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**Health Matrix: The Journal of Law-
Medicine**

Volume 5 | Issue 1

1995

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Recommended Citation

Henry T. Greely, *Policy Issues in Health Alliances: Of Efficiency, Monopsony, and Equity*, 5 *Health Matrix* 37 (1995)

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POLICY ISSUES IN HEALTH ALLIANCES: OF EFFICIENCY, MONOPSONY, AND EQUITY

Henry T. Greely†

*"Marley was dead; to begin with. There is no doubt whatever about that. The register of his burial was signed by the clergyman, the clerk, the undertaker and the chief mourner. Scrooge, signed it: . . . Old Marley was dead as a door-nail."*¹

AND SO IS THE HEALTH SECURITY ACT, the Clinton administration's ambitious plan to reform the American health care financing system, and with it, the mandatory health alliances that were to play the crucial role in implementing the Act. In February 1994, at the time of the conference from which this symposium issue is drawn, mandatory health alliances under the Clinton health reform proposal could have been characterized, to shift centuries, as on life support and the Clinton plan itself in serious condition. By now, the figurative plug has been pulled on both mandatory alliances and on any meaningful health reform. Of course, the problems that sparked the health reform efforts are alive and well, leaving all Americans who are paying attention to wonder "what next?"

This Article attempts to explore the future of one vital part of the Clinton plan for universal health coverage - health alliances.² It argues, perhaps surprisingly, that in one form or

† Professor of Law, Stanford University. I would like to thank the participants in the Case Western Reserve University Law-Medicine Center Symposium, *National Health Care Reform: The Legal Issues*, particularly Professors Max Mehlman, Eleanor Kinney, and Clark Havighurst. I also would like to thank my research assistant, Erik Olson, and the financial support of the Claire and Michael Brown Estate.

1. CHARLES DICKENS, *A CHRISTMAS CAROL* I (Holiday House, 1983) (1843).

2. This Article addresses health coverage rather than health insurance because health coverage for employees, more often than not, is now provided through mechanisms other than "insurance." More than 40 million Americans now receive coverage through health maintenance organizations (HMOs), which do not "insure" consumers but contract to provide them directly with medical services. Tens of millions more Americans receive

another, alliances should have a bright future. These alliances may be mandatory or voluntary, governmental or private, but they will continue to spread as ways for purchasers of health insurance to band together to get better coverage for their money. Health alliances offer too many advantages of too many different kinds to disappear.

Alliances also raise thorny questions that cannot be ignored. Health alliances have attracted support from three very different camps: those interested in them for efficiency, for monopsony, and for equity. For those interested solely in efficiency, health alliances are essentially purchasing cooperatives that allow small buyers to benefit from the economies of scale in bargaining and in implementation that are available to large purchasers of health coverage. For those interested in monopsony, health alliances are able to extort lower prices out of the sellers of health coverage by controlling a large number of the purchasers. For those interested in equity, health alliances are attractive because they offer all consumers within the same alliance access to the same coverage choices. These three different conceptions have different implications for how health alliances *should* be structured.

This Article will take three somewhat separate looks at health alliances (HAs). First, it will explain the background of HAs, their definition, and their history. This section will describe in some detail how HAs were supposed to operate under the Clinton Health Security Act (the HSA or the bill). Second, it will add a bit of empirical evidence to the discussion of HAs by describing two existing entities that operate like health alliances, the California Public Employee Retirement System (PERS) health benefits system and the Health Insurance Plan of California (HIPC). These examples may be useful to anyone interested in the topic. Third, this Article will analyze four difficult issues concerning HAs: bureaucracy, geography, health cost control, and governance. The analysis will focus on HAs

coverage through employers who "self-insure." In these cases, the employers pay the covered health bills themselves, though usually with administrative help from an expert in health coverage, which is often an insurer. Pure "insurance," where an outside party agrees to reimburse a consumer for health coverage expenses the consumer has chosen and paid for, is increasingly rare. For a discussion of the somewhat surprising nature of the current market for private health coverage, see Henry T. Greely, *The Regulation of Private Health Insurance*, in *HEALTH CARE CORPORATE LAW: FORMATION AND REGULATION* 8-1, 8-13 (Mark Hall ed., 1993).

under the Clinton plan, but also will try to illuminate some more fundamental issues. Finally, this Article will offer some thoughts on the future of HAs.³

I. HEALTH ALLIANCES IN THE CLINTON HEALTH PLAN

The intellectual underpinnings of health alliances start with Professor Alain Enthoven and the so-called Jackson Hole group of health policy analysts. In two influential articles, published in January 1989 in the *New England Journal of Medicine*, Enthoven argued that health care should be provided through mandatory employer participation in what he called "Health Insurance Purchasing Cooperatives."⁴ These cooperatives, nicknamed HIPCs (pronounced "hip'-icks") would be

3. Even though they had a central role in the HSA, there has been surprisingly little detailed discussion of HAs as envisioned by that bill. The best discussion was in a short pamphlet by Clark C. Havighurst, *REMAKING HEALTH ALLIANCES* (Am. Enterprise Inst. 1994), which explored some of the problems of controlling HAs. See also HENRY N. BUTLER, *UNHEALTHY ALLIANCES: BUREAUCRATS, INTEREST GROUPS, AND POLITICIANS IN HEALTH REFORM* (1994).

Before the HSA was completed, a useful discussion of the structure and roles of HAs took place in the journal *Health Affairs*. It published four short articles entirely on HAs under the title *Perspectives: Health Insurance Purchasing Cooperatives*, including Walter A. Zelman, *Who Should Govern the Purchasing Cooperative?*, HEALTH AFF., Supp. 1993, at 49; Paul Starr, *Design of Health Insurance Purchasing Cooperatives*, HEALTH AFF., Supp. 1993, at 58; James C. Robinson, *A Payment Method for Health Insurance Purchasing Cooperatives*, HEALTH AFF., Supp. 1993, at 65; and Shoshanna Sofaer, *Informing and Protecting Consumers under Managed Competition*, HEALTH AFF., Supp. 1993, at 76. (Both Zelman and Starr played major roles in drafting the HSA). The issue also contained useful discussions of some of the issues involved in HAs in Paul Starr & Walter A. Zelman, *A Bridge to Compromise: Competition Under a Budget*, HEALTH AFF., Supp. 1993, at 7; Alain C. Enthoven, *The History and Principles of Managed Competition*, HEALTH AFF., Supp. 1993, at 24, and Richard Kronick, *Where Should the Buck Stop: Federal and State Responsibilities in Health Care Financing Reform*, HEALTH AFF., Supp. 1993, at 87.

There has been very little discussion of HAs in the law review literature. The most useful article is probably Janet L. McDavid, *Antitrust Issues in Health Care Reform*, 43 DEPAUL L. REV. 1045 (1994). Issues in consumer protection, particularly of minorities, under HAs are explored in Vernellia R. Randall, *Does Clinton's Health Care Reform Proposal Ensure Equality to Health Care for Ethnic Americans and the Poor?*, 60 BROOKLYN L. REV. 167 (1994). Both of those law review issues, along with 29 WAKE FOREST L. REV., Issue 1, contain symposia on the Clinton Health plan, featuring a wide range of useful analyses of the HSA. Many of these articles discuss HAs in passing, but do not focus on them.

4. See generally Alain Enthoven & Richard Kronick, *A Consumer-Choice Health Plan for the 1990's: Universal Health Insurance in a System Designed to Promote Quality and Economy* (pts. 1 & 2), 320 NEW ENG. J. MED. 29, 94 (1989) (proposing a universal health insurance plan mandating coverage by employers of full-time employees).

large enough to function as efficient purchasers and monitors of health coverage. The HIPC idea, after further elaboration by the Jackson Hole group, became part of the Clinton administration's HSA, as unveiled in October 1993.⁵ HIPCs, renamed as the presumably less-intimidating Health Alliances, were crucial to the Clinton plan.⁶ Although no bills similar to the Health Security Act seem likely to be enacted in the near future, I will discuss HAs as defined in that bill in some detail, as the bill provides the most detailed implementation of the idea of mandatory health alliances available.

Under the Health Security Act, all Americans currently covered by Medicaid, all self-employed or unemployed Americans, and almost all Americans with an employee in the family would get health coverage through an HA. Only two groups of people would not. First, the roughly thirty-five to forty million Americans eligible for Medicare and a few other smaller federal programs would continue to receive their existing coverage.⁷ (In the future, newly eligible Medicare members would be allowed to keep their HA-provided coverage if they chose.) Second, private employers with more than 5000 employees and existing union-based "multi-employer plans" with more than 5000 active participants could choose to set up their own systems, called "corporate alliances."⁸ Families with members covered by such corporate alliances may not have been covered by an HA, although some of these families could have opted to

5. The principles behind the Health Security Act were announced in September 1993. The White House released an incomplete text of the bill on October 27, 1993, before it actually had been introduced in Congress. The White House periodically announced changes in the details of the bill, or floated possible changes, over the next several months. For the most part, this Article will describe the HSA as of October 1993.

6. The bill actually used the term "health alliance" to refer to both the state-created "regional alliances" and the employer- and union-created "corporate alliances." See H.R. 3600, 103d Cong., 1st Sess., §§ 1301, 1311 (1993) [hereinafter HSA].

7. Individuals eligible for Medicare (generally those who are over 65, permanently disabled, or diagnosed with end-stage renal disease) would continue to receive health benefits through Medicare. *Id.* § 1001(d). Military personnel and their families could choose to be covered by a Uniformed Services Health Plan of the Department of Defense, *id.* § 1004(b)(1); veterans and their families could choose a veterans health plan, *id.* § 1004(b)(2); and those eligible to enroll in the health program of the Indian Health Service could continue to receive that coverage, *id.* § 1004(b)(3). In addition, prisoners were to receive health care through the authority responsible for the prisoner. *Id.* § 1001(e).

8. *Id.* § 1311(b). The union plans had to be in existence as of September 1, 1993. Rural electric cooperatives and rural telephone cooperative associations also could constitute corporate alliances if they were offering health benefits as of September 1, 1993 and had more than 5000 employees entitled to health benefits under the plan.

be covered through an HA through a family member employed by a smaller company. The exact number of large employers and unions that would have established such plans, and the number of individuals they would have covered, cannot be determined, but it seems very unlikely to have exceeded fifty million people. Thus, somewhere between 165 and 215 million Americans would have received their health coverage through an HA.

Under the Clinton plan, states would have participated in the HA system in one of three formats. A state could make its HAs part of the executive branch of the state government, an independent state agency, or a non-profit non-governmental organization.⁹ Whichever option the state would choose, the HA had to be governed by a board of directors.¹⁰ The directors were to be equally divided between representatives of employers and representatives of individuals. No one working in the health care industry, or closely related to someone working in that industry, could serve on these boards, but each HA would be required to have a separate medical advisory board.¹¹

Each participating state would have to establish at least one HA. No HAs could cross state lines.¹² States could establish multiple HAs and set their borders, but with several limitations. Each part of the state had to be within the territory of one HA,¹³ no part of the state could be within the territory of more than one HA,¹⁴ and each HA would have to cover a population large enough to give the HA an adequate market share to negotiate effectively.¹⁵ In setting the boundaries of HAs, a

9. The Clinton bill did not require a state to participate in the system, thus avoiding possible legal attacks under the Tenth Amendment. The bill, however, provided such strong incentives for a state to participate that it seems highly unlikely any state would, in fact, have opted out.

States also were given the option of creating a state-wide "single-payer system," which would preempt the HA system. *Id.* §§ 1221-1223. A state was also allowed to create an "alliance-specific single-payer system," in which case the HA would exist, but would differ in some important respects from the "single-payer system." *Id.* § 1224. Neither of these options will be discussed in this Article.

10. *Id.* § 1302(a).

11. *Id.* § 1302(b),(c).

12. States were, however, authorized to allow or require HAs to coordinate their activities within a state or between states. *Id.* § 1202(c).

13. *Id.* § 1202(b)(6).

14. *Id.* § 1202(b)(3).

15. *Id.* § 1202(b)(2)(A). Section 1202(b)(2)(B) provided a safe harbor as to § 1202(b)(2)(A) by providing that if an alliance includes all the portion of a Consolidated

state could not “discriminate on the basis of or otherwise take into account race, ethnicity, language, religion, national origin, socio-economic status, disability, or perceived health status.”¹⁶ Furthermore, no part of a “metropolitan statistical area” contained in the state could be divided into more than one HA.¹⁷ A state’s failure to abide by these rules in setting up the alliances apparently could be challenged by the National Health Board,¹⁸ or in a private action under section 1983.¹⁹

Under the bill, an HA would have four major functions: (1) negotiating with health plans and providers, (2) ensuring the enrollment of all eligible individuals and families, (3) creating and regulating information provided to consumers about their options, and (4) collecting and analyzing data on the quality of care delivered by contracting health plans. In addition, HAs would issue “health security cards,”²⁰ create an

Metropolitan Statistical Area that is within the state, it is presumed to meet the adequate population requirement.

16. *Id.* § 1202(b)(4).

17. *Id.* § 1202(b)(5). The Office of Management and Budget designates geographical regions as “metropolitan areas.” It divides these “metropolitan areas” into three categories: “metropolitan statistical areas” [hereinafter MSA], “primary metropolitan statistical areas” [hereinafter PMSA], and “consolidated metropolitan statistical areas” [hereinafter CMSA]. CMSAs are large urban areas, made up for a number of different PMSAs. MSAs are only those metropolitan areas that are not part of a CMSA. US DEP’T OF COMMERCE. STATISTICAL ABSTRACT OF THE U.S. app. II at 926 (1994). For example, the New York-Northern New Jersey-Long Island, NY-NJ-CT-PA CMSA, the country’s largest with a population of over 19 million, is made up of 15 PMSAs: Bergen-Paddaic NJ, PMSA; Bridgeport, CT PMSA; Danbury, CT PMSA; Dutchess County, NY PMSA; Jersey City, NJ PMSA; Middlesex-Somerset-Hunterdon, NJ PMSA; Monmouth-Ocean, NJ PMSA; Nassau-Suffolk, NY PMSA; New Haven-Meriden CT PMSA; New York, NY PMSA Newark, NJ PMSA; Newburgh, NY-PA PMSA; Stamford-Norwalk, CT PMSA; Trenton, NJ PMSA; and Waterbury, CT PMSA. *Id.* at 933.

Although the large CMSA and its 15 constituents are each “metropolitan areas,” as defined by the Office of Management and Budget, none of them is a “metropolitan statistical area,” the term used in the HSA. It seems likely the drafters intended to refer to both PMSAs and MSAs. There are 250 MSAs in the country, mainly in smaller areas, as compared with 73 PMSAs which combine to form 18 CMSAs. *Id.* at 926. According to the early explanation of the HSA, released as comments on the Preliminary Working Group Draft in September 1993, alliances were not to split PMSAs. PRESIDENT CLINTON’S HEALTH CARE REFORM PROPOSAL — PRELIMINARY WORKING GROUP DRAFT OF SEPTEMBER 7, 1993, reprinted in PRESIDENT CLINTON’S HEALTH CARE REFORM PROPOSAL AND HEALTH SECURITY ACT, (CCH) app. at A-19 (1993).

18. Under this section of the proposed bill, the National Health Board presumably would have to approve the HA boundaries as part of its approval of the state health care system as a whole. HSA § 1511(a) (1993).

19. *Id.* § 5235.

20. *Id.* § 1324.

ombudsman's office,²¹ and collect data and analyze the quality of care provided.²² Under some circumstances, the HAs also would encourage the creation or expansion of health plans in their service areas.²³ The HAs would play a relatively minor role in the implementation of premium and expenditure caps as imposed by the National Health Board.²⁴

Perhaps the most important duty of HAs would be to negotiate with health plans and providers. These negotiations would lead to a set of options from which individual members of the HAs would choose their health coverage. The bill would require HAs to negotiate with any willing state-certified health plan and would not allow them to negotiate with any plan that did not have state certification.²⁵ HAs were not required to offer a contract to any prepaid plan whose premium was more than 120% of the weighted-average premium within the HA or that had failed to comply with previous contracts.²⁶ In addition, at least one of the plans offered by the HA had to be a "fee-for-service" plan.²⁷ Under the bill, HAs would negotiate a fee schedule that would govern the payments the HA (and the corporate alliances in its region) would make under the fee-for-service option.²⁸ Special provisions were made to allow providers to negotiate such a fee schedule with the HAs while enjoying some protection under the "state action" doctrine from the federal antitrust laws.²⁹ The only express limitation on HAs in negotiating these contracts and payment schedules would be that HAs could not bear any "insurance risk."³⁰

21. *Id.* § 1326(a).

22. *Id.* § 1327.

23. *Id.* § 1329(b). The HAs were also to be associated with an administrative claims process for considering consumer or provider claims against health plans with which they contract. This claims process, set out in HSA §§ 5202-5204 and §§ 5211-5214, would involve "complaint review offices" established by the states for each HA. It is not clear from the bill whether these offices would, or could, be part of the HAs.

24. *Id.* § 6012.

25. *Id.* § 1321(a)(1).

26. *Id.* § 1321(b).

27. *Id.* § 1322(c). As part of the fee-for-service schedule, the HAs would be allowed to create a "global budget" for the fee-for-service plan. *Id.* § 1322(d). The HAs also would restrict coverage through utilization review, pre-certification, and exclusion of low quality providers. *Id.* § 1322(b)(2)(B).

28. *Id.*

29. *Id.* § 1322(c)(2).

30. *Id.* § 1329(c).

HAs also would be responsible for ensuring that every eligible person living in their geographical areas was enrolled.³¹ This includes enrolling family members and new residents, as well as providing for "point-of-service" enrollment for eligible people who presented themselves for covered services without being enrolled.³² It also includes a requirement that the HA hold an annual "open enrollment" period to allow its members to change plans, as well as authorization for the HA to allocate membership in any of its plans that is oversubscribed.³³

HAs would play a major role in informing their members about health plans. The HAs themselves would be required to make specific information available to their members that "allows such enrollees . . . to make valid comparisons among health plans offered by the alliance."³⁴ In addition, the HAs would have to approve the distribution of any marketing materials used by the health plans.³⁵

Finally, HAs would play a major role as financial intermediaries. They were to collect funds from employers, covered individuals and families, and governments, and then distribute those funds to health plans and providers. They were also to calculate the premiums to be paid by employers and members, based on the bids submitted by their health plans, and they were responsible for calculating the subsidies, phrased in the bill as a "reduction in cost sharing," available to lower income families in their region.³⁶

To carry out their functions, HAs would be authorized to include an "administrative allowance" in the premiums to be collected.³⁷ This allowance could not exceed 2.5% of an HA's total estimated revenues.³⁸

But what would these HAs have looked like in practice? Much depends on whether the state chose to structure them as part of the state executive branch, as independent state agencies, or as non-profit non-governmental organizations. Much more depends on the political choices of the state of whom to

31. *Id.* § 1323.

32. *Id.* § 1323(a), (b).

33. *Id.* § 1323(c).

34. *Id.* § 1325(a)(1).

35. *Id.* § 1325(b).

36. *Id.* §§ 1131-1136.

37. *Id.* § 1352.

38. *Id.* § 1352(c).

appoint as directors, and whom to use as staff. Whatever the formal structure, the actual workings and decisions of an HA in California, a huge state with an enormous managed care industry, would be likely to look very different from an HA in Indiana, a medium-sized state with a powerful medical profession.³⁹

One thing is clear: these health alliances would deal with vast amounts of money. Los Angeles County, for example, is one Primary Metropolitan Statistical Area and so presumably would have to be included in one HA. It is home to just under nine million people, of whom more than seven million would likely be covered by the HA. If it existed today, the annual revenues of that HA would be about \$12 to \$15 billion, dwarfing the budgets of the City of Los Angeles, about \$3.4 billion in 1991,⁴⁰ and the County of Los Angeles, about \$9.3 billion in 1990-91.⁴¹ Indeed, the budget for that HA would be 20% to 30% of the entire budget for the State of California. And, if it received the maximum 2.5% administrative allowance, the HA would have about \$300 to \$375 million per year to sustain itself. That HA might be the largest in the country, but even HAs in small states would be rich and powerful institutions in the context of their states.⁴² As sources of jobs, money, and power, HAs under the Clinton plan would likely be extremely attractive politically.

II. TWO EXISTING MODELS FOR HEALTH ALLIANCES

The HSA would have written into federal law a detailed set of duties and powers for HAs. No HAs of that type exist, or could now exist absent authorizing federal legislation. Nonetheless, there are prototypes for HAs. One common prototype exists where an employer negotiates with different health plans

39. I owe this insight to Professor Eleanor Kinney, of Indiana University/Purdue University at Indianapolis Law School, who brought these differences forcefully home to me.

40. U.S. DEP'T OF COMMERCE, *supra* note 17, at 312.

41. U.S. DEP'T OF COMMERCE, COUNTY GOVERNMENT FINANCES: 1990-1991, at 9 (1993).

42. North Dakota, for example, a state of about 640,000 people, might opt for a single, statewide HA. That HA would have annual revenues of about \$1 billion and a maximum administrative allowance of \$25 million, in a state whose total budget in 1992 was about \$1.5 billion. *Id.* at 19.

and offers its employees choices among them.⁴³ But some prototypes exist that cover employees in many different firms.⁴⁴ I will discuss two such prototypes in California: The California Public Employee Retirement System and the Health Insurance Plan of California.

A. The California Public Employee Retirement System (PERS)⁴⁵

PERS was founded as the State Employee Retirement System in January 1932. Since then, it has grown to be one of the three largest pension plans in the world, with assets of more than \$79 billion.⁴⁶ It invests funds and pays pensions for most current and retired employees of the State of California and for employees of those local governments in California that have chosen to join it. In that role, it has become famous in recent years because of its assertive posture as a very large institutional investor. In 1962, its duties were expanded beyond pensions to provide health insurance to state employees and, since 1967, to cover employees of participating local governments.⁴⁷

43. For example, for most of its employees, my employer, Stanford University, has negotiated contracts this year with three HMOs. It also provides a self-insured plan, administered by Blue Shield of California, which combines aspects of an HMO, a Preferred Provider Organization (PPO), and a fee-for-service plan. The University pays for 90% of the lowest cost plan for each eligible employee; the employee is encouraged to choose one of the four plans and pays the remaining cost herself. In effect, the University has acted as an HA for its roughly 9000 employees, negotiating with several different plans, providing employees information about the plans, offering employees an annual choice among the plans, and monitoring plan performance.

44. There are still other health plans that cover many employers that could perhaps be viewed as prototypes for HAs. Multi-employer health plans are run by labor unions on behalf of their members, who are employed by a number of employers. These could be viewed as forms of HAs, although in those cases members of the "alliance" have union membership in common which, particularly in crafts unions, is likely to be longer lasting than a relationship to any one employer. There are other forms of multiple employer health plans without a union basis, such as church or professional organization plans, but they do not resemble health alliances.

45. I am currently a member of the Health Benefits Advisory Board for PERS. This membership has been a source of valuable information about PERS; it also may have led to subconscious bias.

46. Letter from Thomas Elkin, Assistant Executive Officer, PERS, to author (Dec. 21, 1994) [hereinafter Elkin Letter] (on file with *Health Matrix: Journal of Law-Medicine*).

47. CALIFORNIA PERS, BOARD MEMBER HANDBOOK 5 (April 1991). These duties now extend to agencies that do not use PERS for retirement purposes, but want to use it for health benefits.

PERS currently provides health coverage for about 965 different employers, ranging in size from the State of California to the two-person Mojave Mosquito Abatement District.⁴⁸ PERS plans cover about 900,000 Californians, about 3% of the State's population.⁴⁹ In 1994, it will spend about \$1.6 billion for their health coverage.⁵⁰

Statewide, PERS currently contracts with eighteen different HMOs.⁵¹ It provides two self-insured fee-for-service plans, administered on its behalf by Blue Shield of California.⁵² It also provides four small so-called "association plans" for certain groups of employees.⁵³ About 74% of PERS members are enrolled in HMOs, 22% are enrolled in the two self-insured plans, and the remaining 4% are in the association plans.⁵⁴ The two HMOs with the most PERS members are the Northern California and Southern California regions of Kaiser Health Plan.⁵⁵ Combined, they cover a little more than 40% of PERS members, and PERS members make up about one-tenth of their California membership.⁵⁶

The extent of a PERS member's choice will vary with her location. In some less populated regions of the state, few options may be available. In the Los Angeles and the San Francisco Bay Areas, however, the home to the majority of the State's population, a PERS member has a choice of more than ten different health plans including the two Preferred Provider Organizations (PPOs).⁵⁷

PERS is an agency of the State of California, though it has limited independence from the executive branch of the state government. It is run by a large and politically chosen Board of Trustees, who, by statute, are required to represent a

48. Elkin letter, *supra* note 46.

49. Susan Duerkson, *State Health Reform: Preview and Remedy Insurance Pool is Option for Small Firms*, SAN DIEGO TIMES, October 27, 1993, at A-1.

50. Elkin letter, *supra* note 46.

51. FOSTER HIGGINS, THE CALIFORNIA PUBLIC EMPLOYEES' RETIREMENT SYSTEM MEDICAL PLAN EXIT SURVEY RESULTS — REPORT OF FINDINGS 19 (November 1993) (on file with author).

52. Elkin letter, *supra* note 46.

53. See FOSTER HIGGINS, *supra* note 51, at 20.

54. *Id.* at 19.

55. *Id.* at 21.

56. *Id.*; see Elkin letter, *supra* note 46.

57. *Id.*

variety of interests.⁵⁸ The health benefits staff totals about ninety people, with an annual budget of around \$8 million. That is about \$8 per person per year, or about 0.5% of its total health coverage expenditures.⁵⁹

PERS has had the time and staff to analyze health plan bids and bargain effectively, and, in recent years, it has been willing to be aggressive. In 1992, when its largest HMO, the Kaiser Health Plan, failed to keep its 1993 premium to what PERS considered an acceptable level, PERS froze Kaiser membership. PERS members who were Kaiser members could remain in that system, but no PERS member, new or existing, could join Kaiser. Kaiser's premium increase the following year was acceptable.⁶⁰

In the fall of 1993, PERS announced that it wanted a 5% reduction in premiums from all the HMOs it contracted with, without any allowance for inflation. It ultimately gained an overall reduction of 1%, in a year when health coverage premiums throughout California and the nation continued to rise. This reduction brought the total premium increase for 1992 through 1994 for PERS to 6%, well under the 30% increase experienced by the average California employer.⁶¹

Interestingly, although PERS has long been a major factor in California's health coverage markets, it began to play this aggressive role only recently. As California's economy fell into recession around 1990, the State experienced (and continues to experience) severe budget crises. In 1991, as part of the re-

58. FOSTER HIGGINS, *supra* note 51, at 9-10. The PERS board has 13 members: one member of the State Personnel Board; the Director of the State Department of Personnel Administration; the State Controller; the State Treasurer; an official of a life insurer, appointed by the governor; an elected official from a local government agency that belongs to PERS, appointed by the governor; a public representative, appointed jointly by the Speaker of the Assembly and the Senate Rules Committee; two members elected by all PERS members; one member elected by state employee members of PERS; one member elected by school district members of PERS; one member elected by PERS members employed by non-school district local government agencies; and one member elected by retirement members of PERS. *Id.*

59. The premiums PERS charges participating employers includes a 0.5% administrative charge. The budget noted in the text undoubtedly does not capture the full cost of the health benefits operations. For example, it does not include any share of the general PERS overhead, some portion of which should be allocated to the health coverage operations. Nevertheless, the full cost of its health coverage operations is unlikely to be much higher. Elkin letter, *supra* note 46.

60. *Id.*

61. *Id.*

sponse to budget problems, the State froze the contribution it would make to employee health insurance. Any premium increase from one year to the next would be paid entirely by employees. This experience seems to have created the political will for PERS to drive hard bargains with its health plans.⁶²

It is possible that PERS has been successful merely through encouraging health plans to shift costs. That is, for every dollar premiums to PERS are reduced, premiums to other employers may be increased. PERS has tried to go beyond cost-shifting to encourage health plans to change how they provide care. For example, the PERS board recently passed a resolution supporting, in principle, the decision of one of its health plans to restrict a high cost intervention of limited value on, in part, cost-benefit grounds.⁶³ It has also recently required all the HMOs it contracts with to standardize the benefit packages they offer to PERS members.⁶⁴ In that way, members will be able to choose among plans on the basis of price and perceived quality, without being forced to try to calculate, for example, whether one plan's higher copayment was counterbalanced by another plan's coverage of durable medical equipment.

PERS also has been active in assessing the quality of both care and service provided by its contracting plans. It has been collecting information about utilization and quality from its health plans for several years.⁶⁵ It has used this quality information in the past in its negotiating, asking one plan, for example, why PERS members enrolled in it had a much higher rate of caesarian sections than other members.⁶⁶ It is now requiring all its plans to submit quality information based on a nationally developed questionnaire called HEDIS: Health Evaluation

62. Credit is also due to Professor Alain Enthoven, one of the architects of the ideas of managed competition and HAs. Several years ago, Enthoven became Chair of the PERS Health Benefits Advisory Board, and, in that role, has encouraged PERS to assert itself in the market. See Thomas S. Mulligan, *State Campaigns for its Health Coverage Plan*, L.A. TIMES, May 18, 1993, at A1 (describing Professor Enthoven as a key designer of the state's managed competition model).

63. Elkin letter, *supra* note 46.

64. *Id.*

65. See FOSTER HIGGINS, *supra* note 51 (summarizing the exit survey results, data, tables, questionnaires, and comments about medical plans and member satisfaction).

66. Elkin letter, *supra* note 46.

Data Information System.⁶⁷ The information collected about quality of care will then be passed on to PERS members.

PERS also collects and distributes information on its members' satisfaction with their health plans. PERS members are sampled every two years to determine their satisfaction with their health plans. The results are made available during the open enrollment period to all PERS members. Similarly, each year, all PERS members who switch from one plan to another — 18,000 in 1993 — are surveyed to determine the reasons for their changes.⁶⁸

PERS differs in important ways from the HAs envisioned by the Clinton plan. Membership in PERS is not mandatory for governmental employers. Many local employers and even some units of the State government, such as the University of California, have chosen not to be covered by it. And PERS has a substantially smaller market share than the Clinton HAs would have. It covers about 3% of the population of its region, compared with an estimated 65% to 85% percent for the HAs proposed in the Clinton plan. In spite of these differences, it appears to have been effective in improving the choices available to its members and at a low cost. It is impossible to determine how effective PERS has been, but it is clearly very promising.

B. The Health Insurance Plan of California (HIPC)

The Health Insurance Plan of California was created by legislation proposed by Governor Wilson and passed in 1992; it began operation in July 1993.⁶⁹ The so-called Plan is actually a health coverage purchasing agent for small employers, modeled on (and named in light of) the Jackson Hole Group's Health Insurance Purchasing Cooperatives.

Employers are eligible to purchase coverage through HIPC if they employed at least four and not more than fifty employees for at least fifty percent of the previous three months.⁷⁰ All eligible employees must work a normal work

67. *Id.*

68. FOSTER HIGGINS, *supra* note 51, at 1-2.

69. CAL. GOVT. CODE § 53201 (West 1994) (proposed as Assembly Bill 1672).

70. The statute set the initial qualifying size at between 5 and 50 employees. For 1994-95, it required HIPC to cover companies with only four employees; in 1995-96, this floor is scheduled to drop to three employees. Susan D. Odom, *California's New Health-*

week of at least thirty hours and at least half of them must be employed in California.⁷¹ Employees can choose to purchase coverage for their spouses and for unmarried children under age twenty-three who live with the employee.⁷²

Participating employers must pay, for each employee, at least half of the lowest available employee-only rate for their region, though they may pay up to 100% of that rate. If the employer pays 100%, its coverage must extend to all eligible employees; if the employer pays less than 100%, it only must assure that at least 70% of the employees join. Employers must recertify each year that they continue to meet most of the small employer requirements.⁷³

In 1994-95, HIPC has contracted with three PPOs and twenty HMOs.⁷⁴ The HMOs with which it contracts must offer two relatively uniform packages, an "HMO Standard" package and an "HMO Preferred" package.⁷⁵ These differ mainly in the size of the copayments required for specific services — for example, the standard package includes a charge of \$15.00 per physician office visit, which the preferred package reduces to \$5.00.⁷⁶ Similarly, it contracts with three PPOs that must each offer a PPO standard and PPO preferred plan.⁷⁷ The standard PPO package has a \$500 deductible; the preferred package has a \$250 deductible.⁷⁸

Employees of participating small employers can choose among any health plans HIPC offers in their geographical area, both when the firm initially joins HIPC and then, each year, during an open enrollment month.⁷⁹ Employers have no discretion to limit the health plans offered, and the health plans

care Agenda, L.A. Bus. J., July 19, 1993; see also Renee Blankenaw, *Designing HIPCs*, HOSPS., July 20, 1993, at 34, 34-35.

71. HEALTH INSURANCE PLAN OF CALIFORNIA, THE HIPC EMPLOYER APPLICATION 3 (June 1993) [hereinafter HIPC EMPLOYER APPLICATION]. Employees from outside California count toward the definition of "small business," but they cannot receive coverage through HIPC. *Id.* In addition, employees who are covered through Medicare or through another employer's health plan (such as a spouse's employer's plan) may waive participation and thus not be counted as "eligible employees." *Id.*

72. *Id.*

73. *Id.*

74. *Id.* at 5, 11, 30-50.

75. *Id.* at 9-10.

76. *Id.* at 9.

77. *Id.* at 10.

78. *Id.*

79. *Id.* at 7.

have no discretion to reject any employer or any eligible employee, spouse, or dependent who seeks coverage, for medical or other grounds.⁸⁰

HIPC divides California into six regions and offers different packages of plans, and different rates, in each region.⁸¹ The number of choices available varies depending on where an employee lives. In a few isolated rural counties, employees have only one or two choices. In most parts of the San Francisco Bay area, an employee of a HIPC member employer has a choice of three PPOs and nine to thirteen HMOs, each offering both a standard and a preferred option. In Los Angeles County, an employee could choose among the same three PPOs and up to fifteen HMOs. Within one PPO or HMO, the premiums charged vary with region, based on the employee's age, the choice of standard or premium coverage, and the family option chosen (employee only; employee and spouse; employee and dependent children; and employee, spouse, and dependent children).⁸²

HIPC is administered by a state agency called the Major Risk Medical Insurance Board (MRMIB). MRMIB was established as part of earlier health reform legislation to administer two state-subsidized health insurance programs, one for uninsured pregnant women and one for people who were medically uninsurable — those with preexisting conditions or health risks that kept them from qualifying for most insurance.⁸³ MRMIB, an independent state board whose members are appointed by the governor and the legislature, has a staff of thirteen people, but contracts for most of the administration of both the medical risk pool and HIPC.⁸⁴ By statute, HIPC is supposed to break even by the end of its first year, based largely on a fee it charges participating employees. For 1994-95, this fee is \$20 per group per month, plus \$2.50 per month per person, which

80. *Id.* at 4 (providing that there are no pre-existing condition exclusions for HMO coverage, but HIPC PPOs may apply a limited six month pre-existing condition exclusion period).

81. *Id.* at 12.

82. *Id.* at 13-24 (showing geographical plan coverage); *id.* at 25-31 (showing premiums for different plans, options, and regions).

83. *The Health Insurance Plan of California, 1994: Hearings on Health Care Reform Before the Senate Comm. on Finance*, 103d Cong., 1st Sess. (1977) (testimony of Lesley Cummings, Deputy Director, MRMIB) [hereinafter *HIPC Hearings*].

84. *Id.*

on average is about 3% of the premium.⁸⁵ For a group with forty covered persons (participating employees, spouses, and dependents), this would amount to \$120 per month, or about 3% of the total costs of the health coverage.

During HIPC's first year of operation, it grew to include more than 3000 employers and more than 25,000 people.⁸⁶ It grew faster than expected, even during a period of relative weakness in California's economy, as it had originally expected to attract only 10,000 to 20,000 employees in its first year.⁸⁷ Its growth still gives it less than 1% of the estimated 360,000 businesses and eight million people in California who could qualify for HIPC.⁸⁸

Perhaps more impressive than its size in employers is the number of major insurers and HMOs that have contracted with it. The HIPCs were part of a broader package of legislative insurance reforms that tightly regulated the small employer health insurance market. The legislation prohibited plans from rejecting or canceling smaller employer groups, limited pre-existing conditions exclusions, and capped the maximum difference between health plans rates for small employers and other employers.⁸⁹ These reforms made participation in HIPC attractive, as its rules were not notably more onerous than those applicable in the rest of the market. It also prevented HIPC from becoming the "dumping ground" for high risk employees and employers who could not get insurance in the private market.

There have been no detailed studies yet of HIPC. According to press accounts, HIPC estimates that employers pay about 15% less for health benefits when they buy through HIPC.⁹⁰ Although there have been occasional complaints about excessive bureaucracy, the press coverage has generally de-

85. HIPC EMPLOYER APPLICATION, *supra* note 71, at 4; *HIPC Hearings*, *supra* note 83.

86. Alfred G. Haggerty, *California HIPC Bears Watching in 1994*, NAT'L UNDERWRITER. LIFE & HEALTH/FIN. SERVICES, Jan. 10, 1994, at 3.

87. *California Health Insurance Pool Getting Strong Surge of Applications*, Health Care Daily (BNA) (July 7, 1993), available in WESTLAW, 7/7/93 HCD.

88. *California's Pioneer Alliance*, SACRAMENTO BEE, Oct. 14, 1993, at B6.

89. CAL. GOVT. CODE § 53201.

90. *HIPC Hearings*, *supra* note 83; Sherry Jacobson, *A Plan with Promise: Texas May Model Health Insurance Changes on Budding California Pooling Program*, THE DALLAS MORNING NEWS, Jan. 24, 1994, at 1A. On the other hand, an insurance company official interviewed by the *Wall Street Journal* estimated the savings at about 5%, based

scribed happy employers and employees. One dark side to HIPC, however, is that it has not expanded health coverage very much. The great majority of employers who participate in HIPC had previously provided health insurance to their employees in other ways. Only 20% to 25% of HIPC members — about 8000 to 10,000 people — were previously uninsured.⁹¹

III. FOUR ISSUES: BUREAUCRACY, GEOGRAPHY, COST CONTROL, AND GOVERNANCE

HAs under the proposed Clinton plan were quickly attacked as adding another massive federal bureaucracy. This insubstantial but rhetorically powerful attack, coupled with the very real interests threatened by HAs, led to a rapid decline in political interest in mandatory HAs. The Clinton plan's model for mandatory HAs did raise some real and important issues, but those received little attention. This section of the Article will look first at the concerns about bureaucracy, and then at three harder issues: drawing the boundaries of HAs, helping HAs control health care costs, and governing HAs. Although the HSA provides the specific model for HAs in these analyses, this Article also discusses other kinds of HAs.

A. Bureaucracy

The specter of vast new federal bureaucracies was used to attack the Clinton plan's mandatory HAs.⁹² This picture was greatly exaggerated — and not just because the HAs would be state bureaucracies instead of federal ones. Increased bureaucracy can be attacked for its size and cost alone, or for how it would function. Most of the opposition focused on size and cost, not on functioning.⁹³ In fact, because the HAs should pro-

largely on economies of scale in administering larger groups. Eugene Carlson, *Mixed Reviews for Health Care Plan Like Clintons*, WALL ST. J., Nov. 26, 1993, at B1.

91. *HIPC Hearings*, *supra* note 83 (20%); Jacobson, *supra*, at 1A (22%); *25,000 Californians Jump Into the Pool*, BUSINESS WIRE, Dec. 16, 1993 (22%).

92. See, e.g., Robert Pear, *Word for Word: The Health Care Papers; Now It Can Be Told: The Task Force Was Bold, Naive and Collegial*, N.Y. TIMES, Sept. 18, 1994, § 4, at 7 (criticizing the plan's cumbersome barriers to service and ineffective cost containment proposals).

93. See, e.g., Spencer Rich, *Benign Watchdog or Bureaucratic Beast? Health Care Alliances in the Clinton Plan*, WASH. POST, March 22, 1994, at Z10 (stating that Clinton's health care alliances are "too big, too much government" and create too much uncertainty); Lynn Wagner, *Clinton's Plan is Nearly Dead, Ideas Still Alive*, MODERN

vide economies of scale in financing health coverage, the system could well lead to fewer employees and less bureaucracy than the status quo. On the other hand, they might function in a somewhat more rigid and bureaucratic manner than does the current system.

1. Size

The key to understanding the issue of bureaucracy is to look at the *net* effects of mandatory HAs. HAs would have been new governmental or quasi-governmental bodies. They would necessarily have employed people in positions that do not now exist. Those positions would have replaced existing positions with employers, insurers, and others. Instead of having tens of thousands of employers as intermediaries between consumers and health plans, the HAs (from 51 to, at most, about 200 in number) would be the intermediaries. Therefore, HAs would make redundant many existing employees of employers and health plans.

Employers would no longer need to hire staff to analyze health plans, negotiate with health plans, and monitor the performance of health plans. Nor would they need to have staff members who help employees with their disputes with health plans. At the same time, health plans would not have to hire people to market their plans to tens of thousands of employers, or staff to deal with each of those employers. They would, and will, continue to have to deal with consumers as they do now, but would have had to deal with far fewer intermediaries. Furthermore, another entire level of intermediaries would have been decimated. Insurance brokers would have lost all their existing business in health coverage. Each of their employees focusing on health insurance or health plans would have become redundant.

And, finally, if the Clinton plan, with its mandatory alliances, had worked as intended, it would have reduced the total number of individual health plans around the country. Far fewer insurance companies would offer health plans and far fewer employers, even under the corporate alliance provisions of the Clinton plan, would create their own self-insured plans.

HEALTHCARE, March 28, 1994, at 29 (criticizing incentives to curb spending under the Clinton plan and health alliances as too bureaucratic, overly regulatory, and too large).

The smaller number of health plans would be offering a much smaller number of largely standardized benefit packages. By reducing the number of health plans, the Clinton plan would have reduced the administrative burden for hospitals, doctors' offices, and other health care providers. As a result, although some people would be new employees of these new HAs, more people would lose their jobs working with the health care financing system among employers, insurers, and health care providers.

It is, of course, impossible to determine exactly how the balance would be struck. It is instructive, however, to look at PERS and HIPC. PERS provides health benefits for nearly one million people with a staff of about ninety and an annual budget of about \$8 million; HIPC currently covers more than 25,000 people with a staff of thirteen people.⁹⁴ PERS includes more than 965 employers; HIPC covers more than 3000.⁹⁵ It is hard to imagine that those employers could deal with providing health coverage for such small numbers.

It is true that HAs, as conceived in the Clinton plan, would have both arranged health coverage for some companies that do not provide coverage and performed some services that existing employers, health plans, insurance brokers, and health care providers do not always provide. The HAs would have been required to provide and review consumer information that is not always made available today. They also would have monitored and publicized the quality of health plans in ways that only a few employers now do. If those activities are beneficial, however, they would be worth a few additional employees.

Thus, on close examination, the size aspect of the bureaucracy argument actually turns on its head. The HAs would have led to the provision of more and better services by fewer employees. There was much discussion of the effects of the Clinton plan on employment, but few politicians acknowledged that the HAs could lead to substantial job losses in the health care financing industry.

94. See *supra* notes 48 and 85.

95. *Id.*

2. "Bureaucratic" Functioning

Of course, bureaucracy means more than size and cost — "bureaucratic" is an adjective with independent and pejorative meaning. Some of the bureaucracy arguments against the Clinton plan may have stemmed from fears that HA employees would be more distant, difficult, and "bureaucratic" than employees who now deal with health financing.

That may well depend on which existing employees are used for comparison. Big firms, those most likely today to provide health benefits, may well be as bureaucratic as the federal government or other notorious bureaucracies. Small employers may be less bureaucratic, though they also may be more arbitrary.

Perceptions as a "bureaucracy" also would depend on how well an HA is run. Whether HAs were "bureaucratic" bureaucracies would depend largely on the states. It should be possible for an HA to function quickly, cheaply, and efficiently just as PERS and HIPC have done so in California. Under the Clinton plan, the number of tasks undertaken by HAs and the style and efficiency with which they would have accomplished them would almost certainly have varied markedly from state to state.⁹⁶ And even the theoretical advantages of economies of scale could be lost if a state created too many small HAs or, perhaps, one or more HAs that were too big — so large as to create actual diseconomies of scale.

Still, however efficient the HAs are, it does seem likely that a shift in responsibilities from employers and insurers to the HAs would lead to some changes in the style of operation. In part to prevent the reality or perception of favoritism, governmental agencies would bend over backward to avoid exercising case-by-case discretion.⁹⁷ It is often difficult for government agencies to ignore rules, deadlines, or "details" that could be winked at by the staff of an employer or a private health insurer. Of course, the other side of this coin is that government

96. Robin Toner, "Alliance" to Buy Health Care: Bureaucrat or Public Servant?, N.Y. TIMES, Dec. 5, 1993, at A1.

97. Earlier styles of government that took advantage of such discretion to make and reward friends were largely replaced by good government reformers. *But see* GRANT MCCONNELL, PRIVATE POWER & AMERICAN DEMOCRACY 5 (1967) (noting that Congress operates in part to give members opportunities for constituent service that will cement political loyalties).

staff, while following rules, may be less likely to try to exploit a consumer, through, for example, denying or delaying a coverage claim, than the staff of a private employer or insurer. Nonetheless, particularly at a time when the very word "government" has nearly become an expletive, the possible rigidity of a new bureaucracy surely was an additional disadvantage to the Clinton plan.

B. Geography

Geography poses interesting problems for HAs. At the most basic level, drawing the boundaries of HAs necessarily determines how large they would be, with implications for their ability to capture economies of scale as well as their power to act as effective monopsonists. But geography could have three other important implications: it could affect whether HAs are state or federal agencies, it could alter the costs of health care for particular communities, and it could raise basic questions about the nature of the health plan. Any new plan for HAs should consider all three points.

1. State Power

A crucial aspect of the HSA was that it expressly confined HAs to one state. This makes little sense in many employment settings. An employer in Manhattan will almost necessarily employ workers living, at least, in New York, New Jersey, and Connecticut. To divide one employment market into at least three HAs would add unnecessarily to the complexity of the system for the employer and divide employees in a somewhat arbitrary manner.⁹⁸ It would have made more sense to require that all parts of metropolitan areas be kept in one HA, respecting the economic connections within such an area. More than a quarter of the country's population lies in metropolitan areas that cross state lines. Of the nation's eighteen CSMAs, seven that encompass more than fifty million people cross state lines. An additional twenty-seven MSAs, with a combined population of eighteen million people, also cross state lines.⁹⁹

98. Of course, that division would not be unique to health care. Employees who work in one place but live in different states face different income tax situations depending on their state of residence.

99. U.S. DEP'T OF COMMERCE, *supra* note 17, at 919-25.

Instead, the HSA expressly forbade interstate HAs. HAs in neighboring states were encouraged to cooperate, but they had to remain firmly under the control of their own state. This result seemed to be a function of politics rather than policy.

Under the Clinton plan, HAs were creatures of the states, to be created in one of three forms as a state chose and to be controlled by states.¹⁰⁰ No interstate body could offer as much power or patronage to state governments. If, for example, the CSMA that includes New York City were to be treated as one HA, it would cover large parts of New York, New Jersey, Connecticut, and a small slice of Pennsylvania. As such, it could not be wholly under the control of any one state. Although an interstate compact could resolve the difficulty, no one could assure that the necessary compacts could be reached quickly or easily. Moreover, in any event, a state government would gain less power from a share of a compact authority than from complete control over its own alliances.

If interstate HAs were to be created, a simpler solution would have been to create some kind of entity operating under federal authority, which would not rely on the agreement of the states involved. That solution, however, would have created political headaches by adding "federal bureaucrats," as well as losing whatever political goodwill from the state governments that might have been created by a plan that gave them more power.

If different states could be expected to serve, in their HAs, as true "laboratories of democracy," the limitation of HAs to one state, and hence one state's control, might have benefits greater than the costs of splitting up a labor market. But although the HSA gave states control over HAs, it was a grant of power largely without express policy implications. The benefits package, the subsidies, and the structure of the competitive market were all set by federal law. Compared with Medicaid or Aid to Families with Dependent Children (AFDC), for example, states would have almost no power to alter the programs implemented by HAs. States could decide whether the HA would be part of the state executive branch, an independent state agency, or a nonprofit, non-governmental organization —

100. See HSA § 1202(b).

and then could appoint its members — but the states could do little to dictate the HA's activity.

To the extent that any power rests within the HA, it would seem to have been the power of invisible discretion. Thus, in negotiating prices with fee-for-service providers, an HA might be aggressive or lax. The appointment of HA members by the states in that case would be more than “mere” patronage, but would, in all probability, result in HAs in some states that were “captured” by provider interests, either physicians or hospitals.

There are some advantages to state-governed HAs. To the extent that health plans are, and would continue to be, regulated by the states, a state-based HA might be able to coordinate better with those regulators.¹⁰¹ These advantages, however, seem small when compared with the costs of breaking up labor markets and encouraging industry capture. As events played out, the political advantages of state-based HAs did no discernible good to the Clinton plan. Future health reform proposals should think seriously about CSMA-based HAs.

2. Changing Costs Between Regions

Under the Clinton plan, health plans must use community rating within an HA region.¹⁰² Community rating would mean not only that older and younger, male and female, and healthy and sickly people would pay the same for health coverage, but also that the residents of all parts of an HA would pay the same amounts — and that residents of different HAs would pay different amounts. The boundary between a high cost and low cost HA could determine the payroll costs of employers and the take-home pay of employees in important ways. Citing gang violence, drug abuse, and “crack babies,” some commentators foresaw massive fights in state legislatures, with subur-

101. In such a case, however, it is worth noting that although all states “regulate” hospitals, almost all states and the federal government have largely ceded their power to the accreditation process of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), a private body controlled by providers and hospitals which almost always satisfies state requirements for hospital licensure. *See, e.g.*, 42 C.F.R. § 488.5 (1993) (describing the effect of JCAHO accreditation).

102. HSA § 1101.

ban representatives trying desperately to avoid having their constituents in health alliances with the inner cities.¹⁰³

In fact, the situation was more complicated. There is little academic data on differences in health costs from region to region and most of the data that exist are drawn from Medicare. Because Medicare covers predominantly the elderly, Medicare data might yield different results from the Clinton plan since the population to be covered by the Clinton plan would almost entirely *exclude* the elderly. The market provides some information about non-Medicare patients through the differences in premiums charged by insurers in different parts of a state. Those premiums, however, might reflect conditions other than just the costs of providing health care, such as differences in who the insurers cover - and do not cover - in different regions. For example, the premiums charged by current health plans, by definition, do not include the direct costs of serving the uninsured. Differences in the uninsured population may skew the current regional cost differences. Finally, even if good data existed about the current regional differences in the costs of care, none of the current data could project the costs under a reformed system, where increased choices for consumers and new competitive pressures for providers might lead to very different patterns of health costs.

With all of these qualifications, the existing data do give us a starting point. The Medicare studies and at least some insurance industry premiums show a consistent pattern: cities seem to be more expensive than suburbs or rural areas.¹⁰⁴ This difference seems to come largely from different practice pat-

103. William J. Bennett & Vin Weber, *Health Plan Is Flawed Prescription*, WASH. TIMES, Nov. 15, 1993 at A16; Tom Redburn, *Conflict Is Set Between Regions in Health Plan*, N.Y. TIMES, Nov. 5, 1993, at A1; Robin Toner, *supra* note 96, at A1.

104. The research has focused largely on understanding geographic variations in medical costs in order to refine payments under Medicare. As a result, the data is almost totally based on the health costs of the elderly; the health costs of those who would have been covered by HAs might well not have the same variation. The geographical differences and their sources are discussed in Jerry Cromwell et al., *Sources of Hospital Cost Variation by Urban-Rural Location*, 25 MEDICAL CARE 801 (1987); W. Pete Welch, *Defining Geographic Areas to Adjust Payments to Physicians, Hospitals, and HMOs*, 28 INQUIRY 151 (1991); W.P. Welch, *Improving Medicare Payments to HMOs: Urban Core Versus Suburban Ring*, 26 INQUIRY 62 (1989).

terns in the urban core and lower rents, wages, and other costs of doing business in rural areas.¹⁰⁵

The geographical pressures on the system, therefore, would come not so much in fights between suburbs and cities as in fights pitting rural areas and suburbs against inner cities. If the current Medicare experience were to continue in a reformed system, rural residents might have health coverage costs up to 20% lower than their urban and suburban neighbors. This conflict would lead to very different political battles than these foreseen. What would these battles look like?

Note first that this issue would not exist for all states. Smaller states, those with fewer than, for example, three million inhabitants, might never consider setting up more than one health alliance. In states that opted for multiple HAs, the terms of the HSA would have affected the boundary battle. Under the HSA, states faced only three limits on drawing HA boundaries. First, each HA had to cover a population large enough to give the HA an adequate market share to negotiate effectively. Second, in setting the boundaries of HAs, a state could not “discriminate on the basis of or otherwise take into account race, ethnicity, language, religion, national origin, socio-economic status, disability, or perceived health status.” And third, states could not divide any part of a “metropolitan statistical area” contained in the state.¹⁰⁶

The third legal requirement effectively eliminates the urban/suburban battle. Metropolitan statistical areas are now drawn very broadly. Some of the initial concern, for example, focused on fights between New York City and its affluent suburbs. But the primary metropolitan statistical area that con-

105. Cromwell, in a very thorough analysis of Medicare data, found that only 10 to 15% of the difference in urban and rural costs for Medicare were explained by differences in diagnoses. A full 25 to 50% of the difference came from differences in the intensity of procedures used in similar patients — urban doctors did more things to their patients than rural doctors did to equivalent patients. Still another third of the difference came from higher wages in the urban setting. See Cromwell et al., *supra* note 104. Welch, in his 1991 article, argues that population density is the key variable affecting size, mainly through its effects on input costs. In his 1989 article, he showed that poverty rates usually did not have a significant effect on a region's health costs. See Welch, *Defining Geographic Areas to Adjust Payments to Physicians, Hospitals, and HMOs*, *supra* note 104.

106. See HSA § 1202(b); *supra* notes 13-17 and accompanying comments.

tains New York City also contains many of its New York suburbs in Putnam, Rockland, and Westchester Counties.¹⁰⁷

In California, the primary statistical metropolitan area that contains South Central Los Angeles also contains Beverly Hills and, in fact, all nine million people in Los Angeles County. Poverty-stricken regions of San Francisco and Oakland are part of a primary statistical area that includes all of the inhabitants of San Francisco, San Mateo, Santa Clara, Alameda, and Contra Costa Counties — more than 5.4 million people, very few of whom live in the “inner city.”¹⁰⁸ And, of course, if the third requirement were not called into play, the second, banning a broad range of discrimination, would undoubtedly have been used in litigation to prevent the creation of a poor, heavily minority “core” HA, surrounded by a rich, largely white “suburban” HA.

But the second rule would not resolve the split between metropolitan areas and rural areas. Nor it is clear whether the third rule would have resolved this split. The HSA would have forbidden states to discriminate on the basis of race, ethnicity, language, religion, national origin, socio-economic status, disability, or perceived health status. In most states, rural and metropolitan areas will differ in a number of those characteristics. Rural areas are generally poorer than metropolitan ones. Their citizens are usually older and thus might be perceived as having a poorer health status. In some states, in the Northeast and Midwest, for example, rural areas will be Whiter than urban areas; in other states, the rural population might be more heavily Black, as in the deep South, or Hispanic or Native American, as in much of the West, than the urban areas. In few, if any, states will all those characteristics be evenly balanced between the two.

If a very strong reading were to be given to the anti-discrimination provision, the issue of HA borders would have been moot — each state would have to have just one HA. Under a more relaxed test, separate HAs, and hence lower premiums, might be questioned only where the state’s metropolitan areas

107. The New York portion of its CMSA adds Dutchess, Nassau, Orange, and Suffolk Counties. See U.S. DEP’T OF COMMERCE, *supra* note 17.

108. *Id.*

(urban and suburban combined) had much higher minority populations than the rural areas.

If the legal challenges did not arise, the issue over which rural areas, if any, would be allowed to enjoy lower rates than the metropolitan areas would be a function of the balance of power between rural and metropolitan areas in the relevant state legislatures. Unlike the political civil war between suburbs and inner cities envisioned by critics, this battle seems of little concern. It would be resolved either by equal rates for all state residents, as part of one big HA, or lower rates for rural residents.

3. Health Plan as a Tax, Benefit, or Market Transaction

The real equity question runs deeper than one of discriminating among cities, suburbs, and rural areas. Why should any Americans pay a different amount for identical health coverage based on where they live? This question goes to the heart of ambivalent status of health coverage under the Clinton plan: Is mandatory health coverage a tax, a government entitlement, or a market commodity?

In effect, the Clinton plan would have combined a complicated tax with an individual's choice among several benefit packages. The individual's employer would generally pay 80% of the cost of the average-priced plan in her HA, the equivalent of an oddly computed employer payroll tax, while the individual would pay the remainder, through her choice among plans of different cost, as a partially voluntary employee payroll tax. An individual without an employer would be covered with a different set of payment percentages, as would a person employed but with a very low income.¹⁰⁹

But those costs — in essence, the payroll taxes — would vary not only with the individual's choices but from HA to HA, both within and between states. Should a person in Cleveland pay more for health coverage than one in Omaha or in Cincinnati? There seems no definitive way to answer that question, but it may help to put it into context.

If the HSA were thought of entirely as a tax, it would face a norm, one that, to some extent, has constitutional force. The

109. HSA § 1006.

Constitution deals with the uniformity of taxes in two places. Article I, Section 2, clause 3, states that “[r]epresentatives and direct taxes shall be apportioned among the several States . . . according to their respective numbers”¹¹⁰ More importantly, the Uniformity Clause, Article 1, Section 8, clause 1 provides that “[t]he Congress shall have the power to lay and collect taxes, duties, imposts and excises to pay the debts and provide for the common defense and general welfare of the United States; but all duties, imposts and excises shall be uniform throughout the United States.” And in practice, the major sources of federal revenue — the personal income tax, the corporate income tax, the gift and estate tax, social security and Medicare taxes, the various excise taxes, and others — apply on equal terms in every state. Californians do not face a different marginal tax rate than Texans.

Of course, this even-handedness is only nominal. In fact, citizens of different states may face substantially different and real federal tax effects depending on their state of residence. For example, state income tax payments, but not state sales tax payments, are deductible from federal personal income tax.¹¹¹ In a state with a high income tax and a low sales tax, residents will pay less federal tax than similar taxpayers in a state that raised the same total revenue with a high sales tax and no income tax. All other things being equal, the average taxpayer will pay federal income tax at a higher rate in richer states than in poorer ones, and less income tax in a state with high

110. The apportionment requirement for direct taxes rarely has been called into play. Direct taxes have been held to be taxes that fall directly on property, real or personal, and on income, at least since the Supreme Court invalidated the second federal income tax in *Pollack v. Farmers L. & T. Co.*, 157 U.S. 558 (1895). Taxes on transactions, even on property involved in transactions, have been held not to be “direct” taxes. *See, e.g.*, *Bromley v. McCaughn*, 280 U.S. 124 (1929). The Sixteenth Amendment reversed the *Pollack* decision, providing “[t]he Congress shall have the power to lay and collect taxes on incomes, from whatever source derived, without apportionment among the several States, and without regard to any census or enumeration.” U.S. CONST. amend. XVI. Thus, the current income tax is not subject to the apportionment requirement, nor are social security taxes, as they also are “income” taxes. *Krzsyske v. Commissioner*, 548 F. Supp. 101 (D. Mich.), *aff’d*, 740 F.2d 968 (6th Cir. 1982).

Presumably, even if the HSA were held to impose taxes, those taxes generally would be characterized as income taxes and hence not subject to the apportionment requirement. Whether the premiums required of the unemployed or those without incomes would be held to be direct taxes could be a complicated question, requiring assessment of some quite old precedents. In light of the demise of the HSA, the issue seems not worth pursuing.

111. 26 U.S.C. § 164(2), (3).

housing prices (and mortgage interest payments) than in a state with low prices. The effects of such contingencies outside the tax law have not been held to violate the Uniformity Clause of the Constitution. These effects do not lead to much controversy.

Nor have taxes that, on their face, varied. In the *Head Money Cases*,¹¹² the Court upheld against a uniformity claim a tax on immigrants that applied only at ports, not at inland places of entry. In *Knowlton v. Moore*,¹¹³ the Court upheld against a similar attack a progressive tax on legacies. The Court has even upheld taxes that varied expressly in different states. In *United States v. Ptasynski*, Congress had expressly singled out oil wells in certain parts of Alaska for special treatment under the Crude Oil Windfall Profits Tax. The Supreme Court held that this discrimination was justified because those parts of Alaska had special characteristics that made drilling wells particularly expensive. Such legitimate discrimination was not made unconstitutional, because Congress used the well's location as part of the description of these special wells.¹¹⁴ If Congress passed something called a health insurance payroll tax that varied from state to state with the states' differing health care costs, presumably it also would pass constitutional muster under the Uniformity Clause. It might well, however, be seen as violating the strong norm of uniformity.

Since the HSA is viewed not as a tax program but as an entitlement, the issue of uniformity becomes somewhat more clouded. In general, federal benefit programs are uniform across the country in one of two ways. Where the federal benefit is cash or its equivalent, the amounts paid are identical. Where the federal benefit is in kind, the amounts provided and the prices charged usually are identical even though the costs may differ substantially from area to area. For example, Social Security, Supplemental Security Income, and veterans benefits are the same to otherwise similarly situated recipients, whether they live in expensive or inexpensive states. The same is true of pensions for federal employees, both military and civilian.

112. 112 U.S. 580 (1884).

113. 178 U.S. 41 (1900).

114. *United States v. Ptasynski*, 462 U.S. 74, 85 (1983).

On the other hand, a person in rural Montana gets much more expensive postal service for the same first class stamp as a person in Chicago. Health services provided by the Veterans Administration or the Indian Health Service may be more or less available in some regions, but carry the same price to the eligible consumer whatever the local price of providing health care. Similarly, the payroll tax paid to support Medicare Part A is the same 2.9% throughout the country. The premium individuals must pay to enroll in Medicare Part B is the same throughout the country. Medicare has the same deductibles, copayments, and annual cap for all recipients, whether they live in a region with high or low health care costs, and the benefits package is essentially identical in every region of the country.¹¹⁵ This parallel is true even though Medicare's methods for reimbursing providers, both hospitals and physicians, include regional factors that make some regions high-cost or low-cost. In all of these examples, people otherwise identically situated will pay the same amount to receive the identical services from the government, but at different costs to the government.

Yet, many federal benefit programs are administered as joint federal-state programs. Payments in (and eligibility for) those programs vary substantially from state to state. Both Medicaid and AFDC, for example, are administered largely by state governments, within broad federal guidelines. Within federal guidelines, the states set their own income and asset levels for eligibility for these programs and set their own levels of benefits.¹¹⁶ These figures, once set, remain the same within the state. An AFDC family in California will receive a very different welfare check and participate in a very different Medicaid program than a similar family in Alabama, but one living in expensive San Francisco would receive the same welfare check

115. See 42 U.S.C. §§ 1395e (deductibles and coinsurance), 1395d (Part A benefits), 1395k (Part B benefits) (1988 & Supp. V 1993). See also 42 U.S.C. § 1395b-2 (1988). The regional financial intermediaries who handle much of Medicare's administration do have some discretion to make regional decisions whether particular services, arguably experimental or not medically necessary, are covered. This leads to a few minor variations between regions, although those variations often will be resolved by a central decision to cover or not cover the services for all regions.

116. See 42 U.S.C. § 1396(a) (1396a & Supp. V 1993); see also 42 U.S.C. § 1382(e) (1988 & Supp. V 1993); ADVISORY COMM'N ON INTERGOVERNMENTAL RELATIONS, MEDICAID: INTERGOVERNMENTAL TRENDS AND OPTIONS (1992).

and participate in the same health program as one living in relatively inexpensive Fresno.

If the HSA were viewed as a fully federal benefit, it would normally have been provided on the same terms across the country. But it had a significant component of state operation, though markedly less than either Medicaid or AFDC, and it would charge different "prices" for the same services depending on one's location. It seemed to follow no precedent very closely. Viewed as an entitlement program, its treatment of regional disparities would break new ground.

The health plans required under the HSA also would look like the results of market transactions. Unlike most federal programs, the consumer would get a choice of options, each provided by private, and often for-profit, competitors.¹¹⁷ In this respect, it resembles the Federal Employee Health Benefits Plan (FEHBP). The FEHBP provides federal employees and retirees with health insurance.¹¹⁸ The government, as employer, makes a contribution generally equal to 60% of the average charges to a defined group of offered plans.¹¹⁹ Covered employees and retirees may then choose among a large number of plans. A few of the plans, such as a Blue Cross/Blue Shield indemnity plan, are available throughout the country. These plans bear the same price everywhere in the country. Most of the plans are available only in particular states or localities; these plans set their own, widely varying prices after negotiation with the government. As a result, health plans in high-cost areas also will be more expensive than those in low-cost areas, although the government's contribution to the costs will remain the same. In the FEHBP, as in other settings that are, or look like, market transactions, price differences are generally not troubling. If gasoline costs more in Chicago than in Houston, so be it.

On the other hand, where the federal government is involved, geographic uniformity can enter into even market transactions. For many years, the federal pay scale, the "GS" system, did not vary with geography, but paid all federal employees at the same grade the same amount. Recently, the

117. See HSA § 1003.

118. See 5 U.S.C. §§ 8901-8914 (1988 & Supp. V 1993).

119. See 5 U.S.C. § 8906(b)(1) (1988) (describing the calculation of the federal contributions).

system has adjusted to allow supplemental payments for people in a few particularly expensive cities — New York, Los Angeles, and San Francisco — but it has not generally adopted geographical variations, regardless of differences in either the market wage or the cost of living.

The foregoing discussion of uniformity in federal government functions is based solely on casual empirical observations. Those observations merely describe current government activities; they do not provide a framework for judging whether it is proper. There seems to be no literature or theory on the uniformity, or lack thereof, of federal government actions. The HSA's complex blend of taxes, benefits, and market transactions would likely be hard to square with any such theory. Interestingly, although nearly everything about the HSA was controversial, including its provision for different prices within a state, the issue of differences among states seems to have been largely ignored. This may be because the plan looked enough like either market transactions or a joint federal-state program to seem familiar. And yet, what is the justification for having residents of different states or regions pay more or less for this governmentally-required health coverage?

There seem to be no strong arguments either for or against different rates. Consider an alternative scheme. Every HA would charge employers and employees the same average amount — for example, \$300 per month for family coverage. The various plans bidding for customers within an HA would bid based on the real reimbursement they expected, but these bids would be transformed into “prices” to the consumers. Those prices would differ from the national average price by the same percentage that the plans' bids varied from the average within the HA. Thus, in a high cost area, the average “real” bid for family coverage might be \$350, with a high of \$400 and a low of \$300. Consumers would see an average price of \$300, with a high of \$343 and a low of \$257. (In a low-cost area, the actual bids would be below the prices seen by consumers.) Consumers would choose among plans in part based on these prices, and they and their employers would make payments to the HA based on these prices. The plans, however, would be reimbursed by the HAs based on the “real” prices they bid.

As a result, HAs in high-cost areas would take in too little money to pay their bills; HAs in low-cost areas would take in

too much. Therefore, there would have to be some kind of revenue-sharing mechanism between HAs. Some such mechanism was already contemplated for out-of-area services; modifying it to make these equalizing transfers should be complex but not enormously difficult. Is there any good reason to prefer the HSA system, with different costs to consumers in different regions, to this more uniform system?

Apart from unusually murky arguments about fairness, the HSA rule would seem to be supported by two points. The first, and more general, is that the price system works best to allocate goods and services efficiently when consumers face the full marginal price of what they purchase. With the uniform payments system, consumers in high-cost states would have incentives to buy too much health coverage; those in low-cost states would have incentives to buy too little. The application of these kinds of market principles to purchasing health coverage, however, must be largely rejected in order to justify mandatory universal health coverage at all, particularly with a uniform benefits package.

The second argument would point out that the uniform payments solution removes pressure on high-cost areas to become low-cost areas. When the costs of medical care are paid fully by a region, a high-cost region will become less attractive to employers or employees than a low-cost region. This kind of "inter-regional" competition, however, has been operating under the present system. While such competition has sparked some recent collaborative employer efforts to control regional health costs, it is too early to predict the success of such arrangements.¹²⁰ In any event, competitive pressures would still exist within each region as every plan tried to become more attractive. Given such direct pressures, the more indirect regional pressures seem insubstantial.

Based on this discussion, should the premiums for health plans be regionally uniform or not? Would the HSA's reformed health system have been a tax, a government benefit, or a mar-

120. See Ron Winslow, *Market Forces are Starting to Produce Significant Cuts in Health Care Costs*, WALL ST. J., June 21, 1994, at A2 (discussing hard bargaining by companies who have joined together to increase their market power); see also Dana Priest, *Try Modest Approaches to Cutting Health Care Costs*, WASH. POST, Nov. 3, 1992, at D1 (describing how a coalition of small Cleveland businesses have acted as a united front to obtain significantly lower rates).

ket transaction? Is it a federal program or a federal-state program? There seems to be little practical reason to choose between the alternatives. A new attempt at comprehensive health reform should consider the equities, and politics, of having regional HAs that charge national rates.

C. Controlling Health Care Costs

Although it was often overlooked in the debate over reform, the Clinton plan was not merely about covering the thirty-nine million uninsured, but was equally aimed at containing, or at least slowing, the constant increase in expenditures on health care. HAs clearly played a major role in such cost control under the HSA, but the exact nature of that role varied depending on who was talking. Someone looking for an efficient agent to “unleash” competitive pressures saw a very different role for HAs than someone seeking countervailing monopsony power to force concessions from the health insurance industry. Ironically, the bill that resulted from the conflict over these ideals, plus the inevitable compromises of politics, satisfied neither view.

The Clinton plan had two main approaches to controlling costs. First, it relied upon the HA structure to force down prices from insurers. In the event that did not work, the HSA provided for “back up” controls on the health coverage premiums within HAs. The second approach was consistently touted as a back-up, to be implemented only if the HAs failed.¹²¹

But the HAs could be used to implement two different solutions to high and increasing costs, based on different understandings of “the problem.” Under the first approach, which may be called the “good broker” solution, consumer pressures would constrain health care prices once consumers were able to make informed choices and had a financial incentive to choose prudently. Today, it is argued, consumers lack choices, information, and financial incentives, all of which combine to make the markets fail. HAs would make sure that the consumers were well-informed about price, access, and quality. They also

121. This position was not always taken at face value. *See, e.g.*, Alain C. Enthoven & Sara J. Singer, *Single Payer in Jackson Hole Clothing*, HEALTH AFF., Spring 1994, at 81 (criticizing the HSA for “placing the federal budget at risk” by attempting to achieve universal coverage and control costs with price controls on health plan premiums).

would be the mechanism through which consumers choose their plans. The standard benefit package would help consumers to compare the costs of health plans directly. The statutory premium structure would give almost all consumers a direct, out-of-pocket financial interest in the cost of health coverage. The result would be cost savings courtesy of Adam Smith's invisible hand, once guided by the managed part of managed competition.

The other approach, the "countervailing power" solution, posits a different and deeper market failure. Under this view, insurers and providers reap inappropriate returns as a result of market power.¹²² Consumers would never be able to make good choices about the price and quality of health care and would probably never want to. Instead, they would be convinced by doctors or insurers to pay whatever was necessary to keep their existing health coverage. Merely making the health coverage market more competitive would not work, just as increased competition over the preceding decade has not noticeably slowed the growth of health expenditures as a percentage of gross domestic product. Under this theory, costs could only be controlled by coercion, forcing insurers and providers to disgorge profits and cut costs.

This coercion could be exercised by direct price controls, but need not be. Instead, one could build up market power on the other side, through pulling consumers together into one large buying organization. If that organization had a large enough share of the market, insurers and providers would be forced to deal with it — after all, neither hospitals nor doctors can quickly and easily change states. Its large share of the market would make it a monopsonist, a monopoly on the purchasing side. And its monopsony power could be used to force down prices without resorting to price controls.

Monopsony, though, has its disadvantages. It can coerce lower prices, but with no guarantee that the new lower prices will be "right." Given the near impossibility under the HSA of escaping from the grasp of the HAs, insurers or providers faced with a monopsonist would have to accept its terms or find a

122. These surplus profits might take the form of insurer profits, open or hidden. They also might flow back to providers, through high medical incomes or particularly good working conditions.

different business. The resulting prices might well be "too low," thus not providing for the long term marginal costs of delivering care and, in effect, forcing some health plans or providers either to operate at a loss or to "ration" care inappropriately, thereby compromising quality.¹²³ In this respect, monopsony power can function like a price control, but without the obvious governmental action or the judicial review the Constitution may require for price control schemes.

The good broker approach requires that the HA be knowledgeable about the terms and quality of the health plans with which it contracts. This approach presumably requires that the HA reach a certain size to justify the investment in gaining expertise. The countervailing power approach, however, requires both a substantial market share, to give the HA the effective power to dictate terms to health plans, and the right to use it. The HSA was consistent in allowing the good broker approach to work, but contained contradictory, and even perverse, provisions from the point of view of the countervailing power approach.

Under the HSA, HAs had to negotiate with any state-certified prepaid health plans that wanted to enter discussions with them (and that had not previously failed to meet the HAs' quality standards). In those negotiations, however, the HAs had to accept contracts from any qualified plans that submitted bids no more than 120% of the average of the bids the HA received.¹²⁴ What would those negotiations have looked like? As long as the health plan came in within 20% of the regional average, the HA had to offer it to recipients. Under these circumstances, over time there would have been substantial upward pressure on that average — if all the plans submit bids 20% above the previous average, the actual average becomes 20% higher than before, which leaves more room for higher bids next year.

Currently, employers can decide to accept or reject offers from health plans. And both PERS and HIPC can decide whether or not to contract with particular plans, based on considerations of price or quality. Two years ago, as discussed

123. Clark Havighurst suggested that the monopsony power of health alliances might be limited by tailored antitrust scrutiny, similar to that provided by the Local Government Antitrust Act of 1984. See generally HAVIGHURST, *supra* note 3.

124. HSA § 1321(b).

above, when PERS was unhappy with the rate increases proposed by the Kaiser Permanente system, it froze Kaiser's PERS enrollment. The next year, Kaiser did not offer a rate increase to PERS; it cut the premiums. Under the HSA, HAs would not have had that power.¹²⁵

The HSA also required HAs to provide fee-for-service coverage options in their territories. HAs had to negotiate with providers in order to create such plans, and the bill gave those providers a special exemption from antitrust liability to allow them to join together to negotiate with the HAs. But again, the apparent negotiations would likely be meaningless. This time the providers would have no choice — they could not, in fact, refuse to meet an HA's terms. It is hard for doctors and impossible for hospitals to change location. If an HA, which provided coverage for all the population not covered by Medicare or corporate alliances, insisted on a particular fee schedule, the fee-for-service providers could either agree to try to make a living from non-HA patients only, or try to move.

Thus, the HSA would have allowed the assertion of monopsony power in the fee-for-service market, but not in the HMO market. This would have had different implications depending on which approach, the good broker or countervailing power approach, was right. If the former was correct, cost control should not be affected. Even if HAs cannot drive hard bargains with prepaid health plans, HA members should force competition by choosing the low-cost plans. But there still would have been some perverse effects. One of the underlying assumptions of health reform, and particularly of managed competition, is that HMOs and other forms of prepaid care are more efficient than fee-for-service practice. The HSA's structure, however, allowed HA's to use monopsony power to depress the price to consumers of fee-for-service plans but not of prepaid plans. The result would be an artificial boost in the allure to consumers for fee-for-service plans.¹²⁶

If, on the other hand, the countervailing power approach is right,¹²⁷ the failure of HAs to be given that power with respect

125. See *supra* note 60 and accompanying text.

126. Of course, by depressing the fees in fee-for-service plans, the HAs might have hastened the move by providers from fee-for-service practice to prepaid practice.

127. It is even possible that both approaches are right, but in different regions. In some areas, such as California, the proliferation of health plans may have stripped the

to prepaid plans would mean that such plans would not have strong incentives to control their costs. Then if the cost control targets set in the bill were not met, the "back-up" strategy of price controls would come into effect. In any event, the stark differences in the treatment of fee-for-service and prepaid plans seems impossible to justify on policy grounds.¹²⁸

D. Controlling HAs

The final question about HAs may be the most important — how should they be controlled? The Clinton plan left that largely up to the states. It required a controlling board, with representatives of named interests and with strong prohibitions on conflicts of interest, but it specified little else about control of HA activities.¹²⁹ Yet HAs, like any other organization, could be run well or run poorly. They could be operated based on the desires of any of many different interested parties. The HSA should have been concerned about two possibilities: either that an HA would be incompetent, or that it would be competent, but that it would pursue the interests of parties other than its members. The HSA contained no effective checks on either threat.

HAs could be controlled in at least four possible ways: through federal oversight, through litigation, through a governance process run by members, or through competition. In reviewing these four approaches, only the third and fourth options seem promising.

1. Federal Oversight

Federal oversight and intervention could guarantee that HAs would adequately represent their members. There are two problems with such an approach, however.

First, federal oversight is difficult, both practically and politically. Judging the quality of HAs, like judging the quality of

plans of any market power, so that only the good broker approach is needed. In other parts of the country, where managed care is rare and one or two plans control the majority of the market, the countervailing power approach may be essential.

128. It seems likely that the requirement that HAs accept any health plan bid that was not more than 20% above the regional average had political, rather than policy roots, as an attempt to mitigate opposition to the HSA from prepaid health plans terrified of the HAs' potential exercise of monopsony power.

129. HSA §§ 1202, 1330.

medical care, would likely be difficult. A federal agency may not find it easy to determine whether the HA responds to member telephone calls in a timely manner, whether it negotiates competently with health plans, or whether it has been captured by industry interests. Even if a federal agency made an accurate determination that an HA was not being run well, it might face political difficulties in openly accusing a state body of incompetence or bias.

These problems would have been magnified under the HSA, because it provided the federal government with only a crude tool to control HAs. Presumably, the federal government could have intervened to stop clear violations of the federal statute governing HAs, such as including physicians on the HA board. But the HSA seemed to give fewer options for dealing with an incompetent or biased HA. The federal government could have decertified a state and barred it from participating in the national health plan entirely. However, that threat is almost like the threat of a first nuclear strike — too drastic to use.¹³⁰ As a result, effective federal oversight is hard to imagine within the HSA.

2. Litigation

Another possible control on HA actions would have been through litigation, whether by citizens or by the federal government. Under the HSA, individuals complaining about the HAs' performance first would have had to pursue their administrative remedies. After exhausting those remedies, the potential plaintiffs could then sue an HA in state or federal court.¹³¹

But what standards would the courts enforce? Apart from the fairly mechanical tests for board membership, conflict of interest rules, and so on, there were few clear statutory mandates in the HSA to form the bases for such suits. The statute seemed to contain no hook that would allow plaintiffs to sue to force HAs to act more competently or to reflect better the interests of their members. Not only did the bill give little justifi-

130. One could, however, view the back-up premium limits contained in the Clinton plan as a method of solving one manifestation of incompetent HAs. If the HA failed, through incompetence or capture, to hold down costs, the federal government, in effect, would take over the price negotiation function of the HA through imposition of the premium caps. This takeover would be only partial and its cure worse than the disease.

131. HSA § 5237(b).

cation for judicial oversight of HA management, but courts would likely be reluctant to get deeply involved in the day-to-day operations of such large entities, operating in such a complex field. Running a state's HAs could make school desegregation litigation look easy by comparison.

3. Governance Structures

HAs should be run for the benefit of their members to make high-quality care available at reasonable prices. But under the HSA those members had no control over the HAs. HAs were to be governed by a board, consisting of equal numbers of representatives of employers and HA members. The appointment of the board members was left up to the state, as was the staffing of the HA. As a result, sympathetic governors or legislators in some states might have appointed board members who are favorable to doctors, or to hospitals, or to HA members. The HA staff may have been newly hired or hired away from existing state bureaucracies. These decisions likely would effect how well HAs function by affecting to whom HA board members owe their jobs.

There are other possibilities not explored in the Clinton plan.¹³² Rather than allowing HA boards to become another patronage possibility for state governors or legislatures, the federal government might require, for example, that board members be elected by the members of the HA. HAs might be required to provide regular reports to their members, including cost and customer satisfaction comparisons with other jurisdictions.

Other paths for member control are also possible. HAs could be required to put controversial issues up for a vote of the members or to create a committee structure with public participation. Alternatively, HA boards could be required to include representatives of interests defined more narrowly than those of employers and employees. None of these methods can be guaranteed to work, however. The majority of HA members may not care enough to take part in such an election, let alone to learn enough to have an informed position on HA policy or board membership. These kinds of structures for greater mem-

132. Havighurst has described in more detail the idea of member-elected boards governing HAs. See HAVIGHURST, *supra* note 3.

ber control over HAs are not inconsistent with the Clinton plan. State legislatures and governors could choose to have HA board members elected, in constituencies or in one state wide election, but the Clinton plan neither required nor even encouraged such experimentation.

4. Competition

The final possibility for exerting some control over HAs lies in opening them up to competition. The HSA explicitly ruled out direct competition by requiring each HA to have its own inclusion area within which no other HA could operate.¹³³ The bill did provide for some limited competition, however, and other competition might be created.¹³⁴

Corporate alliances might emerge as a competitor to HAs. The HSA authorized individual employers or unions, in some circumstances, to continue to buy health plans for their workers. In each case, corporate alliances were only allowed if more than 5000 employees were covered.¹³⁵ It is very difficult to tell how many employers would sponsor corporate alliances. Even the number of Americans who work at firms of more than 5000 employees is not definitively known. The statistical data that addresses workforce numbers all seem to stop at employers with more than 5000 employees. Based on available figures for larger employers, it seems likely that somewhere between ten million and twenty-five million Americans work for firms that could institute corporate alliances.¹³⁶

133. An underlying premise of the entire HSA is that direct competition would not be encouraged.

134. *Id.* § 1325. This consumer information and marketing section of the HSA would allow enrollees to make "valid comparisons among alliance health plans," thus allowing some limited competition.

135. HSA §§ 1311(b), (e)(2). Local, state, and federal government employers were not allowed, under the bill, to form corporate alliances. Their employees had to be covered through the HA.

136. The best assessment of the number of people employed in workforces of different sizes comes from the Statistical Abstract of the United States. The 1994 edition showed that in 1991, the latest year for which data was available, 12.2 million Americans were employed by employers with more than 1000 employees; 6.33 million were at employers with more than 500 and fewer than 1000 employees; and 22.37 million were at employers with more than 100 and fewer than 500 employees. US. DEP'T OF COMMERCE, *supra* note 17, at 546. The abstract does not provide an estimate for employers with more than 5000 employees.

Even if the HSA had provided that employers with more than 1000 employees could form corporate alliances, the number of people who might be covered would still be un-

Those workers, and their households, formed the upper limit to the size of corporate alliances under the HSA, but the bill made it unlikely that limit would ever be reached. Under the HSA, corporate alliances did not seem likely to attract many employers or unions. Firms wishing to create or maintain a corporate alliance would have had to pay a 1% fee.¹³⁷ The sponsors were to be subjected to more stringent federal regulation than they are currently. The corporate alliances also would constantly have to worry about future regulatory changes that would make their separate existence more burdensome. In exchange, the sponsors forming corporate alliances would retain more control over employees' health care, plus obtain rates that reflected the experience of their workers' families, instead of all families within the HA.

Corporate alliances are not the only way to inject some competition into HAs. Clinton's health plan could allow more than one HA to operate in an area. Certainly, some areas have populations large enough to support several HAs. The Los Angeles PMSA includes nearly nine million people; the portions of the New York PMSA located in New York State have about eleven million people. It is hard to see why those areas could not support two or three HAs of sufficient size to reap all the economics of sale.

Groups, public or private, nonprofit or for-profit, could apply for recognition as HAs. Those groups would then negotiate with health plans and compete with each other for members. Each person would still have to belong to an HA, but the individual consumer could choose which HA she wanted.¹³⁸ Con-

known. Unions that currently have health plans with more than 5000 members could continue them. It is not known how many employees are involved in such plans. One also would need to know how many employees with family members with other jobs would opt for HA coverage rather than corporate coverage. Finally, one would have to estimate the average number of people covered for each employee -- spouses and dependents. Taking all these uncertainties into account, I am unable to come up with a narrower range than about 10 million to 25 million.

137. HSA § 7121(a).

138. Alternatively, one could let the employer choose the HA for all its employees. The employer would have financial incentives to choose the HA with the less expensive plans. The employer would not have a strong incentive to choose HAs that provided good member service or excelled in medical quality control, two areas where individual HA members might have strong feelings. On the other hand, employers might be able to assess the general quality of the HAs more effectively than individual HA members could. In addition, it would certainly be simpler for the employers if each employer had to deal with only one HA.

sumers could vote with their feet, deserting HAs that did not seem to be serving their interests for HAs that would meet their needs.

Multiple alliances, whether corporate alliances or other HAs, seem to offer substantial benefits in terms of control and incentives. However, they also would carry some costs. One is that the alliances may be too small to operate efficiently or, under a countervailing power theory, to serve as effective monopsonists.¹³⁹ The existence of multiple alliances also would be confusing, a particularly high cost when trying to pass or implement this kind of legislation.

If the benefits outweighed the costs, what kind of competitive alliances should be allowed? Competing HAs are preferable to a mix of HAs and corporate alliances for two reasons: they produce more direct competition and they are fairer.

First, the competition between HAs and corporate alliances would be too indirect. Only families with multiple workers, some working for companies with corporate alliances and others not, would be able to change between corporate alliances and HAs. Other families generally could not shift between an HA and a corporate alliance without someone in the family changing jobs. Nor could employers easily change. Under the HSA, employers were not allowed to shift from an HA to a corporate alliance, but only in the opposite direction.¹⁴⁰ Without the fear of direct competition for members, the force of competition is limited to its "yardstick" effect — it gives one organization a standard with which it may measure itself. The yardstick may be hard to read as the alliance costs are affected by the health status of their members. Its effects may be too attenuated to keep alliances focused on the interests of their members.

Second, different alliances necessarily presuppose different premium rates. Each alliance would negotiate its own rates and would be a different community for purposes of the required community rating. But those differences open the possibility of

139. Arguably, if monopsony power were that important, one or more HAs would grow to the size necessary to be able to exert that power. That process could take some very valuable time.

140. HSA § 1312(d) (putting strict time limits on when an employer or a union could choose to have a corporate alliance), § 1313 (allowing corporate alliances to choose to dissolve).

risk selection. If a region had two HAs, one with healthy people and one with sick people, their members could pay strikingly different premiums. That kind of difference could not be sustained in a multiple HA system where consumers (or their employers) could choose freely between HAs. Those in the high-cost HA would always want to shift to the lower-cost HA. On the other hand, corporate alliances, by their nature, restrict entry to those associated with the employer. A firm that had workers with low health costs would have a corporate alliance, all other things being equal, with low premiums. Unlike the situation with competing HAs, the employer could maintain that advantage by shutting out non-employees who wanted to join to receive the lower premiums. Corporations with low-cost work forces would thus share lower health bills with those work forces, disturbing the horizontal equity the alliance system offers.

Competing alliances offer some possible benefits, with competing HAs a preferable option to "competition" between HAs and corporate alliances. Concerns about the size of the competing HAs could be mitigated by initially testing this kind of competition within a limited number of competing HAs regions with large populations. If successful, the experiment could be expanded to other areas.

CONCLUSION: THE FUTURE OF HAs

HAs were a fascinating but flawed part of the Clinton health plan. The argument that they would add to the federal bureaucracy contributed unfairly to the Clinton plan's demise, but, in some form, HAs seem likely to survive its death. As the PERS and HIPC examples suggest, HAs are too useful to die. By pooling large numbers of health coverage buyers, HAs make it possible for individuals to get expert help in negotiating, monitoring, and understanding their health plans.

Without broad federal legislation, they will expand, but they will do so slowly. For reasons of both credibility and possible protection from antitrust liability, HAs are likely to grow mainly under the auspices of state governments. As HAs threaten the financial interests of many involved in the health care industry, state adoption and sponsorship may be thwarted by state politics.

When substantial federal health reform does come to pass, HAs will be a very attractive method for implementing the reforms. Private HAs should be encouraged as an option, along with state-controlled HAs, with the role of HAs in *reducing* bureaucracy in health care made clearer. HAs should be allowed to cross state lines, at least within metropolitan areas. HAs should be allowed to say “no” to health plans instead of being forced to offer all plans within 20% of the average premium. More direct consumer influence on and even control over HAs should be considered. And corporate alliances should be abandoned and replaced, at least experimentally in some large regions, by competing HAs. These changes should produce HAs that are more politically palatable and more effective.

Like the Health Security Act, old Marley really was dead. And yet his ghost, and the lessons it provided, accomplished the most unlikely task of reforming Ebenezer Scrooge. May the ghost of the HSA, and its mandatory health alliances, be as successful in leading to reform of our health care financing system.