MANAGED COMPETITION: An Exchange

Mangled Competition

David U. Himmelstein, Sidney Wolfe, Steffie Woolhandler

Despite a once-in-a-generation opportunity, the Clintons are poised to slam the door on single-payer national health insurance and embrace a corporate welfare approach with the oxymoronic name: "managed competition."

Published versions of managed competition would:

- Use tax penalties to push all but the wealthy into stripped down, basic group health plans.
- Deprive most patients of the right to choose their own doctor and hospital, completing the transformation of American medicine from one-on-one doctor-patient relationships to a medical system controlled by enormous corporate bureaucracies.
- Assure a multi-tiered health care system, separate and unequal.
- Perpetuate the private health insurance industry, the principal cause of the crisis.
- Fail to contain costs.

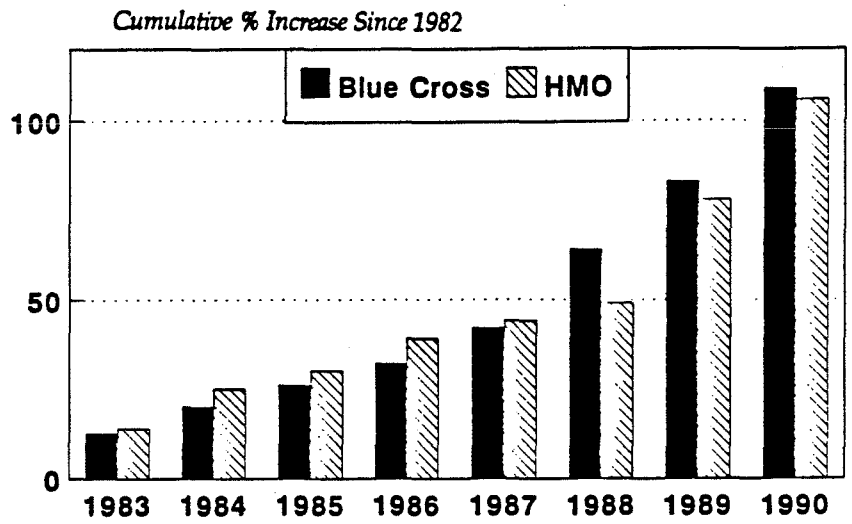
Originally proposed by Alain Enthoven, a Stanford business professor, versions of managed competition have been endorsed by Bill Clinton, George Bush, the *New York Times* (in no less than 23 editorials), several business and insurance organizations, the American Hospital Association, and even some liberals like Paul Starr. This powerful coalition, conspicuously lacking grass roots support, hopes to broker a deal: protect insurers and the most powerful providers, and shift costs from big business to small business and workers.

Managed-competition proposals differ in details, but all are complex, and to most people, incomprehensible. This opacity obscures the central theme—find a way to keep insurance giants such as Aetna and Prudential at the heart of health care.

Under most managed-competition proposals, government would define a standard minimum benefit package. Large employers would contract for this coverage for their employees, and Health Insurance Purchasing Cooperatives (HIPCs) would contract with private insurers on behalf of small employers, the self-employed and unemployed (including current Medicaid recipients). Tax deductions for employer-provided health insurance would be capped at the cost of the cheapest plan (presumably a bare-bones HMO), creating a steep financial penalty for choosing costlier alternatives. Thus, for all but the wealthy managed competition would circumscribe the patients' choice of doctor and hospital to a narrow list prescribed by their employer or their HIPC.

Managed-competition theory ascribes the soaring cost of health care to overinsurance. Americans, too insulated from the costs of care, are choosing to be profligate health care consumers. Hence they must be forced to be more cost conscious in purchasing insurance (by taxing employer-provided coverage), and aided (through the HIPCs) in bargaining with insurers. The powerful HIPCs would lean on the insurance companies and HMOs to lower premiums. They, in turn, would discipline doctors and hospitals by denying contracts to any who refused to comply with insurance company cost-cutting directives. Since a few managed care plans, giants like

Premium Increases: Blue Cross vs. HMOs



Source: Health Insurance Association of America, Group Health Association of America

higher out-of-pocket costs, or to non-CALPERS insurance purchasers.

This catalog of failure has been assembled mainly in urban areas, a setting where managed-competition theory is at least plausible. But in smaller cities and rural America, population is too sparse to support even a semblance of competition. A town's only HMO or hospital cannot compete with itself. The minimum feasible size of a comprehensive HMO is 200,000 to 300,000 enrollees. Only 50 percent of the U.S. population lives in metropolitan areas able to support two or three HMOs, that is, with populations greater than 600,000. Yet even this population density does not guarantee real competition. Two or three HMOs that dominate a market will be tempted to collude in raising prices, enlarging the pie of health care dollars rather than fighting for the biggest piece. Hence, in much, perhaps most of our nation the price competition fundamental to managed competition is inconceivable. A single-payer, regulatory approach is the better cost-containment mechanism.

Managed competition would be further undermined by insurers' efforts to attract healthy enrollees, so-called risk selection. Since 10 percent of the population consumes 72 percent of health care, the easiest way for insurers and HMOs to undercut their competitors' prices is to quietly avoid enrolling sick people in the first place, and drive away the chronically ill by offering unsatisfactory care. Immense financial reward accrues to insurers that successfully avoid risk, assuring extraordinary efforts to circumvent regulatory bans on risk selection. Although managed competition in principle requires open enrollment, such requirements are easy to subvert: place sign-up offices on upper floors of buildings with malfunctioning elevators; refuse contracts to providers convenient to neighborhoods with high rates of HIV (an example of medical redlining); structure salary scales to assure a high turnover among physicians—the longer they're in practice, the more sick patients they accumulate; assure the easy availability of services for the worried well, and assure inconvenience for those with expensive chronic illnesses. In Medicare's HMO Demonstration Project, regulatory oversight did not avert even flagrant abuses. Predictably, the HIPCs' ef-

The Usual Suspects?

Photo by C. Pablo Marcos ©1993 *The New York Times*

Some members of the Jackson Hole Group, which the *New York Times* dubbed "Hillary Clinton's Potent Brain Trust on Health Reform": At left, founder Paul Ellwood. From left on couch, William Link (Prudential), Lawrence English (Cigna), Dan Roble (an attorney), Charles Buck (General Electric), David Scherb (Pepsico); behind, from left, James Todd (American Medical Association), Paul Freiman (Pharmaceutical Manufacturers Association), David Lawrence (Kaiser), Robert Hansberger (Voluntary Hospitals of America) and James McLane (Aetna).

Mayo Clinic already employs 70 full time people just to talk on the phone with managed care utilization reviewers.

Because it bypasses administrative savings that would be available under a Canadian-style system, managed competition can only expand access by increasing health spending. Enthoven estimates his approach would require about $25 billion (in 1992 dollars) in new spending the first year. Clinton's health transition team was demoted for saying this estimate was too low.

Press '1' if You're Depressed

Stripped of rhetoric, managed competition is a plan to save the biggest private insurance companies and sacrifice patients' rights to choose their doctor. It would ensconce a highly bureaucratic health care system, rigidly stratified by income. Its theoretical precepts are irrelevant to rural America and to small cities—to half of our nation.

The rosy image of universal coverage under clones of today's best HMOs is hardly germane. managed competition cannot mean top quality consumer-responsive plans like Group Health Cooperative of Puget Sound, nor even Kaiser, for everyone. Even these HMOs produce one-time savings, but they haven't slowed the rate of growth of health costs. Managed competition means far more stringent limits on care. Massachusetts' Bay State HMO offers a more realistic future glimpse. Facing financial failure, the plan suddenly fired hundreds of psychiatrists. Their patients were instructed to call the HMO's 800 number and describe their psychiatric difficulties; a new mental health provider would be assigned. Under Massachusetts Medicaid's managed competition-style selective contracting, mental health services are covered. But in Springfield contracts have been denied to all Spanish speaking providers, even to those with translators. From

Detoxifying the Debate

A Response by Paul Starr

As an art form, caricature is fun. The caricature of ideas, however, does not have the same appeal. And when the caricaturists seek to arouse fears and anxieties by distorting unfamiliar ideas into misshapen and threatening images of insidious evil and betrayal, they do public debate and even their own case a great disservice.

In an article in the previous issue ("Healthy Compromise: Universal Coverage and Managed Competition Under a Cap," *TAP* Winter 1993), I presented a proposal for universal health insurance through new, regional health insurance purchasing cooperatives, which would represent the consumers and employers who pay for health care and be responsible for keeping the growth of health spending within a nationally set budget limit. The purchasing cooperatives would negotiate with competing health plans over costs and services, provide consumers information about their alternatives, conduct an open enrollment, adjust the total payments to plans in line with the risk of their enrollees, and monitor the performance of plans to ensure that they provided the services to which their enrollees were entitled. These are some of the main responsibilities involved in "managing competition."

The *American Prospect* article was a further development of ideas I outlined in a short book, *The Logic of Health-Care Reform*, published last October. A still more detailed discussion appears in an article that Walter Zelman and I published in a recent special issue of the journal *Health Affairs*, which includes additional papers on the same reform strategy. (As deputy to John Garamendi, California's elected commissioner of insurance, Zelman helped to craft a proposal for publicly financed health coverage through competing plans that set off much of the recent debate.) I invite any reader disturbed by the two previous critiques of managed competition to turn to these sources for a more accurate picture of the approach, as some of us have conceived it. Here, speaking solely for myself, I wish only to restate some key points about this strategy and its relation to single-payer proposals for national health insurance.

Reading these indictments by advocates of Canadian-style single-payer system, one would hardly guess that the single-payer model and the kind of managed-competition approach I've supported have much in common. Both would decouple health insurance from employment—that is, everybody would have a right to health coverage regardless of whether they worked. No one could be excluded or required to pay a higher cost because of any pre-existing condition. Everyone would be entitled to the same broad benefit coverage, according to standards set in federal law.

In their sources of revenue to pay for those benefits, managed-competition and single-payer approaches face similar choices and political constraints. Both approaches could be financed by premiums or taxes, set at the local, state, or national levels. The Garamendi plan relied on a payroll tax. The proposal I outlined in the Winter issue called for the purchasing cooperatives' premiums to be divided between employers and employees, with the employers' share capped as a percentage of payroll and the employees' share as a percentage of family income; similarly, the premium obligations of the self-employed

ing reasons, they are as soft on private fee-for-service providers as they are shrill on health maintenance organizations.

To be sure, a genuine and important difference between these approaches is that managed competition is designed to *reconstruct* the economic incentives in health care to encourage providers and consumers to make cost- and quality-conscious choices. For while a single-payer system might pay for enrollment in integrated health plans, it is not designed to set up a clear comparison among such plans or between those plans and conventional insurance, much less to reward consumers for choosing a plan that succeeds in controlling costs.

Here is where the two models deviate critically from one another. Under the version of managed competition I've supported, the purchasing cooperatives would use their clout to bargain aggressively with plans over their premiums. The plans would range from staff-model HMOs to prepaid provider networks to preferred provider plans to a conventional, free-choice-of-provider insurance plan. (For lack of any ability to exclude high-cost providers, the latter would be virtually certain to be more costly.) All plans would compete on the same benefit package, but some plans could offer that package for a lower price because of their mode of organization. The revenue flowing into the purchasing cooperative from employers, employees, and government subsidies would pay a "benchmark" rate. That benchmark premium could be set at the price of the lowest cost plan, or the average of the three lowest, or at some percentile—say the thirtieth—of all premiums. A consumer that chose a plan that cost more than this benchmark rate would pay the extra out of pocket. On the other hand, a consumer that chose a plan that cost less than the benchmark could get a rebate (this is, in fact, what happens in the employee health benefit program at Xerox).

Perhaps the core disagreement between the critics and supporters of managed competition on the left concerns the significance of this incentive for consumers to enroll in less costly health plans, which in turn encourages groups of providers to organize plans that attract consumers by keeping down their costs. The caricaturists charge that this incentive will "force" Americans into "stripped down" health plans. But let us consider the actual proposal, the principles, and the evidence.

The proposal I advanced—like other well-known managed-competition proposals—calls for a comprehensive, uniform benefit package for all. The benefit package in the Garamendi proposal, for example, covers physicians' services, hospital care, laboratory tests, home health care, and prescription drugs (to give a partial list) without annual or lifetime limitations. It has no deductible and limited copayments. This is no "stripped down" plan. Compare the Garamendi package to Medicare—the Garamendi plan is far more generous.

Indeed, the critics have the story about benefits exactly backward. A proposal for universal health insurance that does not have strong incentives for consumers and providers to reduce unnecessary and inappropriate care will be driven to downgrading the benefit package because there will be no other way to protect the public treasury. The Garamendi proposal could offer more generous benefits than Medicare does because its reference point was a health plan paid by capitation with internal incentives to control costs rather than a fee-for-service plan with incentives to drive up volume and technological "intensity."

The critics suggest that health plans will achieve lower costs by compromising the quality of care. But that is not borne out by the research. Indeed, quite the opposite: where there are measured differences between higher cost fee-for-service insurance and HMOs, the studies favor the HMOs. Deborah Stone writes that "the more money you have to spend" under managed competition, the more likely you will receive early diagnosis. Actually, the evi-

means stripped down.

The caricaturists suggest that Americans will be on the verge of revolution once they learn about this kind of framework. I am not convinced. State and federal employees have good health benefits; a system offering all Americans those choices would hardly be unpopular. The fiscal crisis that hit California in the past few years would have led most other states or private employers to cut back health benefits. That didn't happen in California because the managers of the employee health program, acting like a purchasing cooperative, were able to drive down the rate increases while protecting the benefit package. Other Americans should have been so lucky.

Our health care system does not need a mere takeover so much as it needs a thorough turnaround.

The critics on the left point to Canada and suggest that we could cut our costs through administrative economies alone. But the problem of controlling health care costs is far greater and more difficult in the United States today than in Canada or other countries because of the excesses of recent decades. In addition to training too many specialists, we have built up a huge overload of capacity and costly technology in our hospitals and freestanding diagnostic and treatment centers. Compared with doctors elsewhere, American physicians have adopted more resource-intensive, high-cost patterns of practice. Were we to combine a Canadian-style, fee-for-service insurance system with America's patterns of health care investment and medical practice, the likely result will not be Canada's level of costs, but America's—indeed, quite possibly worse. I cannot think of a quicker way of bankrupting our country—and ultimately producing a backlash against universal coverage—than by agreeing to pay on a fee-for-service basis the costs that our health care system is now capable of generating.

Some critics have questioned how much savings we can expect to achieve through health plan competition alone. That is a reasonable question, but this approach does not rely only on competition. It has other mechanisms to contain costs as well—the concentration of countervailing economic power and expertise in the purchasing cooperatives, giving consumers a strong, informed agent in bargaining; a radical restructuring and consolidation of the insurance market, with the elimination of underwriting and other market-segmentation practices; a federal board to analyze the cost-effectiveness of technologies and procedures and to prescribe uniform enrollment, reimbursement, and other procedures for administrative simplification; and a budgeting system enforced by regulating the flow of funds through the purchasing cooperatives and, where necessary, by setting provider rates.

A comprehensive approach to reform will necessarily be eclectic and pragmatic. Before those on the left respond to what they take to be the ideology of managed competition, they ought to look closely at the framework and the key policy choices that lie within it. In one sense, to insist on nothing less than a government takeover of the health insurance system is too great a demand. But in another sense, it is too little. Our system does not need a mere takeover so much as it needs a thorough turnaround.◆