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Managed Competition Is Back

A few months ago, many on Capitol Hill were pronouncing the Clinton plan "dead." It was commonly assumed that mandatory alliances and other features of "managed competition" were also dead. But as we learn more details about the four versions of the Clinton plan that have emerged in congressional committee bills, it is clear that the reports of the demise of managed competition were premature.

Alliances in the Original Clinton Plan. The idea behind President Clinton's health care reform proposal was to abolish employer plans and force all nonelderly Americans to buy their insurance through alliances in a highly regulated, artificial market called managed competition. As more voters became aware of the dangers of managed competition — including a much lower quality of health care — Congress balked at the idea of mandatory alliances. Yet even though they may not be strictly mandatory, the dreaded alliances are back. Under all four committee bills, most people will be pushed into alliances through the back door by various regulations.

How Alliances Will Become Almost Universal Under the Four Committee Bills. Most Americans could expect to see their employer-provided coverage canceled. In its place, people would purchase insurance from the government (the House Ways & Means Committee bill would create a new Medicare Part C), through a private sector alliance, through a state government equivalent of an alliance or through a federal alliance. Except for employees of the very largest companies, employer-provided insurance would become a relic of the past. Here's why:

- Under all four bills, every state would be required to have at least one alliance, unless it establishes a single payer system.
- Under the Ways & Means bill, the states could make participation in alliances mandatory.
- Under the Kennedy bill (Senate Labor Committee), employers would be forced to buy insurance through alliances, even though individual employees theoretically buy insurance outside the alliances.
- If an alliance existed, all insurers in the region would be required to sell through it; all insurers would be required to community rate — ignoring differences in individuals' expected health care costs; and insurers would be prevented from selling a plan outside an alliance for a lower premium than they charged inside an alliance.
- Under the Ways & Means bill, insurers would be forced to negotiate a discount for alliances, insuring that plans sold outside the alliance would be more expensive.
- Under all four bills, the states would be required to operate risk adjustment schemes — taxing those health plans that have healthier enrollees in order to subsidize those with sicker enrollees — both inside and outside alliances.
- Under the Kennedy bill, and in certain circumstances under the Senate Finance Committee bill, people would be able to buy into the Federal Employees Health Benefits Program (FEHBP), which would function as a federal alliance.

In general, all the functions that were to be performed by alliances under the original Clinton proposal would continue to be performed under the four committee bills — either by alliances or state governments. For example, under the House Education & Labor bill, state governments (or a private entity they contract with) would operate a clearinghouse to collect premiums; and under all four bills state governments would replace alliances as managers of risk adjustment. Moreover,

Four Versions of the Clinton Health Care Plan

Committee Bill	Chairman
House Ways & Means	**S. Gibbons (D-FL)**
House Education & Labor	**W. Ford (D-MI)**
Senate Finance	**D. Moynihan (D-NY)**
Senate Labor	**E. Kennedy (D-MA)**

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because all four bills seek to eliminate any advantages of purchasing (or selling) insurance outside of alliances, it is unlikely that a market for insurance outside of alliances would even exist.

What's Wrong With Managed Competition? Whether imposed by state governments or by private purchasing cooperatives called alliances, managed competition poses a serious threat to health care quality. [See the NCPA Brief Analysis "Managed Competition: Hazardous to Your Health."] Most people would be forced to join HMOs, and HMO bureaucracies would interfere with the doctor-patient relationship — frequently telling doctors how to practice medicine. Perverse incentives faced by patients and by health plans would lead to the following six problems.

Problem No. 1: Health plans would compete to avoid the sick and attract the healthy. Each health plan would have an incentive to attract those who don't need health care and avoid those likely to generate high health care costs, far more so than in today's markets. Since the plans would not be allowed to compete on the basis of price because of the same-premium-for-everyone rule, they would try to compete in other ways — primarily by offering services attractive to healthy people rather than sick ones.

Problem No. 2: The market would become unstable. In the attempt to avoid sick people — like a game of musical chairs — some would be more successful than others. The less successful would experience rising costs and be caught in a "death spiral of adverse selection." Plans that have a disproportionate number of expensive-to-treat enrollees would have to charge above-average premiums. As healthy people leave or avoid the plan, its cost per enrollee would continue to rise, leading to even higher premiums, encouraging even more healthy people to leave.

Problem No. 3: Buyers would tend to choose among health plans based on medical services rather than insurance services. Under managed competition, heart patients would tend to choose the health plan with the best cardiologists, and cancer patients would tend to choose the plan with the best cancer specialists. By contrast, healthy people would tend to choose plans with the best primary care services and amenities — secure in the knowledge that they could always switch plans if they became seriously ill.

This would create extremely perverse incentives for the managers of the health plans. For example, *no plan could afford to have a reputation as providing the best care for those with expensive-to-treat illnesses.* Indeed, the plans that attracted a disproportionate number of sick people would eventually fail and leave the market.

Problem No. 4: Competition would force health plans to underprovide services to the sick. Since sick people would be unprofitable, health plans would not only try to avoid them, they would also try to encourage patients with expensive-to-treat conditions to leave and join some other plan. Indeed, the natural tendency of managed competition would be to spend no more on the care of the sick than the amount of premiums sick people pay. As a result, seriously ill people would be progressively denied access to the benefits of modern medical science.

Problem No. 5: Fee-for-service plans would be unable to survive. In fee-for-service plans, patients are free to select a physician and physicians are free to practice medicine according to their conscience and their expertise. These freedoms would make it virtually impossible for fee-for-service plans to avoid the sick if they were in competition with HMOs. Thus, despite the Clinton administration's recent promise that everyone would have access to a fee-for-service plan, such plans are unlikely to survive.

Problem No. 6: Competition would lead to monopoly. As long as there are at least two firms in the market, competition based on risk selection is likely to continue until only one firm is left. That firm is likely to be a government-regulated utility or a firm owned and operated directly by government. Therefore, despite the intent of its proponents, managed competition is likely to evolve into socialized medicine.

Recommended Reading: *John Goodman and Gerald Musgrave, "A Primer on Managed Competition," NCPA Policy Report No. 183, April 1994.*