworkers') is no longer sound tax or social policy. If unionized workers can recoup the cash lost from the tax cap through the collective bargaining process, let them do so. Unionized workers are far from the neediest cases in our present economy, and their claim for shelter from economic responsibility for their own health costs while other workers go uninsured is no longer valid.

To cushion the impact on family budgets, taxation of benefits could be limited to families with incomes over $30 thousand, leaving those who lack the disposable income to make an after-tax contribution with federal shelter. Everyone who receives health coverage, whether from employers or through public subsidy, should bear a portion of the cost out of their own pockets with after- tax dollars.

Limiting the tax-deductibility of health insurance to individuals will not generate sufficient revenue to fund the vouchers, however. Hence, a federal tax on insurance premiums will be needed to supplement funding. Given the competitive nature of health insurance provision, a premium tax would probably be "eaten" by insurers, rather than passed along to subscribers in the form of rate increases. Insurers would be required to cut their administrative overhead or to increase pressure on doctors and hospitals through selective contracting to absorb the premium tax. The premium tax would replace the present, ad hoc mechanisms of cost shifting with a more rational and equitable process.

Insurance Reform Via Certification

In order to receive federal voucher funds, or to contract for Medicare or Medicaid recipients, health plans would have to be certified by a federal agency. Enthoven's original idea is still valid: let the certification process assure non-discrimination in rates. In addition, individuals should be permitted to sue for specified (and limited) damages if they can prove discriminatory practices in extending benefits. It is not necessary for the

federal body which certifies health plans to collect and disperse the premiums (or administer a system of price controls), to assure that people with pre-existing conditions or groups with high health care use are not discriminated against.

Free the States to Experiment

There is great momentum behind state health reform. Federal barriers to achieving reform via state initiative should be lifted, but in a highly specific, limited way. ERISA pre-emptions should be granted only to states which achieve and fund universal coverage. Only very large (e.g. over 10 thousand employees) multi-state employers should be exempted from benefits design provisions. But states implementing comprehensive health reform must be permitted, if they choose, to tax health premiums paid by all employers, self funded or otherwise, to create pools for the uncovered and high risk.

State legislatures should be forbidden from directly mandating service coverage on self-funded plans beyond a minimalist basic benefits package. Congress must also restrain the temptation to use amending ERISA as a vehicle for imposing additional costs or coverage guarantees on self-funded employers. Self-funded employers must play a role in orderly, comprehensive state-initiated health reform.

Convert Federal Health Programs to Defined Contribution Plans

Policymakers have a powerful tool available to them for containing the cost of Medicare and Medicaid programs - the conversion of open-ended service benefit plans to defined contribution plans which pay on a population, rather than incident- of-service, basis. Congress and state legislatures already have the power to limit public health expenditures for Medicare and Medicaid through the appropriations process. That power has not proved sufficient to prevent these programs from threatening the fiscal integrity of state and federal governments.

Medicare and Medicaid must exit the business of paying providers of care directly, and must rather contract with health plans on an at-risk basis to cover their beneficiaries. The Medicare and Medicaid programs have tremendous clout in the health plan marketplace, and can offer their recipients a range of choices of health benefits and health systems.

In communities where elderly people have been given a choice between fee-for-service and managed care plans, they have flocked to managed care, and dragged their physicians right along with them. Not only are the elderly (and their children) freed from the burden of a completely incomprehensible claims process, but the elderly find additional services available to them that Medicare does not traditionally offer.

No one held a gun to the heads of the elderly in Portland, Oregon, where 63% of the Medicare population have freely chosen HMO's under risk contracts. They chose HMO's because those plans offered with no additional charge most of the services (including prescription drug coverage and in-home care) promised in the Clinton plan. The elderly

have multiple health plan options, including those containing their preferred personal physicians. The antipathy of Washington-based advocacy groups for the elderly toward managed care stands in sharp contrast to the freely expressed preferences of the elderly themselves.

The problem of the federal government "overpaying" HMO's is a problem of enrolling the first 20% of the elderly in health plans. By the time a majority of the elderly in a region are in health plans, the ability of any single plan to skew their marketing toward the "healthy" elderly is severely limited. Everyone is going to get their share of the very sick Plans that deliberately seek to recruit only healthy Medicare or Medicaid beneficiaries can be sanctioned or excluded from future contracting.

The addition of large numbers of elderly and high risk individuals to HMO pools composed primarily of healthy people will force HMO's to actually begin managing the health risk of their enrolled populations. Medicare risk contracting in particular changes the HMO, and forces them away from their traditional acute care focus to a more community based, preventive model. These changes will benefit everyone the health plan serves. As health plan enrollment grows to include a majority of those living in the community, HMO's end up in the public health business, and need to worry about managing population based risk, not merely minimizing the cost of incidents of illness.

Grasping the Electric Fence

After the 1994 health reform debacle, Congressional policymakers cannot be eager to take the issue up anew. The last two times Congress has attempted major healthcare legislation, including the catastrophic 1988 Catastrophic Healthcare initiative, policymakers have received horrible retribution from the electorate they sought to benefit. Healthcare and election year politicking clearly are a lethal combination. The time to take up health reform is in the off-year, at the top of an economic cycle, while health cost increases are moderating.

To achieve meaningful reform, both parties will have to part with pieces of their traditional dogma. Democrats will have to demand sacrifice from their core constituents, rather than showering them with other peoples' money. Republicans will have to tolerate a constructive federal role in health insurance regulation, and honestly raise the revenues to subsidize coverage for the working uninsured. Both parties must part company with the idea of healthcare as an group entitlement, and build upward from the idea of shared responsibility and incentives to conserve health resources.

Health reform hurts: that is the international experience. It is never easy or painless to sort out the true economic value of anything which passes through the hands of the government. But rearranging the economic responsibility for health costs in a way which implicates both providers and citizens is the vital core of a sound health policy. Ultimately, a health policy which is fair and transparent to voters can go some distance toward cushioning the political reaction to a hedging of a fiscally unsustainable social entitlement.

Managed competition may have sustained damage in the 1993-94 miscarriage of health reform. But with modification, it still represents the only viable framework for achieving universal coverage without damaging the fiscal posture of the federal government. Federal action is essential, if only to facilitate state level initiatives. Left to the states, however, health reform will not include all Americans. To wait for another surge of health cost inflation, which is inevitable absent constructive action, will only raise the cost of reform when it can no longer be avoided. The time to complete the work of health reform is now.