THE HISTORY AND PRINCIPLES OF MANAGED COMPETITION

by Alain C. Enthoven

Prologue: *Health policymakers listening to presidential candidate Bill Clinton's proposals for health system reform may have felt a sense of déjà vu as he returned time and again to the theme of "managed competition" in his speeches. The term was familiar to many who had been following the speaking and writing of Alain Enthoven as he refined and articulated the concept. In Enthoven's construct, managed competition relies on a sponsor to structure and adjust the market for competing health plans, to establish equitable rules, create price-elastic demand, and avoid uncompensated risk selection. That sponsor could take the form of a health insurance purchasing cooperative, or HIPC, comprising members of the employer and consumer communities. Enthoven's definition of managed competition is a blending of the competitive and regulatory strategies that have coexisted uneasily for years in the U.S. health care system. As happens with many concepts that become election-year rhetoric, managed competition has come to mean different things to different people. In this essay Enthoven retraces the development of his ideas and rearticulates the principles of managed competition—including what managed competition is not. It is not, he says, "the latest buzzword that anybody should feel free to appropriate . . . [nor is it] just a grab bag of ideas that sound good. It is an integrated framework that combines rational principles of microeconomics with careful observation and analysis of what works." Enthoven is Marriner S. Eccles Professor of Public and Private Management at Stanford University. This paper was presented at "Rethinking Competition in the Health Care System: Emerging New Models," a workshop sponsored by The Robert Wood Johnson Foundation under its Changes in Health Care Financing Initiative. The workshop was conducted by the Alpha Center, 7–8 January 1993, in Washington, D.C.*

Abstract: Managed competition in health care is an idea that has evolved over two decades of research and refinement. It is defined as a purchasing strategy to obtain maximum value for consumers and employers, using rules for competition derived from microeconomic principles. A sponsor (either an employer, a governmental entity, or a purchasing cooperative), acting on behalf of a large group of subscribers, structures and adjusts the market to overcome attempts by insurers to avoid price competition. The sponsor establishes rules of equity, selects participating plans, manages the enrollment process, creates price-elastic demand, and manages risk selection. Managed competition is based on comprehensive care organizations that integrate financing and delivery. Prospects for its success are based on the success and potential of a number of high-quality, cost-effective, organized systems of care already in existence, especially prepaid group practices. As it is outlined here, managed competition as a means to reform the U.S. health care system is compatible with Americans' preferences for pluralism, individual choice and responsibility, and universal coverage.

To understand the procompetition movement and the idea of managed competition, one must first understand the history of the noncompetitive system we have today. The word *competition* as used by economists, if not qualified by some phrase indicating the contrary (such as *nonprice competition*), means price competition. When there is price competition, suppliers compete to serve customers who are using their own money or are otherwise motivated to obtain maximum value for money. *Price competition* does not mean that price is the only factor influencing the customer's choice. Quality and product features also enter in. It simply means that price is one of the factors. Perhaps *value-for-money competition* would be a more apt phrase. One of the striking features of the U.S. health care economy to date is how little value-for-money competition there is.

Charles Weller has described our traditional system of fee-for-service, solo (or small, single-specialty group) practice, free choice of provider, and payment by a remote third party as "guild free choice."[1] The principles of this system and their economic consequences are as follows: (1) Free choice of doctor by the patient, which means that the insurer has no bargaining power with the doctor; (2) free choice of prescription by the doctor, which prevents the insurer from applying quality assurance or review of appropriateness; (3) direct negotiation between doctor and patient regarding fees, which excludes the third-party payer, who would be likely to have information, bargaining power, and an incentive to negotiate to hold down fees; (4) fee-for-service payment, which allows physicians maximum control over their incomes by increasing the services provided; and (5) solo practice, because multispecialty group practice constitutes a break in the seamless web of mutual coercion through control of referrals that the medical profession has used to enforce the guild system.[2]

These principles dominated the U.S. health care system until well into the 1980s, and their effects are still important today. They were enforced by legislation (for example, guild principles were built into all state insurance

codes until the 1980s and into Title XVIII of the Social Security Act), boycotts (for example, by doctors against hospitals contracting with health maintenance organizations [HMOs]), professional ostracism (for example, from county medical societies and hospital staffs), denial of medical staff privileges, and harassment.[3] Blue Cross and Blue Shield were created, respectively, by hospital associations and medical societies as chosen instruments to apply the guild principles to health care financing. For example, hospitals subsidized Blue Cross plans by giving them discounts. Only in fairly recent years have providers been forced to yield controlling positions on Blue Cross and Blue Shield boards.[4] Commercial insurance companies offered coverage based on the casualty insurance model. They comfortably accepted the guild principles because they were and, with a few important exceptions, remain financial intermediaries with expertise in underwriting risk, not in organizing, managing, or purchasing medical care.

Employers also fit into this model. A few attempted to contract selectively with doctors for the care of their employees. But for the most part, this was beaten down by organized medicine.[5] An overwhelming majority of employers offered traditional "guild free choice" coverage of either the Blue Cross/Blue Shield or the commercial variety because that was all there was. The typical pattern was virtually 100 percent employer-paid coverage. This pattern spread rapidly because health insurance was an attractive fringe benefit, it was cheap, it was tax deductible to the employer and tax free to the employee, employment groups could buy coverage at much less than the cost of individual coverage, and employer-paid health benefits were a great source of bargaining prizes for unions. In the minds of many employees, fee-for-service coverage fully paid by the employer became normal, an entitlement. Employment-based insurance spread to small employers. Roughly half of the privately employed labor force is either self-employed or in groups of 100 or fewer. This added another element of noncompetition: Such groups are too small to offer individual employees a choice of health care plans. I return to this point later.

When HMOs entered the scene in large numbers in the 1970s and employers were required to offer them, employers usually agreed to pay HMO premiums in full as long as they did not exceed the cost of the traditional coverage. Thus, HMOs were placed in the noncompetitive system created by the guild model. Medicare and Medicaid also adopted the dominant guild model. Section 1801 of the Social Security Act prohibits any federal interference in the practice of medicine; section 1802 is entitled "free choice by patient guaranteed."

All of this created a system dominated by the cost-increasing incentives of fee-for-service payment combined with the cost-unconscious demand of insured patients. This in turn inspired greatly increased numbers of people

to choose careers in medicine, especially in highly paid specialties. This was fueled by federal grants to induce medical schools to expand. This open-ended, cost-unconscious demand, combined with large increases in federal funding for biomedical research, led to a huge outpouring of costly new medical technologies.

Finally, most well-functioning markets contain an adequate supply of information to assist purchasers in making decisions. In health care, there is no regulation to require the uniform production of health outcomes information. In fact, providers have been active and successful in political activities to block access to such information.[6]

The Beginnings Of 'Competition'

The precursors of competition are many.[7] But the origins of today's competitors are in prepaid group practice: multispecialty group practices that contracted with employment groups and individuals to provide a comprehensive set of health care services in exchange for a periodic per capita payment set in advance. The pioneers of the prepaid group practice movement introduced the "limited-provider" or "closed-panel" plan as a significant competing alternative. They survived strong opposition by organized medicine and proved the acceptability of prepaid group practice and its economic superiority over the traditional model.[8] They successfully advocated dual or multiple choice by individual subscribers of closed-panel plans, as an alternative to guild free choice. The flagships of this movement included Ross Loos in Los Angeles (1929), Group Health Association in the District of Columbia (1935), Group Health Cooperative of Puget Sound (1945), and Kaiser Permanente, with roots in the 1930s.

In 1960 the federal government adopted health insurance for its employees. The Blues and commercial insurers sought a noncompetitive guild model. But federal employees who were members of prepaid group practices were sufficiently numerous and vocal that a compromise was adopted under which the federal government would offer a range of plans for individuals to choose from and a defined contribution. The Federal Employees Health Benefits Program (FEHBP) that emerged had both good and bad design features.[9] On the good side was price-conscious individual choice; on the bad, nonstandard benefits and lack of a design to manage biased risk selection. But it did demonstrate on a large scale that choice-of-plan arrangements were feasible and comparatively economical.

These practical achievements, which were of fundamental importance, came to be reflected in the writings of scholars and public policy analysts. Paul Ellwood, Walter McClure, and colleagues proposed a national "health maintenance strategy" in 1970 that would deal with the crisis in health care

cost and distribution by promoting "a health maintenance industry that is largely self-regulatory."[10] Their work led directly to the HMO Act of 1973. In 1972 and 1973, while serving in the Department of Health, Education, and Welfare (HEW), Scott Fleming designed and recommended a proposal for national health insurance that he called "Structured Competition within the Private Sector."[11] His proposal emphasized practical ways of extending the successful experience of the FEHBP to the entire population. In 1977 I designed the Consumer Choice Health Plan (CCHP), "a national health insurance proposal based on regulated competition in the private sector," and recommended it to the Carter administration.[12] CCHP built on the ideas of Ellwood, McClure, and Fleming and added design proposals to deal with such issues as financing, biased selection, market segmentation, information costs, and equity. In 1978 Clark Havighurst attacked "professional restraints on innovation in health care financing" from the perspective of antitrust law.[13] By the end of the 1970s the idea of a competitive health care economy had attained intellectual respectability and a significant following in Congress.

An additional departure from the guild free choice model occurred in the 1980s, starting with enactment of A.B. 3480 by the California legislature in 1982. A.B. 3480 overturned the previous prohibition on selective contracting with providers by insurers and authorized preferred provider insurance (PPI). Under PPI, the patient obtains better coverage if he or she receives services from contracting "preferred" providers. This creates an incentive for providers to accept the insurer's fee schedule and utilization controls under contract. Many other states followed California in subsequent years.

From Early Competition To Managed Competition

Experience has shown that Fleming's "structured competition" and my "regulated competition" did not quite describe what we had in mind. Under our inflexible form of government, it is difficult and time-consuming to change such things as the Medicare law and regulations, which have been negotiated with financially and politically powerful interest groups that can block efficiency-improving changes that are to their disadvantage. Civil servants are not allowed to use judgment; they are supposed to administer regulations, and they can act only on evidence that can stand up in court. The intent of both of our terms was interpreted as structuring the market by a set of rules laid down once and for all, with purchasing by individual consumers and a passive regulatory agency. Whatever set of rules one proposes, critics could and did dream up ways for health plans to get around them to their advantage. As critics identified actual or hypothetical problems, I would often reply, "I think that problem could be managed using the

following tools. . . ." This led me to believe that a more accurate characterization of what actually works would be *managed competition*.

Managed competition must involve intelligent, active collective purchasing agents contracting with health care plans on behalf of a large group of subscribers and continuously structuring and adjusting the market to overcome attempts to avoid price competition. I call these agents "sponsors;" they play a central role in managed competition. A sponsor is an agency that contracts with health plans concerning benefits covered, prices, enrollment procedures, and other conditions of participation. Managed competition also connotes the ability to use judgment to achieve goals in the face of uncertainty, to be able to negotiate, and to make decisions on the basis of imperfect information. It takes more than mere passive administration of inflexible rules to make this market work.

Managed Competition Defined

Managed competition is a purchasing strategy to obtain maximum value for money for employers and consumers. It uses rules for competition, derived from rational microeconomic principles, to reward with more subscribers and revenue those health plans that do the best job of improving quality, cutting cost, and satisfying patients. The "best job" is in the judgment of both the sponsor, armed with data and expert advice, and informed, cost-conscious consumers. The rules of competition must be designed and administered so as not to reward health plans for selecting good risks, segmenting markets, or otherwise defeating the goals of managed competition. Managed competition occurs at the level of integrated financing and delivery plans, not at the individual provider level. Its goal is to divide providers in each community into competing economic units and to use market forces to motivate them to develop efficient delivery systems.

Managed competition is price competition, but the price it focuses on is the annual premium for comprehensive health care services, not the price for individual services. There are several reasons for this. First, the annual premium encodes the total annual cost per person. It gives the subscriber an incentive to choose the health plan that minimizes total cost. Second, it is the price that people can understand and respond to most effectively, during the annual enrollment, when they have information, choices, and time for consideration. Third, sick, nonexpert patients and their families are in a particularly poor position to make wise decisions about long lists of individual services they might or might not need. They need to rely on their doctors to advise what services are appropriate and on their health plans to get good prices. For economical behavior to occur, doctors must be motivated to prescribe economically. Managed competition is compatible

with selected copayments and deductibles for individual services that can influence patients to do their part in using resources wisely and that are price signals patients can understand and to which they can respond.

Sponsors and managed competition. To understand managed competition, one must begin with the concept of a sponsor. Markets for most goods and services are normally made up of suppliers on one side and individual purchasers on the other. This is not the model that actually works in most of private health insurance in the United States, and, in my view, this model is not workable at the individual level in health insurance, for a number of reasons.

First, insurers have strong incentives to group their customers by expected medical costs and to charge people in each group a premium that reflects their expected costs. This practice is known as experience rating or underwriting. The consequence is that those people having high predicted medical costs face high premiums. Many sick people find such premiums unaffordable and may go without insurance, taking their chances that they will receive free care. Second, healthy individuals face strong incentives to ride free, that is, to go without insurance or with minimal coverage until they get sick, at which point they seek to buy comprehensive coverage. Consumers are more likely than insurers to know more about their prospective medical needs. Third, partly because of the behaviors induced by these incentives and partly because of high marketing costs to reach individuals or small groups, the administrative costs of individual health insurance policies are very high—40 percent of medical claims or more. This creates more of an incentive for relatively healthy people to go without insurance. Rather than bearing the risks and expenses of covering individuals who are sick, even at a high price that would cover their expected costs, most insurers choose not to cover them at any price. Fourth, health insurance contracts are extremely complex and difficult to understand and administer. Insurers deliberately make them even more complex to segment markets and to make it difficult for consumers to compare prices.

The model of private health insurance that works—the one that covers most employed people—is group insurance with a sponsor. Most sponsors are employers, but the federal Medicare program and labor/management health and welfare trusts are also sponsors. Examples of large employers that offer their employees such a multiple choice of health care coverage include the federal government; many states, including California, Wisconsin, and Minnesota; and Stanford University. While some HMOs and some PPI carriers compete for unsponsored individuals, most of their business is in sponsored groups. Sponsors set the rules for competition among them.

Sponsors establish rules of equity. The sponsor has several important functions in managed competition. First, through contracts with the par-

ticipating health plans, it establishes and enforces principles of equity such as the following: (1) Every eligible person is covered or at least is offered coverage on terms that make it attractive, even for persons with low expected medical costs, and at a moderate financial cost. Health plans accept all eligible persons who choose them. (2) Every eligible person has subsidized access to the lowest-priced plan meeting acceptable standards of quality and coverage. Persons choosing a plan priced above the lowest-priced plan must pay the full premium difference with their own money. (3) Coverage is continuous; that is, once a person is enrolled, coverage cannot be canceled (except for nonpayment of premium or serious noncompliance with reasonable norms of patient behavior). Moreover, everyone can re-enroll during the annual enrollment period. (4) Community rating (or limited departures from it) is established, whereby the same premium is paid for the same coverage regardless of the health status of the individual or small group. (This might be blended with, for example, age rating if it is felt that pure community rating requires excessive subsidies of the old by the young.) (5) No exclusions or limitations are placed on coverage for pre-existing conditions. Obviously, some of these principles may have to be compromised with other practical considerations, depending on the circumstances.

Sponsors select participating plans. The freedom of the sponsor in selecting participating plans will depend on the circumstances. A private employer will have more freedom of action then a public employer. And a public employer will be able to exercise more freedom than will a health insurance purchasing cooperative (HIPC) that serves as the gatekeeper for much or all of the market in a geographic area.

Sponsors manage enrollment process. In managing enrollment, the sponsor should serve as the single point of entry to all participating health plans. Subscribers notify the sponsor of their choice of plan (probably through the employer), and the sponsor notifies the health plan. This is normal in large employment groups but, unfortunately, is not the usual practice with such public programs as Medicare and Medicaid. The purpose is to create an institutional embodiment of the principle that health plans take all who apply and to obviate what would otherwise be a large set of opportunities for screening and selecting applicants. The sponsor must define the enrollment procedures, such as giving each subscriber an annual opportunity to switch plans. It also must establish procedures to enroll newcomers and to deal with changes in address or family composition. The sponsor also should prepare informative materials about the benefits covered, the characteristics of the health plans and locations of their providers, and the quality controls in place. The sponsor establishes contractual payment terms with participating employers and individuals. And the

sponsor runs a clearinghouse for the money.

Sponsors create price-elastic demand. Next, the sponsor must seek to create price-elastic demand. (A seller faces inelastic demand if the seller can increase revenue by raising price, and elastic demand if the seller increases revenue by reducing price.) For there to be an incentive for health plans to cut price, demand must be so elastic that the additional revenue gained exceeds the additional cost of serving more subscribers. Managed competition is about creating such price elasticity.[14] The following are some of the main tools for accomplishing this.

(1) *Employer/sponsor contributions.* The key point here is that the sponsor's contribution to the premiums must not exceed the price of the lowest-priced plan. An essential component of managed competition is that it must always be possible for the lowest-priced plan to take business away from higher-priced plans by cutting premiums more. The lowest-priced plan must be able to widen the gap between its price and the next lowest by cutting price. Premiums of course are quoted in the context of annual enrollments. The sponsor sets its contribution after the health plans have submitted their quotes.

(2) *Standardized coverage contract.* Standardization should deter product differentiation, facilitate price comparisons, and counter market segmentation. There are powerful reasons for as much standardization as possible within each sponsored group. The first is to facilitate value-for-money comparisons and to focus comparison on price and quality. The second is to combat market segmentation—the division of the market into groups of subscribers who make choices based on what each plan covers (such as mental health or vision care) rather than on price. The third is to reassure people that it is financially safe to switch plans for a lower price with the knowledge that the lower-priced plans did not realize savings by creating hidden gaps in coverage. The fourth is that biased risk selection can reduce demand elasticity for health plans that enroll a favorable mix of risks.

(3) *Quality-related information.* People will be reluctant to switch from Plan A to Plan B to save $20 per month if they have no information that Plan B is safe for their health. The Jackson Hole Group proposes creation of a national Outcomes Management Standards Board that would set standards for outcomes reporting.[15] Sponsors should play a role in making such information accessible to the local market. Sponsors are also the appropriate agencies to survey their sponsored populations regarding experience with health plans and to publish the results for consumers.

(4) *Choice of plans at individual level.* Sponsors should structure the market to offer annual choice of plan at the individual subscriber level, not the employment group level. Limitation of choice to the group level is a major barrier to price-elastic demand. (Effective managed care plans are

linked to specific doctors. Because some people have strong attachments to their doctors, it is much harder to persuade a whole group to change plans and doctors to obtain lower premiums than to allow individuals who are willing to change to choose to do so.)

There are other opportunities for sponsors to exercise ingenuity in making demand curves for health plans more price elastic. For example, an alert sponsor might create a system to inform all patients of primary care physicians who contract with more than one health plan about which plan has the lowest premium so that patients can switch to the lowest-priced plan covering their doctor's services. Combined with standardized benefits, this could greatly increase people's willingness to switch plans to save money.

Finally, current income and payroll tax laws create a heavy tax on cost containment. These laws must be changed so that a health plan that cuts its premium by a dollar sees the full dollar transmitted to the subscriber, as an incentive to select that plan. This gives the health plan the full marketplace reward (more subscribers) for cutting price. Thus there must be a limit on tax-free employer contributions at a level that does not exceed the premium of the lowest-priced plan. This is beyond the scope of the sponsor and is mentioned here only for the sake of completeness.

Sponsors manage risk selection. Finally, in managed competition, the sponsor must manage the problem of biased risk selection. The goal here is to create powerful incentives for health plans to succeed by improving quality and patient satisfaction, not by selecting good risks and avoiding bad ones. This is a crucial and complex issue. Here I describe the general outlines without getting into technical detail.

Joseph Newhouse has noted that in the RAND Health Insurance Experiment, the 1 percent of patients with the highest costs in a given year accounted for 28 percent of total costs on average.[16] Most of these patients could not be identified in advance. But such concentration suggests that it could be very profitable for a health plan to find ways to avoid enrolling or retaining such patients.

To accomplish the goal of managed risk selection, the sponsor should follow a coordinated strategy with the following elements.

(1) *Single point of entry*. Subscribers notify the sponsor of their choice and the sponsor notifies the health plan. The health plan must accept all enrollees. This should be combined with continuity of enrollment; that is, patients cannot be dropped from enrollment, and they must be allowed to reenroll during the periodic open enrollment in the plan of their choice.

(2) *Standardized coverage contract*. Coverage contract features can be a powerful tool for selecting risks.

(3) *Risk-adjusted premiums*. The general idea is as follows. Health risks are likely to fall differently among the different plans, either by design or by

accident. The characteristics of the population enrolled in the different plans (for example, age, sex, family composition, retiree or disability status, and diagnosis) should be measured and translated into estimates of expected relative medical costs, independent of plan. Each plan can be assigned a relative risk index, for example, 1.01 for a plan with unfavorable selection that makes its expected costs 1 percent above the whole group average. Then a dollar value is assigned to one percentage point of risk. For example, that might be 1 percent of the premium of the lowest-priced plan or the average-priced plan. This is a policy choice; there is no single mathematically correct answer. Surcharges are then applied to premiums of plans that received favorable selection; subsidies are given to plans that received unfavorable selection, to compensate for risk selection. This takes selection out of the competition.[17]

The natural starting point is the available demographic variables (age, sex, family composition, and retiree status). Unfortunately, these do not explain much of the variation in individual annual expenditures. Newhouse found that of the total variation in individual expenditures, only about 15 percent is explainable even with complete knowledge of patient characteristics.[18] Demographic variables might explain two to three of the fifteen percentage points.

There is research under way to develop better risk-adjustment models, based on diagnostic information. It turns out to be much harder than one might think to turn available diagnostic information into good "risk adjusters." For example, among patients diagnosed in one year to have breast cancer or human immunodeficiency virus (HIV), there will be a very wide variation in medical costs the next year. But it seems reasonable to suppose that diagnosis-based models eventually will be available. Another approach may be to fund treatment of some conditions by fixed payments per case outside the capitation payments, or to use specific capitation payments on behalf of people with very costly diseases such as acquired immunodeficiency syndrome (AIDS).

In the Jackson Hole proposal, sponsors are the final arbiters of risk selection. An interesting paper by Harold Luft casts the sponsor in the role of expert mediator among health plans that are in a "zero sum game" over risk selection.[19] This suggests periodic face-to-face meetings with the marketing directors of all participating health plans, with the sponsor serving as honest broker. If Plan A is skimming, that hurts the other plans. The sponsor should lead a discussion on how risk selection can be defined, measured, and compensated for. This is an ongoing process, not a single event.

Since the sponsor must be seen as an impartial broker, not a biased participant, it should not have its own plan. Medicare's management of

competition among HMOs has been seriously impaired by the Health Care Financing Administration's (HCFA's) preoccupation with protecting fee-for-service Medicare, which HCFA considers to be "its plan" to be protected from HMOs. Similar problems occur in the private sector.

(4) *Monitoring of enrollment patterns*. Sponsors should monitor voluntary disenrollments for evidence of risk-selecting behavior. With a brief questionnaire, sponsors can ask people why they switched plans. The box to watch would be one such as, "They told me Plan B was better at treating my kind of cancer."

(5) *Monitoring of specialty care and quality*. Sponsors need to examine the quality of tertiary care arrangements and also monitor access to specialty care. A good way to avoid enrolling diabetics is to have no endocrinologists on staff in the county. A good way to avoid cancer patients is to have a poor oncology department. HMO regulation now monitors such aspects. These are subtle matters in which judgment must be applied.

Health Insurance Purchasing Cooperatives

Large employers of, say, 10,000 or more employees in one geographic area have the size needed to perform the functions of sponsorship with reasonable effectiveness, especially if they collaborate with other large employers. But over 40 percent of the employed population is in groups of 100 or fewer workers. Such groups (and even much larger ones) are too small to spread risks. Thus we observe wide variations—tenfold and more—in the premiums paid by small groups, depending on their claims experience. They also cannot achieve economies of scale in administration. Thus administrative expense reaches 35 percent of claims in groups of five to nine and 40 percent in groups of one to four, compared with 5.5 percent in groups of 10,000 and more.[20] Small groups cannot acquire needed information and expertise to function effectively in this market. In theory, agents and brokers perform this function. In practice, agents and brokers have their own interests, related to the commissions carriers pay, and they lack competence regarding quality or value of medical care.

The Jackson Hole initiative proposes to solve these problems by establishment of a new national system of sponsor organizations—HIPCs—to function as a collective purchasing agent on behalf of all small employers and individuals in a geographic area.[21] HIPCs are designed to correct the problems of market failure in the small-group market and to cut employers' administrative burdens to a minimum (for example, administering for them the requirements of mandated continuity of coverage and public subsidies). They provide a solid basis for determining the competitive costs of covering uniform benefits that could be used to establish a tax-exclusion limitation

for each market area.

HIPCs would be nonprofit membership corporations whose boards would be elected by participating employers. HIPCs would contract with participating employers and would accept all qualifying employment groups in their area. They would not be allowed to exclude groups or individuals because of health status. HIPCs would manage competition, applying business judgment in determining the numbers and identities of competitors, and would carry out all of the sponsor functions described above.

HIPCs would select the participating health plans. Some would favor a rule that a HIPC must offer all health plans that achieve federal certification and that wish to be offered in the HIPC's territory. Whether or not market forces would resolve the problems arising from this arrangement is a debatable proposition about which reasonable people can differ. I would prefer to see that HIPCs have some authority to select and drop health plans. The presumption should favor competition. Thus it would make sense for a HIPC to encourage participation by all provider groups in the territory, but some discretion might be appropriate for the following reasons. First, federal qualification and state regulation do not guarantee financial solvency. Second, many "managed care" plans offer overlapping provider networks (that is, many providers contracting with many plans). Some overlap may not be undesirable. But too many carriers all offering essentially the same set of providers can add to administrative costs and weaken the sponsor's purchasing power with providers. As noted above, managed competition seeks to motivate providers to create efficient delivery systems. Third, HIPCs should be able to drop health plans that persistently achieve very low market penetration. Fourth, HIPCs should be able to drop carriers that are persistently uncooperative with the HIPC's risk management program.

HIPCs would administer health benefit contracts. The HIPC should act like a competent, effective employee benefits office servicing beneficiary inquiries and complaints. It should interpret the contracts for beneficiaries, stand behind patients in disputes with health plans, and resolve disputes on terms that are fair to beneficiaries. This should be much more efficient than taking disputes to litigation. The HIPC also should monitor what is happening in the health care settings. It should survey consumer experience and make the information available for consumers. It should investigate complaints and should aggregate complaint data to identify problem areas.

HIPCs should not bear risk. Health plans should bear all risk for medical expenses, for several reasons. First, if HIPCs were to bear risk, we would have a whole new class of risk-bearing entities that would have to be capitalized and regulated, and we have more than enough of them now. Second, HIPCs should be unbiased, honest brokers among risk-bearing

entities. Third, providers—doctors and hospitals—must be at risk for the cost of care to give them powerful incentives to reduce cost.

Finally, HIPCs could contract with government agencies to cover publicly sponsored populations, such as Medicaid, the otherwise uninsured, and public employees.

Creating HIPCs means that persons and groups with low health care costs in a given year share in the costs of persons and groups with high costs. If given a choice, people expecting low costs are not likely to do so voluntarily. Once the HIPC is operating at a large scale, there will be important benefits for small employers, even those with good health risks—including economies of scale, stable rates, competition, and individual choice of plan. But to get HIPCs going and to prevent a spiral of adverse selection, there must be compelling incentives or legal requirements for all small employers to participate. In the Jackson Hole initiative, small-group participation in a HIPC would be a condition for exclusion of employer contributions from employees' taxable income.

One large and successful HIPC is the health benefits program of the California Public Employees Retirement System (CalPERS). CalPERS arranges coverage and manages competition for more than 870,000 people who are employees, retirees, and dependents of the state and more than 750 public agencies, some of which have as few as two employees. CalPERS offers each subscriber a choice of plan: twenty-three HMOs, four preferred provider organizations (PPOs) offered to employee association members, and a statewide PPO.

Role Of Organized Systems Of Care

Managed competition is not based on a mere hope that the market will somehow generate better models of care. It is based on demonstrations of successful, high-quality, cost-effective, organized systems of care that have existed for years. To date, the strongest evidence of their economic superiority relates to prepaid multispecialty group practices. For example, the RAND Health Insurance Experiment found that Group Health Cooperative of Puget Sound cared for its randomly assigned patients for a cost 28 percent below that for comparable patients assigned to a fee-for-service plan whose care was paid for entirely by insurance or with 25 percent coinsurance (up to an annual out-of-pocket limit of $1,000).[22] The evident marketplace success of Kaiser Permanente, now serving over 6.5 million people, reinforces this finding. Successful large-scale HMOs based on individual practice styles have emerged in recent years. These HMOs carefully select participating physicians and arm physicians and management with strong information systems about practice patterns. These models can ex-

pand rapidly, and they offer a practice style that is familiar to many doctors and patients. While we do not have proof of their efficacy in the form of a randomized controlled trial, we do know that some of them now compete effectively with Kaiser Permanente and Group Health Cooperative.

Compared to the traditional fee-for-service model, there are many things such organizations can do—and, if appropriately motivated, will do—to improve quality and cut cost. (1) Fee-for-service has created a costly adversarial relationship between doctors and payers. Organized systems can attract the loyalty, commitment, and responsible participation of doctors. They can align the incentives of doctors and the interests of patients in high-quality, economical care by appropriate risk-sharing arrangements. (2) Fee-for-service has failed to create accountability for health outcomes and the outcomes information systems doctors need to evaluate and improve practice patterns. Organized systems can gather data on outcomes, treatments, and resource use; evaluate practice patterns; and motivate doctors to choose economical practices that produce good outcomes.

(3) Fee-for-service "free choice" leaves patients to make remarkably poorly informed choices of doctor. Organized systems select doctors for quality and efficient practice patterns, monitor performance, and take corrective action where needed. (4) Fee-for-service has left us with excess supply in many specialties. Organized systems can match the numbers and types of doctors to the needs of enrolled populations. (5) Fee-for-service has left us with major excesses in hospital beds, high-tech equipment, and open-heart surgery facilities. At least some systems can match all resources used to the needs of the enrolled population.

(6) Our present system is characterized by major misallocations of resources. Organized systems can allocate all resources—capital and operating—across the total spectrum of care, including less costly settings. (7) Fee-for-service has little or no capability to plan and manage processes of care across the total spectrum (inpatient, outpatient, office, and home); organized systems do. (8) Organizations that integrate financing and delivery, and doctors and hospitals, can practice total quality management/continuous quality improvement, the powerful management philosophy employed by the most successful world-class industrial companies.[23] This cannot be done effectively with doctors who are in fee-for-service practice in several hospitals and are attached to none.

(9) Fee-for-service has led to a costly and dangerous proliferation in facilities for such complex procedures as open-heart surgery. Such surgery done in low volumes has higher costs and higher death rates than when done in high volumes.[24] Organized systems concentrate open-heart surgery in regional centers with low mortality rates and low costs. Such regional concentration in the most cost-effective hospitals could save a great deal of

money. (10) Systems can organize ongoing technology assessment and facilitate a rational response to the results. (11) HMOs emphasize prevention, early diagnosis and treatment, and effective management of chronic conditions. Traditional third-party coverage is usually based on the casualty insurance model: It pays very generously for costly inpatient episodes but not for the preventive services and management of chronic conditions that can reduce the need for inpatient care. Organized systems can use systematic management processes to make sure these services are actually delivered, not merely covered. And they can be held accountable for their enrolled populations.

Managed Competition In Sparsely Populated Areas

People do not find it hard to visualize managed competition in San Francisco or Boston. What about Wyoming, Vermont, or southern Texas, where there are not enough people to support competing systems?

Creation of a HIPC in such states would consolidate purchasing power so that it could be used more effectively to meet the needs of the covered population. There is such a thing as "competition for the field" where there cannot be "competition in the field." HIPCs might request proposals from established urban comprehensive care organizations to establish and operate a network of primary care outposts, paying doctors and nurse practitioners what is needed to attract them to provide high-quality ambulatory care in rural locations, while giving them professional support in the form of telephone consultations, temporary replacements, continuing education, and transportation and referral arrangements. Organized systems are needed to accomplish this; traditional fee-for-service solo practice has not produced satisfactory results.

In a state with a small population but with perhaps two or three competing health plans, no one plan might be large enough to purchase tertiary care effectively. A HIPC might "reach through" and "carve out" tertiary care and contract for it on a competitive basis with one or another regional center. A doctor with a monopoly in a small town might refuse to contract with any of the health plans on terms acceptable to doctors in other areas. Or, no one of several health plans might have enough patients in town to be able to support its own doctor. The HIPC might "reach through" the health plans, consolidate their purchasing power, and recruit a willing doctor from the outside to contract with all health plans and be the only contracting doctor. The HIPC in a small state might contract with a single HMO based on a primary care network to cover the state in an ongoing bilateral customer/supplier relationship. The HIPC might use "benchmarking" techniques as a substitute for ongoing competition in the field. The

vision of competition in such circumstances should not be limited to large medical center–based prepaid group practices. That is but one model. But, as noted above, modern information technology has enabled primary care individual practice networks to perform management functions that previously required physical proximity.

Why Competition?

Why attempt to bring about these changes through competition and market forces? Why not expect the government simply to order them? First, we have an extremely wasteful and inefficient system that has been bathed in cost-increasing incentives for over fifty years. We badly need a radically more efficient system. That will mean closing hospitals and putting surgeons out of work. As Charles Schultze has written, "Under the social arrangements of the private market, those who may suffer losses are not usually able to stand in the way of change. As a consequence, efficiency-creating changes are not seriously impeded."[25] Government controls, on the other hand, tend to freeze industries in place. Thus we find it extraordinarily difficult to close an unneeded school or air base. Government action is constrained by what Schultze calls the rule to "do no direct harm."

Second, to offset the expenditure-increasing effects of an aging population and an expanding array of medical technologies, we need to foster a process of continuing productivity improvement and of development of cost-reducing technologies. Only ongoing competition to provide value for money can do this. Third, as medical technology and social and economic conditions of the population change, we need a health care system that is flexible and can come up with entirely new ways of organizing and delivering care. Fourth, we need and want a system that is user-friendly. Government monopoly public service agencies are notoriously user-unfriendly.

Fifth, our society needs to make cost/quality trade-off judgments. These should be made by consumers who are using their own money at the margin. For example, given a choice, many might prefer a much less costly style of care, based on limited access in tightly controlled facilities, with more use of physician-extenders, and so on. They might have other worthy uses for their money, such as their children's education. Others may be happy to pay more for wider access and greater convenience. (Note that under managed competition, consumers would be exercising this preference with their own net after-tax dollars, not with pretax dollars and substantial tax subsidies for the more costly choice as happens today.) In this country we are now spending nearly 14 percent of gross domestic product (GDP) on health care services. It is altogether possible that a very efficient competitive system could get us back to 9 or 10 percent. This would free up

resources that are badly needed for education and other investments in long-term economic growth. In theory, a government-imposed "global budget" might be seen as a way to reduce national health expenditures as a share of GDP. In practice, this would be extremely difficult to do if all of the cost-increasing incentives of fee-for-service and all of the wastefulness of the present system were to remain in place. The reduced spending would mean care denied to people who need it and a sustained barrage of complaints by health care providers. The global budget would be hard for our government to sustain politically. Finally, competition is the way to achieve a system that is driven by the informed choices of consumers who are responsible for the cost consequences of their choices. A government-controlled system is driven by political forces.

Why Universal Coverage?

Today, millions of Americans either have no health care coverage or have coverage that will disappear or become extremely costly when they need it. Nobody defends the proposition that people without coverage or money to pay should go without necessary medical care or should be allowed to suffer, be disabled, or die for lack of reasonable care. For this reason our society has developed a complex patchwork of institutions to care for and finance the care of the uninsured. These institutions are extremely wasteful and often unfair, permitting preventable medical bankruptcies and disabilities. They lead to delayed care, which can often mean serious and costly illness that could have been prevented by early treatment. They lead to care in costly settings—particularly, hospital emergency departments—when care could have been delivered at much lower cost in the primary care physician's office. They permit epidemics of communicable diseases that could have been prevented. They generate requirements for costly eligibility determinations. They lead to cost shifting from those who do not pay and those who provide free care to those who do pay for health insurance. They lead to the closing of hospital emergency departments, which are the major point of entry for patients who cannot pay. This, in turn, deprives whole communities of an important resource.

By putting market pressure on providers to cut costs, market reforms promoting competition—if not accompanied by universal coverage—could exacerbate access problems. (This would be true of any serious cost containment program.) It would be more humane, economical, and rational simply to adopt a policy providing coverage to virtually everybody through an integrated financing and delivery organization that provides primary and preventive care as a part of a comprehensive benefit package.

A necessary condition for universal coverage is that everybody who can

contribute to financing the system must do so. A system of universal coverage will not work if everybody is covered, but only those who voluntarily choose to do so pay for it. Such a system would be destroyed by free riders.

Universal contributions might be achieved in a variety of ways that are compatible with managed competition: (1) a requirement that employers and full-time employees jointly buy coverage ("employer mandate"), combined with payroll taxes on part-time employees and taxes on nonpoor nonemployed (such as early retirees), with revenues used to subsidize purchase of coverage for them through a HIPC; (2) a requirement that every household buy coverage through a HIPC or pay an equivalent tax ("individual mandate"), with subsidies to assist low-income households; and (3) payroll taxes or more broadly based taxes.

Managed Competition Or Top-Down Global Budgets?

The level and growth of tax-supported and tax-subsidized national health expenditures is an appropriate object of public concern. Excessive growth in these expenditures, relative to other priorities, crowds out other programs important to our nation's future. Managed competition offers the most powerful force for reducing national health expenditures. That is, it makes economical decisions about health resource use in everybody's personal interest—an almost complete reversal of the cost-increasing incentives that drive the present system. However, as is the case with any other policy, there is no guarantee that managed competition will automatically hold spending growth to acceptable levels, even if implemented optimally as I have proposed here. Patients would be insured, thus not using their own money when demanding care. The health insurance and health services industries have an extensive history of market imperfections, not all of which will be corrected by managed competition. Very costly technologies might emerge. And directly or indirectly (through tax subsidies), government pays about half the bill.

What should government do if national health expenditure growth is excessive under managed competition? "Top-down," government-imposed global budgets are not likely to work well. Such global budgets today would have to be imposed on sectors such as hospitals, doctors, and pharmacies and enforced by price controls. The most plausible candidate for price controls would be Medicare payment methods and volume performance standards, which penalize sectors that increase volume by offsetting reductions in next year's prices. Such controls block efficiency-improving reallocations across sectors, such as doctors working harder to keep people out of the hospital. They create a "tragedy of the commons," penalizing the most

economical doctors. They leave all of the cost-increasing incentives in place and even intensify them as providers struggle to maintain target incomes.

Top-down global budgets, if imposed on capitation rates of integrated financing and delivery organizations, would avoid some of the worst inefficiencies and disincentives. But they would focus the whole health services industry on political efforts to raise or maintain the ceiling as a percentage of gross national product (GNP). The British refer to the likely behavior as "shroud waving." Regulatory authorities are held responsible for the economic survival of the regulated entities. Hospital rate regulators are notoriously unwilling to force unneeded or inefficient hospitals to close. Insurance rate regulators are responsible for the solvency of insurers. So such regulation becomes cost reimbursement. Only impersonal market forces can close down unneeded, inefficient activities. Thus the history of such regulation is that it does not really lower cost to consumers.

Moreover, regulatory authorities are not czars. They must observe the due process requirements of the Administrative Procedures Act and the Fifth Amendment. They must hold hearings, consider arguments, and base conclusions on evidence—all of which can be costly. Such global budgets would raise a whole maze of paradoxes and conundrums: Would they be equal per capita across states, and if unequal, on what basis? How would one deal with high- versus low-cost states? Could one justify locking Massachusetts and Arkansas, with a nearly twofold difference in per capita spending, into the same percentage rate of increase forever? Who decides?

Finally, for managed competition to work well, the managed care industry must make a great deal of investment in corporate restructuring, service expansion, and information and reporting systems, all of which are much less likely to appear attractive if government threatens to set prices and expropriate the return on investment.

How then should government respond? The answer is that the managed competition framework gives government a number of tools to use to influence the outcome. First, government could define as the "global budget" the lowest capitation rate in each HIPC, multiplied by the number of people residing in each HIPC area, added up over all HIPCs. These would be market-determined global budgets and would encompass all publicly supported and tax-subsidized national health expenditures. Government could then decide on a public policy that sets a target for this global budget relative to GNP. If the global budget grows faster than the target, the president and Congress should direct the National Health Board to develop and implement a set of targeted interventions designed to reduce health spending based on solid and current data. The list might include, for example, reducing covered benefits; raising copayments and deductibles

(except for the poor); removing from coverage and inclusion in the uniform effective covered benefit package those drugs and other technologies of very high cost in relation to the benefits produced (with protection against tort litigation for providers who comply); antitrust action against local cartels; and possibly taxing the excess of premiums over the premiums of the low-cost benchmark plan in each area. In other words, government should examine the causes of excess spending and apply specific remedies, rather than trying to sweep the problems under the carpet of a national global budget.

What Managed Competition Is Not

Managed competition is not a lot of things it has been called by people who do not understand it or who prefer central governmental controls to decentralized markets. (1) Managed competition is not a free market. A free market does not and cannot work in health insurance and health care. If not corrected by a careful design, this market is plagued by problems of free riders, biased risk selection, segmentation, and other sources of market failure. Managed competition uses market forces within a framework of carefully drawn rules. (2) Managed competition is not merely a "voucher" system (giving people a certificate and seeing if they can find insurance). In managed competition, sponsors work actively to perfect the market. Everyone is given an opportunity to enroll. (3) Managed competition is not deregulation. It is new rules, not no rules. (4) Managed competition is not what we have had for the past ten or fifty years.

(5) Managed competition is not forcing everyone into large clinic-style HMOs or other types of care they do not like. On the contrary, managed competition emphasizes the importance of individual (not employer) choice of plans. Many systems and styles would be able to compete effectively, including familiar solo doctor styles in some selective individual practice models. However, managed competition does make people bear the economic consequences of their choices. (6) Managed competition is not a reduction in the quality of care. On the contrary, far more often than not, quality and economy in medical care go hand-in-hand. The correct diagnosis done promptly, and the appropriate procedure done by someone very proficient, without errors or complications, is best for the patient and the payer. Competing managed care plans would have powerful incentives to improve the quality of care.

(7) Managed competition is not blind faith in an untested economic theory. We know that some types of managed care can cut cost substantially. We know that there are wide variations in costs for many procedures and that the best producers have the lowest costs. We know that when

given responsible choices and information, most people choose value for money. We know that HIPC-like arrangements work well. All of the pieces of the managed care/managed competition model are in actual successful practice somewhere. The challenge is to put these best practices together into one complete managed competition system. The rest is extrapolation based on generally accepted principles of rational economic behavior. All reform proposals must rely on similar extrapolation. (8) Managed competition is not just the latest buzzword that anybody should feel free to appropriate. It has been explained, developed, and debated in the academic literature for more than a decade.[26] Also, managed competition does not exist in Canada. Managed competition is not just a grab bag of ideas that sound good. It is an integrated framework that combines rational principles of microeconomics with careful observation and analysis of what works.

(9) Managed competition is not a panacea. Its authors do not claim that it can solve America's problems of racism, poverty, homelessness, the frail elderly, and others. It cannot be counted on to bring comprehensive care to Nome, Alaska. Managed competition is aimed at care for the 90 to 95 percent of Americans whose medical needs can be met by programs that look like prevailing employment-based coverage. For most Americans managed competition can mean higher-quality care at a much lower cost, organized and delivered in a much more coherent and satisfactory way. Special programs, usually publicly sponsored, will be needed for special populations. If managed competition is successful, more public money will be available for them.

(10) Managed competition will not take until the year 2010 to transform health care financing and delivery in this country. It does not depend merely on the steady growth of existing prepaid group practices. In response to managed competition, thousands of hospitals and their medical staffs could quickly form integrated organizations and begin accepting capitation contracts. Many individual practice and network HMOs could expand very rapidly. And Blue Cross and/or Blue Shield plans must now have statewide preferred provider networks in existence in practically every state.

Managed Competition And The American Way

The managed competition idea attracted widespread support in 1992, in recognition of the urgent need to do something serious about costs and as an alternative to federal price controls. Paul Tsongas adopted it as his health platform during his presidential bid. In developing its proposal, the Bush administration began with a managed competition model.[27] Unfortunately, for political reasons, they withdrew some of the essential features needed to make it effective, especially the limit on tax-free employer

contributions to employee health care and the powerful tax incentive needed to motivate small employers to join HIPCs. In April 1992 the sixty-member Conservative Democratic Forum (CDF) in the House of Representatives announced its support for the Jackson Hole initiative. The CDF introduced a bill, the Managed Competition Act of 1992, in September 1992.[28] A similar bill was introduced in the Senate and drew bipartisan support. In October 1992 presidential candidate Bill Clinton said, "Managed competition, not price controls, will make the budget work and maintain quality."[29]

Managed competition is compatible with a variety of ways of financing universal coverage—from a tax-financed approach as in the proposal of California Insurance Commissioner John Garamendi and my 1977 proposal to the Carter administration, to an employer/employee mandate plus an individual mandate and subsidies for the nonemployed as in the Jackson Hole initiative, to an individual mandate.[30] Thus, it can appeal to liberals, whose main concern is universal access, and to conservatives, who have strong preferences for decentralized private markets and against centralized governmental power.[31]

Like any serious reform proposal, attempts to enact a national managed competition model will be controversial. Some of the most powerful congressional leaders distrust market mechanisms and prefer direct government price controls. Many of the specific features of managed competition will be opposed by private-sector interests seeking to hold onto the present market imperfections that favor them. However, recent months have seen considerable movement among the private sector toward support of real managed competition as it becomes apparent that government will be forced to act decisively to contain costs.

In the coming debate, managed competition has the important advantage that it is compatible with strong American cultural preferences, as articulated by Alexis de Tocqueville, for limited government, voluntary action, decentralized decision making, individual choice, multiple competing approaches, pluralism, and personal and local responsibility.[32]

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