Chapter Twenty-two

Is Managed Competition the Answer?[1]

Most of the problems of single-payer health care insurance are well known to policy makers and government officials and even to many ordinary citizens in countries with national health insurance. Many of the obstacles posed by the politics of medicine also are well known.

As a result, throughout the 1990s there was growing interest—particularly in Europe—in a new type of system, one in which health care resources would be allocated by competition in the marketplace rather than by politicians. Such a system would not be a free market in the ordinary sense of that term; rather it would be a market in which the rules of competition were set and managed by government. So long as the competitors played by the rules, market forces rather than political forces would determine who got health care and how much. Such a system is called managed competition. And to obtain a model of it, Europeans turned, of all places, to the United States.[2]

Employees, for example, of the federal government make an annual choice among a dozen or more competing health plans.[3] A similar choice system is in place for employees of many state and local governments.[4] Many private employers also give employees a choice of health plans, and where these plans are independent organizations they effectively compete against each other to enroll members.[5]

The competition that exists in these programs, again, is not the same as one would find in a free market. It takes place under artificial rules managed by the employer or some other sponsoring organization. During its first term, the Clinton administration proposed such managed competition nationwide. Its adherents, including Stanford professor Alain Enthoven, still think this is the answer to the nation's health care woes.[6]

MANAGED COMPETITION

Under the health insurance options described above, health plans do indeed compete. But because the way they compete is artificially constrained, the product they sell is different from garden-variety health insurance. For example, each health plan is required to charge the same premium to every applicant (community rating) or to every applicant of the same age and sex (modified community rating) and to accept all applicants regardless of health conditions (guaranteed issue). In the federal employees program, for example, an eighty-year-old retiree pays the same premium to join a health plan as a twenty-year-old employee.[7] As a result, insurers are precluded from competing on their ability to price and manage risk. Instead, they must compete on their ability to provide health care and manage its cost. Such competition is not really competition among firms in the business of insurance; instead, it is competition in the delivery of health care.

The artificial market changes the nature of the product not only for the sellers, but for the buyers. Buyers are not purchasing protection against the loss of their assets when they select one of these health plans. The system as a whole provides protection against the loss of assets due to an expensive illness. What customers are selecting is the right to particular health care services, such as access to one doctor network rather than another. This is comparable to choosing an auto insurer so you can have your car repaired at a particular auto repair shop or choosing a casualty insurer so you can get hail damage repair from a particular roofer.

The benefits of competition are well known to economists and to many noneconomists. These benefits flow principally from the fact that sellers find it in their self-interest to compete for the trade of potential customers. To do so, they make buyer-pleasing adjustments in their competitive strategies. 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 such customers. Yet, these are the perverse incentives that managed competition creates.

People who know before they select an insurer that they need expensive medical treatment will use this knowledge to select a health plan. And since insurers understand this, they can structure their products so as to discourage the most expensive customers. Let's look at some ways this might happen.

HOW PERVERSE INCENTIVES AFFECT THE BEHAVIOR OF BUYERS

Imagine a system in which health plans offer networks of doctors and hospitals in return for fixed premiums. People who are seriously ill and need spe-

cific, expensive medical treatment will select in a very different way from other people. Take a heart patient in need of cardiovascular surgery. The individual has a self-interest in finding the best cardiologist and the best heart clinic. 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 matters little, since the value to the patient of receiving the best cardiovascular care will far exceed any premium payment.

The incentives facing healthy people are different. Since their probability of needing any particular service in the near future is small, they are unlikely to spend much time investigating particular doctors and clinics. To the degree that they do investigate, they are likely to inquire only about the primary care services they are likely to receive. If the need for heart surgery arises, odds are that patients will be able to switch insurers before the surgery is performed.

Thus, the people who carefully compare the acute care services offered by competing health plans are likely to be the people who intend to use them. These are the very people health plans want to avoid. By contrast, those 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 any time, but there are cumbersome screening mechanisms and 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 if we were healthy and switch to the second if afflicted with heart disease or kidney failure. But if everyone acted in this way, the second HMO would attract only expensive-to-treat patients. To cover its costs, it would have to charge a premium many times higher than the first HMO. The premium would have to be approximately equal to the cost of heart surgery or a kidney transplant. But in that case, most people could not afford the premium. Those who could afford it might be better off to simply buy their medical care directly. In any event, the HMO would face financial ruin.[8]

It might seem that the second HMO could compete successfully by offering more primary care services. But to be truly competitive, it would have to change its strategy completely. The easiest way to keep costs down is to enroll only the healthy. And the easiest way to do that is not to have the doctors and facilities sick people want. As Alain Enthoven has noted (disapprovingly), "A good way

to avoid enrolling diabetics is to have no endocrinologists on staff. . . . A good way to avoid cancer patients is to have a poor oncology department."[9]

To attract healthy enrollees, a health plan might offer inexpensive vaccinations, cancer screening and health club membership. 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. Health plans also can target the healthy through the design of their advertisements and in selecting a location to make a pitch to desirable prospects.

A survey by the Kaiser Family Foundation discovered how HMOs were competing for seniors on Medicare. The HMO ads in print and on television showed seniors snorkeling, biking and swimming, but did not feature the sick or disabled. In addition, nearly one-third of HMO marketing seminars were held at sites that were not wheelchair accessible.[10] The following are just a few other examples uncovered by the *Washington Post*[11]:

- When a Minnesota network began offering direct access to an obstetrician while rivals required referrals from a gatekeeper, it attracted disproportionate numbers of pregnant women, lost millions of dollars and soon ended the practice.
- When Aetna U.S. Healthcare offered unusually generous coverage for in vitro fertilization, people with fertility problems flocked to the HMO and Aetna had to end the practice.
- In another case, a California health plan severed its relationship with a university hospital known for practicing high-tech medicine and tackling complicated cases.
- Other HMOs avoid contracting with doctors' groups known for expertise with high-risk patients.

The term *medlining* is sometimes used to describe the practice of avoiding the sick. It's health care's version of redlining, the banking and insurance practice of avoiding deteriorating neighborhoods. The other side of the coin, of course, is attracting the healthy. In addition to health club memberships, health plans also have offered dental benefits and vision care. The theory is that anyone who will switch health plans to get a free pair of eyeglasses cannot be very sick.[12]

THE RESULTS OF COMPETITION

In figure 22.1, patients are arrayed along the horizontal axis from most to least costly (left to right). The cost-of-care line shows what would be spent on

each patient given current standards of medical practice. This line is highly skewed, reflecting the fact that in a typical pool about 2 percent of the group spends more than 40 percent of the health care dollars, 10 percent spends almost three-quarters and the majority have very small expenses. The premium is based on the average cost of care for all patients under community rating. It is the premium that must be charged all plan members if the plan is to cover its costs.[13] The figure also illustrates how healthy people subsidize sick people, since most members have costs well below the premium they pay and a few have costs well above it. 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 22.1 cannot be in 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.[14] However, the plan represented in figure 22.1 can easily become more profitable if it can lower the cost of caring for its sicker members. As long as these members stay in the plan, it will have the same premium income and lower costs. If sicker members shift to another plan, this is even better from the plan's point of view—since the sick are unprofitable by definition. On the other hand, healthier customers are being overcharged, since the cost of care they are receiving is below the premium they are paying. This means that other health plans can lure away these customers by providing higher benefits for the same premium. Thus, in order to retain prof-

FIGURE 22-1

Disequilibrium for a Health Plan Under Managed Competition

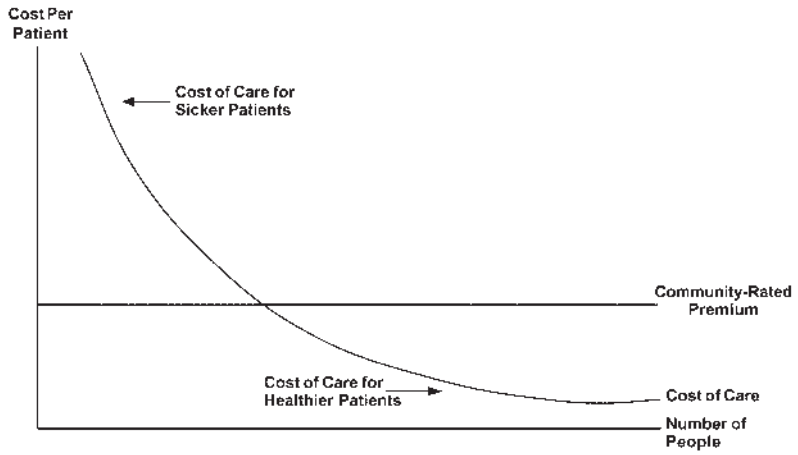
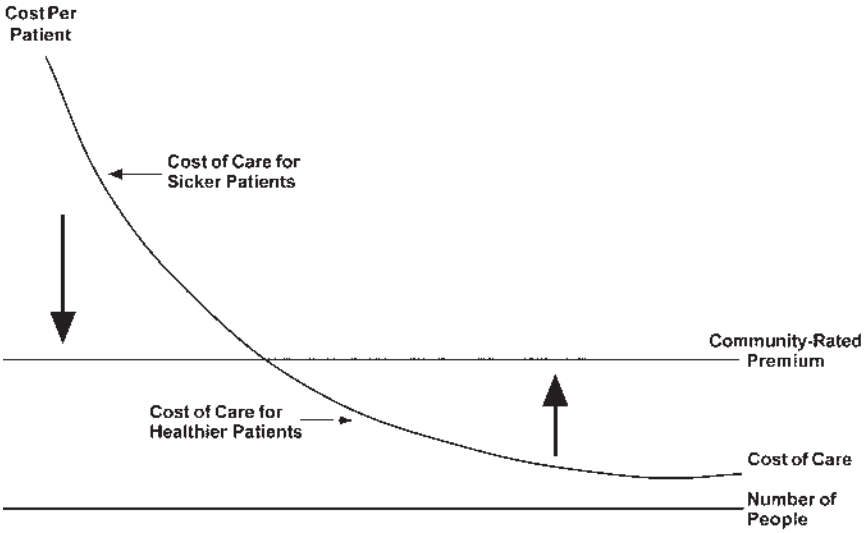


FIGURE 22-2

Competitive Pressures under Managed Competition



itable customers and attract even more, the health plan represented in figure 22.1 should increase the amount it spends on healthy members.

In free markets, competition tends to cause the price to change until it equals average cost. The same tendencies exist under artificial competition. Yet, because community-rated premiums are constrained to be the same for all members, competition will cause cost to change until it equals price. If premiums could rise for "unprofitable" members, health plans would compete them up to the level of the cost of those people's care. But if the premiums are artificially constrained, the plans will compete the cost of care down to the level of the artificial premium.[15] The reverse pressures exist for "profitable" members. 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. Under regulations imposed by the Civil Aeronautics Board (CAB) for most of the post–World War II period, the federal government established minimum air fares higher than would have prevailed in a free market. Unable to compete on price, the airlines competed by offering more frequent flights, more convenient departures, more spacious seating and other

in-flight amenities. The CAB's price regulation potentially allowed the airlines to earn supra-normal profits, but those profits were competed away on passenger-pleasing adjustments.[16]

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, landlords tend to allow housing quality to deteriorate until housing costs equal the government-controlled rent.[17]

Consider this result in terms of a basic principle taught in all introductory economics courses: when firms are maximizing profits, marginal revenue must equal marginal cost. Under artificial competition, marginal revenue (the amount of premium each additional enrollee brings to a plan) must be the same for every enrollee. Thus, if health plans are maximizing profits, marginal cost (the amount the plan spends on the health care of each additional enrollee) also must be the same for every enrollee.

Health plans, therefore, face competitive pressures to adjust the delivery of health care until the cost-of-care line coincides with the (community-rated) premium line (see figure 22.2). This means that health plans have a strong financial self-interest in underproviding services to the sick and overproviding services to the healthy. Left unchecked, the end result of this process is a condition under which each person receives health services whose cost is exactly equal to the premium he or she pays.

THE EFFECT OF LIMITED OPEN SEASONS

The analysis presented here assumes that patients make choices among insurers based solely on the value of medical services those patients consume. This assumption would be justified to the degree that patients can easily shift back and forth among insurers as their health needs change. However, the federal employee program and most other managed competition programs allow plan changes only during "open season" once a year.[18]

To the degree that people's choices are constrained by limited 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. She expects to need well-baby delivery services. However, she might experience complications in pregnancy or childbirth, or her child might be premature and require sophisticated medical treatment. In those cases, the woman would benefit from highly skilled medical personnel. Thus, in selecting a plan she will be interested in purchasing real insurance as well as specific medical services.

For such potential problems as heart disease, cancer and AIDS, it seems unlikely that people will willingly pay much to insure for expensive treatment while they are healthy—if they can switch insurers at least every twelve months. The tendency will be to select a plan that is strong on preventive and diagnostic services, secure in the knowledge that one can rather quickly switch to a plan that is best at treating a particular disease.

Therefore, periodic open seasons cause us to modify our prediction in recognition of an insurance component to people's choices. Yet, even with this modification we are left with the prediction that artificial competition will ultimately result in a radical deterioration in the quality of care sick people receive.

THE EFFECT OF RISK ADJUSTMENT

Proponents of managed competition are keenly aware of the perverse incentives faced by health plans. To thwart these incentives many favor risk adjustment programs that take income away from plans that attract healthier people and give it to plans that attract sicker people.

Many methods of risk adjustment have been suggested. None of them 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.

The problem with this approach is that it does not work very well. 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.[19] More recently, Newhouse and his colleagues have concluded that as much as 25 percent of the variation in health expenditures for individuals can be predicted by such observable factors as health status and prior health expenditure.[20] That leaves 75 percent unexplained.

Some health economists argue that it doesn't matter whether a risk adjustment mechanism is perfect. As long as the adjuster predicts as well as

the health plans themselves, the adjuster can remove any financial incentives a plan has to prefer or avoid a person at the time of enrollment. Yet, this does not solve the problem for two reasons. First, after an initial enrollment, everyone will be a member of a health plan. Therefore, at least one plan can probably predict that member's future health costs better than an impersonal risk adjuster that relies only on statistical data. Second, the perverse incentives of health plans do not end at the point of enrollment. To the contrary, health plans do not have to be able to predict which enrollees will get heart attacks in order to know that it doesn't pay to invest too much in cardiology. The incentive to underprovide to the sick is ongoing, 365 days a year.

If adjustments cannot solve the problem based on prior knowledge of patients, the only alternative is to base them on knowledge of the experiences of patients after they enroll.[21] But if we do that, how much should the plan be paid? Consider again the cost-of-care line in figure 22.2. If the net amount insurers received for each applicant were based on this line rather than on the artificial premium line, insurers would have no reason to overprovide or underprovide care to any enrollee. The problem is that we never get to observe what the efficient cost-of-care line looks like. All an outside observer can see is the actual amount spent. And if we reimbursed health plans for actual expenditures, health plans would have no incentive to provide efficient care. Indeed, the practice of paying providers based on their costs was what led to so much health care inefficiency before the managed care revolution. Whatever the defects of managed care, a return to cost-plus finance is not the answer.[22]

An alternative to paying health plans based on actual costs is to pay fixed fees determined by the patient's diagnosis. This is the way Medicare reimburses hospitals, and it has produced some efficiencies. The reason is that hospitals get to keep the diagnosis-related payment, regardless of actual costs. So the lower their actual costs, the higher their profit or the lower their losses. The disadvantage of this approach is that fixed payment is almost always based on expected average cost for patients with a particular condition. By definition, the sum fails to cover the treatment costs of the sickest patients. The more competitive the market, the greater the pressure is to underprovide to the patients whose cost of care is above average.[23]

Regardless of how risk adjustment is carried out, it can at best ameliorate the problem of quality. It cannot solve it. Even if premiums vary with changes in expected costs, the underlying economics are the same. Health plans here have an incentive to adjust the quality of care they deliver until they are spending an amount on each enrollee equal to that enrollee's risk-adjusted premium.

OTHER BARRIERS TO QUALITY DETERIORATION

Just because health plans have an economic incentive to let treatment costs fall until they are no greater than the premium payments made on behalf of the sickest patients does not mean they will do so. Fear of tort liability lawsuits is one obstacle to quality deterioration. Doctors' fear of censure or loss of a license to practice is another. But these obstacles are somewhat crude instruments for combating incentives that affect every decision providers make.

MANAGED COMPETITION VERSUS SINGLE-PAYER NATIONAL HEALTH INSURANCE

The most serious defect of national health insurance is the tendency to overprovide to the healthy and underprovide to the sick. This, we have seen, occurs because of the pressures inherent in allocating health care resources through the political system. Politicians cannot afford to spend most of the health care budget on the small number who need expensive care. Democratic politics forces them to take from the sick and give to the healthy instead.

However, managed competition, whatever efficiencies it produces, cannot solve this problem. In fact it may make the problem worse. Whereas national health insurance overprovides to the healthy and underprovides to the sick for political reasons, managed competition leads to a similar result because of perverse economic incentives.

MANAGED COMPETITION VERSUS MARKET-DRIVEN HEALTH CARE

One of the ironies of health policy is that some of the strongest critics of national health insurance are also some of the strongest advocates of managed competition; Alain Enthoven is one example. Yet, the closer we come to the ideal world of managed competition, the more likely we are to experience outcomes similar to those of socialized medicine. Moreover, this conclusion is not tied to the design of any particular employer plan. There is a sense in which our entire employer-based system functions as a loose system of managed competition.

Ordinarily, we think of the labor market as being literally a market for labor, with health insurance tacked on as a fringe benefit. But imagine for a moment that it were the other way around. Imagine that employers offered health plans with the provision that you must take a job in order to enroll. Farfetched

as the latter scenario may seem, it is precisely the way thousands of people view the job market. These are people with high health costs or people with a dependent family member whose health costs are high. For this group of potential employees, employers offer competitive health plans—all heavily subsidized and all community rated. The employees switch plans by switching jobs; and because their health costs are so high, the kind of work they agree to do becomes a secondary concern. In fact, they are willing to take jobs for which they are overqualified (a college graduate working in a mailroom, for example) just to access a benefit-rich health care plan.

To large employers with generous health plans, the scenario we are describing is not fanciful. These companies confront similar problems everyday. Indeed, a major reason why K-Mart, Wal-Mart and other large retail chain stores have cut back on their health benefits is not that they are stingy; it is that they were attracting individuals and families with very high health care costs.[24] In protecting themselves from adverse labor market selection, these companies are engaging in the exact behavior predicted by the economic theory of managed competition.

The United States is in danger of evolving a system that underprovides to the sick, not because we have made a conscious decision to socialize health care, but because we have created perverse economic incentives for employers and their employees.

NOTES

1. This section is largely based on John C. Goodman and Gerald L. Musgrave, "A Primer on Managed Competition," National Center for Policy Analysis, NCPA Policy Report No. 183, April 1994.

2. See the brief discussion in the Introduction.

3. The Federal Employees Health Benefits Program (FEHBP) has four main features: (1) federal employees in most places can choose among eight to 12 competing health insurance plans, including Blue Cross and a number of HMOs; (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; and (4) the plans are forced to community rate, charging the same premium for every enrollee. Public employee health benefit options in the state of Minnesota are similarly organized, as is the California Public Employees' Retirement System (CalPERS).

4. Bryan Dowd and Roger D. Feldman, "Employer Premium Contributions and Health Insurance Costs." In Michael Morrisey, ed., *Managed Care and Changing Health Care Markets* (Washington, D.C.: American Enterprise Institute, 1998), 24–54.

5. James Maxwell et al., "Managed Competition in Practice: 'Value Purchasing' by Fourteen Employers," *Health Affairs* 17, no. 3 (May/June 1998): 216–27.

6. The case for managed competition was forcefully argued in Alain Enthoven, *Health Plan: The Only Practical Solution to the Soaring Cost of Medical Care* (Reading, Mass.: Addison-Wesley, 1980). For an update on Enthoven's views on the advantages and disadvantages of the FEHBP, see Enthoven, "Effective Management of Competition in the FEHBP," *Health Affairs* 8, no. 3 (Fall 1989): 33–50.

7. Congress initially exempted itself and other government employees from Medicare coverage, which meant that younger federal employees had to directly subsidize the premiums of eighty- and ninety-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.

8. 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.

9. Alain Enthoven, "The History and Principles of Managed Competition," *Health Affairs* (1993 Supplement): 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* (1993 Supplement): 222; and Joseph Newhouse, "Is Competition the Answer?" *Journal of Health Economics* 1, no. 1 (January 1982): 109–16.

10. Reported in Natalie Hopkinson, "Study Finds Medicare HMOs Target Active Seniors but Not Disabled in Ads," *Wall Street Journal*, July 14, 1998.

11. David Hilzenrath, "Showing the Sickest Patients the Door," *Washington Post,* National Weekly Edition, February 2, 1998.

12. Hilzenrath, "Showing the Sickest."

13. Note that the premium does not have to be the same for all plans, but it must be the same for all members of a given plan.

14. 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.

15. Other analysts have recognized this problem, noting that the 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* (1993 Supplement): 110–22.

16. Edwin S. Dolan and John C. Goodman, "Flying the Deregulated Skies: Competition, Price Discrimination, Congestion." In *Economics of Public Policy,* 5th ed. (St. Paul: West Publishing Co., 1995): 143–59.

17. See William Tucker, *The Excluded Americans: Homelessness and Housing Policies* (Washington, D.C.: Regnery Gateway, 1990).

18. The Jackson Hole Group and other proponents of managed competition argue that open enrollment periods should be infrequent. See Michael Moore, "Risk Adjustment under Managed Competition," Jackson Hole draft discussion paper, March 1993.

19. See Joseph P. Newhouse, "Rate Adjusters for Medicare under Capitation," *Health Care Financing Review* (1986 Annual Supplement): 45–56, cited in Alain Enthoven, "The History and Principles of Managed Competition," *Health Affairs* (Supplement 1993): 24–48.

20. Joseph P. Newhouse, Melinda Beeuwkes Buntin and John D. Chapman, "Risk Adjustment and Medicare: Taking a Closer Look," *Health Affairs* 16, no. 5 (September/October 1997): 26–43.

21. See Harold S. Luft, "Compensating for Biased Selection in Health Insurance," *Milbank Quarterly* 64 (1986): 580; and Alain Enthoven, *Theory and Practice of Managed Competition in Health Care Finance* (New York: Elsevier Science Publishing Co., 1988), 86; and Newhouse, Buntin and Chapman, "Risk Adjustment and Medicare," 34–35.

22. For a discussion of the cost-plus system, see John C. Goodman and Gerald L. Musgrave, *Patient Power: Solving America's Health Care Crisis* (Washington, D.C.: Cato Institute, 1992), chs. 5–9.

23. Under the Prospective Payment System (PPS), there are 503 diagnostic-related groups (DRGs), and physicians and hospitals receive a predetermined amount from the federal government for whatever services they perform. See Goodman and Musgrave, *Patient Power,* 303–6.

24. Bernard Wysocki Jr. and Ann Zimmerman, "Wal-Mart Cost-Cutting Finds a Big Target in Health Benefits," *Wall Street Journal*, September 30, 2003.