

# National Health Expenditure Limits: The Case for a Global Budget Process

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OVER THE PAST 30 YEARS, POLICY MAKERS HAVE vacillated between regulatory and competitive solutions to the health sector cost problem (Luft 1985; Altman and Rodwin 1988). The recent health reform debate placed these approaches in direct conflict, especially with regard to constraining total health expenditures. Although competition among health plans was embraced as a theme in the Clinton health reform proposal, it was to take place in a highly regulated environment. The most important control was to be a national expenditure limit, which would impose an externally determined rate of growth on health insurance premiums. Proponents of competition argued that an overall expenditure limit would hinder price competition among health plans, and was, in any event, unnecessary. In their view, managed competition would curtail our excessive spending, which was due to insufficient consumer cost sharing, tax subsidies supporting overinsurance, and lack of consumer information (Pauly et al. 1991; Enthoven 1993; Enthoven and Singer 1994).

As the arena for health reform is pushed from the national stage to the states, managed competition and related policies that adjust for health services market failures are again moving to the fore. Although it is

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likely to yield short-run savings, there is little assurance that increasing competition among managed care organizations will result in an acceptable growth rate for total health spending, even when combined with small-group and tax reform, better consumer information, and other market improvements. Eventually, health spending growth is likely once again to become intolerable. In response, the pendulum between competition and regulation can be expected to swing back toward regulation and the imposition of supply- and price-control measures.

We believe an intermediate position is attainable, one that builds upon managed competition. It would establish a global budgeting process involving both payers and plans, rather than dictating an externally determined global expenditure limit. Proponents of managed competition rely on player sensitivity to premium differences among plans to promote efficient provision of health services. The global budget process we suggest would additionally require payers to face the aggregate implications of their premium choices, working toward an efficient level of total spending.

Measures that establish health expenditure limits gain their appeal from skepticism about the aggregate outcomes of competition in the health sector. In the first section of this article, we discuss how this mistrust is justified: although it would increase the efficiency of many aspects of health services provision and utilization, managed competition is unlikely to achieve overall efficiency, by which we mean attainment of a reasonable, bounded total for health services production relative to other production in the economy. However, because of the many pitfalls of externally determined expenditure limits and the many benefits of competition, direct expenditure limits are not the policy of choice. In the second section, we present observations from three case studies of expenditure limit systems, prepared for HCFA during the health reform debate (Bishop et al. 1994). These provide evidence that regulated expenditure caps, even as a "backstop" for competition, will undercut competition and condemn policy evolution to increasingly detailed regulatory controls.

In the third part of this essay, we describe a middle ground that could capitalize on competitive incentives for efficiency and yet would limit the growth of total health resource use (Miller and Luft 1994). What is missing from managed competition, and imposed too rigidly by regulated expenditure caps, is a meaningful signal about society's willingness to spend for health services as a whole. This missing piece could be

incorporated into managed competition through a process that forces payers as a group to be sensitive not only to variations in health plan prices but also to total health spending. The process would arrive at a level of aggregate expenditures for a state or region that reflects tradeoffs between health spending and expenditures for other goods and services. A prototype at a state level appears in the Arizona Health Care Cost Containment System. The essay outlines how such a model could build on the strengths of managed competition. It would arrive at totals for health spending, not through unfettered competition or by fiat but through a global budget process with institutionalized joint contracting arrangements.

### Determination of Aggregate Health Spending in Market-Driven Systems

The proportion of health services paid for by third parties has grown steadily during the past 30 years, from about one-half of expenditures in 1965 to over 80 percent in 1993. With individuals paying only a small percentage of resource costs, little pressure exists to hold down health services prices or utilization: there is no overall budget constraint for health spending. Because of the fundamental nature of insured demand and technological change, we cannot be confident that markets for health services will reach appropriate totals for health resource use. This is certainly the case in fee-for-service-oriented health markets. However, even with managed competition's corrections for market failure, the many decentralized decisions of providers and consumers are likely to aggregate to an excessive and unstable total for health resource use. The problem, simply stated, is that even managed, competitive health services markets provide no mechanism for transmitting society's evaluation of spending on health services versus spending on other valued goods and services.

In the market for other goods and services, consumers must align their purchases with their incomes, and producers very quickly feel the consequences of any oversupply with resource cost that exceeds consumers' willingness to pay. In contrast, society is not willing to deny needed health services to those who cannot pay for them, and health insurance is valued exactly because it insulates consumers from financial demands when they need to purchase health services.

Improving market functioning may well increase the efficiency of health services provision. By reducing the subsidization for the purchase of insurance, managed competition would foster price competition among insurance plans. Plans would have more incentives to provide services efficiently and to better align the benefits of treatment with marginal costs. But these savings would be gained for a given state of technology. Over time, medical innovations widen the choices of practitioners, and plans, about how to meet health care needs. Unlike almost any other type of insurance, health insurance covers payment for *needed services*; it is not a contingent money indemnity. Consumers pay only indirectly, through next year's premium, for this year's increases in the quality and amenity of services they receive. This encourages suppliers to develop and provide costly (and of course potentially valuable) technological advances (Weisbrod 1991; Schwartz 1994). The services deemed necessary to provide a community-standard level of care for any given ailment have expanded at a rapid pace. Cost-increasing technological change has accounted for much more of health expenditure growth over the last 30 years than has the increase in utilization attributable to reductions in insured prices (Newhouse 1992; Weisbrod 1991). While some technologies have reduced health care expenditures, on balance technological advances have substantially increased costs because they have expanded the scope of clinical practice.

Increased competition among managed care organizations is likely to increase efficiency and contain the cost of providing the current community standard of care, but it includes no mechanism to convey the reluctance (or willingness) of purchasers as a whole to pay the bill for technology-driven utilization. Newhouse (1992) argues that consumers must be willing to pay for increasing technology because no plans offering lower-technology care, and lower prices, have emerged in the market. It is possible that low-technology plans would be available under full managed competition if consumers had strong enough incentives to shop on the basis of premium. It is more likely that the social and ethical norms that prevent us from explicitly denying needed health services on non-health-related grounds (e.g., ability to pay) would make it difficult to deny specific technological interventions to low-tech-plan members when they needed them.

When managed care insurers compete for market share under managed competition, each has an incentive to provide the current standard of health services efficiently, at lower resource cost. However, they have

no incentive to minimize the total they compete for, and in fact their goal is to "grow" the health sector as a whole. Use of an expensive technology does not put any one insurer at a price disadvantage, if the technique has become the standard of practice adopted by all. Technological innovations expand the scope and quality of health care and, by doing so, increase the expenditure pie. Such advances are in the self-interest of all health care market participants, including patients and providers, as well as insurers. But unbounded growth of total expenditures on health cannot be in the long-run interest of citizens, who need and want other goods and services.

In sum, the foundations of the modern health care sector, health insurance and technological progress, will prevent managed competition from reaching an appropriate expenditure total. Are direct regulatory budget caps any better?

#### National Health Expenditure Limits: Can Global Budget Systems Do Better?

In other nations, governments unilaterally establish and implement expenditure limits that determine total health spending and health services, but, unlike a market system, they do so through administrative means. Mechanisms are included to determine directly the amount of resources that are to flow to health services (i.e., the amount of total expenditures), how health care is to be produced (e.g., the relative importance of the physician and hospital sectors), and how provider capacity (e.g., numbers and types of physicians, hospital beds, and high-tech equipment) is to be distributed across regions or populations. Given that decentralized markets are not capable of effectively constraining health spending, a political process could be a reasonable alternative for determining society's preferred amount of health services. In this view, a "top-down" expenditure limit for health services could yield better outcomes than the "bottom-up" solutions of the decentralized market.

We recently examined three budget systems (Germany, the Netherlands, and the Canadian provinces) that incorporate one element lacking in competitive approaches: a social decision process about what should be spent on health services (Bishop et al. 1994; see also Reinhardt 1993-94; Henke, Murray, and Ade 1994; Van de Ven et al. 1994; British Columbia Royal Commission on Health Care and Costs 1991).

In each case, the success of the limit depends on the widespread acceptance of the need for both cost containment and a criterion that establishes the appropriate amount of health expenditures. The burdens of reunification have encouraged Germans to hold sickness fund premiums to an average of 12 percent of payroll; the Dutch believe that the spending on all social programs, including health, has reached its aggregate limit, and if more community long-term care is to be supported, acute health spending must be restrained; in recessionary times, the Canadian rule of thumb that spending on health should not exceed 30 to 35 percent of provincial revenues is more constraining than it would be in an era of economic growth. Even if health providers complain of difficulty in supplying services within these constraints, they respect the political and solidarity forces that have established each global expenditure limit. The aggregate demand limit is thus meaningful and real.

The budgets are self-regulating within a budget year. The fixed budgets allocated to hospitals in all three countries, and to physician associations in Canada and Germany, put an upper limit on what services can cost. By fixing these sectoral (hospital, physician, pharmaceutical) budgets and delegating them to provider associations and hospitals, the central authority assures that its total expenditure limit will not be breached. When spending in certain subsectors exceeds desired amounts, the regulatory system responds with further regulations addressing specific problems.

However, the methods used to establish and implement social aggregate demand for health services in each nation carry substantial cost. The three national systems provide two types of examples of undesired responses to constraints: at the level of the producer of services and in the overall system. These are symptomatic of the inflexibility of fixed limits and their implementation at the sectoral level.

### *Provider Behavior under Expenditure Limits*

Consider first provider behavior under expenditure limits. Each sector is granted fixed resources and expected to provide health services. Providers then determine the types of services to offer and the population they will serve, making decisions about input mix, adoption of new technology, and professional effort. The budgeted amounts are in effect

block grants to providers. Such a funding mechanism certainly does not foster responsiveness to consumers or efficient linkages with substitute or complementary services. Provider autonomy under block-grant funding has had a number of consequences. As German ambulatory care physicians divide a constant budget over increasing services, fees decline; physicians then provide more visits to maintain income, resulting in a rate of visits per capita more than twice that in the United States. In Germany, some office-based specialists are constrained in their introduction of new technologies because the nationally determined relative fee schedule cannot adjust quickly to changing expenses. Canadian hospitals have been known to close between Christmas and New Year's for all but essential services, in order to live within their budgets. Dutch hospitals develop internal budgets to match costs to resource allocations, and if budgeted supplies for a certain procedure or operation are exhausted midyear, hospital management curtails that service to contain the total budget. In all these examples, the incentives transmitted to providers encourage behavior that is most likely to move care provision away from, rather than toward, the mix most valued by society.

### *Effects of Expenditure Limits on the System*

From a systemwide perspective, the barriers between provider sectors prevent efficient substitutions among types of services. Sectoral shifts do not occur easily when one sector's increased utilization requires special funding increases, while, at the same time, savings realized in another sector are difficult to remove from its budget. It is difficult politically to reallocate resources from one sector to another, even if resource shifts would increase system efficiency and the total production of health. Sectoral shares become fixed over time, with absolute amounts updated by cost of living and other factors that are constant for all providers. In Germany, hospital specialists are paid within fixed hospital budgets and cannot easily shift to outpatient settings, despite clear opportunities to increase efficiency. Also in Germany, many of the increasing number of ambulatory visits include a prescription, and expenditures on drugs have skyrocketed, reaching 16 percent of total expenditures. (The regulators' response to this phenomenon is discussed below.) In all these systems, physicians have little reason to conserve the use of other health

resources, as long as their fees are budgeted completely separately from the budgets for hospital services, pharmaceuticals, and other health services.

Once a central authority controls sector budgets, political realities also hold it responsible for incomes and employment policy for health workers, further decreasing the scope for local hospitals or ambulatory clinics to introduce efficiency measures. In Canada, when hospitals are downsized or closed through central planning, it is politically important to assure that displaced workers move into other jobs, even if they are redundant: in British Columbia, health sector workers have won a three-year job guarantee. National collective bargaining for health sector wages has accompanied the use of government, or quasi-government, agencies as single or major payers in Germany and the Netherlands. The Dutch are attempting to promote competition among both hospitals and sickness funds, but once wages, personnel inputs, and total budgets are set by regulation, there is little scope for efficiency increases.

Health budget officials in charge of these systems are aware of unrealized efficiencies and are working on many fronts to achieve them. But regulatory intervention resolves efficiency problems one by one and results in increased centralization. It is difficult for such systems to delegate responsibility, without oversight and second-guessing, to the providers who could actually improve allocation of resources at the patient level. The case of the specialists in the Netherlands is one example: as total payments to specialists climbed, the central regulatory board responded with a sharp cut in fees; as specialists began providing more hospital-based services to maintain their incomes, their patients' use of hospital services placed further stress on hospitals' strictly budgeted resources. A related example is found in Germany, where perhaps too much accountability for another sector's costs was shifted to physicians: to counteract the spiraling increase spending on pharmaceuticals, physicians as a group were made responsible, beginning in January, 1993, for a limited amount of any overrun of expected total pharmaceutical spending. The result was an immediate 20 percent cutback in this spending, probably realized through substitution of older, lower-cost drugs as well as generics, and an across-the-board cutback in the number of prescriptions. The German system relies on professional ethics to assure that physicians will make appropriate tradeoffs between health outcomes and the threat to their own incomes represented by



pharmaceutical costs, and physicians are not accountable for any resulting impact on other health sector costs.

### Bounded Competition: Efficient Delivery System, Global Budget Process

Regulated spending caps are inconsistent with provider and consumer incentives that foster efficient production and utilization. The challenge is to build on our decentralized health market system and yet incorporate a restraint on the total reached by myriad individual provider and patient decisions. The Clinton health plan took a stand on this problem. It recognized that, for several generations, insurance plans have brokered covered services for populations, with premiums as prices for comprehensive services; they are now managing care and evolving into integrated delivery systems that both insure and serve populations. With their increasing control over the efficiency and effectiveness of care provision, and their comprehensive population-based budgets, they make a plausible focus for appraising and moderating growth of total expenses. But the Clinton health reform plan proposed to do this by mandating premium cuts for health plans with higher premium increases whenever the expenditure growth rate for an area exceeded a government-specified amount. Although preferable to the direct sectoral expenditure regulation we observed in other countries, premium regulation, particularly within very tight overall limits, would have undermined the ability of insuring organizations to compete on price to enrollees and attenuated rewards for efficient and innovative plans.

An alternative approach is to implement a global budget *process*, structured around multiple payers and managed care plans, that restricts total expenditure determination. Such an internalized market process could continue to rely on insurance entities to represent the supply side of the market, but would replace the regulatory authority on the demand side with a coalition of health care payers. As a group, they would express not only the demand of their covered populations for health services, but also the social evaluation of total spending, taking into account what the resources would yield if they were employed for other productive uses.

A version of such an approach with a single payer has been working for some time in Arizona. The Arizona Health Care Cost Containment System (AHCCCS) is a government-sponsored model for allocating health resources across multiple suppliers for a given population while maintaining consumer choice among comprehensive providers and strong incentives for provider efficiency (Bishop et al. 1994; see also Chen 1995; Paringer and McCall 1991; McCall et al. 1994). The demanders in this model are Arizona Medicaid and, since 1987, small employers. All Medicaid eligibles are required to obtain health services from managed care organizations selected in a competitive bidding process and paid on a capitation basis by the state. On the supply side are the managed care organizations, which submit bids in each county, proposing a set of capitation rates differentiated by eligibility category. Acceptable bidding ranges, unknown to the bidders, are determined by state consultant actuaries for each county and type of enrollee. Given the number of enrollees, this yields a target for total expenditure. However, the actual expenditure limit emerges from the bidding process and, if needed, contract negotiations: bids are submitted in a two-stage process, with initial bids followed by "best and final" bids. In most areas (except for several rural counties, where the number of winning bidders to be selected is constrained), the AHCCCS administration lets multi-year contracts to multiple bidders whose rates fall within the acceptable ranges, so that the program does not become dependent on one winning supplier. (In order to heighten competitive pressure, a policy to limit the number of winners in the more populous counties is under discussion.) Medicaid eligibles then choose to enroll in any of the approved plans. However, half of the Medicaid eligibles make no choice, and these persons, along with the state-funded eligibles, are assigned to the lower-priced plans by AHCCCS administration. Specifically, plans are ranked by initial and final bid prices. Those with a lower average rank receive a larger share of the AHCCCS-assigned members. (In Maricopa County, for example, the lowest bidder receives 50 to 55 percent of the assignments in most rate categories; the second lowest bidder receives 15 to 25 percent; and the remaining bidders, 5 to 10 percent each.) The plans that present low initial bids thus gain greater market shares.

Conceptually, the actuarial costs for each population cell, when multiplied by the expected numbers of persons to be covered, aggregate up to a kind of trial budget. The magnitude of this budget is known only to the purchasing organization, but the bidders know that such a target

exists and that their bids must fall within an acceptable range to be considered. But if AHCCCS as a purchaser mistakenly underestimates the amount needed to serve the Medicaid population, the bids will reveal this. On the supply side, the comprehensive health plans competing for AHCCCS populations voluntarily offer prices based on their own cost structure and desired profit margins. The final premiums, derived through joint contracting, can thus accurately reflect both the willingness to pay of demanders and the supply costs for various levels and types of output of suppliers. The final or adjusted bid prices times the number of enrollees in each plan determines the total budget for the year, which cannot be determined in advance, as it responds to market forces. In addition, the state must, and does, respond to market realities in establishing the year-to-year overall budget (Paringer and McCall 1991).

Thus the AHCCCS system both transmits an effective but flexible constraint on aggregate demand and elicits information about supplier costs, analogous to an aggregate supply relationship. AHCCCS has produced savings for Arizona Medicaid except in its first year of operation; savings are estimated at \$51.5 million for fiscal year 1991, about 13 percent less than estimates for the costs of a hypothetical traditional Medicaid program covering Arizona's population (McCall et al. 1994). Annual growth rate for costs over the first eight years of program operation was estimated at 6.8 percent, compared with 9.9 percent for traditional Medicaid growth. The success of AHCCCS in holding down total expenditures demonstrates that a total expenditure limit derived from provider-bid rates need not be an aggregation of free-floating supplier costs. The success of the system also requires the continued participation of multiple managed care organizations, so that it will not collapse into monopoly. The program determines the number of plans selected in each geographic area, depending in part on population scale. In practice, the number of successful bidders in the AHCCCS system has been increasing rather than diminishing.

Plans, and the providers that in turn contract with plans, seem to behave as if the buyer indeed has a constrained willingness to pay, and they apparently realize that purchase decisions are price sensitive—or at least more price sensitive than in fee-for-service markets with their heavily insured and subsidized health care services. The long-run success of the bidding system depends on the establishment of adequate market-clearing premiums to attract a greater number of plans than are

needed to serve the population. This assures competition among the plans. The entry of new HMOs into the most recent round of bids suggests that the AHCCCS system is simultaneously achieving efficiencies at the plan and community level.

### Implementing a Global Budget Process for Health Expenditures

To supply the flexible aggregate demand constraint missing both from managed (and unmanaged) competitive systems and from the rigid national global budget systems, an AHCCCS-style budget process might be developed for a state or national health sector. This discussion concerns implementation of such a process at the state level because it is unlikely that we will soon see major change in health payment policy at the national level. State or regional administration would in any case better allow effective negotiation among participants and adaptation to local concerns. If implemented for the nation, a federal-level board might develop initial trial population-based expenditure limits for states or regions, but it would be up to more local authorities to link multiple local payers with multiple comprehensive providers within that constraint.

It should be possible to extend an AHCCCS-style process to incorporate multiple payers. A quasi-governmental broker agency could bring together privately and publicly funded insured groups, which would collectively set rules for the process. The agency would require more authority than a voluntary purchasing cooperative, for it would need to encompass most, if not all, purchasers within the state. The willingness of society to pay for health services in the aggregate could be reflected by a trial expenditure limit, possibly developed by inflating past per capita spending using an external signal, like percentage growth in per capita income. The collective purchasers would agree in advance that the contract rates for a given comprehensive care plan would apply to all payers, precluding cost shifting.

The agency would then orchestrate competitive bids to serve the population represented by the multiple payers. The budget process satisfies the need for an expenditure outcome that reflects both supply and demand. In the contract negotiations between a broker agency and comprehensive health plans, the plans, which of course possess the most

detailed information about their own experience and efficiency in caring for different groups, would present price bids for the care of different population segments, perhaps, for example, according to age and disability. Consumers would choose among plans based on premium price and plan attributes, so that those providing better value would be likely to gain greater market share. Consumers not expressing preferences could be assigned by each payer. The practice of assigning larger market shares to the lower bidders would reinforce incentives for competing health care plans to bid efficient premium prices, yet multiple suppliers would continue to participate in the market. The joint purchasing arrangement also entails that all purchasers pay the same premium to a given plan for coverage of individuals of a given type: in other words, the process would arrive at different contract prices for specific population segments for each provider, but prices would not vary by payer. The accepted premiums times the number enrolled at each premium would fix total expenditures for the duration of the contracts, constituting a global budget limit.

Finally, the contracting process must include performance standards for access and quality of care. Performance contracting and monitoring would encourage efficient production of what the multiple purchasers value: care for the state population at a desired level of access and quality of care. Payers would have clear criteria for assessing penalties for non-performance: nonrenewal of contracts, and, if necessary, termination of plans before the contract expired.

## Conclusions

A global budget process that establishes total expenditures through a flexible interaction of supply and demand is preferable to one in which expenditures are driven by supplier costs (as in the United States) or established by the government (as in global expenditure limits abroad). When we look beyond our borders, we are impressed, not with the cost-containment record of foreign countries that fix expenditure limits, but with the great potential of the U.S. health economy to incorporate both demand and supply considerations in determining total health expenditures.

The nations that have relied on sectoral budgeting of health expenditures are facing increasing system inefficiency and are attempting to

respond. But their ability to make significant changes appears to be limited. Governments responsible for health payment are locked into corresponding responsibility for health jobs and health incomes, precluding major shifts in resources. Foreign health systems are administered from the top down, blocking efficiency gains that might result from the independent activity of providers. These countries are attempting to implement increased "competition" through new pricing formulas and broadened consumer choice. However, when inputs, input prices, and output are regulated, there is little scope for competition among providers or insurers. They are attempting to achieve the benefits of internalized health markets without releasing the grip of regulatory controls. In the Netherlands, for example, a market reform initiative has led to the opposite result: sick funds, now paid on a per capita formula basis in the expectation that they would strive for greater efficiency, are unable to achieve it because provider prices and utilization are not subject to negotiation. The funds must pay for the services of any hospital or physician, regardless of efficiency, at government-set prices. Under pressure to compete on price, the sick funds are pursuing the only cost-cutting opportunity open to them: combining and merging to spread uncontrollable risks and administrative costs.

In the U.S. health system, in contrast, market forces encouraging efficiency in service delivery are very much at work. The problem is the absence of an aggregate demand constraint. We would argue that the flexible health market system in the United States may have less difficulty in moving toward a middle ground for establishing overall expenditures than will the rigid, centrally budgeted regulatory systems. Unlike their highly regulated counterparts abroad, American providers are used to responding to market incentives. In the United States, health care delivery systems are increasingly integrated at a lower level, closer to the provider-patient interaction, than are the segmented (institutional versus ambulatory care; specialist versus general practitioner) health systems of sectoral-budget countries. It is critical to efficient, flexible resource allocation that physicians be positioned in the budget structure so that they have authority and can take responsibility for managing resources; capitation payments to physicians and to physician-directed organizations support this role of physicians as decision makers. Comprehensive health providers, which assume the responsibility of managing care for all of an insured consumer's health needs, are ideal participants in the global budget process we have outlined here. They

are beginning to dominate the U.S. health marketplace and do not need to be invented for the purpose of participating in joint determination of health expenditure limits. Instead, the task is to bring our multiple payers to the negotiation table across from the comprehensive health insurers and providers. A competitive bidding process, operating within a target overall budget with multiple suppliers voluntarily offering services to multiple purchasers, would develop and harness market forces promoting both micro- and macroefficiency in determining total expenditures. Such a global budget process has the potential to support innovation and to yield a more appropriate allocation of our national economy to health care.

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