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# MANAGED COMPETITION: AN AGENDA FOR ACTION

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by Alain C. Enthoven

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**Prologue:** *More than any other individual, Alain Enthoven of Stanford University has devoted his intellectual energies to transforming the rhetoric of health care competition into the reality of a policy agenda for action. Enthoven initially advanced that agenda in 1978 while he served as a consultant to the then secretary of health and human services, Joseph A. Califano, Jr. Califano rejected Enthoven's proposal in favor of a hospital cost-containment scheme that relied on government regulation. Nevertheless, Enthoven's plan has served as the basis for a decade of discussion over the merits of incorporating market principles into American medical care. He has promoted medical care delivery reform through the marriage of two ideas: (1) the creation of a network of competitive medical plans that would operate under economic incentives that encourage efficiency and (2) the development of a regulatory framework that insures the operation of these plans on a basis reflecting the best interests of society. Ironically, the Reagan administration, which in most instances fervently promotes marketplace approaches to policy making, never warmed to Enthoven's ideas because they included a strong role for government as the regulator of health care competition. In this paper, Enthoven revisits the themes he put forward a decade ago. He relies on economic incentives rather than government mandates to influence the directions of medical care. But he also recognizes that the federal government is never going to allow unfettered competition to rule the allocation of scarce medical care resources. Thus, Enthoven issues a stronger call for managed competition with active agents on the demand side that contract with competing health care plans. This process, he asserts, must be adjusted continually to overcome the market's tendencies to fail. Enthoven, a member of the Institute of Medicine of the National Academy of Sciences, was assistant secretary of defense under former secretary Robert McNamara and also was formerly president of Litton Medical Products.*

**F**or better or for worse, the United States's approach to health care organization and finance is pluralistic, decentralized, and relies heavily on market forces modified by a haphazard array of federal and state regulations, programs, and tax incentives. One reason for this is the American cultural preference, as de Tocqueville described it, for pluralism, diversity, local solutions, and individual responsibility. Another is that reliance on market forces is viewed as promoting efficiency and responsiveness, while institutions such as federal price controls are seen as locking in inefficiency. Whether an efficient system will emerge out of this potpourri remains to be seen. At least in some important respects, we appear to be moving away from these goals. This article accepts the pluralistic policy choice as a given and explores what is needed to make it work.

In recent years, health care in the United States has moved in the direction of "competition," in particular through the rapid growth of health maintenance organizations (HMOs) and preferred provider insurance (PPI) plans, as well as other forms of selective contracting. But we are far from adopting a "competition strategy" of the sort proposed by the "market-oriented reformers" of the 1970s.<sup>1</sup> For a market system in health care financing and delivery to produce a reasonable approximation to efficiency and equity, several conditions must be satisfied.

First, choice of health plan must be cost-conscious. Those who choose one health plan that costs more than another (adjusted for health risks of the covered groups) must pay the extra cost with their own net after-tax dollars. This principle is not yet widespread. Most employers remain on a "defined benefit" or "entitlement to open-ended fee-for-service" plan. Through the tax exclusion, government subsidizes choices of more costly plans.<sup>2</sup> Medicare remains largely a fee-for-service (FFS) system, even under prospective payment. Thus, we still have a large, open-ended, cost-unconscious sector in our health care economy.

Second, the provider community must be divided into competing economic units. One key to economy is matching resources used to the needs of the population served, including numbers and specialties of doctors. Price competition among "limited-provider" or "closed-panel" plans was supposed to put them under economic pressure to bring numbers of doctors and beds into balance with the needs of their enrolled populations. Ten independent practice associations (IPAs) or preferred provider insurance plans in town, with practically all doctors contracting with all plans, is not competition in this sense. Few, if any, communities have experienced real competition of efficient closed-panel plans.

Third, coverage must be universal. Competition systematically attacks cross-subsidies such as charity and bad debt care by doctors and hospitals.

Cost-conscious buyers shop for the lowest price. In a competitive system, if a hospital seeks to load extra charges onto its prices to cover uncompensated care, it will lose business to other hospitals that do not. Increasingly, hospitals find that under prospective payment and selective contracting by Medicaid, HMOs, and PPI plans, nobody is willing to pick up the tab, and financial survival comes to depend on avoiding patients who lack coverage. Today, at least 31 million Americans have no coverage at all, while millions more have inadequate coverage. The original competition proposals of Fleming and myself were for universal health insurance with subsidies and government-sponsored coverage for everyone. In view of the predictable effects of competition on cross-subsidies within hospitals and health plans, we did not consider that competition would produce morally acceptable results except in the context of health care coverage for everyone.

Finally, for competition to produce reasonable efficiency and equity, there must be a system of rules for the competition, subsidies for health plan enrollments, and active management of the process to overcome many sources of market failure. My purpose is not to defend “competition” versus “regulation.” Rather, it is to clarify in principle and in practice what it would take to make competition work to produce efficient care equitably delivered. My analysis is followed by an agenda for action that includes a new approach to universal health coverage.

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### **Managed Competition: The General Idea**

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The markets for health insurance and health care are not naturally competitive. “Deregulation” will not make them competitive. In a free market made up of health care financing and delivery plans on the supply side and individual consumers on the demand side, without carefully drawn rules and active management by sponsors, health plans could pursue profits or survival using competitive strategies that would destroy efficiency and equity. Individual consumers would be powerless to counteract them. The list of such strategies includes selection of preferred risks, market segmentation, product differentiation that raises information costs, discontinuity in coverage, refusals to insure certain individuals or to cover treatment of preexisting medical conditions, biased information regarding coverage and quality, and erection of entry barriers. Market failures also could result from sponsor behavior and the behavior of consumers.

But experience with successful models of competition among health plans suggests that tools are available to enable sponsors to use competition to achieve a reasonable degree of efficiency and equity for their

sponsored populations. Sponsors are active collective agents on the demand side of the market who contract with the competing health plans and continuously structure and adjust the market to overcome its tendency to fail. A sponsor assures each eligible beneficiary of financial coverage of health care expenses at a reasonable price. The sponsor is the ultimate guarantor of coverage, though it may share risk with health plans. In a competitive model, the sponsor serves as the broker that structures the coverages, contracts with the beneficiaries and health plans regarding the rules of participation, manages the enrollment process, collects premium contributions from beneficiaries, pays premiums to health plans, and administers cross-subsidies among beneficiaries and subsidies available to the whole group. In the United States, sponsors are mainly employers, labor/management health and welfare trusts, the Health Care Financing Administration (HCFA), and state governments.

The essence of *managed competition* is the use of available tools to structure cost-conscious consumer choice among health plans in the pursuit of equity and efficiency in health care financing and delivery.<sup>3</sup> The market in a system of managed competition should be viewed as “three-cornered”—including consumers, health plans, and sponsors—and not merely two-sided.

This concept is an important clarification to what Fleming and I wrote in the 1970s. What we both had in mind was something like the Federal Employees’ Health Benefits Program (FEHBP). It subsequently became apparent to me that my 1977–1978 writings left the incorrect impression that I was proposing an unmanaged market system made up of competing health plans on the supply side; and fixed and fairly minimal rules, and only passive supervision of them, by government. Such a market cannot produce efficiency and equity.

I became uncomfortable as some supporters of the competition idea praised this “free-market thinking.” I wrote that we cannot have a completely free market in health insurance.<sup>4</sup> Critics of the competition idea hypothesized a contest between intelligent, adaptive health plans and an unchanging set of rules—an unequal contest at best. As they identified actual or hypothetical problems, I would often reply, “I think that problem could be or is being managed, using the following tools . . .,” implicitly assuming someone was *managing* the process. Finally, my experience as chairman of the Committee on Faculty/Staff Benefits at Stanford University, where four HMOs and a PPI plan compete to serve our 9,000 employees, brought home the reason why our system was working. It was because the university was contracting with the competitors and actively *managing* the process, using competition to achieve as much efficiency and equity as we could.

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## Market Failure

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The reasons for market failure are many and powerful. Here I will explain some of these problems.

**Risk selection.** The most prominent feature of markets for health care coverage in which individuals have a choice of plan is that “health risks” or expected medical costs may be distributed unevenly among the different plans (biased selection). Achievement of a favorable selection may be very advantageous to an insurer. Biased selection may result from insurer action, consumer action, or the interaction of the two as insurers manipulate consumers’ choices. Many techniques exist for selecting risks. Some of them are very subtle. The range of available techniques becomes much more extensive in the case of limited-provider plans. Newhouse and others have hypothesized that such competition would encourage discrimination against the sick in the form of underservice and pressure to disenroll.<sup>5</sup>

In extreme cases, competition among health plans may lead to cancellation of coverage or refusal to renew a policy, producing widespread lack of coverage that is concentrated among many of the people who need coverage most. If not constrained to insure a whole group for the same premium, insurers may seek to subdivide each group into those with higher and lower costs and charge separate premiums to each subgroup. Or a different insurer might contract with each subgroup. This process of subdivision theoretically could lead to complete segmentation of the market to the level of individual risks.<sup>6</sup> This raises the problem of inequity. In the absence of action to the contrary, the sick would pay the full expected costs of their care. Biased risk selection also can occur as the result of opportunistic risk selection by patients: switching plans from year to year because of changes in expected medical needs. It can lead to instability in the marketplace as adverse selection drives up the cost of the more comprehensive coverages. Thus, a “free market” of health plans and individual consumers is likely to include some combination of high premiums and poor coverage for the sick and/or discrimination against the sick.

**Segmentation and product differentiation.** Health care coverage does not naturally come in simple, clean, comprehensive packages that can be compared easily with other packages. There are endless possibilities for differentiating one package from another by including, excluding, or limiting coverage of specific services. As well as being a tool for selecting risks, benefit package design can be used to segment the market to avoid price competition and to differentiate the product in ways that make price comparisons difficult. A market of competing health plans is

particularly easy to segment because health care is largely a locally provided service.

**Information cost.** At best, health care coverages are complex and difficult to understand, evaluate, and compare. This can impair the efficiency of the market, since people will find it very costly in terms of their own time to understand sufficiently the different plans, thus enabling them to choose with confidence. When they find an alternative that seems satisfactory, the “information cost” will deter them from considering other alternatives.

**Discontinuity of coverage.** If not inhibited by contract or regulation, insurers would seek to drop coverage of people with chronic diseases as soon as the contract period expired, or to raise the price of coverage to reflect the patient’s new condition. The latter would create an equity problem. The former creates a problem of discontinuity of coverage. Some insurance plans have had tricky exclusions—“air pockets,” such as no automatic coverage for newborns, that people do not notice until they are in need. Discontinuity interacts with risk selection. Some might propose requiring insurers to offer long-term contracts with a guaranteed annual right to renew. But if insureds who acquire chronic conditions are not also guaranteed the right to enroll with other insurers, they are denied an annual choice of health plan, and competition to cover them is destroyed.

**“Free riders.”** As experience shows, a free market is likely to lead to the noncoverage or undercoverage of large numbers of people. If permitted to do so, many consumers will seek a “free ride” and wait to buy insurance until they get sick. Thus insurers must adopt elaborate strategies to prevent this, including medical review of applicants, waiting periods, and exclusion of coverage for care of preexisting medical conditions. Most insurance companies have withdrawn from the market for individual unsponsored coverage. What remains is mostly poor coverage at high prices.

**Entry barriers and oligopoly.** The presence of even several health plans in an area does not guarantee lively competition. The market may be segmented, or a pattern of “live and let live” may evolve. Potential new entrants to a given market may perceive that the costs of entry are high because, to succeed, they would have to attract patients away from established HMOs as well as the unorganized fee-for-service sector. Even though several health plans are present, each of them might contract with most providers in town in a way that creates little economic competition at the provider level.

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### **Managed Competition: How Sponsors Counteract Market Failure**

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It is not unreasonable to wonder whether any kind of competitive

market that includes individual consumer choice is possible. Nevertheless, we have seen large-group buyers such as the Federal Office of Personnel Management, the State of California's Public Employees' Retirement System, the University of California, Stanford University, and a number of large industrial employers structure workable models of competition and manage them successfully, some for more than twenty-five years. These large-group buyers or sponsors *manage* competition using tools they have found to counteract market failure. The following is an inventory of such tools.

**Pricing.** The perverse incentives in biased selection occur because the insurer cannot charge each insured a price equal to the latter's true expected medical cost (plus administration). This is due to either institutional requirements on the insurer or private information known to insureds but not available to insurers, or both. One important part of the successful management of this problem is to attenuate the incentives for biased selection by a system of accurate pricing. In the extreme, one could imagine a sponsor's soliciting a competitive bid for a year's comprehensive care from each health plan for each insured after allowing each health plan to inspect the medical records and physically examine each insured. Then the sponsor could offer to pay the price of the low bidder on behalf of each insured, leaving it to the insured to decide whether he or she wanted to pay the extra cost to join a higher-priced health plan. Of course, the transaction costs of such individual pricing would be enormous, so practical sponsors and insurers adopt approximations that fall far short of that extreme.

These approximations are called "risk rating." Persons or groups are identified by certain characteristics that help predict medical expense, and a price is quoted for insuring people in each subgroup. Risk rating can be used to accomplish two important things. First, the incentive to discriminate against the sick can be reduced by allowing the plans to charge higher prices for the care of people in categories with greater predicted costs. And second, inequity can be avoided by tying the sponsor's contributions to the costs in each category, thus protecting the sick from higher costs. Such a system does not have to be even near-perfect to work, especially when used with other incentives and contractual provisions that I will describe. Because such a high percentage of cost and variance in cost is associated with a small percentage of patients, I believe effective risk-rating systems, such as the Medicare prospective payment system, will have to use patient-specific diagnostic information for high-cost diagnoses.<sup>7</sup>

**Standardized benefit packages.** The simplest and most effective way to prevent manipulation of benefit packages appears to be for the sponsor to

contract with all of the competing health plans to cover exactly the same standard package of basic health services, possibly even requiring the same schedule of copayments, if any. This would make the coverages easy to compare. I believe these reasons create a strong presumption in favor of standardization. But there are also valid reasons for departing from a standard package in some cases. The “bottom line” on this issue is that the sponsor should control and adjust the benefit packages for the benefit of the covered population, and not allow the health plans to select the coverage they offer for purposes of risk selection and segmentation.

**Annual enrollment process.** In the successful employment-based multiple choice systems, such as the Federal Employees’ Health Benefits Program, the sponsor manages an annual enrollment period. The beneficiaries deal with the employee benefits office, and the benefits office notifies the health plans regarding the beneficiaries’ selection of plans for the coming year. This procedure deprives health plans of a tool for selecting risks through direct contact with would-be subscribers. Sponsors’ management of the process enables them to structure side-by-side comparisons that facilitate informed choice.

**Continuity of coverage.** Disenrollment can be as important as enrollment in the selection of risks. Sponsors must manage the process to prevent health plans from dumping bad risks. Contracts should assure that subscribers can keep their coverage through the contract year and can renew it in subsequent years. Contracts also should provide for automatic coverage of newborns to prevent health plans from avoiding the risks of neonatal care. Indeed, continuity of coverage itself is an important goal, beyond its implications for risk selection, and ought to be a basic law governing all health care coverage contracts.

**Surveillance by sponsor.** Sponsors and health plans should agree in contracts that health plans will participate equitably in covering the sponsor’s entire group of beneficiaries, that they will seek to provide high-quality care economically, and that they will not play games to select risks or segment the market. In matters so complex, there is no such thing as a perfect contract. Enduring business relationships in the private sector usually are built on understanding and trust. Sponsors should monitor health plans’ performance, watch for signs of inappropriate risk-selecting behavior, and take corrective action. Sponsors must be free to use judgment based on reasonable but less-than-conclusive evidence. Graduated responses should be available to sponsors, short of termination of entire contracts.

**Quality assurance.** Some aspects of quality of care and service can be judged adequately by individual patients and their families. But some very important aspects, such as whether effective medical care makes sick



patients better, are statistical matters that can be judged only on the basis of the experience of large populations. This is an undeveloped area, but one in which large sponsors have a much better chance than unaffiliated individuals to develop or obtain the data to evaluate quality. Even without sophisticated quality measures, complaints can inspire the employee benefits manager to confer with the health plan about ways to improve service. There are several steps, short of refusing to renew the contract, that the benefits manager can take with a health plan giving poor service. Ultimately, to be effective in negotiating for quality improvements, the sponsor must be free not to renew the contract without being tied up in court for years.

A competitive market will not automatically produce high-quality care, especially to the extent the market is characterized by poor information about quality. Suppliers to a competitive market seek to produce what the purchasers want. If the purchasers do not measure and demand high-quality care, there is little reason to expect they will get it. It is hard for consumers to judge the technical quality of care. Thus quality evaluation is an appropriate role for sponsors, who need data to do a good job of quality evaluation. Public-sector sponsors also need data to satisfy demands for accountability in the use of public funds. Data are costly to collect, provide, and interpret. Each demand for data should be justified on its own merits with benefits balanced against cost. But if sponsors are buying a service, they have a responsibility to determine what they are buying and whether their beneficiaries are getting it.

**Procompetitive action by sponsors.** Sponsors so inclined can encourage entry of new competitors when they consider the existing degree of competition to be inadequate. A group of employers together could invite a group- or staff-model HMO to open a branch in their area and could promise support in the enrollment process. Or they could divide the provider community into competing economic units by demanding that their contracting HMOs offer panels limited to one or another multispecialty group practice, or to a tightly limited panel of good-quality busy doctors instead of the usual "every doctor in town" offering.

**Sponsor management of subsidies.** Sponsors may manage subsidies or their contributions to achieve several purposes. First, subsidies can be used as a tool to motivate universal coverage within the sponsored group. Usually, having some coverage is not optional, in the sense that individual members of the group cannot take the money the sponsor would contribute to their coverage and spend it on something else. Many employers offer a substantial subsidy, thus giving even the healthy an incentive to insure.

Second, access to the subsidies can be used as a tool to motivate health

plans to contract with the sponsor and to abide by the contractual terms. If the subsidy is available only for enrollments in contracting health plans, the only way health plans can reach that market is by participating in managed competition.

Third, subsidies can be managed to send correct economic signals to health plans and consumers. For example, the sponsor's contribution on behalf of individuals in each risk class should be a fixed dollar amount that is independent of the plan chosen. If people want to enroll in a more costly plan, they should be expected to pay the full incremental cost. Health plans in competition should be allowed to charge people in each risk class what they consider necessary to cover their cost, including return on capital, to serve people in that risk class. They should be economically neutral with respect to enrollments of high-risk and low-risk people.

Fourth, management of sponsor subsidies can promote equity. In a "free market," people with chronic disease would find themselves paying, through premiums or out of pocket, the extra costs associated with their illness. Health plans would want to charge each person a premium sufficient to cover expected medical cost plus administrative cost and profit. This would produce an inequitable situation. Yet, as explained earlier, allowing health plans to charge more to care for predictably sicker people is probably necessary to prevent discrimination against the sick and to take away an important incentive for risk selection. Sponsors can resolve this conflict by adjusting the subsidies to the predicted need of each class of beneficiary. The sponsor should seek to set the subsidies so that the absolute difference between the price of the lowest-cost acceptable plan in each risk class and the sponsor's contribution is the same. Then the price paid by enrollees, at least to join that plan, is the same whether they have high or low predicted medical costs.

Thus, a central idea of managed competition is to shift the locus of cross-subsidies of the sick by the well from health plans and hospitals to sponsors. In price competition, health plans and hospitals cannot be expected to cross-subsidize. To the extent they tried to charge low-cost patients more to subsidize high-cost patients, other health plans and hospitals would offer lower prices to cover or care for low-cost patients and take away the source of the subsidies.

In sum, if large buyers have the motivation, freedom, and understanding to use all of these tools and to develop new ones, it seems reasonable to suppose that an efficient and equitable health care system would evolve to serve sponsored populations. But such good results will not occur automatically. Sponsors must manage the demand side to make the market achieve desirable results.

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### Some Implications

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This is a much more complex, dynamic, and sophisticated view of competition in health care finance and delivery than one usually finds in apologia for free markets. This should not be too surprising. Health care finance and delivery are exceptionally complex fields of activity. The complexity is not especially a product of the competition strategy. It is an inescapable problem for anybody who cares about equity and efficiency. The British and Canadian systems might appear simpler than a system of managed competition, but they cap total spending and contain little or no incentive for efficiency. (They do avoid some of the gross forms of waste that characterize the present American system.) If they got serious about efficiency, they would face many of the same problems.<sup>8</sup>

This view of competition has a number of implications. First, the holy grail of “the level playing field” cannot be found simply in a fixed set of rules passively administered. Such fixed rules would create an unequal contest in which health plans could develop their strategies creatively in the absence of active countermeasures. Additionally, there must be referees who can watch the play and make judgment calls and a commissioner who can modify the rules.

Thus, fair competition must find its practical realization as much in a process as in a set of rules. One requirement of such a process must be unbiased sponsors motivated to make the process work. Such sponsors may be few or nonexistent. For example, a sponsor cannot be unbiased if it has its own self-insured or experience-rated plan and seeks to dump its bad risks onto community-rated plans. A great deal of sponsor bias comes from contribution policies such as employer-pays-all, thereby paying more on behalf of people who choose more costly health plans. Public-sector sponsors may grant preference to a health plan because its owner has made well-placed campaign contributions. Public and private sponsors may be unable to manage competition according to the economic principles of efficiency because health care is only one of the items on their agenda and because it is in their interest to trade off health care efficiency for other issues.

“Leveling the playing field” refers to the rules of competition within a sponsored group. Consider, for example, the standardized benefit package. What is important is standardization within any sponsored group; it is not necessary to have uniformity across groups. Thus, external rules that apply to some competitors and not to others are counterproductive. For example, suppose an unbiased, appropriately motivated sponsor wishes to offer employees a choice of some HMOs, some commercial insurers, Blue Cross/Blue Shield, and perhaps a self-insured, self-admin-

istered plan. The HMOs, if federally qualified, must cover a certain benefit package. The commercials and the Blues may be under various mandates concerning covered benefits or services, and inhibitions regarding selective provider contracting. The Employment Retirement Income Security Act (ERISA) preemption leaves the self-insured plan free of all these restraints. It could be very difficult for this sponsor to level the playing field.

The sponsor needs to be large enough and the sponsored group diverse enough that risks can be spread and that there are sufficient numbers of healthy to subsidize the costs of the sick. Also, the sponsor needs to be large enough to achieve economies of group purchasing and to acquire the needed data and expertise. I doubt that employers of 100 or fewer employees, perhaps even 500 or fewer, are likely to be large enough to be effective sponsors.

Fairness in pricing is a function of the sponsor's contribution policy. A health plan that has suffered adverse risk selection must charge a higher average price than an equally efficient plan that has experienced a favorable selection. Whether pricing to the consumer is fair depends on whether the sponsor makes appropriate risk-related contributions.

Finally, the sponsor role could be shared between government and private-sector sponsors in various ways. For example, the government could make fixed risk-related contributions on behalf of individual subscribers to health plans meeting general requirements, but leave to the private sponsor the job of contracting with health plans and managing the process.

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### Agenda For Action

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**Education.** This is a much more complex view of what it takes to make competition produce acceptable results than what apparently has been perceived by most employee benefits managers and public officials. For example, several of the provisions of Section 1876 of the Medicare law reflect a lack of understanding of the requirements of managed competition. Many employers who continue to pay the full price of the HMO of the employees's choice, up to the level of the insured FFS plan, and then express surprise and disappointment that the HMOs engage in "shadow pricing," apparently do not understand the economic principles of this market.

Statements of the basic principles of competition have been around for at least ten years. But much of our present understanding of pricing is based on recent and fast-moving research.<sup>9</sup> For example, in the summer of 1987, HCFA convoked a study panel on the adjusted average per capita

cost (AAPCC) to examine the Medicare HMO pricing system. The depth of understanding and the subtlety of research on which it was based were far ahead of what was available even a few years ago. Moreover, experience with Medicare PPS has taught us a good deal about pricing based on diagnostic information. This information needs to be communicated to a wider public. I believe a large and important job of education is ahead of us if we are to achieve a general level of common understanding sufficient to make managed competition work.

**Social compact.** The commercial insurance industry seeks to insure people who do not need care and to avoid insuring anyone who might be a higher-than-average risk. This is understandable from the point of view of profit maximization and self-protection from the free-riding proclivities of the general public. But it can produce unsatisfactory results in a society that seeks equitable coverage for all. If the industry is made up largely of firms dedicated to maximizing profit through aggressive use of risk selection and other techniques outlined here, then there is plenty of reason to be pessimistic about the ability of managed competition to produce acceptable results.

The commercial insurance industry has used its considerable political resources to assure its ability to make a short-term profit rather than to create a social framework that would assure everyone equitable coverage while still allowing the companies to make a good profit. One example is the industry's opposition to converting the tax subsidies to health insurance from today's open-ended exclusion of employer contributions from the taxable incomes of employees to a system of refundable tax credits or other fixed-dollar subsidies equally available to everyone. If this large and powerful player persists in opposing efficiency and equity, it will be very difficult to achieve agreement on a set of rules that will guide the market toward, rather than away from, these objectives.

The situation calls for responsible action and enlightened long-term self-interest. We need an industry of competitive managed care plans that understands and accepts the rules and spirit of managed competition and is willing to support policies that cover everyone. We need a social compact that reconciles market forces and equity. If we cannot achieve this, then I think the appeal of something like the Canadian model will become very strong. In contrast to our worsening paradox of excess and deprivation, the Canadians cover *everybody* for about 8.5 percent of gross national product (GNP), and they do it without the help of insurance companies.

How would the principles of managed competition apply more specifically in practice? First, the government should seek to be an ideal sponsor for the populations it now sponsors.

**Medicare.** The following is a list of ways in which the federal government could make the HMO/competitive medical plan (CMP) option in Medicare, Section 1876, into a much more effective system of managed competition.

(1) HCFA should see its role as that of an *active sponsor* on behalf of its beneficiary population, managing Section 1876 contracts the way an enlightened employee benefits office would—monitoring performance and acting promptly to correct problems. The Reagan administration was misled by too much confidence that the market would take care of the problems of deficient health plans.

(2) The formula for paying HMOs, the AAPCC, suffers from numerous deficiencies and anomalies. The variables used to adjust for patient risk explain little of the variation in individual medical expenses. This leads to concern over inadequate or excessive payments because of biased selection, and incentives to avoid enrolling, to disenroll, or to underserve patients who are seriously ill. There is a need for a risk-rating system that uses specific diagnostic information about high-cost patients. Because Medicare FFS costs are the standard, the AAPCC varies widely from one county to another in amounts not explained by differences in factor prices or medical need. These variations result from factors such as practice patterns; supply of providers; presence or absence of veterans and military retirees eligible for Medicare, working aged, and “snowbirds” whose numbers may appear in a county’s Medicare population denominator but whose medical expenses may not appear in the numerator; and presence or absence of supplemental insurance. Yet the reference to FFS costs cannot be abandoned altogether because of equity and the fact that HMOs must compete with FFS. Various approaches are possible. What is needed is a transition to a rational prospective payment system that enables efficient HMOs to participate and prosper.

(3) The requirement that HMOs provide “Medicare benefits” for an amount that does not exceed 95 percent of AAPCC may force the HMO to do more for 95 percent of AAPCC than Medicare does for 100 percent. The HMO has to pay the entire actual doctor fee while Medicare pays 80 percent of the fee it approves; the HMO must provide access that is typical for people with supplemental coverage. Some HMOs have reason to fear that as Medicare “ratchets down” on FFS, those providers will be able to shift costs to cost-unconscious non-Medicare patients while HMOs will not be able to do so. The effect may be to force non-Medicare HMO patients to subsidize Medicare patients even in efficient HMOs. HMOs should be allowed to set their price at whatever they think they need, and the government should rely on managed competition (with FFS Medicare and with Medigap if HMOs are not available) to hold

down the price.

(4) All HMOs should be required to offer a standard benefit package that includes Medicare services without limit on physician and hospital services and then be allowed to offer one or a few separately priced optional add-ons. I appreciate the difficulties: some HMOs will argue they should not be forced to offer more than Medicare, while others will not want to limit coverage of hospital days. Perhaps passage of catastrophic expense coverage will help to simplify this. In any case, competition can be defeated if HMOs are allowed too much latitude in designing benefits packages.

(5) There should be a coordinated annual open enrollment in each area run by HCFA or a neutral broker with enrollment transactions managed by the broker, and with good comparative information provided to beneficiaries.

(6) The present option to disenroll in thirty to sixty days is an invitation to abuse that adds to cost and complexity. It ought to be replaced by the annual lock-in that has proved itself and become standard in the private sector for over forty years.

(7) There should be active surveillance of disenrollment patterns and active quality monitoring, with meaningful information provided to consumers. HCFA should support consumer coalitions that want to survey consumers about satisfaction and publish the results.

(8) HCFA should explore possible procompetitive strategies to encourage high-quality HMOs to enter noncompetitive markets.

**Medicaid.** Medicaid and HMOs have never been very compatible. State governments like to be able to make sudden, across-the-board cuts in response to budget stringencies. Efficient HMOs have no easy way to absorb such spending cuts. Unfortunately, government has often proved itself to be an unreliable business partner.

Fluctuating Medicaid eligibility adds to administrative costs. HMOs contract and plan based on annual lock-ins. Having a defined population for which to plan resources is an essential part of economy in health care. When people "spend down" into Medicaid eligibility, there is a problem of adverse risk selection and instability. In effect, if Medicaid enrolls "spend-downs" in an HMO, it is attempting to use the HMO as an episodic care system. Good HMOs have been able to get all the private-sector business they can handle. Why get involved with the state and face the risks of acquiring a welfare image, of getting caught in political cross-fires, and of attempts by legislatures to force them to subsidize Medicaid?

In principle, I believe Medicaid programs ought to look like employee benefits offices, offering beneficiaries a choice of mainstream HMOs and PPI plans, with continuous guaranteed annual enrollment. But I am

inclined to think this will have to await the arrival of universal health insurance.

**Public employees.** For twenty years after its inception in 1960, the Federal Employees' Health Benefits Program (FEHBP) served as a model of health plan competition and cost-conscious choice. It demonstrated the feasibility of choice-of-plan arrangements and opened this important market to cost-effective managed care systems. And it gave millions of federal employees and their dependents the opportunity to get more value for their money by choosing efficient systems of care. The FEHBP did suffer from significant design deficiencies, but market forces in the 1960s and 1970s were sufficiently attenuated that these deficiencies did not cause serious problems until the 1980s, when, among other things, instability was induced by adverse selection. Here are some of the problems and suggested corrections.

(1) *Multiple "free-choice" fee-for-service plans.* The FEHBP now offers a bewildering array of "free-choice" FFS insurance plans. Many of these are offered through employee associations that rake off millions of dollars of unearned profits through "associate member" dues. The multiplicity of such plans contributes very little to provider competition. Rather, it creates a setting for risk-selection games by health plans and employees. It contributes to excessive consumer information costs, forcing consumers to evaluate differences that serve no useful social purpose, and to instability induced by a cumulative process of adverse selection. This multiplicity drains resources of the Office of Personnel Management (OPM) that could be used elsewhere. Some of these plans (such as the Foreign Service Overseas plan) serve genuine specialized needs, but most do not. They should be reviewed, with a view to consolidation into relatively few offerings.

The multiplicity of HMO/CMP offerings, on the other hand, does contribute to local provider competition and does increase employees' access to cost-effective managed care plans. These plans do not contribute to a "bewildering array" because, generally speaking, only a few serve any employee's area of residence. OPM ought to be provided the resources to supervise and manage these offerings effectively.

(2) *High options attract bad risks.* Several of the carriers have offered "high-option" and "low-option" or "standard-option" plans. The high-option plans have attracted a progressively worsening mix of risks, actually driving some of them out of the market.<sup>10</sup> These plans ought to be consolidated into a single standard plan in each region. OPM should be authorized to make periodic adjustments in deductibles and other aspects of plan design to keep the mix of health risks they attract sufficiently close to those attracted by the HMOs so that they can remain



viable competitors.

(3) *Multiple benefit packages.* The plans offered include a great variety of benefit packages. This multiplicity contributes to segmentation, risk selection, and consumer information costs. For example, some plans do not cover outpatient prescription drugs, an effective technique for avoiding patients with costly chronic diseases. Benefits packages should be standardized.

(4) *Retirees in the same risk pool.* Active employees, retirees without Medicare, and retirees with Medicare (who use their FEHBP coverage as a Medicare supplement) are all rated in the same risk pools. Because retirees without Medicare have predictably much higher costs than active employees, the competitive position of health plans with higher percentages of such retirees is damaged. Thus, they have an incentive to be unattractive to retirees. At the same time, the combined coverage is overly generous to retirees with Medicare. The FEHBP should introduce a system of risk rating with separate categories and prices for active employees, retirees without Medicare, and retirees with Medicare. To the extent equity demands it, the beneficiaries should be held harmless by appropriate adjustments in the employer contribution. More sophisticated risk-rating systems should follow.

(5) *National versus regional pricing.* Because the FFS plans are priced nationally and because health care costs vary widely among regions, the competitiveness of these plans depends on the accidents of geographic location of their subscribers. HMOs price by geographic area, and FFS plans should do likewise. Then competitiveness will more clearly depend on the efficiency of local providers and insurers. Experience with Medicare shows that defining areas for health plan pricing is a complex issue that will take time, research, and politics to resolve. Eventually, it would make sense for the federal government to settle on one geographic system for pricing all its health plans.

(6) *Employer contribution tied to fee-for-service.* The government, as employer, contributes 60 percent of the unweighted average high-option premium of six of the largest health plans in the FEHBP (but not more than 75 percent of the premium for any plan). This selection is dominated by high-option FFS plans. The problem with this is that traditional free choice is going into a “death spiral.” The providers remaining in that sector are those least willing to contract and to accept utilization controls. As HMOs balance their numbers of providers with the needs of the populations they serve, the excess of providers becomes more concentrated in the “noncontracting” sector. And providers with some of their business in HMOs and PPI plans and some in the free-choice sector compensate for reduced revenues in the competitive sector by charging

more in the free-choice sector. The government, like employers generally, needs to disconnect its contribution from the FFS sector's costs. For example, it might instead adjust its contributions for regional costs and raise them each year in proportion to HMO dues rates, which are increasing at a much lower rate.

**Government and private-sector employers.** In this section, I discuss employers large enough to be competent sponsors.

(1) *Cost-conscious demand.* One of the most fundamental reforms needed to create a competitive health care economy is to create full cost-consciousness in choice of health plan on the part of economically self-sufficient persons. One of the main reasons for the continuing acceleration in health care spending as a share of GNP is that so many people remain in the open-ended cost-unconscious sector in which there is no incentive to contain costs. A recent survey indicated that in 1986 as many as 54.9 percent of employers paid the entire health insurance premium for their employees, up from 38.6 percent in 1981.<sup>11</sup> In such an environment, even if HMOs are offered, there is little or no price competition.

In a community in which most employers are in the open-ended system, an individual employer can gain little by converting to a defined contribution approach and making its employees cost-conscious. The HMOs can get plenty of business without cutting price. So the employer's health care costs are likely to rise with those of other employers in the community. The most important effect of cost-consciousness comes when most or all of the employers convert to a cost-conscious approach. Then the health plans have to compete on price and efficiency. Thus, some collective action is needed. One powerful remedy would be a limit on the amount of employer contribution that can be tax-free to the employee, or, better still, replacement of the exclusion by refundable tax credits or other fixed-dollar subsidies usable only for the purchase of health care coverage.<sup>12</sup>

(2) *State and federal mandates on health care coverage.* Today numerous state and federal mandates govern health care coverage contracts. They fall unevenly on the different types of coverages. This makes it difficult, if not impossible, for some employer/sponsors truly to level the playing field. Many of these mandates of particular provider services are little more than income protection for provider groups.

From a managed competition perspective, perhaps the best action would be for the federal government to preempt regulation in this area and to replace all mandates on HMOs and health insurers, as well as any remaining inhibitions on selective provider contracting, by a set of fairly general minimum requirements placed on employer/sponsors as a condition of favorable tax treatment of the employer's entire health plan. This

list would include catastrophic expense protection (an annual limit on employees' out-of-pocket expenses for a defined list of services), continuity of coverage (such as that mandated in the Consolidated Omnibus Budget Reconciliation Act, 1985), nondiscrimination, offering of coverage for dependents, a ban on waiting periods and exclusion of coverage for preexisting conditions, and a prohibition on cancellation of coverage for reasons other than nonpayment of premium.

(3) *Risk rating and biased selection.* Employers who offer their own self-insured or experience-rated health plans in competition with community-rated HMOs have powerful incentives to bias the selection by counseling high risks into the community-rated plans. I believe this will force HMOs gradually to convert to "utilization-adjusted community rates," an approximation of experience rating. In that circumstance, health plans that attract sicker patients will have to charge higher premiums. If the employers do not risk adjust their contributions, they will, in effect, be requiring sicker employees to pay more for coverage, damaging the competitive position of the health plans suffering the adverse selection, and allowing the plans with the best risks to profit.

To survive in such competition, the plans getting the high risks will have to find ways to avoid enrolling such patients. Managed care plans will have an incentive to avoid enrolling or to disenroll the sickest patients—just the ones on whom their expertise can yield the largest savings. For the competitive system to work, employers must learn to risk adjust their contributions.

Today few employers know much about risk adjusting contributions or risk rating in general. Moreover, the industry would become even more chaotic if every employer/sponsor insisted on its own risk-rating system. The data requirements and other administrative costs would be enormous. The federal government could help to produce a more efficient outcome by sponsoring research and development in risk-rating systems, as HCFA does for Medicare. Perhaps the FEHBP would be a good choice for a pilot program. There will be a need for some institutional mechanisms that encourage employers and health plans to agree on one or a few risk-rating systems so that everyone can work from the same definitions and data sets.

**Government as a sponsor for the unsponsored.** We Americans have stumbled into a system of health care finance that is extremely unfair. Our employment-based system of coverage protects most of those who are steadily employed with a strong employer or through a strong union, subsidizes the coverages of those with higher incomes, and excludes millions who are unemployed, employed part-time (including multiple part-time jobs), self-employed, working for employers who do not offer

health care coverage, retired and under sixty-five, and others. The great majority of these people are not offered even the opportunity to buy decent coverage, especially if they have a history of chronic diseases. And they do not receive the tax subsidies that average- and upper-income employed people enjoy. (Even successful business executives who believed themselves exempt from any unfilled material need may find themselves without a job and without health insurance when their company is acquired by another or when the company from which they retired goes bankrupt and cannot continue to pay medical bills. Their dependents may be “uninsurable.”) This system has strong support from those who benefit from it, but its unfairness should be obvious.

The uncovered are increasing in number, and their plight is worsening. The growth of competing limited-provider plans attacks the internal cross-subsidies that used to enable hospitals to provide “uncompensated care.” Moreover, in the wake of growing numbers of uninsured and the taxpayer revolt, county hospitals and other public providers of last resort are increasingly strained. Competition can produce morally acceptable results only in the context of universal coverage or provision of care.

Universal health insurance in the United States would not have to entail massive income redistribution. In at least some European countries, health insurance is supported by payroll taxes paid primarily by the same income groups as benefit from the coverage. Universal health insurance does not have to mean drastically altering the arrangements that millions of insured Americans consider satisfactory now. Universal health insurance would not have to mean “socialized medicine” with the extent of government involvement found in Canada, Great Britain, or Scandinavia. But universal health insurance does have to be “compulsory” in the sense that each person must pay what society considers appropriate and then is entitled to coverage. The nongroup sector in the United States, a market characterized by freedom of individuals to insure or not and of insurance companies to insure people or not, breaks down because of free riders and risk selection. Thus, to achieve universal health insurance, we must have public policies that require everyone who is able to contribute to do so and that make coverage available to everyone at a reasonable price.

I proposed one such model, the Consumer Choice Health Plan, in 1977.<sup>13</sup> It would have replaced employer-sponsored coverage with the government as sponsor for everyone. That may still prove to be the only practical model of competition. But one of its political shortcomings is that it would upset existing arrangements that millions of employed Americans consider satisfactory. It would be more acceptable politically to attempt a model that blends private sponsorship, where it is satisfac-

tory, with public sponsorship where private sponsorship fails to do the job.

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### **Universal Health Insurance**

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Here, in broad conceptual outline, is how our employment-based system of health insurance might be extended to achieve near-universal coverage. I do not put this forward as a finished proposal, but to suggest that the development and implementation of such a plan should rank high on the agenda for action.

(1) The federal government should enact legislation giving each state powerful incentives to create a “public sponsor” agency to serve as sponsor for the unsponsored.

(2) The federal government should require all employers to arrange and pay for most of the coverage of all full-time employees (defined as, say, twenty-five hours per week or more). Small employers would be able to contract for this through the public sponsor at a cost not to exceed, say, 8 percent of payroll.

(3) The public sponsor would contract with a wide spectrum of managed care plans to be offered to the participating population in a competitive annual enrollment.

(4) The public sponsor would offer to contract with any individual who wishes to participate and abide by the conditions of participation. The sponsor also would contract with small employers who believe that they cannot be effective sponsors and wish to benefit from the economies of scale of a statewide agency. The conditions would include enrollment during the annual open enrollment period (say, the month of November for the coming year) and a “lock-in” for the full year. Participants would pay in advance and specify a regular method of payment (payroll deduction or a standing order to a bank).

(5) Individual purchases of coverage would be subsidized so that the remaining cost to the individual subscriber would be low, ideally practically free for the lowest-priced coverage. Sources of money for the subsidies would include the following. First, a payroll tax of perhaps 5 to 10 percent of the first \$20,000 (or some such amount) would be enacted with proceeds payable to the public sponsor. This tax would not be payable on behalf of employees covered by a qualified plan. Thus, the great majority of employer-sponsored people would be unaffected except for the replacement of their income tax exclusion by a fixed-dollar subsidy. Thus all employment would bear the costs of health insurance roughly equally. There no longer would be a large economic advantage associated with not covering employees. This tax would provide a means of aggregating

contributions from millions of people not currently insured. The progressivity of the tax would be worked out in the political process. Second, the exclusion of employer contributions from taxable incomes should be repealed or capped. If the exclusion is repealed, the substantial revenue savings to the federal budget (variously estimated at \$35 to \$50 billion) would be converted into risk-rated fixed-dollar payments for subsidizing health care coverage. And third, current sources of support for "uncompensated care" would be tapped for support of universal coverage.

(6) Generally speaking, people would keep whatever coverage they had for a year at a time. COBRA continuity provisions would be modified to require employers to make continued purchase of existing coverages available at subsidized group rates only to the end of the year to people who lose membership in the employed group. That would give people time to enroll for the coming year through the public sponsor.

Some may be concerned that the availability of public-sponsored insurance would induce many employers to drop their own provision of coverage for part-time workers. Of course, under this scheme they would then have to pay the payroll tax. If the taxes and subsidies are arranged appropriately, it should be a matter of indifference from the public policy perspective whether people are covered under employer-sponsored or public-sponsored insurance. If individuals and employers make the decision on the merits of each, the interests of efficiency should be served.

I am not yet prepared to say that this is the best or even a feasible model. Preliminary efforts to work out the details suggest the problems of blending public and private sponsorship are complex. It may be that a universal public sponsor is more practical. What I am prepared to argue is that the design of an equitable, efficient model of universal health insurance deserves to be at the top of the agenda for action.

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## NOTES

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