Questions and Answers about Managed Competition

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Two proposals for health care reform have emerged as the leading contenders: a single payer national health program and "Managed Competition". Originally proposed by Stanford Business School Professor Alain Enthoven\(^1\), versions of Managed Competition have been endorsed by Bill Clinton, George Bush, the New York Times, and several business and insurance organizations.

What is Managed Competition?

Managed Competition would push all but the wealthy into cut rate versions of HMOs and similar closed-panel managed care plans, most owned by insurance firms. Government would define a standard minimum benefit package. Large employers (so-called sponsors) would contract for this minimum coverage with the lowest cost plan, with steep financial penalties for employees choosing better plans. For small firms, the self-employed, and unemployed, the government would act as the "sponsor", setting up a new bureaucracy to contract for coverage with private insurers. Again, stiff penalties would discourage people from choosing any but the cheapest plans. Eventually, Medicaid coverage would probably also be contracted out to the cheapest managed care plans through the government sponsor.

According to Enthoven's theory, Managed Competition would contain costs because the large and powerful sponsors would lean on the insurance companies/HMOs to lower premiums. They, in turn, would discipline doctors and hospitals, who would comply with insurance company directives or be denied contracts. Since virtually all patients in a region would be enrolled in a few large managed care plans, providers denied contracts, or refusing to accept the terms dictated by insurance companies/HMOs would be forced out of business/practice.

Various proposals offer different wrinkles on this basic structure. Alain Enthoven's original formulation called for employees to bear 20% of the premium for the lowest cost plan, and to pay 20% co-payments for covered services. He would require all employers to offer this basic coverage (or to pay a tax to the public program), and suggests that the minimum wage be lowered 8% to cushion the impact on employers. Though employers could offer more generous coverage, government would discourage this by counting the extra cost of a better plan as taxable income for employees. The self-employed and unemployed would purchase coverage through the public sponsor, with subsidies to assist the poor.

Though, as of this writing, Bill Clinton has offered only a broad outline of his plan, it resembles Enthoven's proposal, with the following exceptions. Clinton would not tax employer-provided coverage that exceeded the required minimum - an important modification. Enthoven and his colleagues assert that without this tax penalty their strategy cannot work; employees would continue to be insulated from premium costs, and would have little incentive to join the cheapest plans. Clinton would add expenditure targets to Enthoven's mix, setting an overall cap on health spending in each state, though he has not described how these targets would be enforced. (Enforcing expenditure caps under a multiple-payer system is a daunting task; at present no reliable data exists on how much is spent on health care in each state). He has not suggested lowering the minimum wage.

A more liberal version of Managed Competition, offered by California Insurance Commissioner John Garamendi, Senator Bob Kerrey, and Princeton sociologist Paul Starr would largely eliminate employer-based coverage. Instead, employers would pay a tax into a public fund, which would serve as the universal sponsor and contract with private plans for the minimum benefit package. Individuals (or their employers) would bear the extra costs of better plans, with employer-provided benefits being taxed as income.

The most conservative renditions of Managed Competition (eg. the Bush administration's plan) would omit requirements that employers contribute to coverage. Instead government would offer modest tax incentives for individuals who purchase coverage, and set up sponsors similar to those described above to serve as large insurance purchasing agencies on behalf of employers and individual.

Is there evidence that "Managed Competition" will control health care costs?

No. Managed Competition has never been tried anywhere. Its major assumption is that pushing most people into HMOs that would compete to offer the lowest price would lead to cost savings from more efficient care. Unfortunately, there is considerable evidence that this will not work.

The rapid expansion of HMO's in the past 15 years (about 40 million people are now enrolled in HMOs and 65% of Americans are in some form of managed care) has occurred at a time of unprecedented cost increases. Moreover, in states with the highest penetration of HMOs (California, Minnesota, Massachusetts) costs are no lower than elsewhere, and nationwide premiums for managed care plans are rising at about the same rate as traditional indemnity plans. Similarly,
over the past decade a growing number of big employers and state Medicaid programs have engaged in the kind of hard bargaining envisioned by Managed Competition, with no noticeable effects on health care costs. The Federal Employee Health Benefits Program, often cited as a model for Managed Competition, has averaged double digit rate increases since 1984. Robert Reischauer, Director of the Congressional Budget Office, has estimated that enrolling all Americans in stringent managed care plans would result in a one-time savings of 1%-2% of health spending. Hence, for Managed Competition to control costs, far more coercive measures would be needed. HMOs/insurers would have to squeeze patients, doctors and other health workers much harder than at present.

Moreover, half of all Americans live in regions with population densities too low to support more than one large managed care organization. Hence, in much of our nation the price competition fundamental to the Managed Competition strategy is impossible. A single HMO, cardiac surgery group or intensive care nursery cannot compete with itself. The minimum feasible size of a comprehensive, closed-panel HMO is 200,000 to 300,000 enrollees. Only 50% of the U.S. population lives in metropolitan areas with populations greater than 600,000 (hence able to support 2 or 3 HMOs); 35% live in areas with populations under 200,000.

The Managed Competition strategy would also be seriously undermined if insurers continued to compete by attracting healthy enrollees. Since 10% of the population consumes about 75% of health care, the most effective way for insurers/HMOs to lower their prices is to avoid enrolling sick people in the first place, and to drive away chronically ill enrollees by offering unsatisfactory care. Immense financial reward accrues to insurers that succeed in avoiding risk, assuring extraordinary, and probably successful efforts to circumvent regulatory bans on risk selection. Requirements for open enrollment are easily subverted. Place enrollment offices on upper floors of buildings without elevators. Refuse contracts to all providers convenient to neighborhoods with high rates of HIV. Assure a high turnover rate 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 inconvenience for those with expensive chronic illnesses. There is evidence from Medicare's HMO Demonstration Project that adjusting the capitation fee for age or other predictors of health risk cannot compensate for the creative and subtle means by which unscrupulous insurers/HMOs avoid the sick. Insurers that effectively dodge health problems are sure to succeed, those that tackle them likely to fail.

Will "Managed Competition" reduce administrative costs?

No. According to the U.S. General Accounting Office, under a Canadian-style system, the U.S. would save enough on administrative overhead (about 10% of total health spending, $80 billion in the first year alone - other estimates put this figure at over $100 billion) to cover all of the uninsured and eliminate co-payments and deductibles. The Canadian-style system is more efficient because a single insurance plan in each province handles all bills, regardless of place of employment, while the 1,500+ insurers in the U.S. create a blizzard of paperwork and regulations, and useless expenditures for marketing that results in enormous costs for bureaucracy rather than patient care.

Managed Competition would fail to capture most of the potential administrative savings because it would leave the current system of multiple insurers intact. In fact, Managed Competition is likely to increase administrative costs (as Enthoven forthrightly admits), as well as administrative hassles for patients. Much of the new coverage would be purchased through private insurers with high overhead expenses. Private insurance overhead averages 14% in the U.S., while overhead costs for Canada's program are less than 1%. The overhead in managed care plans is no lower than in other forms of health insurance. For instance, Prudential's managed care plan in New Jersey employs 18 nurse and 5 physician reviewers; 8 provider recruiters; 15 sales representatives; 27 service representatives; and 100 clerks to administer a program enrolling 110,000 people.

Moreover, Managed Competition would add yet another layer of bureaucracy - the "sponsors" - to the already byzantine insurance system. Instead of buying coverage directly from an insurer/HMO, most businesses and individuals would contract with a sponsor who would, in turn, contract with insurers (who would, in turn, contract with doctors and hospitals). The pattern familiar from each attempted reform of the health insurance system over the past quarter-century seems likely to recur. New bureaucrats will join rather than replace their predecessors.

Because it bypasses administrative savings and leaves the current bureaucracy-ridden system intact, the only way for Managed Competition to expand access to all of the uninsured is to increase spending on health care (mainly through increased out-of-pocket expenses for patients) and/or by squeezing the clinical work force. Enthoven estimates that his approach would require about $25 billion (in 1992 dollars) in new spending in the first year. He hopes for savings that would offset these added costs in future years. Most analyses also conclude that many clinical personnel would be laid off, and those remaining would be under increasing pressure, both clinically and financially.

Will "Managed Competition" cover all the uninsured?

Enthoven's proposal called for universal coverage, though most of the newly insured would bear the cost of their new coverage with little subsidy. Clinton's plan appears similar.
The Republican plan would certainly leave at least 22 million uninsured.

All of these projections assume that Managed Competition will successfully contain costs. If this assumption is not met, rising costs will quickly reverse any progress in extending coverage.

How will "Managed Competition" affect the coverage of Americans who already have insurance?

Managed Competition (a la Enthoven) would tax employer contributions that exceeded 80% of the cost of the cheapest plan, effectively raising insurance costs for most employees. Hence most currently insured employees would face a distasteful choice: accept a plan offering less coverage and less choice of provider, or pay dearly to maintain their present coverage (and current doctor). Those HMOs that currently offer superior quality and coverage would face far greater pressure to make excellence a lower priority than cost containment. Many people would probably continue to be underinsured, i.e. to have coverage that would leave them bankrupt in the event of a serious illness. None of the Managed Competition proposals have included coverage for long term care.

Most of the Managed Competition proposals would initially leave Medicare unchanged. The elderly would continue to pay more in out-of-pocket expenses than prior to the establishment of the Medicare program. Eventually, Medicare coverage might also be contracted out to the lowest cost HMOs.

Will "Managed Competition" limit free choice of physicians, or require that people enroll in HMOs or other managed care plans?

For most Americans, an employer would select the cheapest available HMO or similar closed panel managed care plan, offering a very restricted choice of doctors and hospitals. Those wishing a wider choice would face high out-of-pocket costs. Physicians and patients could look forward to even more intrusion from cost-conscious insurers/HMOs in personal medical decisions. Micro-management of physicians' decisions, which has never been shown to be cost-effective, would increase.

Will "Managed Competition" cover long-term care at home or in nursing homes?

Long term care is not addressed by proponents of managed competition. Older Americans would continue to live in fear of the expenses of chronic illness and institutionalization, with little chance of obtaining home services.

Will Managed Competition make health care more accountable or responsive to consumers?

Managed Competition would make health care more accountable to employers, insurers, and managers. Individuals would be able to choose between the lesser of several evils, and pay heavily for it.

Is there an alternative to "Managed Competition"?

Yes, a very popular one. Many polls show that a clear majority (70% or more) of Americans want a national health program like Canada's. A Canadian-style plan would offer universal coverage, a free choice of provider, and far less bureaucratic intrusion in medical practice. Cost savings would be derived from administrative streamlining, improved health planning, and the ability of a single payer to set and enforce overall budgets. Moreover, actual experience in a medical and cultural milieu almost identical to our own has shown that this strategy works.

While corporate leaders and politicians have flocked to Managed Competition, there is little evidence that this strategy is popular, or even acceptable, to most Americans. In essence, it would sacrifice patients' choice of provider, and providers' clinical freedom in order to maintain a central role for the private insurance industry. Even with these sacrifices it may well fail.

Multi-million dollar insurance company lobbying has created gridlock on health policy, blocking reforms that might hurt them. That same lobbying effort now seeks to break the gridlock through a scheme that gives private insurers direct control of hospitals and doctors in a vertically integrated health care system.

References


