A Primer on Managed Competition

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NCPA Policy Report No. 183

April 19, 1994

ISBN # 1-56808-017-4

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Executive Summary

Managed competition is the central idea behind the Clinton administration's plan to reform the nation's health care system. It is also the main idea behind several competing plans, including those designed by Representative Jim Cooper (D-TN), Senator John Chafee (R-RI) and others. This study analyzes the concept of managed competition and concludes that:

- The unifying objective of all proposals for managed competition is to create an artificial market for health insurance in which individuals choose among competing health plans that are forced to charge the same premium to every applicant, regardless of expected health care costs.
- Among people entering a health plan, a person who has AIDS would pay the same premium as someone who does not, and people in hospital cancer wards would pay the same premiums as people who do not have cancer.
- Because of the one-price-for-all rule, the premiums sick people pay would be well below the expected cost of their treatment, while the premiums of healthy people would be substantially higher.
- As a result, the incentives for the plans to avoid sick people and attract healthy ones would be far worse than under the current system.

On the consumer side, heart patients would tend to choose the health plan with the best cardiologists, while 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 competitor could afford to have a reputation as being the best plan 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. Moreover, each health plan would have an incentive to underprovide services to the sickest people and overprovide services to the healthy. Specifically:

- *The natural tendency of managed competition is to compete the amount health plans are willing to spend for the care of the sick down to the level of the premiums sick people pay.*
- By contrast, *there would be a natural tendency to compete the amount health plans are willing to spend on the healthy up to the level of the premiums healthy people pay.*
- As a result, *seriously ill people would be progressively denied access to the benefits of modern medical science, while healthy people would have access to services that are medically unnecessary and only tangential to health care.*

These conclusions follow from well-known principles of the economics of regulation. In competitive markets, price tends to change until it equals average cost. But if prices are constrained, competition will cause cost to change until it equals price, primarily through changes in quality. For example, when housing rents are kept artificially low by rent control, landlords tend to allow housing quality to deteriorate until housing costs fall to the level of the government-controlled rents. When airfares were kept artificially high under airline regulation, the airlines tended to increase quality by adding more flights and amenities until their costs rose to the level of the government-controlled fares.

A different way of appreciating this result is to consider it in terms of a basic principle taught in all introductory economics courses: when firms are maximizing profits, marginal revenue must equal marginal cost. Under managed competition, marginal revenue (the amount of premium each enrollee brings to a plan) must be the same for every enrollee. That means that marginal cost (the amount the plan spends on health care for a patient) must also be the same for every enrollee.

We do not expect the quality of care delivered to the sick to deteriorate immediately. Nor will all diseases be affected in the same way. Health policy analysts believe the patients at greatest risk initially will be those with chronic conditions — those in need of mental health care, custodial care or long-term care. Where physicians have discretion, as in the treatment of leukemia or in efforts to save premature babies, the tendency will be to save money rather than prolong life. Expect a substantial decrease in the number of CAT and MRI scans and other costly tests that detect brain tumors, cancer and other life-threatening conditions. Where possible, expensive surgery (such as bypass operations) will be delayed — if for no other reason than to take advantage of the chance that the patient might switch health plans and have the surgery performed by a competitor.

Advocates of managed competition like to stress the word "competition." But in order to preclude the disaster just described, policymakers would have to focus on "management" (read: regulation). Various proposals would try to restrain perverse behavior by (a) limiting the freedom of enrollees to change plans to "open enrollment" periods, (b) rigidly insisting that everyone have exactly the same package of health insurance benefits, (c) requiring everyone to have the same deductibles and copayments, (d) transferring income back and forth among insurers under "risk adjustment" schemes and (e) imposing regulations designed to prevent the deterioration in quality of care.

Some of these features would lead us to modify our predictions. For example:

- If the premium income each enrollee brings to a health plan were risk adjusted, then competition would tend to make the cost of care equal to the risk-adjusted premium for every patient.
- If government succeeded in setting a floor under the quality of care for the sick, then competition would tend to compete the quality down to the government-imposed minimum standard.

But because these restrictions do not correct the fundamental problem — incentives distorted by artificial prices — they are unlikely to make managed competition workable. And each new set of regulations is likely to create pressures to enact even more regulations.

Advocates of managed competition point to three operational examples of the reform they propose: the health care program for federal employees and programs for public employees in the states of California and Minnesota. Although all three have confronted some of the problems described above, they have not yet produced the radical changes in health care delivery predicted by economic analysis. The primary reason is that in these programs most people are enrolled in health plans that are primarily selling *insurance* services to a wider market, rather than *medical* services to public employees. That makes the public employee plans distant cousins of managed competition, rather than examples of the real thing.

Under pure managed competition, there would be no need for insurance companies. Health plans could just as easily be operated by hospitals or physicians' groups. Indeed, physicians and hospital personnel are likely to have a competitive advantage over insurance companies in a very important respect: their "hands-on" relationships with patients would put them in a much better position to encourage the least profitable enrollees to move to some other plan. Thus the existing plans — both public and private — that allow choice and competition among insurers tell us very little about what would happen if the market for insurance were effectively abolished under managed competition.

Managed competition would make no sense unless most health care were delivered in health maintenance organizations (HMOs), employing the techniques of managed care. That is why most proponents of managed competition oppose traditional insurance and fee-for-service medicine. They want physicians to become agents of bureaucracies rather than agents of their patients, and they want medical practice to be determined more by computer-generated mandates than by the physician's best judgment.

Yet these views reflect the prejudices of a small group of health policy reformers and are not based on the results of academic research.

- Rand Corporation studies show that people spending their own money are more effective at controlling costs than are HMOs.
- The Mayo Clinic, which mainly caters to fee-for-service clients, shows that managed care need not be combined with an HMO.
- Studies show that physicians using their own judgment can outperform computerized protocols.
- And health economists have shown that the problems of the 1 percent of the population that is uninsurable can be adequately solved through risk pools and government subsidies, without regulating the premiums of the other 99 percent.

Managed competition is much more than an untested theory. Its underlying assumptions are contradicted by reality. And its likely outcome would be hazardous to our health.

Introduction[1]

"Managed competition is the centerpiece of the Clinton health care plan."

Managed competition is a concept that has dominated the recent health policy debate.[2] It was the key health care reform idea for candidate Bill Clinton during the 1992 presidential election and, after significant modifications of the original concept, it is the centerpiece of the administration's current health care plan.

Managed competition also has attracted an unusual array of economic interests. Support ranges from the AFL-CIO to the U.S. Chamber of Commerce, the National Federation of Independent Business (which represents small business) and the Business Roundtable (the nation's 200 largest companies).[3] It even includes those who have been portrayed by the Clinton administration as villains in the health care debate. For example, despite the fact that the administration has repeatedly attacked the health insurance industry, the so-called "big five" commercial insurers — Aetna, Travelers, Cigna, Prudential and Met Life — are actively promoting managed competition through magazine advertisements, lobbying efforts and other means.[4] No industry has suffered more verbal abuse from the Clintons than pharmaceuticals, and company stock prices have plummeted because of it.[5] Yet the Pharmaceutical Manufacturers Association (PMA) also has endorsed managed competition. So have others whom the Clintons have portrayed as greedy and profiteering — including a number of physicians' organizations.[6]

Support for managed competition also spans the political spectrum — from the liberal editorial page of the *New York Times*[7] to the normally conservative Heritage Foundation.[8] While the Clinton health care proposal is generally viewed as left of center, managed competition forms the basis for the "centrist" bipartisan bill proposed in the House of Representatives by Jim Cooper (D-TN) and Fred Grandy (R-IA) and in the Senate by John Breaux (D-LA) and Dave Durenberger (R-MN); the "moderate" Republican bill proposed by Senator John Chafee (R-RI); and the "conservative" bill proposed by Senator Don Nickles (R-OK) and Representative Cliff Stearns (R-FL), although they object to the "managed competition" label. [See the sidebar on Varieties of Managed Competition.]

One reason why managed competition is difficult to define is that there are so many variations on the core idea. For example:

- The Clinton administration proposal combines managed competition with the Canadian system of global budgets and price controls.[9]
- Both the Chafee bill and the Nickles-Stearns bill combine managed competition with Medical Savings Accounts (MSAs), and the Cooper-Grandy bill creates the opportunity for MSAs.[10]

- The Cooper-Grandy bill, thought to be the purest version of managed competition, does not require anyone to purchase health insurance, whereas the other three plans contain individual and/or employer mandates.[11]
- And although the original idea behind managed competition was to encourage managed care through health maintenance organizations (HMOs), the sponsors of all four plans are stressing provisions of their proposals that appear to give individuals the freedom to choose physicians.[12]

Adding to the confusion is the shifting position of the Jackson Hole Group — the health policy analysts who are credited as the intellectual architects of managed competition. This group, discussed below, originally favored universal coverage through government mandates and opposed medical savings accounts.[13] However, its most recent "draft proposal" drops the endorsement of mandates and includes Medical Savings Accounts.[14]

Proposals for managed competition also contain other important reforms. For example, all four bills would provide tax relief for those who purchase their own health insurance, in contrast to the current system of restricting tax subsidies to employer-provided coverage.[15] All four also would provide more generous tax relief to lower-income families, in contrast to the current system of giving the most generous subsidies to higher-income families.[16] And in contrast to the current system of subsidizing generous and even wasteful employer-provided health insurance, Nickles-Stearns would limit the tax subsidy (depending on family income) and the Cooper-Grandy and Chafee bills would limit the amount employers could deduct to the cost of a basic plan.[17] All four bills also would give Medicaid enrollees an opportunity to become full participants in the private health insurance marketplace and give Medicare beneficiaries an opportunity to participate as well. Elsewhere, we have argued that each of these reforms is desirable, whereas global budgets, price controls and mandates are not.[18]

"The idea is backed by the largest health insurance companies and other powerful interest groups."

Given that there are so many varieties of managed competition and that the core idea has been combined with so many other reforms — some good, some bad — small wonder that there is so much confusion about the concept, even within the health insurance industry. In what follows, we sift through the complexities and identify the common ideas that unite the proposals.

What Is Managed Competition?

Claiming to avoid the polar extremes of socialized medicine and free markets, the advocates of managed competition say they have found a workable middle ground — capturing the benefits of competition and solving social problems at the same time. The following is a brief description.

Varieties of Managed Competition

Under all four bills before Congress, people would choose among competing health care plans. These plans would be required to charge everyone the same premium (community rating) and to take all comers (guaranteed issue). As a result, people in need of expensive medical care would be choosing not among insurers, but among providers of medical care, and the premium they paid would be well below the cost of their treatment.

For the reasons given in the text, all four systems would be extremely unstable, and competitive pressures would induce the health plans to underprovide care to the sick and overprovide care to the healthy. The designers of these proposals are generally confused about how competition works. For example, when competitors have proper incentives, less regulation is normally a good thing. However, under managed competition, competitors have perverse incentives that will produce disastrous results if not counteracted by regulation.

The Clinton Proposal. All health plans would be forced to offer the same basic benefit and have the same patient cost sharing, a practice that would increase competitive pressures by encouraging people to focus only on premiums and quality. People could switch health plans once a year, more frequently for "good cause." In an imperfect attempt to counteract the perverse incentives the plan creates, premiums would be risk adjusted, so that plans with sicker enrollees would get more income. The alliances regulating the system would also have considerable power to try to avert adverse risk selection. Everyone would be required to join, and employers would pay at least 80 percent of their employees' premiums. Premium controls and global budgets would almost certainly drive fee-for-service plans from the market and intensify the downward pressure on the quality of care received by the sickest enrollees.

The Cooper-Grandy Bill. To gain favorable tax treatment, small business employers would be required to make federally certified health plans available to their employees. Like the Clinton plan, this bill would require the same benefit package and the same patient cost sharing. Premiums would be risk adjusted. Unlike the Clinton plan, participation would not be mandatory. Perverse incentives would be reduced somewhat because of modified community rating — premiums could vary by age. Instability would be enhanced, however, by the farmer's market approach in which the health plan purchasing cooperatives (the regulatory body) would interfere very little in the competitive process.

The Chafee Bill. All individuals would be required to purchase a standard benefits package. As in the other bills, there would be subsidies for low-income families. There also is a provision for Medical Savings Accounts. Unlike the Clinton and Cooper proposals, participation in an alliance would not be mandatory, and alliances would not have monopolies over geographical areas. To limit responses to perverse incentives, a national commission would devise a risk-adjustment scheme.

Conservative Proposals. Like the Chafee bill, the Nickles-Stearns bill has an individual mandate and calls for modified community rating. The Medical Savings Account provision is much stronger than under the Chafee bill and deductibles can range as high as $1,000 per individual and $2,000 per family. To counteract perverse incentives, premiums would be risk adjusted by state governments. A pass-back provision would allow income shifts between plans when patients switch plans. Nickles objects to the term "managed competition," and *Barron's* calls the bill "unmanaged competition." He also is considering dropping the mandate and raising the allowed deductible. This plan has the least regulation of the four — for example, it has no provision for alliances. But for that reason it is the most potentially unstable.

Creating an Artificial Market for Health Insurance. Under managed competition, employees would choose from an array of health insurance plans. The employer's contribution would be a fixed sum of money, and the employee would pay the balance of the premium. If an employee chose a more expensive plan, the extra cost would come out of that employee's pocket. Presumably this would make employees more price-conscious and encourage health insurers to be more competitive by holding down the cost of their plans.[19]

However, the premiums employees face would be artificial, because insurers would be forced to charge the same premium to every applicant (community rating) or to every applicant of the same age and sex (modified community rating)[20] and to accept all applicants regardless of health conditions (guaranteed issue). Thus, insurers would be precluded from competing based on their ability to price and manage risk. Instead, they would be forced to compete based on their ability to provide health care and manage its cost.[21]

Most proposals for managed competition would create a regulatory body called a Health Insurance Purchasing Cooperative (HIPC) or, more frequently these days, a health alliance. The function of the alliance would be to "manage" the competition although, as we show below, the proponents of these schemes disagree over how much management is necessary. Although proponents of managed competition frequently talk about "competition," they do not advocate competition among firms in the business of insurance. Indeed, they want to get rid of insurance as such and turn insurers into managers of health care delivery. The radical nature of this idea is seldom appreciated, even among congressional cosponsors of managed competition. Yet what is being proposed *is comparable to insisting that auto insurers get out of insurance and into managing and perhaps delivering automobile repairs or that fire and casualty insurers switch from insuring homes to managing home repairs.*

"Insurers would be forced to manage care instead of managing risk."

When Insurers Manage Care Instead of Managing Risk. Managed competition not only changes the nature of the product the sellers are selling, it also changes the nature of the product buyers are buying. In a very real sense, buyers are not buying protection against the loss of their assets when they select a health plan under managed competition. This is especially true under the four bills before Congress. *The system as a whole provides protection against the loss of assets* due to a catastrophic illness. But in selecting one plan over another, customers are actually selecting the right to consume particular health care services. This is *comparable to choosing an auto insurer in order to have the right to obtain car repair services or choosing a casualty insurer in order to obtain home repairs.*

"Most advocates of managed competition want to abolish the market for health insurance and replace it with a market for managed care."

Rethinking the Bias against Insurance. Scratch a garden variety proponent of managed competition and one almost always finds someone who has a deep-seated hostility toward the concept of insurance. Thus it is not surprising that managed competition would abolish insurance and replace it with something else. Because some readers may harbor similar hostilities, it may be worthwhile to pause for a moment and consider why health insurance is socially valuable — quite apart from the fact that it allows individuals and families to protect their assets by transferring risk to others.

Suppose there were no such thing as private or public health insurance. How would our health care system be different? Without insurance, individuals would have to fund from their own resources such expensive procedures as bypass surgery, organ transplants and state-of-the art treatment for cancer and AIDS. And since many — perhaps most — patients would not be able to pay for these procedures, the market for them would be very thin. In fact, it might be so thin that the technology would never be developed in the first place.

By providing funds to pay for the treatment of catastrophic illnesses, health insurance has helped to make possible the development of expensive procedures that most people could not pay for on their own. *Without health insurance, much of what medical science makes available to us today would have been lost.* As we show below, that loss is likely to befall us in the future if we adopt managed competition.

Prototype of Managed Competition: The Federal Employees Health Benefits Program (FEHBP). The program most often cited as an operational example of managed competition is the Federal Employees Health Benefits Program (FEHBP).[22] As we shall see below, the FEHBP is probably better thought of as a "distant cousin." Nonetheless, it has four main features that proponents of managed competition advocate: (1) federal employees in most places can choose among eight to 12 competing health insurance plans;[23] (2) the government contributes a fixed amount that can be as much as 75 percent of each employee's premium; (3) the extra cost of more expensive plans must be paid by the employee with aftertax dollars;[24] and (4) the plans are forced to community rate, charging the same premium for every enrollee.[25]

Despite glowing descriptions by its defenders,[26] however, the FEHBP has few of the desirable characteristics of a competitive system. Most people familiar with the FEHBP have concluded that it needs reform.[27] This is the opinion of the Office of Personnel Management (OPM), which oversees the program, and of other analysts inside and outside of government.[28] And although there is some disagreement over the issue, the program does not appear to have succeeded in controlling costs.[29] For example:

- During the 1980s, the federal government's spending on employee health benefits grew at a faster annual rate than employer-provided health insurance generally (11.22 percent versus 10.01 percent).
- Adjusted for the number of employees, the federal employees' plan's spending grew more than 25 percent faster than spending for private sector plans.

One reason why the FEHBP has not controlled costs is that buyers never confront prices that reflect the real cost of services they intend to use. For the sickest patients — those likely to comparison-shop most carefully — the expected benefits of treatment are so much higher than the premium payment that quality of care rather than price tends to govern choices. And for the healthiest patients who are being overcharged, competition induces insurers to create additional services, thus adding to total cost.

"The federal employees' health plan is seen as a prototype for managed competition."

Other problems result from regulations designed to prevent adverse selection. For example, while most private employers are increasing their deductibles, Blue Cross's FEHBP "high-option" plan has a deductible of only $200, and its "standard-option" plan has a deductible of only $250. Why are the deductibles so low? Because OPM won't allow Blue Cross or any other plan to raise its deductibles or copayments, fearing that plans with greater patient cost-sharing and cheaper rates would attract younger, healthier employees. OPM rigorously reviews every attempt to tailor the plans to the employees' needs in order to make sure that no plan appeals more to good risks than to bad ones. For example, OPM will not allow a plan to include coverage for teeth cleaning but omit coverage for dentures, on the theory that such a change would make the plan more attractive to young people.[30]

Even with this regulatory micromanagement, outside analysts say that for the most part competition is for good risks and does not approach what managed competition advocates imagine.[31] Indeed, it is precisely because they attracted too many bad risks that Aetna recently left the FEHBP, leaving Blue Cross as the only systemwide fee-for-service insurer.[32]

Other Prototypes of Managed Competition. The public employee health plan in the state of Minnesota is also a distant relative of managed competition.[33] The California Public Employees' Retirement System (CalPERS) is another. And, as in the case of the FEHBP, there is disagreement over how well these programs have succeeded in controlling costs. One recent study found that average family insurance premiums for CalPERS enrollees increased more rapidly between 1982 and 1992 than the national average — 9.8 percent for CalPERS HMOs and 12.9 percent for its PPOs versus 9.4 percent for all employers nationally.[34] Furthermore, critics contend that CalPERS' ability to hold down premium increases is due primarily to cost shifting to other plans. For example, while the Foundation Health Plan (which

has about 10 percent of all CalPERS enrollees) did not increase premiums for CalPERS in 1993, it did increase its premiums for other customers by 5 to 7 percent.[35]

California also is one of a number of states that are creating voluntary alliances for the private sector. In Florida, for example, these alliances are part of general health care reform.[36] [See the sidebar on state reforms.] The state of Washington is creating mandatory, monopoly alliances as part of its new program of managed competition — to be phased in over several years.[37] Under the system, employers will be required to (a) give their employees a choice of three qualified health plans, (b) enroll their employees in the state's plan or (c) allow their employees to choose among health plans offered through a Health Insurance Purchasing Cooperative (HIPC), which is comparable to a Clinton-proposed alliance. Like the Clinton bill, Washington will impose premium caps on the health plans — effectively enforcing a global budget for the state. Unlike the Clinton bill, Washington is forcing everyone to join an HMO or managed care program. As we show below, the new reforms have already been implemented for the state's Medicaid population, with some of the negative consequences predicted in this report.

"Public employee plans are distant cousins of managed competition."

The concept of managed competition is also gaining interest internationally. For example, the health care reforms initiated by Margaret Thatcher are generally described as a movement from socialized medicine to managed competition.[38] And both the Netherlands[39] and Israel[40] are about to adopt managed competition nationwide. Below, we briefly consider some of the problems these countries are having.

How Managed Competition Differs from Conventional Employer Plans. Most large employers give their employees options. In a typical case, employees can choose from at least three options: (1) a high-deductible plan, (2) a low-deductible plan and (3) an HMO. Moreover, insofar as the employees bear any part of the premium, the premiums usually are community-rated — all employees pay the same price regardless of expected health care costs. How does this arrangement differ from managed competition?

The main difference is that employees who have choices are mainly choosing among *insurers* who are offering *insurance* services, not health plans offering *medical* services. In order to convince an employer to offer its plan, an insurer must show that it will adequately cover a broad range of illnesses. To get a contract, therefore, an insurer must appeal to the *entire group* of employees rather than to *selected employees* with particular health needs. Similarly, in negotiating with insurers, employers act on behalf of the group as a whole.

Under managed competition, employers will no longer act on behalf of employees. They will make individual choices instead. And insurers will no longer offer insurance services. They will offer medical benefits instead.

"Existing plans tell us very little about how managed competition would work."

This distinction will become clearer below. But in order to better appreciate it at this point, consider that under pure managed competition there would be no need for insurance companies. Health plans could just as easily be operated by hospitals or physicians' groups. Indeed, physicians and hospital personnel are likely to have a competitive advantage over insurance companies in a very important respect: their "hands-on" relationships with patients would put them in a much better position to encourage the least profitable enrollees to move to some other plan. Thus the existing plans — both public and private — that allow choice and competition among insurers tell us very little about what would happen if the market for insurance were effectively abolished under managed competition.[41]

Evolution of the Concept of Managed Competition

In 1978 Alain Enthoven, a Stanford University professor and former Assistant Secretary of Defense, wrote a trend-setting, two-part article in the *New England Journal of Medicine*.[42] In this article, later expanded into a book,[43] he used basic concepts of economic theory to argue that (1) economic incentives in health care matter a great deal, (2) many of the defects of the current health care system are the result of perverse economic incentives and (3) in order to create a workable health care system, good incentives must replace the bad ones.[44]

For example, Enthoven argued that because of perverse government tax subsidies, employers and their employees have an incentive to buy too much insurance. Where employees have choices, they tend to pick overly generous plans because they do not bear the full cost of their choice. Moreover, when employees enter the medical marketplace, they make wasteful choices and overconsume health care because their employer — or some other third party — is paying the bill. Finally, just as employees have an incentive to overuse the health care system, physicians have an incentive to encourage overconsumption because it increases their incomes.

When Enthoven published his ideas, physicians considered them radical. The medical literature of the time was dominated by the notion that economic incentives did not or should not motivate the behavior of doctors or patients. All medical schools tended to encourage budding physicians to ignore costs in prescribing treatments, and there were virtually no classes on medical economics.[45] Today things are very different. Health economists and other health policy analysts readily accept an economic diagnosis of the problem. However, many do not endorse Enthoven's recommended cure.

The Movement Toward Managed Competition Among the States: Health Alliances

	Fully Operational	Characteristics	Size of employer group	Health Plan Participation	Risk Adjustment
California	July 1993	Single statewide alliance, with regional plan offerings	Four to 50 employees	All participating insurers	Health plans are compensated if they get a disproportionate share of high risks, as defined by the state
Florida	Early 1994	11 noncompeting alliances, each covering a portion of the state	50 or fewer employees	Accountable health partnerships, certified by the state	Small group insurers can assume risk or deed risk to state-run insurance pool
Iowa	Not Set	Two competing alliances permitted per geographic area; state to be divided into seven or eight markets	Any size, but law was written for small business; individuals may also be served	At the discretion of the alliances; law authorizes and encourages "organized delivery systems"	To be based on usual demographic factors
Minnesota	1993	Single state-wide alliances, with regional plan offerings (separate alliance for state employees)	All with two employees or more; employer must have 95% of its workers in the state	Integrated service networks (all-payer system outside of ISNs)	Retrospective adjustment for private employee alliance
North Carolina	January 1995	From four to 12 noncompeting alliances, each covering a defined geographic area	Three to 49 employees	Accountable health carriers, accredited by state	To be based on factors (to be determined) that will predict utilization of services
Ohio	Early 1994	Multiple competing alliances; can be privately formed by employers	150 or fewer employees	Open to all insurers and managed care plans	None
Texas	Early 1994	Multiple competing; one state sponsored alliance in each geographic area; unlimited private alliances, not necessarily geographically based	Three to 50 employees	At alliance's discretion	To be implemented in 1998
Washington	July 1995	Four public, regional noncompeting alliances, (separate alliance for state employees)	7,000 employees and under	All those certified by state	To be developed

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Alain Enthoven's Consumer Choice Health Plan (CCHP).[46] To remedy the problems in the existing system, Enthoven called for reform based on an operating model: the aforementioned Federal Employees Health Benefits Program (FEHBP), in which employees choose from an array of competing health plans once a year during an "open season." And although the federal system allows fee-for-service options, Enthoven's preference was for the type of managed care practiced in HMOs.

Despite Enthoven's interest in the general problems of health economics, he appeared uninterested in health insurance as such. His book contained virtually no discussion of the economic value of insurance markets. And although he recommended a system of community rating, he barely discussed the problems that would be created by the system's artificial health insurance premiums, including the problem of deterioration in the quality of care, which is discussed below.

The Jackson Hole Group. Enthoven's ideas were subsequently developed in conjunction with those of Paul Ellwood (a former health advisor to President Nixon who is generally credited with coining the term "health maintenance organization") and Lynn Etheridge (formerly with the Office of Management and Budget and now a private consultant on health care issues). Because these three began a series of off-the-record meetings with key industry leaders and health policy analysts at Ellwood's home in Jackson Hole, Wyoming, they and their colleagues came to be known as the Jackson Hole Group. Their proposals for health policy reform became known as "managed competition."

The Jackson Hole philosophy had considerable appeal for some of the largest health insurance companies. These firms had long ago ceased selling anything resembling real insurance. They had left the market for small group and individual policies and specialized instead in managing health care costs for large employers. The prospect of replacing a market for health insurance with a market for managed care was quite consistent with their financial interests. As a result, they sent representatives to the Jackson Hole meetings and backed the group financially.

"Despite the Clintons' attacks on insurance companies, the president has adopted the plans of the large insurers."

The national media have underreported the extent to which Bill Clinton's health care plan has been shaped and molded by a reform package backed by the nation's largest health insurance companies. Some might suppose that the full-page advertisements in which the "big five" tout managed competition are simply a show of support for the president. In fact, it's the other way around. The president has endorsed the plan of the large insurers, who are convinced that under managed competition most of their small competitors will be pushed aside and they will be able to carve up the market among themselves.[47] Indeed, at a Jackson Hole meeting last year, following Ira Magaziner's presentation of the Clinton plan to a modest gathering of

insurance industry executives,[48] Paul Ellwood is reported to have said, "I'd say you have in this room 90 percent of those who are going to be in the managed competition business."

Yet despite insurance industry influence, the Jackson Hole Group appears to have underestimated the problems that will arise because of adverse selection. And they apparently have paid little attention to the even more serious economic problems discussed below.

Left-Wing Version of Managed Competition: The Clinton Plan. Although candidate Bill Clinton promised to base his health care reform plan on managed competition, the Jackson Hole supporters were outvoted by "single-payer" advocates on Hillary Clinton's health care task force. Thus, although the plan that emerged had the administrative design called for by managed competition advocates, it was clearly put together by people who had no faith in competition.[49] As protection against failure, the single-payer advocates borrowed key ideas from Canada's system of national health insurance, including price controls and global budgets.[50]

"Bill Clinton proposes to merge managed competition with price controls and global budgets."

Enthoven and Ellwood were outraged. Ellwood cried "foul" in a *Wall Street Journal* editorial: "White House planners never fully embraced the managed competition reform model the president endorsed during the campaign."[51] His sentiments were echoed by Enthoven, who complained that the Clinton plan "will cause more problems than it solves."[52] Until recently, Enthoven believed that the defects in the Clinton plan could be remedied by Congress, but now he's changed his mind. "The first thing Congress should do is delete pages 1 through 1,342 of Clinton's 1,342-page bill," he says.[53]

Centrist Versions of Managed Competition: The Cooper-Grandy and Chafee Bills. Unhappiness with the left-wing tilt of the Clinton plan produced two alternatives that were truer in spirit to the Jackson Hole philosophy. Jim Cooper openly called his plan "Clinton lite," and conservative Republicans applied the same term, derisively, to John Chafee's plan in the Senate. In contrast to the heavy hand of regulation that many saw in the Clinton plan, Cooper called for a "farmer's market" approach, in which any plan would be allowed to compete so long as it offered a basic package of benefits.[54]

"Conservative and moderate versions would have fewer regulations."

Yet despite Cooper's promise to rely on competition rather than regulation, as more details came out more regulation emerged. For example, Cooper now insists that everyone must have the same basic benefit package and that deductibles and copayments must be the same for everyone. Another new twist is a risk adjustment process in which funds would be shifted from plans that attract healthier to those that attract sicker people. And although Cooper and other major cosponsors have expressed support for Medical Savings Accounts, it now appears that the artificial markets created by the Cooper plan would be too fragile to allow individual patients even the bit of freedom that MSAs would provide.[55]

Conservative Versions of Managed Competition.[56] A number of conservatives have also modeled health reform proposals on the federal employees plan. Although Senator Nickles objects to the term "managed competition" and *Barron's* has called it "unmanaged competition" — the Nickles-Stearns bill is often described as promoting consumer choice and free enterprise — it is not significantly different from other versions of managed competition and in some respects calls for even more regulation than the Cooper-Grandy and the Chafee bills.

- In contrast to Cooper-Grandy, Nickles-Stearns would require every individual to purchase a basic health insurance policy — a mandate that would inevitably invite government regulation of the entire health care system.[57]
- And unlike Cooper-Grandy, Nickles-Stearns would outlaw many of the most important cost control techniques being implemented by large employers.[58]

The Nickles-Stearns bill does allow Medical Savings Account (MSA) contributions of up to $3,000,[59] but it limits the deductible on the required health insurance plan to $1,000 for an individual and $2,000 for a family. Thus, even though people are allowed to have MSAs, Nickles-Stearns significantly reduces their use in the purchase of medical care.

A Closer Look at Artificial Markets for Health Insurance

The essence of managed competition is the creation of an artificial market for health insurance. As noted above, managed competition is not designed to reform the market for health insurance or to make it work better. Its purpose is to abolish health insurance altogether and replace it with something entirely different.

How Managed Competition Differs from Real Competition. A competitive market is one in which risk tends to be priced accurately. People entering an insurance pool are charged premiums based on the expected cost and risk that they bring to the pool. As a result, each person tends to pay a premium equal to the value of the insurance that person receives.

"Everyone would pay the same price, regardless of expected health costs."

Managed competition, by contrast, would force health plans to sell to all applicants at the same price — no matter how sick or well the applicants are.[60] Under "pure" community rating, the plans would be forced to charge the same price to every applicant, regardless of age, sex, occupation or any other indicator of health risk. Thus, despite the fact that health costs for a 60-year-old male are typically three or four times higher than for a 25-year-old male, both would pay the same premium.[61] Under "modified" community rating, price differences would be allowed based on age and perhaps on geographical location as well. Other than that, sick people would be able to obtain coverage for the same price as healthy people. Thus:

- A person who has AIDS would be able to join a health plan for the same price as someone who does not.
- People in hospital cancer wards would be able to join a plan for the same price as people who do not have cancer.

In a competitive insurance market, two similarly situated individuals could expect to purchase health insurance for the same premium *before* either of them becomes sick. Under managed competition, they would be able to join a health plan for the same premium *after* one of them becomes sick. If the same procedure were applied to other forms of insurance, people would be able to purchase life insurance from any carrier at normal premiums after they became terminally ill. People would be able to purchase fire insurance on their home while it was burning or casualty insurance on an automobile after it had been destroyed in an accident.

Placing a Bet after the Dice Are Thrown. All insurance involves a gamble and health insurance, like life or fire insurance, is a gamble most of us hope we will lose. People who purchase insurance are transferring risk to an insurer, and when risky events occur the insurer bears the cost. As noted above, in a competitive insurance market premiums tend to be actuarially fair. In such a market, people have the opportunity to make rational choices about how much risk to transfer to third parties and how much to self-insure against.

One way to think about managed competition is to see it as a game in which people are allowed to place bets after the dice have been thrown. Premiums do not buy insurance against risky events; instead they constitute prepayment for the consumption of medical care. In such a system, there is no relation between the amount people pay and the value of services they receive. People can't make rational choices between self-insurance and third-party insurance, since under managed competition there is no such thing as an actuarially fair premium. Every premium is artificially set either too high or too low relative to the risk and expected cost the individual brings to the insurance pool.

"Someone with AIDS would pay the same premium as someone who is healthy."

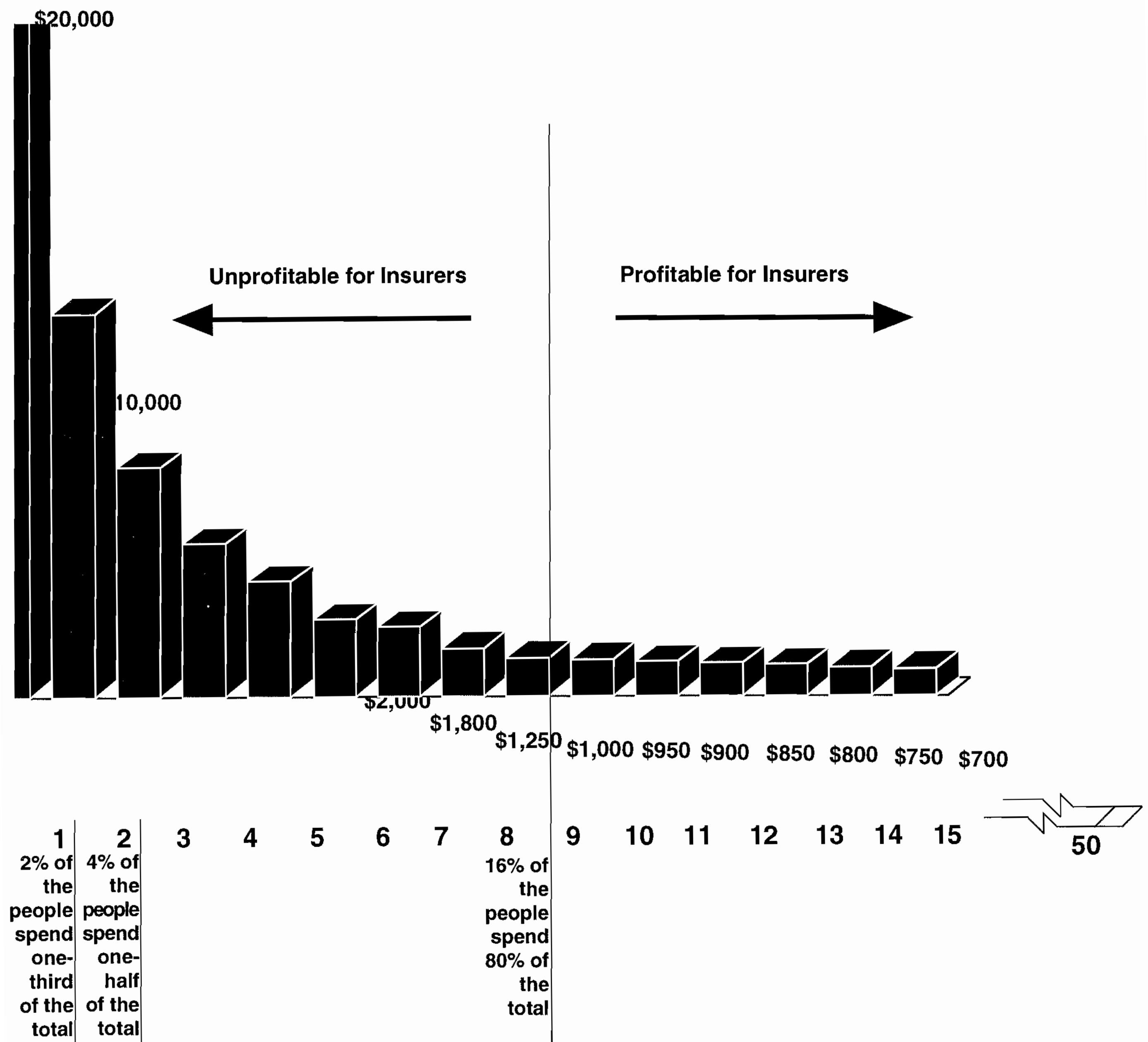
In a competitive insurance market, people are encouraged to make choices that are socially good, in the sense that they lead to an efficient allocation of risk. Under managed competition, people would be encouraged to engage in opportunistic behavior to the detriment of everyone else.

The Consequences of Choosing Insurers after People Get Sick. The distribution of medical expenses in Figure I is a reasonable representation of what happens in most insurance pools in any given year. In this case, a group of 50 people spend $60,000 on health care — $1,200 per person on the average. As the figure shows, the distribution of expenses is anything but uniform. The vast majority of people incur costs well below the average and most of the money is spent on a small number of people. Specifically:

- About 4 percent of the group (two people in this example) account for 50 percent of health care spending.
- About 16 percent of the people account for 80 percent of the spending.
- And about 30 percent of people account for 90 percent of all of the spending.

FIGURE I

Distribution of Medical Expenses Among 50 People



If the example were broadened to include a much larger group, the extremes of the distribution would become more evident. A few people would have medical expenses of several hundred thousand dollars, while many others would have no medical claims. The characteristics of the distribution, however, would be similar to those shown in Figure I.[62] Indeed, some health economists have estimated that 1 percent of the population as a whole accounts for 30 percent of the spending and 10 percent accounts for 70 percent.[63] For private insurance, 1 percent apparently can account for 50 percent[64] and the concentration remains even if considered for as long as a decade.[65]

Now imagine that these 50 people are allowed to purchase health insurance in a competitive market. If they are all in similar health at the time they insure, then the premium will tend to be the same for each of them. If we ignore administrative costs, an actuarially fair premium would be $1,200 — since, on the average, they are expected to spend $1,200. In this example, we discovered after the fact that eight people were unprofitable because they incurred expenses in excess of $1,200. By contrast, 42 people turned out to be profitable because their expenses were less than $1,200.

"About 4 percent of the patients spend half the health care dollars."

Under managed competition, people would have an option they do not have in competitive markets. They would be able to *reselect* among health plans *after* they got sick and still pay the common premium of $1,200. Thus, under managed competition both the insured and the insurers would be allowed to recontract in full knowledge (for the most part) of who the eight unprofitable people were.

When Sellers Compete to Avoid Buyers. The benefits of competition are well known to economists and are becoming increasingly known to noneconomists everywhere. These benefits flow principally from the fact that sellers find it in their self-interest to compete for the trade of potential customers. It is precisely because *sellers want to sell to buyers* that they constantly make buyer-pleasing adjustments in their competitive strategies.

"Instead of competing to attract people who are sick, health plans would compete to avoid them."

However, *none of the valuable benefits of competition can be expected to emerge if sellers find it in their self-interest not to sell to some buyers and if they compete with each other to avoid customers.*

In the example illustrated in Figure I, eight people paid premiums equal to $9,600 and consumed medical services worth $54,000. The health plans that attracted them incurred a loss equal to $44,400 (again, ignoring administrative costs). By contrast, 42 profitable people incurred only $6,000 of medical expenses but paid $50,400 in premiums. The plans that attracted these people realized a profit of $44,400. Under managed competition, each health plan would have incentives to compete vigorously for the profitable 42 while avoiding the unprofitable eight.

Competing would be easier if the plans knew who the eight unprofitable people were. But even if they did not, they could successfully avoid them so long as the eight knew. People who know before they select an insurer that they need expensive medical treatment will use this knowledge in selecting a health plan. And since the insurers understand this, they can structure their product so as to discourage the eight. Let's look at some ways this might happen.

How Perverse Incentives Affect the Behavior of Buyers. Imagine a system of managed competition in which health plans offer networks of prepaid doctors and hospital services in return for fixed premiums. People who are seriously ill and need specific, expensive medical treatment will select in a very different way than other people will. People who are sick will shop not for insurance benefits but for medical services. In choosing a health plan, they will be buying medical care, not health insurance.

Take a heart patient in need of cardiovascular surgery. The individual has a self-interest in finding out who the best cardiologist is and what heart clinic has the best services. Armed with this knowledge, the patient will try to learn which health plan employs the cardiologist or has a contract with the clinic. The premium charged is unlikely to matter very much, since the patient knows that the price of his care will exceed his premium many times over.

Notice that this behavior is different from the likely behavior of a healthy person choosing a health plan. Healthy people must consider all the illnesses they might have and all the medical attention they might need. Since their probability of needing any particular service such as heart surgery in the near future is very small, they are unlikely to spend much time investigating particular doctors and clinics. To the degree that healthy people investigate the services offered by competing health plans, they are likely to inquire only about primary care services such as vaccinations, mammograms and general checkups — since these are the services they are likely to receive.

"Heart patients would search for plans with the best heart doctors; cancer patients would seek out the best oncologists."

Another consideration is likely to influence the choices of healthy people. Under managed competition, people can change plans if their health condition changes. Thus, if the need for heart surgery arises, odds are that the patients will have an opportunity to switch insurers before the surgery is performed. They can wait until the need arises before choosing an insurer based on its cardiology services.

The bottom line is: The people who carefully compare the heart services offered by competing managed care programs are likely to be the people who intend to use the services and that insurers will want to avoid. By contrast, people who choose a plan based on the quality and accessibility of nonacute services are more likely to be healthy.

How Perverse Incentives Affect the Behavior of Sellers. To see how managed competition affects the incentives of insurers, imagine two competing HMOs. In the first, enrollees can see a primary care physician at the drop of a hat, but there are screening procedures and sometimes lengthy waiting periods for kidney dialysis, heart surgery and other expensive procedures. In the second, dialysis and heart surgery are available when needed, but primary care facilities are limited. Given a choice, most of us would enroll in the first HMO until we got sick, then switch to the second. But if everyone did that, the second HMO could not survive financially.[66] Clearly, it is in the self-interest of insurers not to be the second HMO!

Now it might seem that the second HMO could successfully compete by offering more primary care services. But in order to be truly competitive, it must change its strategy completely. The easiest way to keep costs down is to have only healthy enrollees. And the easiest way to accomplish that feat is to have none of the doctors and facilities that sick people want. As Alain Enthoven has noted (disapprovingly), "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."[67]

"No plan could afford to get a reputation for being the best at treating costly illnesses."

To successfully compete for profitable enrollees, a different strategy is needed. It might work something like this: In order to attract healthy enrollees, a health plan might offer services that are not attached to a risky event but are simply consumption items. For example, the plan might offer preventive medical services, free or relatively inexpensive diagnostic tests and access to a health club. The plan also might offer services at more convenient times and locations, free parking and other amenities. Of course, these services might be attractive to all potential applicants, but they are more likely to be decisive for healthy people. People who are sick tend to put more value on other services.

Ten Problems of Managed Competition

Advocates of managed competition often refer to their proposal as a "market-based" solution. However, since they explicitly reject free competition, the benefits normally associated with competitive markets would not necessarily be produced. What would happen under managed competition? Let's take a look.

Problem No. 1: Health plans would compete to avoid sicker people and attract healthier people.

As we have already discussed, each health plan would have an incentive to attract healthy people and avoid those likely to generate high health care costs. Since the plans would not be allowed to compete on the basis of price, they would try to compete in other ways — primarily by offering services that attract healthy people rather than sick ones. The general tech-

niques for engaging in this type of "biased risk selection" are well known. They have been discussed both in Jackson Hole meetings and in the professional literature.[68] But while health economists have a general understanding of the problem, their knowledge is far from exhaustive. As a result, there has been no credible proposal for preventing biased risk selection through regulation (including various risk adjustment mechanisms). The issue is discussed in greater detail below.

Problem No. 2: The more fiercely the plans compete to avoid bad risks and attract good ones, the more unstable the market would become.

Health plans could not afford to be known for providing the "best" care — especially for expensive-to-treat diseases — for the reasons given above. In the attempt to avoid sick people — like a game of musical chairs[69] — some would be more successful than others.[70] The less successful would have higher costs, which would require higher premiums, which would result in fewer customers. Eventually, the less successful insurers would leave the market. Some criticize the current system for allowing insurers to "skim the cream" and to compete based on their "ability to select good risks." Indeed, advocates of managed competition have been at the forefront in advancing these criticisms. However, under managed competition the results would be worse. Under community-rated artificial premiums, there would be far more cream and the pressures to skim it would be far more intense.

"Competition would force plans to underprovide to the sick and overprovide to the healthy."

Problem No. 3: Competition would force the plans to underprovide services to the sick and overprovide services to the healthy.

Health plans could underprovide services to the sick vis-à-vis the healthy in numerous ways.[71] These include (1) making facilities less accessible (e.g., locating in healthier areas and making access inconvenient for the disabled), (2) making patients wait for service, (3) withholding information and (4) providing substandard care.[72] Health economists — both those who favor and those who oppose managed competition — generally acknowledge these techniques.

Problem No. 4: Buyers would tend to choose among health plans based on medical services rather than insurance services.

As noted above, the *system* of managed competition provides insurance against the loss of personal assets due to illness; however, individual health plans offer not insurance but medical services. It is inevitable that both the sick and the healthy will select plans based on the quality of the services they intend to use.

Problem No. 5: Because a successful competitive strategy requires limiting expensive services to the sick, fee-for-service plans would be unable to survive.

By the nature of fee-for-service plans, patients are free to select a physician and physicians are free to practice medicine according to their conscience and their knowledge of medical procedures. These freedoms would make it virtually impossible for fee-for-service plans to avoid the sick if they are in competition with HMOs. Fee-for-service plans, therefore, are unlikely to survive.[73] Proponents of managed competition are well aware of this. Jim Cooper, for example, says, "My guess is that fee-for-service medicine will be discouraged and mostly die out."[74]

One way such a plan might try to survive is by imposing a fee schedule — limiting the amount it pays for different services. But if the plans were allowed to underpay for, say, the treatment of chronic conditions they would use this ability to make their plans more attractive to the healthy than to the sick. According to Alain Enthoven, this cannot be allowed:

> What about indemnity insurance as one competitor? I rather doubt that this can be reconciled with managed competition. Indemnity insurance means no contract between a carrier and providers, and that means no defined provider group for quality accountability. And without a contract with providers, the insurance may not be paid in full. ... It is difficult to design properly for risk management with indemnity insurance.[75]

Problem No. 6: Health plans would have very weak incentives to find quality-enhancing and cost-reducing ways of caring for the sick.

That there would be little advantage in finding innovative ways of curing the ill should be clear. The incentives would be to reduce spending in this area, not increase it. But suppose that an innovation succeeded in reducing the cost of care. In today's market, a facility that discovered cost-reducing innovations in the treatment of a disease such as AIDS would have an incentive to advertise for patients and profit from its discovery. Under managed competition, the most efficient provider for AIDS patients would have an incentive to avoid those patients, as would every other health plan.[76] Incentives to such innovation would, therefore, be very weak.

"Each buyer would tend to get medical services that cost no more than the premium paid."

Problem No. 7: If competition were not constrained, health plans would naturally tend to supply each buyer with medical services which cost exactly the same as the community-rated premium.

Economists have employed the concept of "equilibrium" to describe competitive markets. The concept can also be applied to managed competition. But to our knowledge, no one has ever constructed a mathematical model of a managed competition market. As a result, the existence and stability of an equilibrium has never been analyzed. Intuition suggests that there probably is no equilibrium under pure managed competition, for the reasons given above. If there is equilibrium, it would be very different than the one that characterizes competitive markets.

How Controls on Payments to Providers Lead to Lower-Quality Medical Care

The critical defect in managed competition is that it gives health care providers incentives to underprovide services to the seriously ill. This is because managed competition effectively abolishes the market for health insurance and replaces it with a market for medical care in which expensive-to-treat patients pay premiums that are well below the cost of their treatment.

When the payment to health care providers is below the cost of care they are expected to provide, their first inclination is to shift costs. However, competition ultimately makes cost shifting impossible. As a result, providers are forced to lower the quality of care they deliver.

Some may wonder whether quality really can deteriorate in the face of regulations and tort law. In fact, there is plenty of evidence that a drop in the quality of care coincides with inadequate reimbursement rates in current government programs. Take Medicare, for example:

- Although hearing loss is the most prevalent chronic disability among the elderly and affects one-third of all Medicare patients, Medicare's reimbursement rate for cochlear implants is so low that only a handful of Medicare patients have received the treatment.
- When Medicare reduced the reimbursement rate (in real terms) for kidney dialysis in the 1980s, many physicians reduced the treatment time — a practice that reduced their patients' chances of survival.
- A survey of 21 medical conditions for which an implanted medical device was indicated found that for 18 of them the government's payment was well below hospital cost, and in more than half the cases Medicare patients did not receive the device.

Even when Medicare's reimbursement equals the average cost of treatment, price fixing discriminates against above-average-cost patients. These tend to be the sickest patients and more often than not they are low-income and nonwhite. For example, blacks and Hispanics have more severe illnesses, longer hospital stays and higher hospital costs than white patients, on the average.

Price controls are also used in the Medicaid program, where it is not uncommon for government to pay as little as 50 cents on the dollar for services for low-income patients. As a result, the quality of service has deteriorated for many Medicaid patients, while Medicaid has not succeeded in controlling spending. For example:

- Medicaid spending in Illinois increased from $200 million in 1970 to $4.8 billion in 1993, an increase of more than 2,000 percent.
- One physician who made $120,000 from Medicaid in 1991 didn't even take his Medicaid patients' vital signs until his office reimbursement was increased from $8 to $18 per patient.
- Some physicians who treat Medicaid patients exclusively boast that years of experience have made them efficient enough to see between 60 and 70 patients a day.

Sources: Nancy M. Kane and Paul D. Manoukian, "The Effect of the Medicare Prospective Payment System on the Adoption of New Technology," *New England Journal of Medicine* 321, No. 21, November 16, 1989; "Proposed Rate for Prospective Payment of Cochlear Implantation," *Government Affairs Review,* September/October 1990; Edward E. Berger and Edmund G. Lowrie, editorial, *Journal of the American Medical Association* 265, No. 7, February 20, 1991; and "Medicaid: System in Chaos," a series in nine parts, *Chicago Tribune,* prepared for the 1992 Governor's Health Care Reform Task Force by the Illinois Department of Public Aid, October 31-November 9, 1993.

As Table I shows, in competitive markets competition tends to cause the price to change until it equals average cost. Thus, to the extent that price is a measure of the value consumers place on a good or service, the marginal benefit people receive tends to equal the cost of producing that benefit.

The same tendencies exist under managed competition.[77] Yet because prices (community-rated premiums) are artificial, cost must change to equalize price and average cost. Take those patients whom we have identified as "unprofitable." If premiums are free to rise for those people, insurers will compete them up to the level of the cost of their care. But if the premiums are artificially constrained at a lower level, insurers will tend to compete the cost of care down to the level of the artificial premium.[78] As Table I shows, the reverse pressures exist for those people we have identified as "profitable." If the artificial premiums cannot be competed down to the level of average cost, the tendency will be to compete cost up to the level of the artificial premium.

These conclusions follow from well-known principles of the economics of regulation. In the United States, we have had decades of experience with regulated markets. [See the sidebar on why price controls won't work.] For example, under regulations imposed by the Civil Aeronautics Board (CAB) for most of the post-World War II period, the government dictated airline fares. Unable to compete on price, the airlines competed by offering more flights, flights at more convenient times, more spacious seating and other amenities. Price regulation imposed by the CAB was similar to cartel pricing and had the potential to allow the airlines to earn supra-normal profits. However, these profits were competed away as airlines increased their costs by making passenger-pleasing adjustments.[79]

"Unable to compete price up to the level of costs, health plans would reduce quality to compete cost down to the level of price."

The reverse tendency emerges when prices are kept artificially low. Under rent control laws, landlords are prohibited from raising their rents to the level of average cost. Since rents cannot rise, quality tends to fall. Landlords tend to allow housing quality to deteriorate until housing costs equal the government-controlled rent.[80] A similar phenomenon is evident in the Medicare and Medicaid programs, where below-cost levels of reimbursement have caused a lowering of the quality of care. [See the sidebar on controls on payments to providers].

A different way of appreciating this result is to consider it in terms of a basic principle taught in all introductory economics courses: when firms are maximizing profits, marginal revenue must equal marginal cost. Under managed competition, marginal revenue (the amount of premium each enrollee brings to a plan) must be the same for every enrollee. That means that marginal cost (the amount the plan spends on health care) must also be the same for every enrollee.

TABLE I

Equilibrium in Different Insurance Markets

Market	Equilibrium
Competitive Market	**Competition causes price to change until it equals average cost**
Managed Competition: High-Cost Patients	**Competition forces average cost down to the fixed price[1]**
Managed Competition: Low-Cost Patients	**Competition forces average cost up to the fixed price[1]**

[1] The fixed price is an artificial price produced by the requirement of community rating. Health plans are free to choose any premium, but they must charge the same premium to everyone and accept all applicants.

"Fee-for-service plans could not survive."

Figures IIA and IIB are simplifications of Figure I. In the diagrams, the "cost-of-care" line shows what would be spent on patients given current standards of medical practice. The artificial premium line is based on the average cost of care for all patients under community rating. The figure illustrates a condition under which healthy people are subsidizing sick people. Clearly, this is what many proponents of managed competition believe equilibrium would look like for each health plan under their scheme. But simple analysis shows that the diagram in Figure IIA cannot be an equilibrium and that it must give way to something else.

Roughly speaking, an equilibrium exists if no health plan can adjust to become more profitable.[81] However, the plan represented in Figure IIA can easily become more profitable if it can lower the cost of caring for its sicker customers. As long as these customers stay in the plan, it will have the same premium income and lower costs. If they shift to another plan, this is advantageous since the sicker customers are unprofitable by definition. On the other hand, the fact that healthier customers are being overcharged — the cost of care is below the premium they are paying — means that other health plans can lure these customers away by providing higher benefit levels for the same premium.

The illustration in Figure IIA, therefore, cannot represent equilibrium for any health plan under managed competition. Instead, competitive pressures exist to change medical practice until the cost-of-care line coincides with the artificial premium line.[82] [See Figure IIB.] This means that *health plans would be forced to underprovide services to the sick and overprovide services to the healthy until each person receives health services whose cost of production is equal to the community-rated premium they are paying.*

Problem No. 8: If premiums were risk adjusted, each customer's cost of medical services would tend to equal that customer's risk-adjusted premium.

"A good way to avoid cancer patients is to have a poor oncology department."

As we shall see below, most advocates of managed competition favor risk adjustment mechanisms. Under these schemes, the amount of premium *paid* would be determined by community rating. But the amount of premium a health plan *receives* would be determined by the expected health costs of the plan's enrollees. Premiums could be adjusted *prospectively* by a government agency such as a HIPC or alliance or *retrospectively* by waiting to see who gets sick, then assessing some plans and using the proceeds to subsidize others.

All such mechanisms cause plans to attach an expected premium to each enrollee.[83] And, based on the argument given above, competition will tend to wipe out any arrangement under which some people are subsidizing the health care of others. New entrants into the market (or existing plan) will find it in their self-interest to offer either a lower price or more services to those who are being overcharged. At the same time, health plans will find it in their self-interest to lower the cost of care for enrollees who are being undercharged.

Problem No. 9: To the extent that government establishes a floor on quality — through regulation or tort law — health plans would tend to provide the minimum level of quality care to the sick.

Health economists disagree on how far health plans could go in reducing the quality of care they deliver before the government would intervene. Consider the example given by Enthoven:

> Think of drugs like Ceredase, for people with Gaucher's disease: recommended doses cost $360,000 a year. ... A decentralized private market cannot deal effectively with such situations. If some health plans cover Ceredase and some do not, guess which will get all the Gaucher's patients?[84]

Enthoven's solution is to have a national health board dictate whether or not health plans must provide Ceredase. However, health economist Mark Pauly argues that these kinds of mandates are inconsistent with the spirit of managed competition. He writes that:

> a sine qua non of managed competition [is] that managed-care plans be permitted to refuse to deliver beneficial technology that they judge not to be worth the price and that negligence law not be permitted to override these choices.[85]

Of course, it would be impractical for a national health board to dictate every quality decision to doctors and hospital personnel and to the health plans that employ them. But to the extent that government succeeds in establishing a floor on quality, our analysis implies that competitors will compete the level of quality down to the floor.

Problem No. 10: Despite competition along the way, a monopoly would tend to arise as smaller competitors were forced out of the market.

"Ultimately there would be a monopoly — answerable only to government."

While it's not clear that managed competition would provide enough stability to allow an equilibrium to emerge, if one does emerge there is likely to be only one firm left in the market. Our prediction of monopoly is based on the fact that the health plans that are the victims of adverse selection will experience rising costs, in what some health economists have called a "death spiral of adverse selection."[86] Plans that have a disproportionate number of expensive-to-treat enrollees will have to charge above-average premiums. As healthy people leave or avoid the plan, its cost per enrollee will continue to rise, leading to even higher premiums, encouraging even more healthy people to leave.

Note that this death spiral occurs precisely because of the community rating requirement. If health plans could charge each new enrollee a premium that reflected the expected cost and risk that enrollee brought to the insurance pool, the spiral could be avoided. Under community rating, however, new enrollees must pay not only for their own insurance (or expected health care), but also for the care of sick people already in the pool. The more sick people a health plan includes, the stronger the incentives for healthy people to flee. Losers in this system, therefore, tend to get progressively worse off. And since biased risk selection will exist 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.

"The easier it is for patients to switch health plans, the quicker quality will deteriorate."

A Qualification: The Effect of Open Seasons. The analysis presented here assumes that patients make choices among insurers based solely on the value of medical services those patients consume. Under that assumption, market equilibrium requires that each patient receive services whose cost is exactly equal to the premium paid. This assumption would be justified to the degree that patients can easily shift back and forth among insurers as their health needs change. The Clinton plan has an *annual* open enrollment period and allows more frequent changes for "good cause." Presumably, a switch of plans by a seriously ill patient to obtain better medical care would constitute good cause. The Cooper-Grandy and Chafee bills also have an open season but are more restrictive about switching plans at any time. The Nickles-Stearns bill has no open enrollment period and appears to allow continuous movement among plans. However, the Federal Employees Health Benefits Program allows plan changes only once a year, and the managed competition plan about to be implemented in the Netherlands permits changes only once every two years.[87] The Jackson Hole Group and other proponents of managed competition argue that open enrollment periods should be infrequent.[88]

FIGURE IIA

Disequilibrium for a Health Plan Under Managed Competition

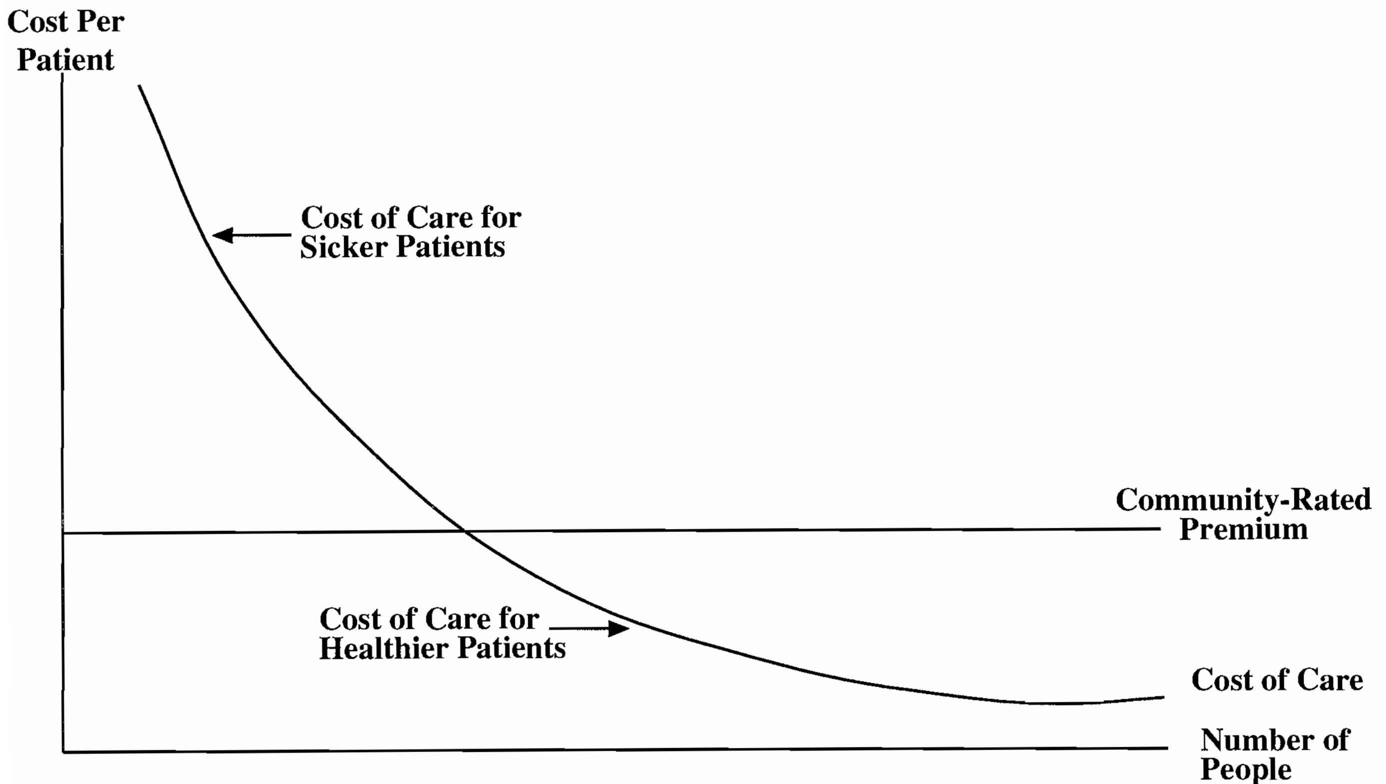
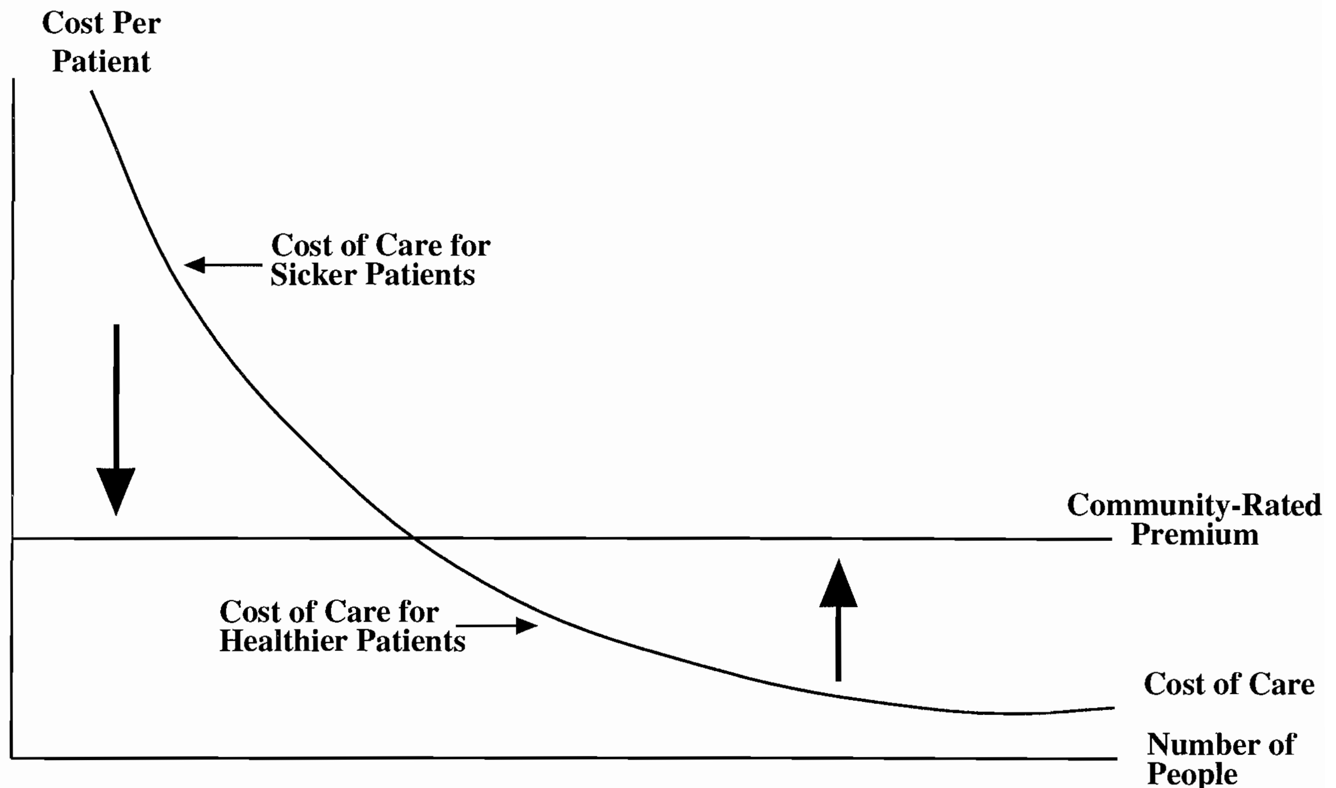


FIGURE IIB

Competitive Pressures under Managed Competition



"Healthy people will select plans based on convenience and amenities, secure in the knowledge that they can switch plans if they get sick."

To the degree that people are constrained in their choices by open seasons, they must consider the insurance value of the plan they select as well as its direct consumption value. Consider an expectant mother choosing among competing health plans. The direct services she intends to consume are the services of well-baby delivery. However, there is some chance that there will be complications of pregnancy or that her child will be born prematurely and require sophisticated medical treatment and, in that case, the woman would benefit from highly skilled medical personnel. Thus, in selecting a plan she will be purchasing *real insurance* as well as specific medical services.

For such major health problems as heart disease, cancer and AIDS, however, it seems unlikely that people will be willing to pay much to insure for expensive treatment while they are healthy — if they can switch insurers at least every 12 months. The tendency will be to select a plan that is strong on preventive and diagnostic services, secure in the knowledge that in a reasonable amount of time one will be able to switch.

The existence of periodic open seasons, therefore, causes us to modify somewhat the diagram in Figure IV, in recognition of an insurance component to people's choices. Yet even with this modification we are left with the prediction that managed care will result in a radical deterioration in the quality of care sick people receive.

To conclude this section, consider a possible objection to our analysis. Suppose everyone reads this study and becomes aware of the problem. Wouldn't it be in their self-interest to pay higher premiums to plans that offer expensive, sophisticated medical care just to insure that type of care would be available if and when they needed it? Collectively, it would be. But under managed competition people do not make choices collectively. They make choices as individuals. And their incentive is to join low-cost plans while they are healthy and switch to high-cost plans when they get sick.[89]

A Closer Look at Distant Relatives of Managed Competition

As noted above, its advocates point to three operational examples of managed competition: the federal employees' health care program and programs for public employees in California and Minnesota. As we shall see below, these programs are experiencing some of the problems we have identified in this report. but they have not produced the radical changes in health care delivery that economic analysis predicts.

A primary reason may be that in all three programs most employees have joined plans that are primarily competing in the general market for health insurance. In the federal program, for example, more than 70 percent of enrollees are in fee-for-service plans,[90] and most of those are in one of two plans operated by Blue Cross, which also sells health insurance to people outside the federal system. Most employees, therefore, have joined plans that are primarily in the business of selling health *insurance* services in a wider market, rather than just selling *medical* services to federal employees. If the market for insurance were effectively abolished and everybody were forced into managed competition, we would expect more dramatic changes in the quality of care delivered.

"Public employee plans already confirm the predictions of economic theory."

For this reason, the so-called operational examples are probably better described as distant relatives of managed competition, thus affirming the Congressional Budget Office conclusion that "managed competition [is] an approach that has not been tried anywhere in the world."[91] Nonetheless an examination of these relatives is revealing.

Evidence from the Federal Employees Health Benefit Program (FEHBP) and the Public Employee Plans in California and Minnesota. During the 1970s and early 1980s, Blue Cross regularly refused to pay for CAT scans and MRI scans, claiming they were still experimental procedures long after they were the standard of care in the medical community. Some FEHBP insurers wanted to put a cap on yearly prescription benefits shortly after it became apparent that costly AZT would be prescribed for many AIDS patients. The cap would have also limited coverage for drugs used in chemotherapy, which can cost thousands of dollars.[92]

More recently, the Blue Cross and Blue Shield plan in the Washington, D.C., area unveiled a PPO[93] for federal employees that excluded more than 40 percent of the area doctors who had previously been under contract. Blue Cross also is limiting the number of specialists. In deciding whom to exclude, the insurer relied on a computer program that rejects "higher-cost" doctors. For example, a physician who is more likely to order an MRI scan in the presence of certain symptoms might be rejected by the plan. Proponents of the approach contend that the program identified the most cost-effective physicians. Critics claim that the choices are based solely on cost and ignore quality. There is some evidence that area physicians with excellent credentials are being rejected by Blue Cross and other insurers.[94]

"There is only one system-wide fee-for-service insurer left in the federal employees' system."

Furthermore, health insurers in the FEHBP often try to limit or avoid coverage that can result in ongoing expenses such as mental health care, custodial care and long-term care. The insurers' philosophy might be summed up as, "If it can't be cured, don't call us."[95] To counteract these tendencies, FEHBP staff responsible for oversight of the program scrutinize every benefit change. Advertising is also monitored to make sure that no insurer is trying to appeal to the best risks. For instance, one insurer cannot compare itself with another in the program. Even so, insurers might advertise that office visits to a primary care physician are only $5 in an effort to appeal to those who are focused on primary care services, or they might show pictures of young healthy families in their advertisements — *but no plan ever advertises that it has the best specialists.*[96]

There are numerous other examples of opportunistic behavior on the part of plans that are competing to attract good risks and avoid bad ones. For example, two plans — the Beneficial Association of Capitol Hill Employees and the Secret Service plan — limit enrollment to employees and exclude retirees.[97] It is amazing that the Office of Personnel Management allows this practice, considering that about 40 percent of FEHBP enrollees are retirees[98] and those not covered by Medicare are several times as costly as the average employee.[99] In addition, a number of employee association indemnity plans pay poorly for services associated with chronic conditions. In this way, they are attempting to dump their sicker patients on other plans, in what Alain Enthoven calls "a textbook for how to create a risk-selecting scheme."[100] Similar efforts have been spotted in the CalPERS system in California.[101]

Another prediction that is borne out by the federal employees' plan is the tendency to monopoly, at least in the provision of fee-for-service medicine. In recent years, the decline in the number of fee-for-service plans available to any federal employees has been dramatic:[102]

- Between 1987 and 1991, the number of fee-for-service plans available somewhere in the country dropped from 35 to 19.
- The number of such plans available in the Washington, D.C., area fell from 33 to 17.

As noted above, all but one of these plans are available only to particular groups of employees. The only systemwide fee-for-service insurer left is Blue Cross. Yet the demise of a plan does not necessarily mean that it was not well managed. For the reasons given above, random chance can cause plans to fall victim to adverse selection. As one observer commented, among the "unfortunate consequences [of the FEHBP is] the demise of well-managed, low-cost plans that suffered a death spiral from adverse selection."[103]

"Each plan trys to attract the healthy and avoid the sick."

Perhaps because Blue Cross is a fee-for-service plan and because it is the *only* general fee-for-service plan, we have not seen anything like the deterioration in quality that economic theory predicts. In general, sick people will choose fee-for-service plans over HMOs; and those most likely to leave HMOs are people who get sick.[104] Having found the physicians they want to treat them, these patients know they can continue to see them under a fee-for-service arrangement. By contrast, even if the same physicians are on an HMO panel, there is no guarantee they will not leave the panel during the patient's course of treatment.

Blue Cross, therefore, tends to attract the less profitable patients in the federal system. But because of its monopoly position, Blue Cross can also offer a low-option plan (now called a standard-option plan), attract healthier people and use the premium income to cross-subsidize its high-option plan. Ironically, *managed competition works as well as it does for federal employees precisely because it is characterized by monopoly rather than competition.*[105] A similar development has occurred in the Minnesota state employees' program, where Blue Cross operated the fee-for-service option until cost increases forced abandonment of the plan and its replacement by a Blue Cross PPO.[106] Monopoly, however, is not what the proponents of managed competition are advocating. As we shall see below, they recommend a number of regulatory measures to keep competition alive.

Evidence that the FEHBP is not nearly as competitive as it could be is that the premiums charged by various plans often do not reflect their true actuarial value. As a dramatic example:[107]

- Actuaries calculate that there is virtually no difference between the value of the high-option and standard-option plans Blue Cross offers to federal employees.
- Yet the premium for single people in the high-option plan is almost four times as high ($2,040 vs. $540 in 1993).

Interestingly, there is very little movement among plans even during the annual open season. Only 5 percent of enrollees switch plans each year, and that figure includes movement out of plans that drop out of the system.[108]

Enthoven argues that there is not enough competition in the FEHBP because there is too much product differentiation.[109] If all the competing plans were forced to offer exactly the same package of benefits, people (or at least healthy people) could focus exclusively on price. As we shall see below, managed competition purists almost always want a same-benefit-for-all regulation, and this approach has been adopted by Clinton, Cooper and Chafee. Given a free hand, they could no doubt make the FEHBP much more competitive than it is now — but the competition, of course, would be dominated by perverse incentives and the losers would be the federal employees.

Evidence from the State of Washington. As noted above, Washington is implementing managed competition for all of its residents. In the first stage of reform, the state's Medicaid beneficiaries are being assigned to (or allowed to choose among) certified health plans (CHPs) or primary care providers (PCPs). In contrast to Medicaid's traditional fee-for-service method of payment, these organizations receive a fixed fee for each enrollee and are supposed to manage their care.[110] The 75,000 AFDC[111] enrollees in King County (Seattle-Bellevue) were forced into these managed care networks on October 1, 1993. *Yet within three months the state had to modify the program and allow the high-cost patients to drop out.* Significantly, the patient — not the CHP or the PCP — has to request an exemption. Presumably, this happens when patients perceive they are not getting the care they need.[112]

"No plan ever advertises that it has the best specialists."

Evidence from Other Countries. As noted above, managed competition is being implemented in the Netherlands and is about to be adopted in Israel as well. In both countries, health economists have been focusing on the types of problems discussed in this report and the results are not all positive.

Israel already has a modified form of managed competition, although it contains too many imperfections to pass muster with Enthoven and other managed competition purists. The country's health system is dominated by four HMO-type organizations called sick funds. The oldest, Kupat Holim Clalit, is controlled by the trade unions and covers 70 percent of the population. It runs perpetual deficits, has lengthy waiting lines for services and is experiencing quality-of-service deterioration. As a result, healthier and wealthier enrollees are switching to other plans, including Maccabi, which is

reputed to have no waiting lines for primary services and the best heart facilities.[113] Because plans do not have to accept sick (or high-risk) patients from each other, however, labor's plan is being selected against.[114]

Under the system about to be adopted, however, the plans will be required to offer the same benefits, charge community-rated premiums (with subsidies from government for low-income families) and accept all applicants regardless of health risk.[115] To assess what these rules are likely to mean, a soon-to-be-released government study investigated why people switched health plans. The answer: enrollees were relatively insensitive to price differences and very sensitive to quality differences among the plans.[116] These results are the opposite of what Alain Enthoven anticipates, and they are devastating to the case for managed competition. Enthoven wants patients to be primarily sensitive to price because he wants health plans to compete based on their ability to manage health care costs.[117] If instead they compete primarily on the basis of quality, all of the dire predictions made in this report are more likely to come true.

"In Britain, Israel and the Netherlands, some advocates of managed competition are having second thoughts."

The Netherlands also is in the process of implementing a full-scale system of managed competition. In an attempt to avoid the adverse effects of competition based on risk selection, the government proposed a system of risk-adjusted premiums. But Dutch health economists were able to show how easily health plans would be able to reap huge profits by cream skimming, and the government has backed away from its risk-adjustment scheme. Unfortunately, the health plans now will have even worse incentives.[118]

Five years after managed competition reforms began in Britain, things are not going well for some patients:[119]

- A student with a kidney infection waited in agony for 23 hours for a hospital bed; while she waited, one administrator urged her to "go private" and receive immediate treatment.
- An 87-year-old with bone cancer sat for 5 1/2 hours on a chair while nurses searched desperately for a bed.
- As hospitals in London close, there are numerous reports of seriously ill patients being kept on stretchers in hallways because of a shortage of beds.

Because incidents like these occurred routinely under the previous system, it is hard to be sure that managed competition is to blame. The reforms do appear to have made British medicine more efficient, notably so for people without serious medical problems. Quality of care for the truly sick may have declined, however.

The Politics of Medicine. Some might argue that it is the purpose of government to assure that quality is maintained. Yet while regulation might prevent some of the worst abuses, political pressures will tend to reinforce rather than to counteract the competitive tendencies identified in this report.

Research conducted by the authors for more than a decade and a half convinces us that in every country there are strong political pressures to divert funds from the sick to the healthy. Spending 50 percent of a country's health care budget on 4 percent of its population may make good medical sense, but it makes no political sense. In a democracy, the 4 percent (who may, after all, be too sick to vote) simply can't compete against the other 96 percent. That's why governments of other countries tend to restrict expensive lifesaving technology and to overprovide services to the healthy.[120]

We would expect similar results when global budgets are imposed on the private sector, as they would be under the Clinton plan and in Washington state. The politicians who must implement the controls will face the same pressures that politicians in other countries face. Moreover, it is worth remembering that even without global budgets and price controls, the so-called HIPCs and alliances under most managed competition proposals will be governmental entities. For that reason, they will be subject to all of the influences that arise from the politics of medicine.

Why Managed Competition Requires Extensive Regulation

Congressman Jim Cooper is fond of saying that his health care proposal would create a farmer's market approach to managed competition. The image conjured up by that phrase is one of minimum bureaucratic interference in the competition between rival health plans. But as Enthoven has explained, managed competition won't work unless there is considerable intervention:

> 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.... *It takes more than mere passive administration of inflexible rules to make this market work.*[121]

"To prevent a disastrous drop in quality, regulation is required."

For the reasons given above, managed competition — and, indeed, any plan that combines community rating with competition — creates two inherent problems: (1) biased risk selection and (2) deteriorating quality. Biased risk selection is a problem in any insurance market that has artificial prices. No applicant is a "good" or a "bad" risk independent of a premium, and if the market works well and risk is priced accurately no applicant is more desirable than any other.[122] It is only artificial premiums that create good and bad risks, and where they exist insurers naturally will pursue the former and avoid the latter. To keep that from happening, the managers or sponsors must regulate actively. As Enthoven explains:

> In the Jackson Hole proposal, sponsors are the final arbiters of risk selection. ...[This may require] 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.*[123]

Jackson Hole proponents have devoted almost all of their attention to the problem of biased risk selection and very little attention to the problem of deterioration in quality.[124] Nonetheless, to deal with both problems, proponents usually advocate limited open enrollment periods, although this feature is absent from at least three of the managed competition bills in Congress. In addition, proponents invariably propose a complex government bureaucracy designed to (a) tightly regulate the content of health insurance policies and require everyone to have the same basic benefits package, (b) prevent insurers from offering higher deductibles or features likely to attract healthier subscribers and (c) redistribute funds from profitable to unprofitable insurers.[125]

Important Regulatory Bureaucracy: Health Alliances. In most managed competition proposals, a health insurance purchasing cooperative (HIPC) or a health alliance would serve as the primary regulatory body. The Congressional Budget Office recently described the Clinton plan's health alliances as agencies that "would combine the functions of purchasing agents, contract negotiators, welfare agencies, financial intermediaries, collectors of premiums, developers and managers of information systems and coordinators of the flow of information and money between themselves and other alliances."[126] In the Clinton plan, participation in health alliances would be mandatory, and only one (monopoly) alliance would govern any particular geographical area. [See the sidebar on proposed regulations.]

"Is a regulatory body, or health alliance, the alternative to 13 trillion pages of regulations?"

The Cooper alliance would also be mandatory,[127] but would have very few powers. Chafee's alliances would be neither mandatory nor monopolistic, and the Nickles plan has no alliances. In Florida's new reform plan, the alliances are voluntary and a similar approach has been taken in California. And some powerful participants in the health care debate in Congress would like to strike alliances altogether from the Clinton bill. For example, Senate Republican leader Bob Dole of Kansas has said that alliances have to go, and Representative Pete Stark, the California Democrat who heads the House Ways and Means Subcommittee on Health, has declared that "There is not one chance in 100 that mandatory alliances will survive."[128]

Alain Enthoven, however, argues that voluntary alliances will not work.[129] Managed competition requires regulation and there cannot be competing regulators. A recent editorial in the *New York Times* explains why:

> Did the insurer recruit only in Scarsdale? Did the insurer answer phone calls from potential applicants in Harlem? Did the insurer tailor its benefits package so that AIDS patients would not apply?
>
> Congress could, of course, enact 13 trillion pages of rules to stop these practices. But a more effective, less regulatory answer is to require most individuals or their employers to buy coverage through a cooperative, or an alliance.[130]

The only thing missing from this editorial is an appreciation of the fact that the alliance also will have to impose 13 trillion pages of rules, or the regulatory equivalent thereof.[131]

Important Restriction: Same Health Benefits for Everyone. Jackson Hole proponents insist that benefits be the same for everybody — at least everybody in each group in which choices are exercised.[132] Under the Clinton plan, for example, the benefit structure would be dictated by a national health board. The Clinton plan's fee-for-service option, for example, entitles every woman to a free yearly mammogram at age 50 but not at age 40.[133] Not only would Washington's micromanagement of benefits be extreme, but people would be forced to pay for benefits whether they wanted them or not. There would be no such thing as plans tailored to individual and family needs.[134]

Important Restriction: Same Deductible and Copayments for Everyone. Health insurers know that deductibles and copayments make more sense for some people than others and that they are more effective in curtailing waste in some locations than others.[135] Yet under most managed competition proposals, insurers would not be allowed to take advantage of that knowledge.[136] For example, the Clinton plan imposes the same cost sharing on every person in the entire country,[137] and part of Jim Cooper's reluctance to fully endorse Medical Savings Accounts is the belief that without uniform cost sharing the market would collapse.

"Risk adjustment payments would switch funds back and forth among the health plans."

Important Regulation: Risk-Adjustment Mechanism. Almost all proponents of managed competition know that even with every attempt to impose uniformity, their system will eventually produce winners and losers — if only by random chance. As a result, they favor taking income away from plans that attract healthier people and giving it to plans that attract sicker people. Many ways to do this have been suggested. Yet even the strongest advocates of managed competition admit that none of them would work very well.

It might seem that the logical way to start constructing a risk-adjustment mechanism would be to tax or subsidize health plans based on the health of people *at the time they joined a plan.* Thus, sicker people would have a subsidy added to their premium payments and healthier people would have a tax deducted from theirs. Although enrollees would *pay* the same community-rated premium, health plans would *receive* a risk-adjusted premium. In theory, this would make the health plans indifferent between potential enrollees.

Proposed Regulations in Managed Competition Proposals

	Benefits	Cost Sharing[2]	Open Season	Risk Adjustment	Alliancies
Clinton	Same for everyone	Same for everyone	Annual period with more frequent changes for "good cause"	Administered by alliances	Mandatory; monopolistic
Chafee	Same for everyone, but catastrophic option[1]	Allows MSAs	Annual period with more frequent changes allowed	Administered by states	Voluntary; competitive
Nickles	Same for everyone, but catastrophic option[1]	Allows MSAs	Continuous open season	Administered by states	No alliances
Cooper	Established by national board	Same for everyone	Annual period with more frequent changes allowed	Rules established by national commission	Mandatory; monopolistic[3]

[1] Allows choice of a catastrophic plan with a Medical Savings Account.

[2] Deductibles and copayments.

[3] Tax break available only to individuals and employers of fewer than 100 people who join the alliance.

The problem with this approach is that it doesn't solve the problem. Health economist Joseph Newhouse notes that in the Rand Health Insurance Experiment, 1 percent of the patients accounted for 28 percent of the total costs, but most of the high-cost patients could not have been identified in advance. In fact, Newhouse found that only 15 percent of the variation in health care costs among individuals could be predicted in advance, even when researchers had full knowledge of the patients' demographic characteristics.[138]

"Only 15 percent of the variation in health costs among individuals can be predicted in advance."

This finding is consistent with other studies, which conclude that at most 20 percent of the variation in health expenditures for individuals can be predicted by such observable factors as health status and prior health expenditure.[139] Therefore, no risk adjustment mechanism, even in principle, can compensate health plans for more than 20 percent of the potential adverse selection.

If adjustments cannot solve the problem based on *prior* knowledge of patients, the only alternative is to base them on *past* knowledge, the experiences of patients after they enroll.[140] In other words, we could wait and see who gets sick before we start shifting money among insurers. For example, consider again the cost-of-care line in Figure IV. If the net amount insurers received for each applicant were based on this line rather than on the artificial premium line, then insurers would have no reason to prefer one patient over another. The problem is that if we reimburse health plans for what they spend, we are merely replicating the cost-plus system of health care finance that helped to create the crisis we now face.[141] On the other hand, if we pay health plans based not on actual costs but on fixed fees determined by the patient's diagnosis, we would have all of the problems we have in Medicare's current system of hospital reimbursement.[142]

"As a result, a risk-adjustment mechanism can't solve the problems."

A perfect risk-adjustment mechanism — which doesn't exist — would eliminate the problem of competitive pressures to underprovide care for the sick and overprovide it to the healthy. It would do so by assuring each health plan exactly the right payment for each patient. But such a system would be totally based on regulation, not competition — thus undercutting the entire Jackson Hole rationale for reform. In the language of the *New York Times* editorial quoted above, a perfect risk-adjustment mechanism is supposed to solve problems that would otherwise require 13 trillion pages of regulations. Yet in order to make the mechanism work, we would probably need even more regulations. Put another way, risk-adjustment mechanisms don't remove the need for regulation, they simply rename it.

Creating an Artificial Market for Medical Services

Suppose we imposed a system of managed competition on the market for life insurance. It might work something like this. Insurers would be required to sell a basic benefit (say, a $250,000 death benefit) to all applicants for the same premium, regardless of age or health condition. Thus, the terminally ill would pay the same premium as the young and healthy. Other things being equal, people would tend to choose the insurer that offered the lowest premium. But the only way insurers could keep their premiums down would be by attracting young, healthy customers and avoiding those close to death. No doubt they would think of ingenious ways of doing so.

Sound silly? It is. And managed competition in health insurance is equally silly. It is no accident that most advocates of managed competition also advocate managed care. Unless most people are going to be in managed care programs, there is no reason whatsoever to have managed competition.[143]

"Managed competition would make no sense unless most people were in HMOs."

Managed Care. Although the term managed care is applied to a wide range of activities designed to make medical care more cost-effective, in almost all of its versions it involves third-party interference with the practice of medicine.[144] Supporters of managed care argue that they can make the health care system more efficient and more affordable, in part by promoting primary and preventive care and reducing the need for specialized acute care. By encouraging physicians to follow "practice guidelines," they maintain that they can improve quality at the same time they control costs.

The most common setting in which managed care is fully implemented is a prepaid plan, or HMO, in which patients pay virtually nothing at the time they consume medical services (e.g., no deductibles or copayments). Since these patients perceive medical care as "free," they have incentives to overconsume it. The HMO bureaucracy must institute barriers to keep that from happening. Just as managed competition creates an artificial market for health insurance, managed care creates an artificial market for medical care in which the price system is almost completely suppressed.

Outcomes Research and Practice Guidelines. A natural extension of the concept of managed care is the establishment of practice guidelines, which could be used by public and private sector bureaucracies to dictate the standard-of-care therapy for any given diagnosis. Proponents want medical professionals to conduct outcomes research in order to determine the most effective medical treatments. They argue that practice guidelines developed in this manner will help physicians deliver quality care and prevent them from ordering unnecessary tests or procedures.[145]

Currently, the American Medical Association and the Rand Corporation are working on national practice guidelines, and Congress has mandated that the Department of Health and Human Services do the same. The resultant

computerized protocols will tell physicians what to do when they confront certain patient symptoms and conditions.[146] These protocols are expected to play a major role in health care under the Clinton plan, and they are a key component of other managed competition proposals as well.

Will the guidelines work? That's not clear. Many people believe they will be a waste of money. Some argue that they take so long to develop that medical science will have outpaced them by the time they are available. In other words, computerized protocols will always be years behind medical advances. Others object that computerized protocols can not determine correct medical procedures. And in fact, one test compared the judgments of general practitioners to three different computerized protocols in the treatment of patients with abdominal pain. The GPs outperformed the protocols in every test.[147]

If workable computerized protocols were available, they might prove valuable as tools. A physician could consult the computer, then substitute his own judgment where appropriate. Less complicated protocols might allow patients to ask their home computers whether to see a physician, for example.

On the other hand, if computerized protocols and practice guidelines were used to control the behavior of physicians and patients, they could threaten the quality of medical care. And, unfortunately, that threat is real. Researcher Robert Brook has argued that the Rand Corporation's techniques can be used to ration health care under the Medicare system, if Medicare funds run short.[148]

"The danger of computerized protocols is that doctors will be forced to practice 'cook-book' medicine."

Lurking behind the public discussion of practice guidelines is a fundamental difference of philosophy that is rarely discussed in print. The bureaucratic view of health care is usually also a technocratic view. Its more extreme proponents are fundamentally antiphysician and antipatient in the sense that they believe the attitudes and judgments of individuals are largely irrelevant. Ultimately, the technocrats do not see the computer as an aid to physicians and patients but as a substitute. They envision medical practice for the country as a whole being literally dictated from Washington.

Although the discussion of practice guidelines frequently is couched in terms of helping physicians make good decisions, the technocrats also see the guidelines as a means of exerting control. In their view, physicians who substitute their own judgment for the computer's should have to prove that they are right, which would require them to use cumbersome and costly bureaucratic procedures. As a result, failure to follow the guidelines would become rare.

Do HMOs Control Costs? The evidence is mixed.[149] Some studies indicate that the adoption of managed care techniques can lead to a one-time reduction in costs of about 10 to 15 percent by substituting less expensive for more expensive therapies. For example, since physician therapy and drug therapy are both less expensive than hospital therapy, managed care tends to substitute the former for the latter whenever possible.

On the other hand, because HMOs make services "free" to patients at the time they are consumed, they face the problem of overconsumption.[150] The NCPA/Fiscal Associates Health Care Model indicates that the nation's annual health care bill could be reduced by as much as 15 percent by substituting less expensive for more expensive therapies. This gain would be more than wiped out, however, by the increased consumption that would occur if out-of-pocket spending were reduced, say, from 21 percent to 10 percent of total health care costs.[151]

Even if HMOs do result in cost reductions, those reductions tend to be one-time events. After an initial drop, managed care costs grow at the same rate as costs in other types of health care delivery systems — if not faster.[152] The reason managed care is not able to reduce costs significantly is that it has not come to grips with the primary problem of the health care industry: when consumers enter the medical marketplace, the vast majority are spending someone else's money. Economic studies and common sense confirm that we are less likely to be prudent shoppers if someone else is paying the bill.[153] Ultimately, if costs are to be controlled, *someone* must choose between health care and other uses of money.

"There is no evidence that HMOs ultimately control costs."

This is the opinion of William Schwartz (University of Southern California) and Daniel Mendelson (Lewin-VHI), who argue that managed care has already achieved most of the savings that are achievable by reducing hospitalization. The only way for managed care to control the long-term rise in health care costs, they say, is to deny people access to expensive but useful technology.[154]

Do HMOs Lower the Quality of Care? Even without major health care reform, many of today's HMOs are experiencing the kinds of pressures described earlier in this study. For example, at one meeting of the Jackson Hole Group, an executive of an HMO explained that "You cannot afford to get a reputation for excellence. The way to run an HMO successfully is to provide cheap care at a cheap price." Do HMOs result in a lower quality of care? Scholars have been unable to document a systematic deterioration in quality under HMOs.[155] On the other hand, there is considerable anecdotal evidence of deterioration, including major legal victories against HMOs.

If quality does suffer, it is more likely to do so in those areas where there are not clear standards of medical practice and where the exercise of discretion on the part of physicians can save money for the managed care

organization. For example, lacking any clear guidelines from the medical community, an HMO will realize considerable savings if it fails to take so-called heroic measures to save premature, low-weight babies. The treatment of leukemia patients varies, depending on the preferences of physicians. At one level of care, the cancer may go into remission — thus prolonging a lingering death. Yet at a lower level of care, the patient may die and treatment costs cease. Bypass surgery for a man in his 60s can often be postponed — perhaps to the age of 65 when Medicare, rather than the HMO, will pay the bill. And, as we show below, physicians have considerable discretion in deciding how much to spend on the care of the chronically ill.[156]

A major difference between managed care and fee-for-service medicine is in the use of diagnostic tests. For example:[157]

- According to the National Ambulatory Medical Care Survey, HMOs and other managed care programs are less likely to authorize expensive diagnostic tests, and for MRI and CAT scans the difference is a factor of at least two to one.
- As a consequence, patients with diseases such as cancer are likely to have their conditions detected at a later stage, making treatment more difficult.

"There is anecdotal evidence that HMOs threaten the quality of care."

The pressure to lower quality derives from the pressure to lower costs. Surveys of corporate buyers of health care show that employers are more concerned about price than about quality. And that preference is reflected in the attitudes of managed care organizations that cater to corporate needs. For example, a Foster Higgins survey of managed care organizations found that employers rated price over quality by a large measure.[158]

The Texas Medical Association (TMA) has identified 2,100 complaints related to the rationing of health care services by managed care organizations in Texas since 1990.[159] In some cases, the TMA has filed suit against the third-party payer. It is not alone. In one case a California jury awarded $89 million in damages to the family of a woman who died after her HMO refused to pay for a bone marrow transplant. The jury was impressed by the fact that the HMO's medical director pressured the woman's physician to recommend against the treatment.[160]

The medical literature is full of testimonials from physicians describing subtle and overt ways in which HMOs pressure physicians to skimp on quality to save money.[161] Even more frightening, managed care organizations are finding more physicians already predisposed to the HMO philosophy — thus obviating the need for pressure from HMO managers.[162]

Patients are also beginning to complain. Jan Gribbon, for example, who ruptured a disk in her back, had to wait two weeks for her HMO's physician gatekeeper to refer her to a specialist. Then she had to wait several more

weeks to get back the results of two tests which her physician later explained were ineffectual but were ordered because the HMO did not have access to the test she needed. When her doctors finally verified her ruptured disk and scheduled her for surgery, it was six months after the injury, the last two of which she was in pain, on her back and out of work. Then her surgery was flawed. As a result, she now relies on "nerve blocks" to stop her pain and has been told she will need surgery again in a few years.[163] It would be nice if Jan Gribbon's case was rare. In the future it may not be.

Case Study: Chronic Illness.[164] As noted above, for chronic illnesses the appropriate standard of care often is not well defined. Where the norms are vague, there are wide variations in the amount spent. In general:

- Although HMOs and fee-for-service plans tend to adopt the same method of treatment where norms are well-defined, where norms are vague the prepaid plans provide significantly reduced levels of treatment.[165]
- Mental health expenditures, for example, are one-third to one-fifth as large under prepaid plans as they are under fee-for-service plans, other things being equal.[166]

"Patients with chronic illnesses are the ones at greatest risk."

One problem that arises is the HMO's practice of using primary care physicians as gatekeepers. These physicians often lack the expertise to identify certain chronic conditions. For example, physicians generally detect depression only about half the time, and prepaid physicians detect depression less often than fee-for-service physicians.[167] This may be partly due to the fact that prepaid physicians have a financial self-interest in not referring patients to a specialist.

Another problem is that HMOs that specialize in the treatment of chronic illness tend to provide more care and better care than HMOs that see chronic patients infrequently.[168] Yet such specialized HMOs are unlikely to exist under managed competition. As we saw in the case of the federal employees' plan, the very nature of managed competition discourages competitors from specializing in chronic conditions, because the community-rated premiums will be lower than the cost of care.

Conclusion: Why Not Real Competition?

By pointing out the need for market-based reforms, the advocates of managed competition have performed a valuable service. The problem is that they promise too much management and permit too little competition. Moreover, where the Jackson Hole Group and other advocates of managed competition would replace markets with regulations derives more from their personal preferences than from any findings of health economics. For example, the Rand Corporation's Health Insurance Experiment found that allowing patients

to control more of their health care dollars was twice as effective as using HMOs to control costs.[169] Yet Enthoven and others have ignored these findings in constructing their plan.[170]

Moreover, the only reason to have community-rated premiums is to subsidize people who would otherwise be charged exorbitant premiums because of preexisting illnesses. Yet only about 1 percent of the population under 65 years of age is uninsurable, and health economist Mark Pauly estimates that their health conditions would expose no more than 5 percent of the population to pay 50 percent above normal premiums in a competitive insurance market.[171] These problems are easily dealt with by such reforms as risk pools and government subsidies for health insurance premiums, without subjecting the other 99 percent of the population to price controls.[172]

"Instead of deciding how medicine should be practiced, government should level the playing field and encourage competition."

What is needed is *real* competition. We should allow individuals rather than bureaucrats to choose health insurance benefits in the face of market prices and to make their own decisions about the desirability of managed care. Competitive markets can perform quite well without the heavy hand of government. In another context we have already outlined the public policies needed to unleash the power of markets to solve our most important health policy problems.[173]

The most important role for government is to level the playing field so markets can determine what works and what doesn't. The last thing we need is for government to select a winner before the competition begins.

NOTE: Nothing written here should be construed as necessarily reflecting the views of the National Center for Policy Analysis or as an attempt to aid or hinder the passage of any bill before Congress.

Notes

[1] The authors would like to thank Merrill Matthews for help in the preparation of this manuscript. We are also indebted to Morgan Reynolds, Peter Ferrara, Greg Scandlen, Jack Strayer, Jesse Hixson, Randy Suttles and Rusty Ring for helpful comments and suggestions.

[2] See Alain C. Enthoven, "The History and Principles of Managed Competition," *Health Affairs* (Supplement 1993), pp. 24-48.

[3] Specifically, the AFL-CIO has endorsed the Clinton proposal, while the Chamber of Commerce, the NFIB and the Business Roundtable have rejected the president's plan and endorsed the Cooper-Grandy bill, discussed below. The National Association of Manufacturers has rejected the president's plan but has not yet endorsed Cooper-Grandy. See "The Road to Socialized Health," *Investor's Business Daily,* January 21, 1994; and Louis Uchitelle, "Manufacturers Oppose Clinton Plan," *New York Times*, February 6, 1994.

[4] These five companies withdrew from the Health Insurance Association of America (HIAA), the principal trade association for health insurers, and formed a group called the Alliance for Managed Competition. They also work through the Group Health Association of America, the major trade group for HMOs. In general, the big five are financial supporters of the Jackson Hole Group (discussed below). They have used their political clout to promote managed competition on Capitol Hill and to oppose its alternatives. For example, their full-page advertisements championing managed competition have appeared in the *National Journal* and the *New Republic.* On divisions within the health insurance industry and the activities of the big five in supporting managed competition, see John Hood, "Insurance Salesmen," *Reason*, February 1994, pp. 41-43. See also Rick Wartzman, "Insurance Industry Is Split Over Level of Confrontation in Health Care Debate," *Wall Street Journal*, March 15, 1994; and Harris Meyer, "Insurance Giants Bet on Managed Care," *American Medical News*, February 7, 1994, p. 3.

[5] A recent study by S. Craig Pirrong of the University of Michigan found that over the first nine months of 1993, stock prices for the pharmaceutical firms studied fell more than 27 percent relative to the rest of the stock market, resulting in nearly $62 billion in losses for the firms' stockholders. This fall was apparently directly related to Clinton administration pronouncements. See S. Craig Pirrong, "Political Rhetoric and Stock Price Volatility: A Case Study," Catalyst Institute, November 1993. See also "Health Care Cost Containment: A Bitter Pill for the Pharmaceutical Industry," Bernstein Research, November 1993.

[6] The supporting physicians' groups are the American Society of Internal Medicine, the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the American College of Preventive Medicine, the American Medical Women's Association, the American Society of Internal Medicine, the American Thoracic Society, the National Hispanic Medical Association and the National Medical Association (an African-American organization). See Robert Pear, "Doctors' Groups Endorse Clinton's Health Plan," *New York Times,* December 17, 1993.

[7] The newspaper's most recent editorial on the subject calls for a compromise between the Clinton administration approach and the Cooper approach. See "Compromise on Health Care," *New York Times*, January 16, 1994.

[8] The Heritage Foundation is generally given credit for developing the Nickles-Stearns proposal, discussed below. See Stuart M. Butler and Edmund F. Haislmaier, "The Consumer Choice Health Security Act," Heritage Foundation Issue Bulletin No. 186, December 23, 1993.

[9] See John C. Goodman and Michael C. Walker, "What President Clinton Can Learn from Canada about Price Controls and Global Budgets," National Center for Policy Analysis, NCPA Policy Backgrounder No. 129, October 5, 1993. See also Joanna Miyake and Michael Walker, "Waiting Your Turn: Hospital Waiting Lists in Canada, Third Edition," *Fraser Forum*, May 1993.

[10] Medical Savings Accounts are tax-free accounts that would be the property of the employee. Money could be withdrawn without penalty to pay medical expenses or health insurance premiums, even during periods of unemployment. Money not spent would grow tax free and could be used for medical expenses after retirement or rolled over into an IRA or pension plan. It would become part of a person's estate at death. See John C. Goodman and Gerald L. Musgrave, "Controlling Health Care Costs with Medical Savings Accounts," National Center for Policy Analysis, NCPA Policy Report No. 168, January 1992. See also Goodman and Musgrave, "Personal Medical Savings Accounts: An Idea Whose Time Has Come," National Center for Policy Analysis, NCPA Policy Backgrounder No. 128, July 22, 1993. For a discussion of the role of Medical Savings Accounts in the Nickles-Stearns bill, see Butler and Haislmaier, "The Consumer Choice Health Security Act." Chafee's bill includes a detailed provision for Medical Savings Accounts, but they are considerably restricted. For example, his plan does not allow for the tax-free buildup of funds in MSA accounts. Although it is rarely discussed, the Cooper-Grandy bill contains the following obscure provision relating to Medical Savings Accounts. Title I, Section 1302, "Specification of Uniform Set of Effective Benefits," subsection (c), deals with cost sharing and reads as follows:

(c) *Basis for Cost-Sharing.* In establishing cost-sharing that is part of the Uniform Set of Effective Benefits, the Commission shall:

(1) include only such cost-sharing as will restrain consumers from seeking unnecessary services,

(2) not impose cost-sharing for covered clinical preventative services,

(3) balance the effect of the cost-sharing in reducing premiums and in affecting utilization of appropriate services,

(4) establish a limit on the total cost-sharing that may be incurred by an individual (or enrollee unit) in a year, and

(5) incorporate, consistent with the previous provisions, incentives for individuals to control their utilization of health care services and shall (for this purpose) *consider incorporating the concept of Medical Savings Accounts and wellness dividends.*

To the extent consistent with the previous provisions, the Commission shall design such cost-sharing in a manner so as to maintain overall utilization levels at a level no higher than current overall utilization levels. (Emphasis added.)

[11] The Clinton administration proposal requires employers to pay at least 80 percent of the cost and employees 20 percent. People who do not obtain insurance through an employer are required to purchase their own policies, with subsidies available depending upon family income. Both the Chafee bill and the Nickles-Stearns bill require individuals to purchase insurance (again with subsidies that vary inversely to income), and they require employers to facilitate this mandate by deducting premium payments from employee wages.

[12] The original Cooper bill subsidized only managed care plans. The latest version, however, extends a tax subsidy to all qualified health plans, including fee-for-service plans.

[13] For a description of the original plan, see Alain C. Enthoven, Paul M. Ellwood and Lynn Etheridge, "The Jackson Hole Initiatives for a Twenty-First Century American Health Care System," *Health Economics* 1, 1992, pp. 149-68.

[14] "Draft Proposal: Managed Competition II." Updated February 21, 1994 and March 18, 1994. See also Jerry Geisel, "Support for Clinton Reforms Erodes," *Business Insurance,* March 7, 1994. In testimony before the Senate Finance Committee, Paul M. Ellwood, president of the Jackson Hole Group, said he favors a mandate only on companies with more than 100 employees, leaving open the possibility that the mandate could be expanded later. *The CQ Fax Report,* March 1, 1994.

[15] The self-employed currently may deduct only 25 percent of their health insurance premiums.

[16] In 1992, federal tax subsidies for employer-provided health insurance totaled about $65 billion. However, the average subsidy for families in the top 20 percent of the income distribution was about six times higher than the subsidy for families in the bottom 20 percent. See C. Eugene Steuerle, "Finance-Based Reform: The Search for Adaptable Health Policy," paper presented at an American Enterprise Institute conference, American Health Policy, Washington, DC, October 3-4, 1991.

[17] Under current law, employer-provided health insurance benefits are excluded from employees' taxable income. The Clinton administration proposes to limit the exclusion to the cost of a basic benefit plan after a period of five years.

[18] See John C. Goodman and Gerald L. Musgrave, *Patient Power: Solving America's Health Care Crisis* (Washington, DC: Cato Institute, 1992).

[19] Additional reforms would extend health insurance coverage to more people and make the coverage personal and portable so that employees would not lose coverage when they change jobs. Insurers would not be able to cancel the policies of people who get sick or to single them out for premium increases.

[20] Some versions, such as the Jackson Hole plan discussed below, endorse modified community rating in which premiums can vary by age — not because the proponents find the practice fair or desirable, but because they judge it necessary in order to induce young people to buy insurance.

[21] Managed care is sometimes referred to as coordinated care.

[22] See Alain C. Enthoven, *Health Plan: The Only Practical Solution to the Soaring Cost of Medical Care* (Reading, MA: Addison-Wesley, 1980), pp. 114-44, pp. 82-84 and p. 119. For Enthoven's more recent views on the advantages and disadvantages of the FEHBP, see Enthoven, "Effective Management of Competition in the FEHBP," *Health Affairs*, Fall 1989, pp. 33-50.

[23] The Blue Cross high-option and standard-option fee-for-service plans are available to all federal employees. Seven other fee-for-service plans, including the Alliance Health Plan, American Postal Workers Union Plan, Postmasters Health Benefit Plan, Government Employees Hospital Association and the Mail Handlers Health Plan, are sponsored by unions or employee organizations and also are available to all. Health Maintenance Organizations (HMOs), which are geographically based and

thus available only to those living in specific areas, make up the remaining FEHBP options. Some plans are restricted to specific groups of employees, including the Foreign Service Health Plan, the Secret Service Health Plan, Panama Canal Area Health Plan and the Rural Carrier Benefit Plan.

[24] Although the federal government allows millions of American workers to pay for their share of the premiums for employer-provided health insurance by using Flexible Spending Accounts (FSAs), the government does not make the FSA option open to its own employees. See "Statement of the Consultants of the Committee on Post Office and Civil Service before the Subcommittee on Compensation and Employee Benefits," May 20, 1992. Testimony before the House Subcommittee [hereinafter referred to as "Consultants' Statement"]. For a discussion of FSAs and their treatment under the tax law, see Alain C. Enthoven, "Health Policy Mismatch," *Health Affairs,* Winter 1985, pp. 5-13.

[25] Congress initially exempted itself and other government employees from Medicare coverage, which meant that younger federal employees had to directly subsidize the premiums of 80- and 90-year-old retirees. The policy was changed for new employees in the early 1980s so that 80 to 85 percent of federal employees now have Medicare coverage — and Medicare is the payer of first resort.

[26] See, for example, Walton Francis, "The Political Economy of the Federal Employees Health Benefits Program," in Robert B. Helms, ed., *Health Policy Reform: Competition and Controls* (Washington, DC: American Enterprise Institute, 1993), pp. 269-307.

[27] See Janet P. Lundy, "The Federal Employees Health Benefits Program," Congressional Research Service, CRS Issue Brief, updated June 11, 1992.

[28] For example, a Towers, Perrin, Forster & Crosby study concluded that "fundamental legislative reform is urgently needed." Cited in Lundy, "The Federal Employees Health Benefits Program."

[29] See the discussion in John C. Goodman and Gerald L. Musgrave, "State Health Care Reform under the Clinton Administration," National Center for Policy Analysis, NCPA Policy Report No. 173, November 1992. A recent study by the Congressional Budget Office also is pessimistic about the ability of managed competition to save money. See "Managed Competition and Its Potential to Reduce Health Spending," Congressional Budget Office, May 1993; and the more recent comments of CBO Director Robert Reischauer in David Rogers, "CBO Chief Is Doubtful of Cost Controls under Conservative Health Care Plans," *Wall Street Journal,* February 10, 1994. For the argument that the FEHBP has controlled costs better than the private sector, see Francis, "The Political Economy of the Federal Employees Health Benefits Program."

[30] The problem of adverse risk selection in the FEHBP used to be much worse; the program has standardized its plans. The ability to shift between plans, especially indemnity plans, created what Enthoven called "a textbook for how to create a risk-selecting scheme." See Alain C. Enthoven, "The Effects of Managed Competition: Theory and Real-World Experience," in Helms, *Health Policy Reform,* p. 226.

[31] "Consultants' Statement."

[32] Lundy, "The Federal Employees Health Benefits Program," p. 7.

[33] Roger Feldman and Bryan David, "The Effectiveness of Managed Competition in Reducing the Costs of Health Insurance," in Helms, *Health Policy Reform,* pp. 176-217.

[34] Service Employees International Union, "The CalPERS Experience and Managed Competition," SEIU Position Paper, March 1993, pp. 45-54.

[35] See also Steven Findley, "CalPERS: A Model for Health Care Reform?" *Business & Health,* June 1993, p. 2; and "At Issue," National Association of Health Underwriters, April 23, 1993.

[36] On the state of Florida, see Phillip Longman, "Think Global, Act Local," *Florida Trend,* Vol. 35, No. 9, January 1993, pp. 36-44.

[37] See Peter J. Ferrara, "Power to the Government: The Washington State Health Reforms," Evergreen Foundation, *In Brief,* Vol. 3, No. 2, September 15, 1993.

[38] Alain C. Enthoven, the "father of managed competition," usually is also credited with providing the intellectual basis for Britain's reforms. See Enthoven, "Internal Market Reform of the British Health Service," *Health Affairs* (Fall 1991), pp. 60-70; and Patricia Day and Randolf Klein, "Britain's Health Care Experiment," *Health Affairs* (Fall 1991), pp. 39-59.

[39] See Jeremy W. Hurst, "Reforming Health Care in Seven European Nations," *Health Affairs* (Fall 1991), pp. 18-19; and Wynand P.M.M. Van De Ven and René C.J.A. Van Vliet, "How Can We Prevent Cream Skimming in a Competitive Health Insurance Market?" in P. Ziveifel and H.E. Frech III, eds., *Health Economics Worldwide* (Dordrecht, Netherlands: Kluwer

Academic Publishers, 1992), pp. 23-46.

[40] See *State Commission of Inquiry into the Operation and Efficiency of the Health Care System in Israel,* Report: Volume 1, The Majority Opinion, Jerusalem, 1990.

[41] See "Life, Death and the Insurance Companies," *New England Journal of Medicine*, Vol. 330, No. 7, February 17, 1994, pp. 498-99.

[42] Alain C. Enthoven, "Consumer Choice Health Plan" (in two parts), *New England Journal of Medicine* 298 (March 23 and 30, 1978), pp. 650-58 and 709-20.

[43] See Enthoven, *Health Plan.*

[44] For updated versions of these ideas, see Alain C. Enthoven and Richard Kronick, "A Consumer-Choice Health Plan for the 1990s," *New England Journal of Medicine*, Vol. 320, Nos. 1 and 2 (1989) and Alain C. Enthoven and Richard Kronick, "Universal Health Insurance through Incentives Reform," *Journal of the American Medical Association,* Vol. 265, No. 19 (May 15, 1991), pp. 2532-36.

[45] Health economics as a discipline in hospital administration and public health education was well developed by this time. To satisfy the large university market, a major text appeared. See Paul Feldstein, *Health Care Economics* (New York: John Wiley & Sons, 1979).

[46] Enthoven's ideas have been influential in other countries as well. As noted above, he helped design Margaret Thatcher's health care reforms in Britain and was instrumental in the development of reforms being implemented in the Netherlands. Although neither Enthoven nor other members of his Jackson Hole Group were personally involved in Israel's new health care reform plan, Israel may become the first nation in the world to fully implement managed competition.

[47] Robert O'Brien, executive vice president of Cigna Companies, predicted to the *Congressional Quarterly* that "about half of the insurance companies would beknocked out of the market" by managed competition. Others industry insiders would put the percentage even higher. See Hood, "Insurance Salesmen," p. 42.

[48] Ira Magaziner is a special assistant to President Clinton who, under Hillary Rodham Clinton, has served as the President's point man on health care. For an interesting background piece on Magaziner, See Jacob Weisberg, "Dies Ira," *New Republic*, January 24, 1994, pp. 18-24.

[49] Aides to the task force apparently shared this "secret" eagerly with their friends on the left. See David Corn, "Bill of Health," *The Nation,* March 7, 1994, p. 294.

[50] On the case for global budgets in the context of managed competition, see Paul Starr and Walter A. Zelman, "Bridge to Compromise: Competition under a Budget," *Health Affairs* (Supplement 1993), pp. 7-23; Paul Starr, *The Logic of Health-Care Reform* (Knoxville, TN: Grand Rounds Press, Whittle Direct Books, 1992); Stuart H. Altman and Alan B. Cohen, "The Need for a National Global Budget," *Health Affairs* (Supplement 1993), pp. 194-203; and Henry J. Aaron and William B. Schwartz, "Managed Competition: Little Cost Containment without Budget Limits," *Health Affairs* (Supplement 1993), pp. 204-15. Henry Aaron, director of the Economic Studies Program at the Brookings Institution, has advocated his own method of integrating managed competition and global budgets. See Henry J. Aaron, "Budget Limits and Managed Competition: Allies, Not Antagonists," *Health Affairs*, Fall 1993, pp. 132-36. See also Joseph White, "Markets, Budgets and Health Care Cost Control," *Health Affairs*, Fall 1993, pp. 44-57.

[51] Paul M. Ellwood, "Clinton Forgets His Health Care Allies," *Wall Street Journal,* August 10, 1993.

[52] Alain C. Enthoven, "A Good Health Care Idea Gone Bad," *Wall Street Journal*, October 7, 1993.

[53] See Robert Pear, "Warning on Health Plan from Author of Idea," *New York Times*, January 13, 1994.

[54] Unlike the Clinton plan, Cooper's bill does not require people to purchase health insurance and does not require employers to pay part of the cost. Instead of universal coverage, which Clinton claims is a nonnegotiable goal, Cooper is pursuing universal access — a system in which people have the opportunity (largely because of tax subsidies) to purchase insurance at an affordable price, given their family income. Chafee's bill does contain an individual mandate.

[55] Cooper continues to say that he is interested in adding Medical Savings Accounts to his plan (see *Congressional Quarterly*, January 8, 1994, p. 28) and privately says that there is in any event no reason why large employers should not be able to offer MSAs.

[56] The Nickles-Stearns approach is based on a plan designed by the Heritage Foundation. It is strikingly different from the pro-free-enterprise approach that Heritage took only a few years ago. Indeed, Heritage's new position on health policy reform has shocked and dismayed other conservatives. See Ruth Shalit, "The Wimp-Out," *New Republic,* February 14, 1994, p. 22.

[57] See, for example, Goodman and Musgrave, *Patient Power,* p. 68-69.

[58] The Nickles-Stearns bill would impose a maximum deductible of $1,000 per individual and $2,000 per family. This would eliminate the high-deductible plans that are currently being used, with great success, to control costs at *Forbes* magazine, Golden Rule Insurance Company and many other companies.

[59] The taxpayer may contribute an additional $500 for each dependent in the household.

[60] See the discussion in Mark Pauly, "Killing with Kindness: Why Some Forms of Managed Competition Might Needlessly Stifle Competitive Managed Care," in Helms, *Health Policy Reforms,* p. 152 ff.

[61] Before New York state began requiring all insurers to community rate, Guardian Insurance (a commercial insurer) charged a monthly premium of $149 to single people under age 30 and $349 to single people age 60 to 64. By contrast, Blue Cross — which was required by its charter to community rate — charged $184, regardless of age. See Peter Passell, "What Hidden Cost in Spreading the Health Risk?" *New York Times,* July 12, 1992. In states where insurers can rate based on sex, the premium difference for males of different ages is greater than for females.

[62] See, for example, Blue Cross and Blue Shield System, *Reforming the Small Group Health Insurance Market,* March 1991, p. 6.

[63] Marc L. Berk and Alan C. Monheit, "The Concentration of Health Expenditures: An Update," *Health Affairs,* Winter 1992, pp. 145-49.

[64] Henry J. Aaron, Testimony before the Subcommittee on Health for Families and the Uninsured, Senate Finance Committee, January 12, 1994.

[65] Henry J. Aaron, *Serious and Unstable Condition: Financing America's Health Care* (Washington, DC: Brookings Institution, 1991).

[66] The HMO would receive premiums only from people who were about to undergo expensive medical procedures. Thus the average premium would have to equal the average cost of the procedures. It is precisely because most people cannot easily bear such a financial burden that health insurance is desirable in the first place.

[67] Enthoven, "The History and Principles of Managed Competition," p. 35. On the practice of encouraging high-cost patients to "disenroll," see Jonathan E. Fielding and Thomas Rice, "Can Managed Competition Solve the Problems of Market Failure?" *Health Affairs* (Supplement 1993), p. 222; and Joseph Newhouse, "Is Competition the Answer?" *Journal of Health Economics,* Vol. 1, 1982, pp. 109-16.

[68] See Michael Moore, "Risk Adjustment under Managed Competition," Jackson Hole draft discussion paper, March 1993; and Van de Ven and Van Vliet, "How Can We Prevent Cream Skimming in a Competitive Health Insurance Market?" pp. 29-30.

[69] Enthoven (attributing the analogy to Joseph Newhouse) has likened the situation to a game of hearts, in which all the players try to pass off the queen of spades. See Alain Enthoven, "The Effects of Managed Competition," p. 221.

[70] Note that this problem arises only because of price controls. Health plans would have no reason to avoid applicants if each person who enters an insurance pool pays a premium that reflects the expected cost and risk the person adds to the pool. See Pauly, "Killing with Kindness," p. 155.

[71] These same tendencies characterize single-payer systems (national health insurance) and arise from the pressures of democratic voting. In the absence of a competitive market, people living in countries with national health insurance may find it in their rational self-interest to vote for a policy of increased primary care services funded by a reduction in acute care services. See the analysis in John C. Goodman and Gerald L. Musgrave, "Twenty Myths about National Health Insurance," National Center for Policy Analysis, NCPA Policy Report No. 128, December 1991.

[72] See the discussion in Van de Ven and Van Vliet, "How Can We Prevent Cream Skimming in a Competitive Health Insurance Market?" pp. 29-30; Enthoven, "Consumer Choice Health Plan," p. 711; H.S. Luft, "Health Maintenance Organizations and the Rationing of Medical Care," *Milbank Quarterly,* Vol. 60, 1982, pp. 268-306; H.S. Luft, "Compensating for Biased Selection in Health Insurance," *Milbank Quarterly,* Vol. 64, 1986, pp. 566-91; Newhouse, "Is Competition the Answer?" p. 113; and Stan Jones, "Commentary," in Helms, *Health Policy Reform,* pp. 228-31.

[73] See Hood, "Insurance Salesmen," p. 41.

[74] Enthoven has also been quoted as saying: "We doubt that (private practice doctors) would generally be compatible with economic efficiency. We would expect this type of practice to continue, but to decline gradually in importance." See John Merline, "Can Dr. Marcus Welby Survive? Or Will Health Care Reform Kill Private Practice?" *Investor's Business Daily,*

October 6, 1993.

[75] Enthoven, "The Effects of Managed Competition," p. 226.

[76] "[Suppose a plan] takes care of certain chronic conditions in a way less costly and more satisfactory to the patient ... [It] offers the new coverages and terms to its subscribers who are diagnosed with the condition. But the plan does not advertise its new service or add it to the open season brochure. If it did, it might attract many or most of the employees with this condition." Harry Sutton, Jr., "Commentary," in Helms, *Health Policy Reform,* p. 231.

[77] We ignore here the role of malpractice tort liability, not because the tort system is unimportant but because the advocates of managed competition want quality to be determined in the marketplace rather than by tort law. If the analysis in this section is correct, however, tort liability is the only thing that would prevent a catastrophic decline in the quality of health care under managed competition.

[78] There is at least some recognition in the health policy literature that this tendency is one of "the free market pitfalls of managed competition" (p. 118), that "one of managed competition's greatest challenges is to safeguard quality of care without robbing the system of free-market efficiencies" (p. 110) and that "managed competition carries an inherent risk of discrimination against enrollees who incur high health care costs" (p. 120). See Alan L. Hillman, William R. Greer and Neil Goldfarb, "Safeguarding Quality in Managed Competition," *Health Affairs* (Supplement 1993), pp. 110-22.

[79] See Edwin S. Dolan and John C. Goodman, "Flying the Deregulated Skies: Competition, Price Discrimination, Congestion," in *Economics of Public Policy,* 4th ed. (St. Paul, MN: West Publishing Co., 1989), pp. 113-27.

[80] See William Tucker, *The Excluded Americans: Homelessness and Housing Policies* (Washington, DC: Regnery Gateway, 1990).

[81] More formally, an equilibrium is said to exist when no participant in the market — including all buyers and sellers — can improve his or her position by any unilateral move.

[82] Note that the premium does not have to be the same for all plans, but regulation requires that it be the same for all members of a given plan.

[83] That is, if the health plan does not know in advance what premium will be paid for an individual enrollee, it will form an expectation about the probable premium based on the individual's characteristics.

[84] Enthoven, "The Effects of Managed Competition," p. 219.

[85] Pauly, "Killing with Kindness," p. 171.

[86] Pauly, "Killing with Kindness," p. 153.

[87] Van de Ven and Van Vliet, "How Can We Prevent Cream Skimming in a Competitive Market?" p. 25.

[88] See Moore, "Risk Adjustment under Managed Competition."

[89] Might not some individuals voluntarily pay higher premiums than necessary in order to insure high-quality treatments for everyone? They might. But this is the classic "public good" problem that economists have analyzed at great length. Economic theory does not say that public goods will never be produced. It does say that they will be underproduced. And what will be underproduced under managed competition is high-quality (expensive) health care for the sick.

[90] Francis, "The Political Economy of the Federal Employee Health Benefits Program," Table II-2, p. 276.

[91] Congressional Budget Office, *Managed Competition and Its Potential to Reduce Health Spending* (Washington, DC: CBO, May 1993), p. 8.

[92] Personal communication with a former FEHBP official.

[93] A preferred provider organization (PPO) pays full benefits only when subscribers see doctors who are part of a network.

[94] Karen Riley, "Managed Care Has Ailments," *Washington Times,* February 6, 1994; and Karen Riley, "Select Plan's Culling Out of Doctors Raises Questions on Reasons, Results," *Washington Times,* February 6, 1994.

[95] Personal communication.

[96] Ibid.

[97] Francis, "The Political Economy of the Federal Employees Health Benefits Program," p. 273.

[98] Ibid., p. 276.

[99] Ibid., p. 289.

[100] Enthoven, "The Effects of Managed Competition," p. 226.

[101] Ibid., pp. 224-25. Although all of the CalPERS HMOs covered outpatient drugs, one did not cover the delivery system for insulin — thus making it unattractive to people with diabetes.

[102] Francis, "The Political Economy of the Federal Employees Health Benefits Program," Table 1-1, p. 274.

[103] Francis, "The Political Economy of the Federal Employees Health Benefits Program," p. 289 and pp. 305-06.

[104] It is generally acknowledged that sicker enrollees are more likely to withdraw from HMOs. See Jonathan E. Fielding and Thomas Rice, "Can Managed Competition Solve the Problem of Market Failure?" *Health Affairs* (Supplement 1993), p. 222. See also the discussion in Newhouse, "Is Competition the Answer?" The experience of Hawaii, which is dominated by managed care, may also be instructive. In that state most plans provide free preventive services while limiting coverage for hospital care and requiring copayments for inpatient surgery, emergency room visits and other hospital-based services. See Linda A. Bergthold, "Benefit Design Choices under Managed Competition," *Health Affairs* (Supplement 1993), p. 103.

[105] Blue Cross's behavior may also be affected by the fact that it sells insurance in the private sector, which may support quality and also provide funds for cross-subsidies to the federal system.

[106] Feldman and David, "The Effectiveness of Managed Competition in Reducing the Costs of Health Insurance," p. 186.

[107] Francis, "The Political Economy of the Federal Employees Health Benefits Program," p. 288.

[108] Ibid., pp. 270-71.

[109] Alain C. Enthoven, "Why Managed Care Has Failed to Contain Health Care Costs," *Health Affairs*, Fall 1993, pp. 38-40.

[110] "Healthy Options Program," State of Washington Department of Social and Health Services, Medical Assistance Administration, update, August 1993.

[111] Aid to Families with Dependent Children.

[112] Letter from Dr. Jeffrey J. Graham, medical director of the Medical Assistance Administration, to the King County Medical Assistance Providers, January 11, 1994. These results were predicted by an early analysis of the program. See Ferrara, "Power to Government: The Washington State Health Care Reforms."

[113] The other two sick funds are Le'umit and Me'uhedet.

[114] Membership has fallen from 90 percent of the population to 70 percent over the past decade.

[115] See the *State Commission of Inquiry into the Operation and Efficiency of the Health Care System in Israel.*

[116] Personal communication.

[117] Enthoven wants to move from a market in which demand is inelastic to one which is elastic in price. See Enthoven, "The Effects of Managed Competition," p. 221; and Enthoven, "Why Managed Care Has Failed to Contain Health Costs."

[118] Van de Ven and Van Vliet, "How Can We Prevent Cream Skimming in a Competitive Market?"

[119] Robert Woodward, "British Health System Gags after Tinkering," *Washington Times*, February 1, 1994.

[120] The theory of the politics of medicine was first outlined in John C. Goodman, *National Health Care in Great Britain: Lessons for the USA* (Dallas: Fisher Institute, 1980), ch. 10. The theory was subsequently developed in Goodman and Musgrave, *Patient Power*, ch. 18. See also John C. Goodman and Gerald L. Musgrave, "Twenty Myths about National Health Insurance," National Center for Policy Analysis, NCPA Policy Report No. 166, December 1991.

[121] Enthoven, "The History and Principles of Managed Competition," p. 29. Emphasis added.

[122] See John C. Goodman, "Should Healthy People Pay More for Health Insurance?" National Center for Policy Analysis, NCPA Policy Backgrounder No. 115, April 2, 1992; and Pauly, "Killing with Kindness," p. 153.

[123] Enthoven, "The History and Principles of Managed Competition," p. 34. Emphasis added.

[124] See, however, Enthoven's recognition of how the problem will arise. Ibid., p. 35.

[125] See Pauly, "Killing with Kindness," p. 154.

[126] Cited in Robin Toner, "Heart of Clinton's Health Plan, the Purchasing Pool, Has Ever Fainter Beat," *New York Times,* February 18, 1994.

[127] A federal tax break is available only to individuals and employers of fewer than 100 people who join an alliance.

[128] Toner, "Heart of Clinton's Health Plan, the Purchasing Pool, Has Ever Fainter Beat."

[129] Enthoven, "The Effects of Managed Competition," p. 226.

[130] "Health Tinkering Is Not Reform," *New York Times,* February 22, 1994. The idea that alliances are essential is also promoted by Clinton health care advisor Paul Starr, a professor of sociology at Princeton University. See Paul Starr, "Alliances for Progress," *New York Times,* March 6, 1994.

[131] The editors of the *Times* apparently believe these problems can be solved by transferring money among insurers through a risk-adjustment mechanism. As this study shows, no such solution is adequate.

[132] Enthoven, "The Effects of Managed Competition," pp. 32-33. According to Enthoven, the plan does not need to be the same for every group, but it must be the same for everybody within each group. See also Enthoven, "Why Managed Care Has Failed to Contain Health Care Costs," pp. 38-40.

[133] See the White House Domestic Policy Council, *The President's Health Security Plan: The Clinton Blueprint* (New York: Times Books, 1993), p. 24. On the mammography debate, see Gina Kolata, "Avoiding Mammogram Guidelines," *New York Times,* December 5, 1993; and Gina Kolata, "Mammogram Debate Moving from Test's Merits to Cost," *New York Times,* December 27, 1993.

[134] The Cooper-Grandy, Chafee and Nickles-Stearns bills also would require the same benefit package for every participate; however, Chafee and Nickles allow a Catastrophic Option to be combined with a Medical Savings Account.

[135] Southern California has among the highest health care costs in the nation. As a result, Californians who buy low-deductible policies are being especially wasteful compared to, say, people in Vermont. For example, a California couple with no children will pay from $1.00 to $2.63 (depending on their age) for each dollar of additional insurance if they choose a $500 rather than a $1,000 deductible. See Goodman and Musgrave, *Patient Power,* pp. 233-40.

[136] See the discussion in Enthoven, "The History and Principles of Managed Competition," pp. 33-35.

[137] Under the Clinton fee-for-service option, for example, everyone must have a $200 deductible and a 20 percent copayment. See *The President's Health Security Plan*, p. 40.

[138] See Joseph Newhouse, "Rate Adjusters for Medicare under Capitation," *Health Care Financing Review* (1986 Annual Supplement), pp. 45-56. Cited in Enthoven, "The History and Principles of Managed Competition," pp. 33-34.

[139] See the review of the literature in Van de Ven and Van Vliet, "How Can We Prevent Cream Skimming in a Competitive Health Insurance Market?" See also A.M. Epstein and E.J. Cumella, "Capitation Payment: Using Predictors of Medical Utilization to Adjust Rates," *Health Care Financing Review*, Vol. 10, No. 1, 1988, pp. 51-69; and J.W. Thomas, R. Lichtenstein, L. Wyszewianski and S. Berki, "Increasing Medicare Enrollment in HMOs: The End for Capitation Rates Adjusted for Health Status," *Inquiry*, Vol. 20, 1983, pp. 227-39.

[140] See Luft, "Compensating for Biased Selection in Health Insurance," p. 580; and Alain C. Enthoven, *Theory and Practice of Managed Competition In Health Care Finance* (North Holland: American Elsrvier, 1988), p. 86.

[141] For a discussion of the cost-plus system, see Goodman and Musgrave, *Patient Power*, chs. 5-9.

[142] Under diagnosis-related groups (DRG) systems, physicians and hospitals receive a predetermined amount from the federal government for whatever services they perform. See Goodman and Musgrave, *Patient Power*, pp. 303-06.

[143] William Glaser of the Graduate School of Management at the New School for Social Research in New York City has written that "the managed competition scheme was never more than a thinly veiled attempt by leaders of the HMO/IPA industry to make their schemes universal." See Letter to the Editor, *Health Affairs,* Fall 1993, pp. 277-78.

[144] For a review of the effects of HMOs, see John K. Iglehart, "The American Health Care System: Managed Care," *New England Journal of Medicine*, Vol. 327, No. 10, September 3, 1992, pp. 742-47.

[145] Proponents also argue that practice guidelines, by establishing an official standard of care, will help protect physicians who follow them from the threat of malpractice suits. However, because practice guidelines are just beginning to be developed, there is little agreement on what procedures should be included or how they should be developed and utilized.

[146] See the discussion in Goodman and Musgrave, *Patient Power,* pp. 114-20.

[147] Jane Orient, "An Evaluation of Abdominal Pain: Clinicians' Performance Compared with Three Protocols," *Southern Medical Journal,* Vol. 79, No. 7, July 1986, pp. 793-99.

[148] Robert H. Brook, "Practice Guidelines and Practicing Medicine: Are They Compatible?" *Journal of the American Medical Association* 262, No. 21 (December 1, 1989), p. 3021.

[149] See, for instance, CBO Staff Memorandum, "The Effects of Managed Care on Use and Costs of Health Services," Congressional Budget Office, Washington, DC, June 1992, p. 17.

[150] Ibid. The CBO contends that staff and group model HMOs "reduce hospital use significantly," but those savings are often offset by an increased use by patients of the HMOs' services. Other types of managed care have produced up to 8 percent reductions in overall expenditures. See CBO, "The Effects of Managed Care on Use and Costs of Health Services," p. 13.

[151] Gary Robbins, Aldona Robbins and John C. Goodman, "How Much Inefficiency Is in the U.S. Health Care System and What Can We Do about It?" National Center for Policy Analysis, NCPA Policy Report No. 182, April 1994.

[152] This is the opinion of, among others, Robert Reischauer, director of the Congressional Budget Office. See "Statement of Robert D. Reischauer" before the Subcommittee on Health of the House Ways and Means Committee, March 2, 1993.

[153] See Robert H. Brook et al., *The Effect of Coinsurance on the Health of Adults* (Santa Monica, CA: Rand, 1984); and Willard Manning et al., "Health Insurance and the Demand for Health Care: Evidence from a Randomized Experiment," *American Economic Review*, June 1987.

[154] William B. Schwartz and Daniel N. Mendelson, "Why Managed Care Cannot Contain Hospital Costs," *Health Affairs,* Summer 1992.

[155] See Hillman et al., "Safeguarding Quality in Managed Competition," p. 114.

[156] See Paul Sperry, "Saving Money or Saving Lives?" *Investor's Business Daily,* January 17, 1994.

[157] Steve Salemo, "High Price of Managed Care," *Wall Street Journal,* January 18, 1994.

[158] Ron Winslow, "In Health Care, Low Costs Beat High Quality," *Wall Street Journal,* January 18, 1994.

[159] Sperry, "Saving Money or Saving Lives?"

[160] Michael Meyer and Andrew Mun, "Not My Health Care," *Newsweek*, January 10, 1994, pp. 36-38; and Christine Woolsey, "Jury Hits HMOs for Coverage Denial," *Business Insurance,* January 3, 1994.

[161] See, for example, Dr. Charles C. Douglas, Letter to the Editor, *Wall Street Journal,* January 3, 1994.

[162] See the discussion in Hillman et al., "Safeguarding Quality in Managed Competition," p. 115.

[163] Kathy Kristof, "HMO Horror Story: Why Are Consumers Skeptical? Ask Jan Gribbon," *Los Angeles Times,* January 2, 1993.

[164] This section is based largely on Mark Schlesinger and David Mechanic, "Challenges for Managed Competition from Chronic Illness," *Health Affairs* (Supplement 1993), pp. 123-37.

[165] Ibid., p. 128.

[166] See W. Manning and K. Wells, "Preliminary Results of a Controlled Trial of the Effect of a Prepaid Group Practice on the Outpatient Use of Mental Health Services," *Journal of Human Resources*, Vol. 21, 1986, pp. 293-320; and Mark Schlesinger, "Striking a Balance: Capitation, the Mentally Ill, and Public Policy," in David Mechanic and L. Aiken, eds., *Integrating Mental Health Care Services through Capitation* (San Francisco: Jossey-Bass. 1989), pp. 97-116.

[167] K. Wells et al., "Detection of Depressive Disorders for Patients Receiving Prepaid or Fee-for-Service Care," *Journal of the American Medical Association,* Vol. 262, 1989, p. 3298-302.

[168] Schlesinger and Mechanic, "Challenges for Managed Competition from Chronic Illness," p. 128.

[169] Willard Manning et al., "A Controlled Trial of the Effect of Prepaid Group Practice on the Use of Services," *New England Journal of Medicine,* Vol. 310, June 7, 1984, pp. 1505-10.

[170] According to Enthoven, "Cost sharing at the point of service is not the primary incentive to economical behavior. When an injured child is bleeding on the operating table, whether the patient must pay a $10 copayment for each stitch does not help in making good decisions about care." See Enthoven, "The Effects of Managed Competition," p. 219.

[171] Pauly, "Killing with Kindness," p. 159.

[172] Ibid., pp. 160-61.

[173] See Goodman and Musgrave, *Patient Power,* ch. 3.

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