UC Berkeley

UC Berkeley Previously Published Works

Title

The politics of managed competition: public abuse of the private interest

Permalink

<https://escholarship.org/uc/item/1858k8jh>

Journal

Journal of health politics, policy and law, 28(2-3)

ISSN

0361-6878

Author

Robinson, James C.

Publication Date

2003-04-01

Peer reviewed

The Politics of Managed Competition: Public Abuse of the Private Interest

James C. Robinson

University of California, Berkeley

Abstract The doctrine of managed competition in health care sought to achieve the social goals of access and efficiency using market incentives and consumer choice rather than governmental regulation and public administration. In retrospect, it demanded too much from both the public and the private sectors. Rather than develop choice-supporting rules and institutions, the public sector has promoted process regulation and benefit mandates. The private health insurance sector has pursued short-term profitability rather than cooperate in the development of fair competition and informed consumer choice. Purchasers have subsidized inefficient insurance designs in order to exploit tax and regulatory loopholes and to retain an image of corporate paternalism. America's health care system suffers from the public abuse of private interests and the private abuse of the public interest.

Managed competition emerged as a doctrine in the 1970s, a period of political adherence to the egalitarian objectives but disillusionment with the regulatory instruments of the Great Society. In the nonhealth sectors of the economy, the 1970s were a period of deregulation, beginning with the airline and railroad industries and continuing into the telecommunications, banking, and utility sectors. While command-and-control methods remained strong for newer areas of governmental intervention, especially environmental pollution and racial inequality, the dominant tone for traditional policy arenas emphasized incentives over regulation, outsourcing to private firms over administration by public agencies, and tax cuts over bureaucratic expansionism. The spirit of the times was best captured, per-

Support for this research was provided by the Robert Wood Johnson Foundation.

Journal of Health Politics, Policy and Law, Vol. 28, Nos. 2–3, April–June 2003. Copyright © 2003 by Duke University Press.

haps, by Charles L. Schultze (1977), chair of the Council of Economic Advisors under President Jimmy Carter, in a series of essays titled *The Public Use of the Private Interest*, a paean for pursuing liberal ends with conservative means.

The market-oriented strategy for health care and health insurance reform, pioneered by Paul Ellwood and Alain C. Enthoven (1977, 1980), was in many ways a direct application to health care of the principles articulated in Schultze's essays. Ellwood and Enthoven saw the social goals of universal coverage, comprehensive benefits, cost-effectiveness, and quality enhancement as too ambitious and complex to be achieved through a top-down governmental approach, and as needing bottoms-up change in incentives and institutions. Managed competition combined traditionally private sector instruments, such as price and quality competition for providers and informed, cost-conscious choice for consumers, with traditionally public sector instruments, such as uniform benefits, risk-adjusted community rating, and tax reform. The central roles would be played by two organizational innovations, the health maintenance organization (HMO), an entity that would integrate the financing and delivery of care, and the purchasing alliance, a "sponsor" that would amalgamate passive payers into sophisticated purchasers. The HMO and the purchasing alliance were to be accountable both to individual consumer preferences and to collective social goals, and would match consumer preference with service characteristics while restraining cost inflation and ensuring universal access.

The global trend away from public regulation toward private incentives has continued and even accelerated since the 1970s, as socialism has been replaced by capitalism in eastern Europe, nationalized firms have been privatized in western Europe, and detailed rate setting has been rescinded for airlines and phone lines in the United States (Friedman 1999; Yergin and Stanislaw 1998). The application of analogous principles to health care has proceeded less far, however, as cost inflation, quality deficits, the conversion of health care organizations to for-profit ownership, and a general state of turbulence has nurtured dissatisfaction with many components of managed competition. The HMO, as the organizational embodiment of the use of private interests to achieve public goals, has proven the bellwether of the shifting politics of health care. The HMO once was embraced by politicians from Richard Nixon to Ted Kennedy, promoted through legislation from the HMO Act of 1973 to the Health Security Act of 1994, and conceptualized as the mechanism for mainstreaming Medicare beneficiaries, Medicaid dependents, the privately insured, self-

insured, and uninsured into one health insurance system. But now, after thirty years in the political maelstrom, it has come to be the favored whipping boy of legislators, regulators, litigators, journalists, activists, physicians, patients, and health services researchers.

Health plans now are responding to their unpopularity by broadening provider networks, lightening up on utilization management, reverting from capitation to fee-for-service payment, abandoning the Medicare and Medicaid programs, and redefining themselves as choice-oriented and Internet-enabled providers of consumer information, clinical decision support, physician and hospital price discounts, and voluntary disease management programs. The era of dual accountability is ending, as the insurance sector redefines itself as accountable only to its individual enrollees, and not as responsible for reform of the delivery system, income redistribution from healthy to sick, or any of the other social goals that enthused the first generation of HMO entrepreneurs.

It is too early to pronounce the defeat of the private sector strategy for achieving public sector objectives, but it is a moment of humility rather than hubris among policy reformers of the market-oriented persuasion. In retrospect, managed competition demanded too much individual restraint and too much joint collaboration on the part of both the public and private sectors. The center did not hold and the two ends have gone their own preferred ways—the public sector toward a bureaucratic strategy of micro-regulation and benefit mandates, and the private sector toward a product design strategy that protects healthy enrollees from economic responsibility for the sick uninsurables.

Public Use of the Private Interest

The 1960s surge in popular enthusiasm to solve the most intractable of social problems contained ambivalent sentiments concerning the tools available to the public sector. The decade witnessed a major expansion of public programs and the taxation to support them, illustrated most clearly in the creation of the Medicare and Medicaid programs. But the 1960s and the decade that followed also spawned a neopopulist critique of government as bureaucratic, inefficient, and prone to capture by special interests (Stigler 1971; Barney 1973; Wilson 1980). So while government programs and regulations expanded dramatically in some arenas, they contracted just as dramatically in others. The movement toward national health insurance, once viewed as politically inexorable by all observers, was caught in the crosswinds. It embodied the pursuit of a core social goal

through governmental control at the moment when much of the public had become weary of tax increases and intrusive regulation.

Schultze articulated a policy perspective that sought to achieve the social goals of the era with market incentives rather than centralized regulation. He accepted the inevitability of increased collective, as distinct from individual, decision making in society because of the growing prosperity and the rising expectations it created. Even though poverty was receding, racial and gender inequality was diminishing, environmental pollution was abating, and health status was improving as the decades of the twentieth century passed, public impatience to accelerate reform was higher than ever. But public frustration with ever greater taxation and bureaucratization also was increasing. Schultze was concerned lest the resistance to the regulatory means impede achievement of the public goals. He advocated the use of incentives that harnessed the pursuit of private gain and protested against regulations that sought to block the pursuit of private gain (as unlikely to succeed). Of the three principal methods for inducing individuals to pursue socially desired goals, coercion, socialization, and incentive alignment, the third was, for Schultze, the most effective and the most respectful of individual autonomy. He argued that socialization and coercion should be treated as scarce social resources, to be used only when incentive-conscious alignments of private with public interests could not be crafted.

The market-oriented approach to health insurance reform embodied the same perspective of pursuing social goals through private incentives. Enthoven was explicit in describing the doctrine of managed competition as the application to health of *The Public Use of the Private Interest* (1980). He argued that centralized regulation is particularly ill-equipped for influencing the intimate, emotional, and ethically charged problems posed by the health care system. Attempts to enhance cost-effectiveness, narrow unjustifiable variations in practice patterns, reduce medical errors, and make providers more sensitive to consumer preferences through a uniform, top-down system centered in Washington, D.C., would be the health care equivalent of trying to defeat the Viet Cong by bombing them from 36,000 feet. Physicians paid fee-for-service and patients exempt from cost-sharing would create a politically unstoppable tornado of moral hazard that would sweep away public agencies already weakened by an American political culture that interpreted strong government as tyrannical government. What was needed, in Enthoven's view, was incentive realignment, an on-the-ground guerrilla strategy that included limits to open-ended tax subsidies, a dismantling of anticompetitive barriers to entry,

risk-adjusted subsidies to the poor and the sick, public disclosure of data on price and quality across plans and providers, open enrollment, guaranteed issue, and a host of other rules that promoted rather than frustrated choice and competition.

Central to the market-oriented strategy was to be organizational innovation in the financing and delivery of health care. Professional dominance and open-ended Medicare subsidies had frozen into place an indemnity structure to health insurance and a cottage-industry structure to health care. Enthoven looked to the multispecialty medical group as the logical locus of coordination for increasingly specialized health care services and to prospective payment as the logical method for instilling cost consciousness among the clinical decision makers. The HMO embodied the vertical integration of financing and delivery, the means for leveraging health care quality and efficiency through changes in health insurance incentives. In Enthoven's thinking, HMOs should not be granted exclusive franchises or special subsidies or favored status but, on the contrary, should be required to compete for the hearts, minds, and premium dollars of informed and price-sensitive patients. The choices of individuals were to be supported by a policy framework that limited itself to leveling the playing field and by public and private health care purchasing alliances who had the scale and sophistication to counter any socially undesirable strategies that emerged in the competitive market, be they risk selection, quality shading, or cartel pricing.

After an initial flurry of political interest, managed competition was slow to gain momentum. An analysis in the early 1980s declared that HMOs would never play significant roles in American health care (Brown 1983). The ink was barely dry on that skeptical assessment, however, when the HMO sector began to boom. The costs of indemnity insurance had continued to inflate rapidly, the chance of a governmental takeover had evaporated after the presidential election of 1980, and for-profit conversions brought capital and entrepreneurial talent into the sector. The incumbent insurers fiddled a while and then rushed to jump onboard a runaway train, building or buying HMO networks and, in some cases, physician clinics. Capitation payment, utilization management, primary care gatekeeping, expansion of preventive services, and other hallmark HMO features rolled from west to east as everyone seemed to believe that the vertically integrated insurance and delivery organization was the unstoppable future of American health care. The high water mark of the managed competition movement came when President-elect Bill Clinton promised universal coverage through "private insurance, publicly guar-

anteed.” Health insurance purchasing cooperatives were retitled “health alliances” and HMOs were retitled “accountable health plans,” but otherwise the Health Security Act appeared the classic embodiment of a strategy of pursuing public goals using private interests (Zelman 1994). Market competition and consumer choice were to leverage universal coverage and global cost control. The doctrine of managed competition was to be a “bridge to compromise” that brought together Democrats dedicated to public sector ends and Republicans dedicated to private sector means (Starr and Zelman 1993).

Public Abuse of the Private Interest

As emphasized by economic analysis since Adam Smith and as reemphasized by Schultze and Enthoven, the achievement of social goals through incentive-driven private interests requires a market-oriented institutional framework, itself supported by sustained and clear-headed public policy. Tax subsidies, quality regulations, benefit mandates, antitrust statutes, and other rules of the game need to be calibrated to channel individual self-interest in a direction compatible with, rather than contrary to, collective well-being. This challenge often overwhelms the intellectual competencies and political powers of the public sector. Politicians, regulators, administrators, judges, and attorneys general tend to hold a worldview according to which direct intervention through regulatory mechanisms is more effective, or at least more predictable, than indirect intervention through incentive mechanisms. They are under relentless pressure from the interest groups that prospered in the cozy, noncompetitive, and subsidized world of public administration and rate regulation. They are tempted to exploit every business failure and corporate scandal to demand a return to the regulatory status quo ante.

The public sector embraced the doctrine of managed competition in health care but proved itself an unfaithful partner. Some units of government, especially the federal and some of the state public employee health benefits programs, outpaced the more timid corporate purchasers in offering multiple health plans, price-conscious choice, and other hallmark characteristics of the market strategy. Medicare and many of the Medicaid programs contracted with HMOs and sought to move their beneficiaries into managed care. Professional cartel structures and anticompetitive restraints were rolled back in several important instances. But the key tasks in the health policy agenda to align private to public interests remained undone. The regressive tax subsidy for comprehensive fringe

benefits was never capped. Purchasing alliances for individuals and small businesses never received more than token support. No clear guidelines were developed for complex and hence litigious concepts such as medical necessity and experimental treatment. Most important, the citizenry was never informed that it paid for health care and hence that cost-reducing initiatives saved money for the consumer and patient, rather than just for insurance industry stockholders and executives.

As the technology-driven growth in health care costs pushed against the competition-driven limits on health insurance premiums, the pain experienced by consumers and providers changed the political landscape. Legislators and regulators sensed the potential for gaining significant political capital by attacking the organizational embodiments of the private sector strategy. Rather than seek to fashion rules that aligned private interests to public goals, the new wave of statutes and regulations sought to constrain, control, or ban the instruments used by HMOs in the marketplace (Peterson 1999). Network contracting, utilization management, and benefit design were limited by legislators, regulators, and the courts until almost no flexibility remained for the health plans. Regulation was applied much more broadly and strictly to HMOs than to indemnity and quasi-indemnity preferred provider organization (PPO) products, to insured than to self-insured benefit programs, and to capitation than to fee-for-service. Rather than seek to clarify and resolve clinical ambiguities, politicians invited private litigation.

Medicare, which passively reimbursed the wide geographic variations in utilization patterns through its fee-for-service program, never developed a sophisticated payment method for its managed care program, alternatively overpaying HMOs in some regions and time periods while underpaying them in others. State Medicaid programs pursued the age-old strategy of bait and switch, offering generous initial payments to entice HMOs to enroll public beneficiaries, then cutting and freezing payments to squeeze out profits, and finally denouncing the money-losing health plans that exited the public programs as guilty of abandoning the poor. The greatest political betrayal of managed competition was by the one who had proclaimed himself its greatest friend. President Clinton transformed the health insurance purchasing coalition from a mechanism to stimulate diversity on the demand side of a competitive health care market to a governmentally controlled monopsony in each state; created rate regulation mechanisms to replace market contracting if cost inflation surpassed arbitrary trigger points; mandated a uniform benefit package rich enough to satisfy every politically mobilized constituency; and announced that insur-

ance coverage for all, forever, did not require tax increases but would be financed by unspecified savings from reduced administrative and clinical inefficiencies. Feted initially by the Clinton team as the intellectual father of their Health Security Act (Starr 1992; Starr and Zelman 1993; Enthoven 1993), Enthoven became disenchanted at what he came to see as a veneer of market rhetoric that masked a command-and-control, tax-and-spend, governmentally centered scheme (Enthoven and Singer 1994). The American people voted their agreement in the Republican electoral landslide of 1994 (Blendon et al. 1995).

Private Abuse of the Public Interest

The unwillingness or inability of the public sector to create the rules needed to ensure that a market-oriented health care system would achieve social goals was matched by a commensurate failure of will by the private sector. There was an initial flurry and then sporadic revivals of social entrepreneurship to create prepaid group practices and health insurance purchasing alliances, to craft risk-adjusted methods of payment and severity-adjusted methods of quality reporting, and to define a decent minimum benefit package and actuarially sustainable community rates. In the absence of strong public support and, over time, in the face of ever harsher public regulation, however, the industry began to move away from managed competition.

Outside of Kaiser-Permanente and a few other market anomalies, the entity currently referred to as an “HMO” bears almost no resemblance to its progenitors. Most of the HMOs have moved from vertical integration with a multispecialty medical group to spot contracting with a broad and hostile physician network; from prospective capitation payment for a spectrum of clinical services to retrospective, fee-for-service payment for individual providers and procedures; from a focus on populations to a focus on individuals; from comprehensive benefits with minimal copayments to thin benefits with large copayments; and from insured and regulated products to self-insured and hence relatively unregulated products (Draper et al. 2002; Gabel et al. 2001; Hurley et al. 2002; Robinson 2002). Now most of the prepaid group practices have sold out or closed down; national carriers such as Aetna and CIGNA that once promoted HMO products are buffing their PPOs; and BlueCross–BlueShield plans that came late to managed care are reaping the rewards of having retained a quasi-indemnity product portfolio (Robinson and Casalino 2001; Robin-

son 2001; Cunningham and Sherlock 2002). HMOs are retreating from rural areas dominated by provider systems, from individual and small group market segments constrained by detailed regulation of price and product, from Medicaid programs that pay below-market rates, and from Medicare markets where double-digit drug cost inflation outruns single-digit federal payment increases. By the turn of the millennium it had become time to ask: What if someone offered a market-oriented health policy and no market organizations came to play?

The failures of the health insurance industry were both the cause and the consequence of a failure by corporate purchasers of health insurance benefits to pursue public goals with private means. Some employers did structure their premium contributions to reward price-conscious choice by their employees, offer multiple health plans and products to encourage the growth of prepaid group practice, create or join alliances that pooled the purchasing power of multiple firms, collect and disseminate information on clinical quality, and educate their employees to realize that health benefits ultimately are financed from the same payroll funds that otherwise could be allocated to wage increases. But most did not.

The dominant approach to health insurance purchasing in the private sector emphasized administrative ease, exploitation of tax loopholes, and avoidance of mandated benefits rather than the fostering of consumer education and incentives (Maxwell and Temin 2002; Enthoven 2002). Rather than do the hard work of contracting with multiple health plans, defining fixed-dollar contribution strategies, risk-adjusting premiums, and disseminating information on quality across plan offerings, most employers, large and small, offered a single health plan or just a few choices, subsidized with higher contributions employees who choose offerings with higher premiums, and insisted that health plans offer most physicians and hospitals (thereby recreating “any willing provider” designs and eviscerating prepaid group practices). They countered the regulatory fervor of the public sector by self-insuring their benefit programs, thereby exploiting an unintended feature of the Employment Retirement Income Security Act (ERISA), which exempted them from state-mandated benefits and premium taxes designed to finance care for the uninsured. They retained the obfuscation that health insurance benefits were a form of beneficent profit-sharing with employees rather than a deduction from wages. As the cost of their indemnity insurance benefits skyrocketed, they herded their employees into PPO and HMO product designs, thereby contributing mightily to the consumer backlash against managed care. And as the back-

lash swelled to tsunami levels, the corporate purchasers hid their heads, denied having herded anyone anywhere, and allowed their hired health plans to take the full hit.

The Failure of Dual Accountability

American health policy and politics are currently at a moment of indecision in the wake of the failure to achieve the balance of public and private interests embodied in the principles of managed competition. Some liberal enthusiasts hope for a radical shift toward public sector ownership and control of health insurance, fueled by the popular backlash against managed care and the intractable problems posed by the uninsured. But elected politicians manifest little appetite for the thankless job of reconciling limited budgetary resources with unlimited social expectations for high-tech, high-touch medicine. Some conservative enthusiasts hope for a radical shift toward private sector principles, the mass customization of insurance products to fit each preference and pocketbook without interference from regulators and agency administrators. But the citizenry manifests no willingness to acquiesce in the allocation of health care services based on income, shopping acumen, and caveat emptor. The perplexities of the moment are best exemplified by the multiple uses of the terms *consumer*, *consumerism*, and *consumer-oriented*. Left-wing activists interpret health care consumerism as cost-unconscious choice among services whose price, quantity, and quality have been homogenized by law and regulation. Right-wing activists interpret consumer-driven health care as a public policy of laissez-faire toward whichever mix of benefit designs, premiums, and underwriting practices the unregulated private market generates. And it is worth remembering that even managed competition once labeled itself as the “consumer choice health plan” (Enthoven 1977).

With the benefit of hindsight, it now is apparent that the public use of the private interest in health care demanded too much from both the public and the private sectors. For managed competition to have succeeded, the public sector would have needed to distinguish excessive from inadequate intervention, to regulate without falling victim to regulatory capture, to redistribute income from the healthy to the sick rather than from the politically quiescent to the politically mobilized, and, generally, to alleviate market failure without aggravating government failure. The private sector, for its part, would have needed to balance cooperative with competitive initiatives to limit underwriting, risk-adjust premiums, severity-adjust measures of quality, and, generally, pursue moderate profitability

over the long term rather than high profitability in the short term. Purchasers would have needed to shed their paternalistic skins and acknowledge that they had been buying health insurance benefits not with their money but with their employees', and hence that choice was a right and a responsibility for consumers and not for human resource managers.

America now faces the worst of both worlds, the public abuse of the private interest and the private abuse of the public interest. The public sector is energized to mandate benefits, regulate prices, encourage litigation, and, generally, do everything but insure the uninsured, reform the health care tax code, promote nonlitigious conflict resolution, and enforce anti-trust laws. The private sector seems to lack the will and the way to do what it does best, which is innovate in new forms of organization, finance, and processes of care. Its focus is resolutely on the margins rather than the mainstream, tinkering with benefit designs, pricing models, and underwriting techniques until these too are regulated into gridlock.

Conclusion

The health maintenance organization began as a revolutionary attempt to move the delivery system from a fragmented cottage industry to organizational integration, from cost-sharing and demand-side incentives to capitation and supply-side incentives, from a sole focus on the individual patient to a dual focus on the patient and the population, from asymmetric information and professional guild structures to information disclosure and consumer sovereignty, and from quality assurance based on trust to quality assurance based on measurement. Now it is but one insurance product design among many, and one suffering a terrible brand image, heavy governmental regulation, and endless litigation. The HMO appears to be the Cheshire Cat of health care, a fading memory ever less relevant to the over-regulated and undermanaged delivery system. Once an organizational locus for the public use of the private interest, the HMO has been demonized, diluted, and finally downsized till not much is left but the smile.

References

- Barney, Daniel R. 1973. *The Monopoly Makers: Ralph Nader's Study Group Report on Regulation and Competition*. New York: Grossman.
- Blendon, Robert J., Mollyann Brodie, and John Benson. 1995. What Happened to Americans' Support for the Clinton Health Plan? *Health Affairs* 14(2):7–23.
- Brown, Lawrence D. 1983. *Politics and Health Care Organization: HMOs As Federal Policy*. Washington, DC: Brookings Institution.
- Cunningham, Robert, and Douglas Sherlock. 2002. Bounceback: Blues Thrive As Markets Cool towards HMOs. *Health Affairs* 21(1):24–38.
- Draper, Debra A., Robert E. Hurley, Cara S. Lesser, et al. 2002. The Changing Face of Managed Care. *Health Affairs* 21(1):11–23.
- Enthoven, Alain C. 1977. Consumer Choice Health Plan. *New England Journal of Medicine* 298(12):650–658 and 298(13):709–720.
- . 1980. *Health Plan: The Only Practical Solution to the Soaring Cost of Medical Care*. Reading, MA: Addison-Wesley.
- . 1993. The History and Principles of Managed Competition. *Health Affairs* 12(suppl.):24–48.
- . 2002. The Fortune 500 Model for Health Care: Is Now the Time to Change? *Journal of Health Politics, Policy and Law* 27:37–48.
- Enthoven, Alain C., and Sara Singer. 1994. A Single-Payer System in Jackson Hole Clothing. *Health Affairs* 13(1):81–95.
- Friedman, Thomas L. 1999. *The Lexus and the Olive Tree: Understanding Globalization*. New York: Farrar, Straus, and Giroux.
- Gabel, Jon, Larry Levitt, Jeremy Pickreign, et al. 2001. Job-Based Health Insurance in 2001: Inflation Hits Double Digits, Managed Care Retreats. *Health Affairs* 20(5):180–193.
- Hurley, Robert, Joy Grossman, Timothy Lake, and Lawrence Casalino. 2002. A Longitudinal Perspective on Health Plan-Provider Risk Contracting. *Health Affairs* 21(4):144–153.
- Maxwell, James, and Peter Temin. 2002. Managed Competition versus Industrial Purchasing of Health Care among the Fortune 500. *Journal of Health Politics, Policy and Law* 27:5–30.
- Peterson, Mark A. 1999. Politics, Misperception, or Apopos? *Journal of Health Politics, Policy and Law* (special issue, Managed Care Backlash) 24:873–886.
- Robinson, James C. 2001. The End of Managed Care. *Journal of the American Medical Association* 285(20):2622–2628.
- . 2002. Renewed Emphasis on Consumer Cost Sharing in Health Insurance Benefit Design. *Health Affairs*, Web exclusive (20 March): W139-W154. Available on-line at www.healthaffairs.org.
- Robinson, James C., and Lawrence P. Casalino. 2001. Reevaluation of Capitation Contracting in New York and California. *Health Affairs*, Web exclusive (May): W11-W19. Available on-line at www.healthaffairs.org.

- Schultze, Charles L. 1977. *The Public Use of the Private Interest*. Washington, DC: Brookings Institution.
- Starr, Paul. 1992. *The Logic of Health-Care Reform*. New York: Grand Rounds.
- Starr, Paul, and Walter A. Zelman. 1993. Bridge to Compromise: Competition under a Budget. *Health Affairs* 12(suppl.):7–23.
- Stigler, George J. 1971. The Theory of Economic Regulation. *Bell Journal of Economics and Management Science* 2(spring):3–21.
- Wilson, James Q. 1980. *The Politics of Regulation*. New York: Basic Books.
- Yergin, Daniel, and Joseph Stanislaw. 1998. *The Commanding Heights*. New York: Simon and Schuster.
- Zelman, Walter A. 1994. The Rationale behind the Clinton Health Reform Plan. *Health Affairs* 13(1):9–29.