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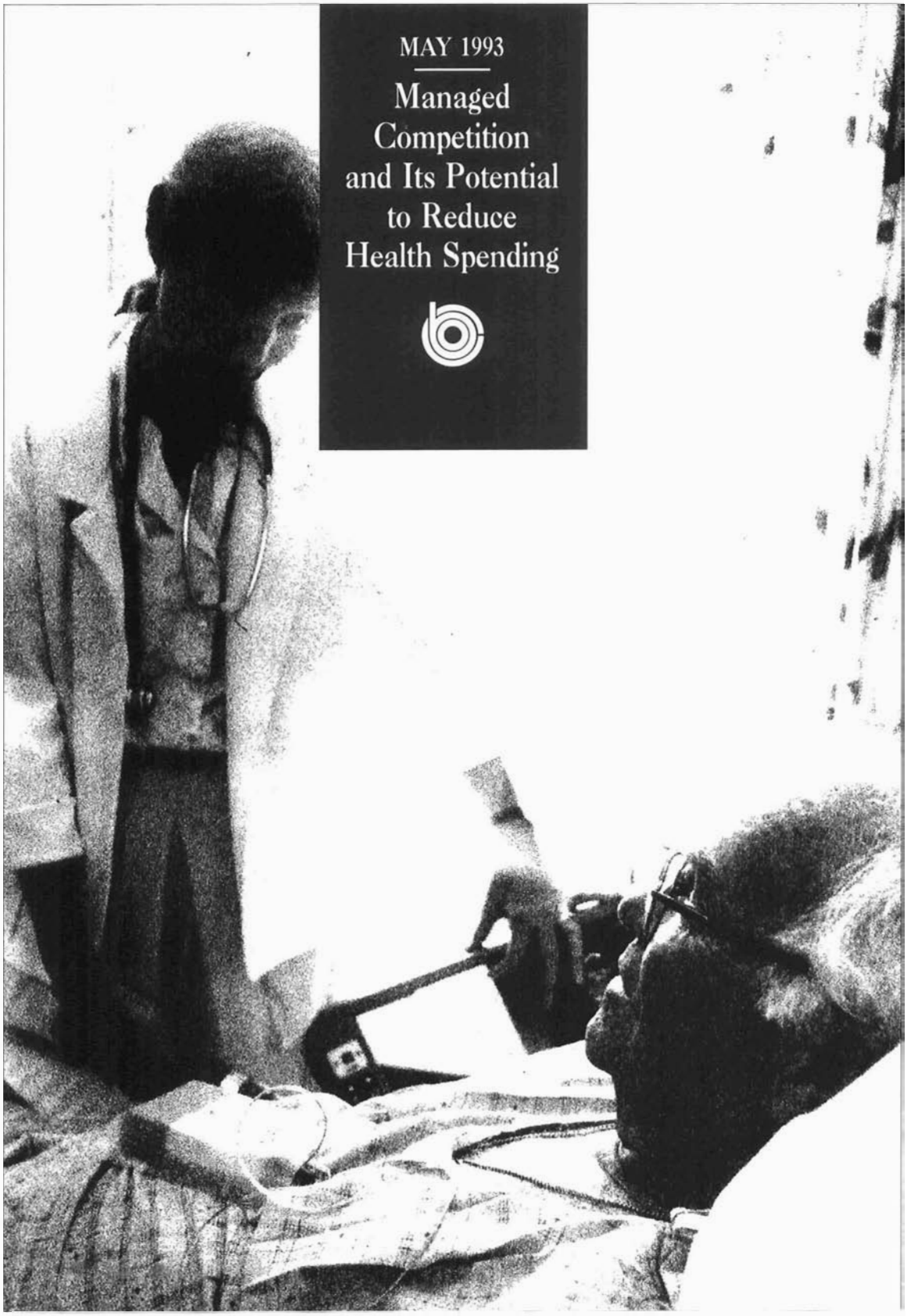
Managed Competition and Its Potential to Reduce Health Spending



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MANAGED COMPETITION AND ITS POTENTIAL TO REDUCE HEALTH SPENDING

The Congress of the United States
Congressional Budget Office

NOTE

Numbers in tables may not add to totals because of rounding.

Preface

The Congress is considering a range of alternatives for reforming the health care system. This study, requested by the Subcommittee on Health of the House Committee on Ways and Means, examines the potential of the managed competition approach to reduce the level and rate of growth of national health expenditures, and the specific features of managed competition that could generate significant savings. In keeping with the Congressional Budget Office's (CBO's) mandate to provide objective and impartial analysis, this study contains no recommendations.

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Robert D. Reischauer
Director

May 1993

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Summary

Although many aspects of the current U.S. health care system are highly regarded, the system as a whole is widely perceived to be in crisis. Health care spending, which absorbed 7.4 percent of gross domestic product (GDP) in 1970, consumed about 14 percent of GDP in 1992. Current trends would raise this share to 19 percent by the year 2000. Yet about 35 million people lacked insurance coverage in 1992. Others fear that their health insurance coverage might not continue. Many analysts interpret these problems as evidence that markets for health services and insurance fail to function satisfactorily and may need restructuring.

Two distinctive characteristics of health care markets are that the likelihood of any individual becoming ill is uncertain and that the costs associated with treatment are potentially high. These characteristics cause a highly uneven distribution of health expenditures and lead people, rationally, to seek insurance for their health care costs. Current insurance arrangements, however, alter how consumers, insurers, and providers behave in ways that increase health spending.

Insurance gives consumers greater financial access to health care, but in the process allows them to pay little heed to costs when they need major medical attention. This lack of price-consciousness is compounded by favorable tax treatment of employers' contributions to employees' health insurance costs, which encourages employees to purchase more generous insurance plans than they otherwise would.

Moreover, insurance creates strong incentives for insurers to maintain profits by selecting people who are thought to be favorable risks. To minimize claims from people who are likely to need medical care, many insurers use background information about the health status of applicants to limit the individuals, the medical conditions, and the time periods for which they will offer coverage and to vary premiums accordingly. Insurers also tend to set significantly higher premiums for individuals and small groups than for large groups.

Insurance has insulated providers of health care services as well from financial pressure to practice medicine in the most cost-effective ways, although it had done so less fully in recent years. Also, providers confront an array of private insurers and government health care financing programs that vary in their market power and their ability to insist on discounted prices. As a result, providers have incentives to charge different purchasers different prices for the same services. On average, for example, Medicare and Medicaid pay hospitals less, relative to the costs they incur, than indemnity insurers pay.

An Overview of Managed Competition

Managed competition is one of several proposed strategies for fundamentally reforming health care. It emphasizes motivating consumers, insurers, and providers to be more cost-conscious, and it tries to imbue the health

care system with the efficiency, flexibility, and innovation of competitive markets, without the undesirable outcomes of the present system. Much decisionmaking would remain decentralized. Managed competition would also pursue expanded or universal access to health insurance coverage, partly because that is an objective in its own right and partly because shrinking the pool of uninsured people would enhance the effectiveness of other changes designed to contain costs.

To alter incentives for consumers, managed competition would eliminate, reduce, or measure the nonprice differences among insurance plans--for example, standardizing coverage, measuring the average quality of care under each plan, and setting premiums for plans based on the average health status among the population. It would then make individual consumers use their own after-tax incomes to pay the additional costs of purchasing insurance plans other than the least expensive one within their region.

In those ways, managed competition would encourage consumers to be more price-conscious when making decisions about their health insurance. In turn, that would give insurers, and through them providers, motives to become more cost-conscious and efficient. Managed competition would shift the focus of competitive behavior in health care markets from amenities and perceived quality to differences in price for measured differences in quality. It would rely on price competition among networks of providers that are organized by insurers (insurer/provider networks) to provide the spur to efficiency.

For insurers, managed competition would make it more difficult to compete by attracting relatively healthy consumers or by emphasizing the unmeasured, nonprice advantages of their plans; payments to insurers would be adjusted for differences in the average health status of the members of their plans. It would also create an impetus for insurers to develop networks of affiliated providers who delivered high-quality, cost-effective care and to pay providers the lowest acceptable prices for their services.

In this altered environment, providers would be challenged to find more cost-effective ways to deliver clinically effective care of high quality and would possibly also have incentives to form groups to negotiate with insurers. In addition, those developing new medical technology would find that innovations that reduced total health care costs would be relatively more attractive to providers and insurers under managed competition than under the present system.

Managed competition--an approach that has not been tried anywhere in the world--would require new kinds of institutions to be established, new information and analyses to be developed and used, and new patterns of behavior among health care providers, insurers, and consumers. Its success or failure would hinge on the interaction of its many parts. Managed competition could increase access to insurance and thus to health care services. It could also reduce spending on health care for those who are currently insured.

To cut spending substantially, however, managed competition would have to restructure the health care market dramatically. Consumers would probably have less choice, more limited access to many providers, fewer services, and slower access to new technologies. In addition, the number of insurers could drop dramatically, and providers would be paid at lower rates and would face more extensive guidelines when making clinical decisions. In other words, the type of health care people receive and the manner of its delivery would change significantly.

Opponents of managed competition criticize it on various grounds. They are skeptical that it would work at all and note that the proposals rely on various elements whose feasibility or effectiveness are unproven. These elements include, for example, new organizations to manage regional health insurance markets that might themselves not face strong incen-

tives to perform effectively. Also necessary would be new systems to collect standardized data, monitor the performance of providers, and adjust payments to insurers for the average health status of their enrollees.

Thus, critics observe, the effectiveness of managed competition in containing health care costs remains a matter of conjecture. They also point to the major and often disruptive changes--noted above--that would be necessary to control costs. Finally, because the basic managed competition model relies on effective price competition, critics conclude that it would not work satisfactorily in many rural areas, where the population is too scattered to support multiple insurer/provider networks, or in those inner-city areas where providers are sparse.

Keys to Achieving Potential Savings on Expenditures

Many different proposals have been put forth under the "managed competition" umbrella. Some would reduce national health expenditures, while others would have little effect. Eight specific features in managed competition proposals would greatly enhance the prospects for achieving the full savings potentially available under that approach.

One key feature is to create regional organizations (for example, health insurance purchasing cooperatives, or HIPCs) that would oversee and operate the restructured insurance market and help consumers make better-informed choices of standardized plans. Among other things, each HIPC would determine which insurers could offer plans in its region, notify all potential purchasers about the various plans available and the quality of their care in previous years, enroll consumers in the plan of their choice, collect premiums, remit the premiums to insurers after adjusting them for differences among plans in the average health status of each plan's enrollees, and monitor whether insurers complied with their contractual obligations.

Creating HIPCs is a key element in managed competition for several reasons. HIPCs would reintegrate and thereby enlarge the currently segmented market for health insurance. By organizing the demand side of the market and enforcing open access to health insurance, HIPCs would also create countervailing power for purchasers of this insurance in their relationship with its sellers. In addition, HIPCs would restructure competition within insurance markets by providing clearer information about differences among insurer/provider networks, inhibiting insurers from pursuing nonprice competition based on selection of favorable risks, and increasing the incentives for insurer/provider networks to reduce premiums by delivering high-quality care to their enrollees in more cost-effective ways.

A second key feature is a requirement that employers contribute no more than a fixed dollar amount toward their employees' health benefits. The limit could not exceed the premium for the least expensive plan available through the HIPC. This feature would effectively limit the open-ended tax subsidy to employment-based health insurance and would require the additional cost of purchasing a more expensive plan to be paid out of pocket from the consumer's after-tax income.

Third, to help minimize nonprice differences among insurance plans and to reduce the ability of insurers to pursue favorable selection, two standardized insurance plans would be specified as the only plans that insurers could offer through the HIPC. Both plans would cover identical services, but they would incorporate alternative standardized copayment provisions. One would have copayment provisions modeled on the low deductibles and coinsurance typical of health maintenance organizations (HMOs), while the other would have provisions modeled on the higher deductibles and coinsurance typical of indemnity insurance plans. In addition, to en-

hance the savings from managed competition, there would be prohibitions on balance-billing and supplemental insurance covering the standard copayments, additional services, or alternative coverage outside the managed competition framework.

Allowing two patterns of copayments to be combined with standardized coverage of services would enable people who selected indemnity insurance to pay higher copayments to retain the right to exercise greater choice over their providers. It would also avoid the higher health care use and spending that could result if indemnity insurers were required to set lower coinsurance rates that were closer to those of HMOs.

A fourth feature is a new system to make available uniform, reliable data on the costs, outcomes, and quality of care for individual providers and each insurer. Consumers could then take account of any differences in the quality of health care services and the medical outcomes for the patients receiving them when interpreting the significance of price differences between insurers.

Fifth, changes in the marketing of insurance would create open access to health insurance for all individuals on an essentially equal basis. Insurers would be required to offer open enrollment periods, base premiums on community rating (with only a small number of categories), eliminate restrictions on coverage for preexisting conditions, and guarantee renewal of coverage. Individual consumers could choose for themselves which of the plans offered through the HIPC they preferred, rather than having an employer select one plan for all employees. In addition to promoting access to insurance and thus to health care services, open enrollment would make it harder for insurers to enroll only the healthiest consumers and, in this way, would induce insurers to compete by organizing more cost-effective systems for delivering care.

Sixth, some mechanism would be required that assured insurance coverage for each individual. This mechanism would almost certainly have to include subsidies for those with low earnings or limited resources. Universal access would also help to contain costs because the strengthened appeal for consumers of basing their choice among insurers on price would apply to the entire population.

The seventh feature is an accurate method to adjust for differences among insurers in the health status of their enrollees. To the extent that it was accurate, the mechanism for adjusting risk would eliminate the incentive for insurers to pursue enrollees who are healthier than average, and it would protect insurers from the financial disadvantage that would otherwise accompany random, unfavorable risk selection.

The last of these features is not a structural one that could be incorporated in the design of a managed competition plan but rather a characteristic of how the system would need to function. Specifically, to be effective in reducing the growth rate of spending on health care, a managed competition system would need to result in a relatively small number of insurance organizations that had substantially nonoverlapping networks of affiliated providers--or at least primary care physicians--and that competed on the basis of their efficiency in delivering care of high quality. Otherwise, the providers in any particular network would essentially be competing with themselves as they wore the different hats of other networks. Consequently, they would have few reasons for changing the way they practiced to be more cost-effective or to internalize the practice styles sought by insurers.

If a managed competition policy containing these elements were adopted and price competition among insurers increased, the number of insurers would probably be significantly reduced. Most primary care providers, and some specialists, would be affiliated exclusively with one insurer. Over time, such a restructuring could reduce the rate of increase in national health care spending.

Omitting some of these elements from a managed competition policy, however, would

significantly weaken its effectiveness in achieving the reductions in health care spending that managed competition could potentially deliver. Yet, because reducing spending is only one of many objectives, policymakers might weaken some of the elements as they sought to balance cost containment with the attainment of other health care policy objectives. These objectives might include, for example, retaining a degree of choice for consumers and providers, rapid progress in medical technology, and minimum disruption of the health care system during any transition to a new one.

Some managed competition proposals, for example, would weaken aspects of the standardization of insurance products discussed above. Alternative proposals would permit balance-billing and supplementary insurance and would relax the requirement that services covered by plans offered through HIPCs be completely uniform. Other proposals would exclude from the system large employers who self-insure their health plans and some government health care financing programs, thereby making its coverage of the population much less complete.

The Effect of Managed Competition on National Spending for Health Care

Adopting the approach to managed competition described above would affect national spending for health care and its rate of growth in numerous and complex ways, and the end result would depend on their relative impacts. Extending insurance coverage to people currently without it would increase spending. So would new costs from creating and operating HIPCs and from collecting additional data.

In contrast, creating incentives that would encourage an expanded role for managed care and more widespread adoption of cost-effective approaches to medical practice would gradually reduce spending. Some of these effects on costs would be apparent quite quickly, while others--such as pushing technological development in a cost-saving direction--would emerge or build over time. Although the net effect could be to reduce spending in the longer term, the available evidence does not permit the magnitude or timing of these changes to be forecast with any precision. Decisions about the details of the policy would affect the outcome. Moreover, important behavioral responses to these changes have not yet been quantified.

The apparent extent of inappropriate care, the existence of duplicate capacity, and the unused potential of managed care together suggest, however, that significantly reducing health care spending on the insured population is possible without compromising their quality of care. For example:

- A literature review in 1989 concluded that, in a wide variety of contexts, a significant portion of current medical care is inappropriate and that the most important factor explaining the amount of inappropriate care seems to be the practice style of the individual physician. More recent evidence, however, raises a question as to whether the extent of unnecessary medical care nationwide might be lower than previously thought.

- Parts of the health care system appear to exhibit duplicate capacity and any reduction in its prevalence would offer scope for savings.

- Moving people from fee-for-service medicine into staff- and group-model HMOs would reduce health care spending. If everyone with health insurance were to enroll in these HMOs, national health expenditures could decline by up to 10 percent.

But whether savings would be sufficient to cover the costs of expanded coverage or to reduce the rate of growth in health spending in the longer term is unclear. A series of questions highlights many sources of uncertainty.

- How much of the health care market would be covered by managed competition?
- Would the standardized benefit package be set at a minimum level, the average currently available, or a more generous level?
- What would be the initial difference in health insurance premiums between efficient HMOs and other insurers, and would it increase over time?
- How much would spending rise to cover the uninsured and to cover expanded use by insured people if a package were adopted that provided more generous benefits than many people have now?
- How would consumers respond to having to pay more of their insurance premiums from after-tax dollars?
- How would consumers, providers, and insurers react to more and better information about insurance choices and about the quality and costs of individual providers?
- Could guidelines on practice and research on outcomes improve the efficiency of health care markets over time by reducing inappropriate and unnecessary care?
- Would technological change slow under managed competition? Alternatively, would its impact shift toward cost-reducing rather than cost-increasing innovation?
- How would administrative costs change under managed competition?
- Would the market coalesce into a small handful of insurers affiliated with specific, largely nonoverlapping networks of providers--especially physicians?
- Finally, over what time period would such changes occur?

Conclusion

Overall, one can identify a number of features whose inclusion within a system of managed competition would help to achieve its full potential for reducing spending on health care. If managed competition were introduced in such a form, spending on people who are now insured would be lower than under current trends, and insurance coverage would be extended to people now uninsured. Total spending on health care might also be lower in time than it would be if there were no changes in current policies.

The last outcome, however, would depend partly on what proportion of the people who are not currently in staff- and group-model HMOs switched to them (or similarly cost-effective plans) under managed competition. It would also depend on whether key features that have not been tried anywhere could be made to work satisfactorily in practice. Those critical features include effectively functioning HIPCs, accurate mechanisms to adjust payments to insurers for differences in risk, and new data systems that would enable consumers to make informed, price-conscious choices among competing insurance plans.

Introducing managed competition in a form that might achieve its full potential for lower spending, however, would change the health care system radically. The health insurance industry would be totally restructured. Policies would be standardized, experience rating would be eliminated, and payments to insurers would be adjusted for the average health status of their enrollees. The focus of competition would then shift from the selective enrollment of the healthiest people to cost-effective delivery of high-quality care for covered medical needs. In response, insurers would probably develop networks of affiliated providers whose styles of practice were cost-effective, and the number of insurers could fall greatly. Indeed, an early warning signal of whether

managed competition would lower the level or growth rate of health care spending significantly might be the extent to which insurers developed substantially nonoverlapping networks of providers. The market share of conventional indemnity plans would also drop in favor of forms of managed care that are able to lower costs. Moreover, self-insured employer plans would be abolished.

Consumers' health care payments and choices would also be restructured. Consumers would pay from their after-tax incomes all of the additional costs of choosing an insurance policy other than the least expensive one offered through their region's HIPC. Most people with employer-sponsored coverage could therefore expect to pay more than at present in out-of-pocket premium costs if they purchased an indemnity plan allowing a degree of choice among providers similar to the choice that such plans currently permit. There would be fewer reasons why premiums should differ and better information about the remaining sources of differences. Consequently, consumers would shift the focus of their decisions among plans from amenities and the perceived quality of care to differences in premiums for measured differences in quality. Consumers would have less choice about the range of services covered by insurance as well as about the providers from whom they could receive care. They might also have slower access to new technology.

If managed competition indeed succeeded in reducing health spending significantly, it would be because most physicians--especially those providing primary care--responded to the changes in insurance markets by affiliating with the network of a single insurer. Providers would also find that their clinical decisions were constrained more than at present by practice guidelines and by the scrutiny of insurers that were encouraging them to adopt cost-effective practice styles. The rates at which providers were paid might also be lower because insurers would face stronger incentives than at present to reduce them.

Reaction to the scale of these prospective changes could create pressure to modify the design of any managed competition plan that was to be introduced in ways that would give greater weight to other possible goals of health care policy, such as retaining choice for consumers and providers, advancing medical technology, and minimizing disruption during any restructuring of the health care system. Such changes, however, would lessen the ability of managed competition to contain the current rapid growth in health care spending.

Chapter One

Introduction

Managed competition is one of several fundamental reforms being proposed to respond to the problems of the current health care system--high and rapidly rising costs, uncertain continuation and renewability of health insurance coverage, and a substantial number of citizens who lack any coverage. The strategy particularly emphasizes providing consumers, insurers, and providers with incentives to be more cost-conscious.

Context of Managed Competition Proposals

Proposals for managed competition reflect judgments that the health care system performs inadequately in important respects; they also reflect perceptions about the nature of the underlying problems.

How the Current Health Care System Performs

The United States spent about 14 percent of its gross domestic product (GDP) on health care in 1992--a relatively high proportion by international standards and up from 7.4 percent of GDP in 1970. If current trends persist, the Congressional Budget Office expects that spending on health care will grow to 19 percent of GDP by the year 2000 (see Table 1). Moreover, because of the rapid growth in health care costs, contributions by employers to health insurance absorbed more than half of the gains that workers made in inflation-adjusted compensation between 1973 and 1989, thereby limiting growth in their cash incomes.

Notwithstanding the relatively high level of U.S. spending on health care, about 35 million people under the age of 65 did not have insurance coverage in 1992. (Because almost all elderly people are covered by Medicare, nearly all uninsured people are under age 65.) Compared with workers who have health insurance, those without it tend to be younger and less skilled, have lower incomes and unstable jobs, and work for small companies. Lack of insurance can significantly impede access to health care services--for example, spending per person on those without insurance is thought to be a little less than two-thirds of spending for otherwise similar people who have insurance, and the quality of the care that uninsured people receive is on average lower.

The persistence of high and rapidly rising costs alongside incomplete and insecure insurance coverage of the population has led to considerable dissatisfaction with the overall performance of the present health system, even though many aspects of it are highly regarded. The latter include, for example, the extensive choice among providers and the rapid access to advanced technology that are available to those who are insured. Reinforcing the dis-

satisfaction is a perception that the problems of cost and access to care have arisen despite the apparently rational response of most groups within the health care sector--consumers, providers, insurers, and health care researchers--to the incentives that each faces. Accordingly, these problems have been interpreted as evidence that the markets for health services and health insurance fail to function satisfactorily and may need to be restructured. Proposals for managed competition represent one way to do so.

Reasons for the Health Sector's Unsatisfactory Performance

Various factors have contributed to the coexistence of high spending and incomplete coverage. These factors have been interpreted in two complementary ways. At a general level, they are widely discussed in the ongoing debate on health care reform. At a more technical level, economists employing the perspective of public finance interpret them as illus-

Table 1.
Actual and Projected National Health Expenditures, by Type of Spending, Selected Calendar Years, 1965 to 2000

Type of Spending	Actual					Projected			
	1965	1980	1985	1990	1991	1992	1993	1995	2000
	Billions of Dollars								
Hospital	14	102	168	258	289	321	351	421	644
Physician	8	42	74	129	142	156	171	205	309
Drugs, Other Nondurables	6	22	36	56	61	66	71	83	117
Nursing Home	2	20	34	53	60	67	75	91	137
All Other	12	64	110	179	201	222	244	290	425
National Health Expenditures	42	250	423	675	752	832	912	1,089	1,631
	Average Annual Growth Rate from Previous Year Shown (Percent)								
Hospital	n.a.	14.2	10.4	8.9	11.8	11.4	9.3	9.4	8.9
Physician	n.a.	11.5	12.1	11.7	10.2	9.6	9.9	9.5	8.5
Drugs, Other Nondurables	n.a.	9.1	10.8	9.0	9.0	8.2	8.1	7.9	7.2
Nursing Home	n.a.	17.9	11.3	9.3	12.4	12.1	11.4	10.2	8.5
All Other	n.a.	12.0	11.4	10.2	12.0	10.8	9.9	9.0	7.9
National Health Expenditures	n.a.	12.7	11.1	9.8	11.4	10.7	9.6	9.3	8.4
Memoranda:									
Gross Domestic Product (Billions of dollars)[a]	703	2,708	4,039	5,522	5,677	5,943	6,255	6,942	8,627
Average Annual Growth of Gross Domestic Product from Previous Year Shown (Percent)	n.a.	9.4	8.3	6.5	2.8	4.7	5.2	5.3	4.4
Ratio of National Health Expenditures to Gross Domestic Product	5.9	9.2	10.5	12.2	13.2	14.0	14.6	15.7	18.9

SOURCE: Congressional Budget Office.

NOTE: n.a. = not applicable.

a. Economic assumptions reflect the Congressional Budget Office baseline of January 1993.

trating sources of market failure in the health sector.

A General Interpretation. Within markets for health care services, special factors in the nature of care and the way it is financed tend to inflate the level of spending. Because of the prevalence of insurance arrangements for health care, most consumers pay little heed to costs when they need major medical attention. Moreover, because consumers know relatively little about medicine, they entrust many health care decisions to professionals. The training and professional standards of providers, in turn, lead them to supply services that are expected to have positive benefits for patients, with little regard for the services' costs or the limited nature of the benefits. Those patterns are reinforced by financial incentives facing many providers and by the limited consensus about the best medical treatment for many conditions. In the meanwhile, advances in medical technology regularly create new options for prevention, diagnosis, and treatment that frequently increase total health care spending.

Most of those factors, however, are not unique to the United States. Consequently, they cannot fully explain the health sector's larger share of GDP in this country than in other countries, where budgets, regulatory constraints, or other countervailing forces help to keep health care costs below the U.S. level.

In addition, aspects of how health insurance markets are structured or function have contributed to high costs, lack of universal care, or both. First, employers' contributions to the cost of their employees' health insurance receive a degree of tax preference that some analysts consider excessive because it encourages employees to purchase more generous insurance plans than they would otherwise choose. Insurance, especially if its coverage is generous, in turn exacerbates lack of price-consciousness on the part of consumers.

Second, insurers face strong incentives to select low risks and therefore tend to avoid risk rather than to redistribute or control it. To minimize the claims they will receive from people who are likely to need medical care, insurers therefore use medical underwriting (basing coverage and premium decisions on the health status of the individual insured), restrictions on whom they will cover, exclusions for preexisting conditions, and premium increases that reflect both experience with prior claims and the declining predictive value of previous underwriting. As a result, many insurers try to maintain profitability by selecting people who are thought to be favorable risks rather than by aggressively pursuing greater efficiency in providing health insurance or health care services.

Third, issues of risk selection are more salient when insuring small groups of people. Consequently, small employers and their employees have particular difficulty obtaining and renewing insurance coverage at affordable rates. Individuals who are self-employed or not in the work force have similar problems.

Fourth, insurers vary in their ability to influence the prices that they face, which encourages providers to charge different purchasers different prices for the same services. Insurers with sufficient market share (including governments that operate public insurance programs) are able to negotiate or insist on discounted prices for health care services. Less favored insurers and uninsured individuals, who lack significant market power, face higher prices.

Accordingly, advocates of health care reform typically identify, as its primary goals, a move toward universal access to affordable, renewable health insurance as well as reductions in the level and growth rate of health care costs. Like some other health reform strategies, proposals for managed competition are designed, in large part, to address the concerns about health insurance markets with

the expectation that, by doing so, they would reduce the level or the growth rate of health care costs.

Sources of Failure in the Markets for Health Services and Insurance. Economists look for the sources of market failure in structural aspects of health insurance and services markets--for example, in imperfect information available to buyers or sellers, barriers to participation in these markets, factors that distort prices, collusion among buyers or sellers, spillover effects where actions by one person have consequences for others, and the ability of individuals who receive uncompensated care to be free riders who can consume without first purchasing. From this perspective, the elements of health care reform proposals should each specifically address ways that the market has failed.

In most circumstances, the market provides an efficient mechanism for allocating resources in the economy. To achieve such efficiencies, however, markets must operate under certain conditions. They work best when the consumer has good information about the characteristics of products and their prices--information that is most easily obtained if products are well defined and standardized and if prices can be ascertained without excessive search. In addition, market efficiency requires that a large number of sellers compete with each other over prices that reflect true resource costs. With a large number of sellers, no single vendor has the power to control prices, and price competition among sellers lowers prices to the point where they reflect the marginal costs of production.

The market for health care, however, does not meet many of these conditions. Indeed, the deviations from ideal markets are particularly pervasive in medical markets. Products or services in health markets are highly individualized and personal. Product quality is difficult to judge, and consumers often have little idea about what the product is or about its effectiveness. So they delegate decisions to their doctors, who are trained to provide the best possible, rather than the most cost-effective, care. Consumers are usually unable to evaluate their doctors' competence or recommendations independently. Moreover, consumers of health care are often in no position to shop around; they may lack the necessary information or they may be sick and therefore want treatment quickly. The incentive to shop around is further weakened because much of the cost of health care is paid indirectly through third-party payers--insurance companies or governments. In addition, technological change in health care is rapid but, in many cases, market constraints that might ensure that new technologies are used in a cost-effective way have little effect. Thus, although health care providers are numerous, they do not always compete effectively with one another on the basis of price.[1]

The prevalence of third-party payers in health care markets is itself the result of two distinctive underlying characteristics of these markets--uncertainty about the incidence of illness, and the potentially high costs associated with treatment. These characteristics result in an extremely uneven distribution of health expenditures. For example, when consumers in 1987 were ranked by their health expenditures, the top 1 percent accounted for 30 percent of all such spending and the top 10 percent of consumers accounted for 72 percent of all spending, while the bottom 50 percent accounted for only 3 percent of total spending.[2] It therefore makes sense for individuals to insure against such expenses in the same way that they insure against fire or theft.

Two features of health insurance markets lead some economists to conclude that the current arrangements contribute to an inefficiently high level of health care spending. First, health insurance is different from fire or theft insurance because the nature of the event insured against is less clearly defined,

1. For a fuller discussion of these issues, see Congressional Budget Office, *Economic Implications of Rising Health Care Costs* (October 1992).

2. Marc L. Berk and Alan C. Monheit, "The Concentration of Health Expenditures: An Update," *Health Affairs* (Winter 1992), pp. 145-149.

the cost of care for covered conditions has few limits, and the amount of the loss by the insurer is largely at the discretion of consumers and doctors. As a result, health insurance is more subject than fire or theft insurance to "moral hazard," a phenomenon that arises whenever purchasing insurance alters an individual's behavior in ways that would affect the amount of the likely loss. In the case of health care, insured consumers pay only relatively small copayments--sometimes none at all--and the remaining costs are spread out among an insurance company's policyholders. Thus, they consume much more care than if they were uninsured. Since the same discretion applies to the great majority of decisions about medical treatment, the cost of health care to society can increase significantly.

Second, employer-provided health insurance receives a major subsidy because employers' contributions to the health insurance costs of their employees are excluded from employees' taxable incomes but can be deducted as business expenses by the employer. Partly as a result of this favorable tax treatment, about two-thirds of the population under the age of 65 had health insurance through some employment-based group in March 1992.[3] The value of the subsidy varies with an employee's income and tax rates. For an individual paying a marginal income tax rate of 15 percent, a federal payroll tax of about 8 percent, and a state income tax rate of 5 percent, this exclusion means that $1 spent by the employer generates $1 of health insurance at a cost to the employee that is equivalent to 72 cents of after-tax cash income. Similarly, for individuals facing the maximum statutory marginal tax rate of 31 percent, $1 spent by the employer could generate $1 of health insurance at a cost to the employee that is equivalent to 56 cents of after-tax cash income.

These examples do not take account of the share of payroll taxes for Social Security paid by the employer. In the long run, the employer's share is probably best considered to be paid by employees in the form of lower cash earnings. Allowing for this would imply that the tax subsidy for employer-paid health insurance is even larger. This subsidy is widely assumed to increase the amount of insurance purchased and, indirectly, the amount of health care used.[4]

Health care markets vary in other ways from the competitive market model. For example, federal and state governments act as insurers themselves--most notably through the Medicare, Medicaid, and Veterans Affairs programs. Governments also heavily regulate the current market through such mechanisms as licensure requirements for providers and numerous obligations imposed on insurers. A further departure is that some people who do not pay for care nevertheless receive it. This phenomenon, known to economists as the "free rider problem," was reflected in an estimated $13 billion of uncompensated hospital care in 1991--or 6 percent of the total costs of community hospitals.[5]

A perfectly competitive market for health insurance, however, might not lead to outcomes that society would find acceptable. For example, efficient, competitive markets for health insurance would set premiums for individuals that reflected the expected costs of their care, given what is known about each individual's health status and expected future use of health care. (They would also include funds to cover the administrative costs of pro-

3. See statement of Nancy M. Gordon, Assistant Director, Human Resources and Community Development Division, Congressional Budget Office, before the Subcommittee on Health, House Committee on Ways and Means, January 26, 1993.

4. Moreover, the tax preference may make it less expensive for consumers to insure low-cost, routine care than to pay for it directly because the estimated value of the subsidy could exceed the administrative costs of the insurance arrangements per dollar of coverage. See Mark V. Pauly, "Taxation, Health Insurance, and Market Failure," *Journal of Economic Literature*, vol. XXIV, no. 2 (June 1986), pp. 629-675.

5. Uncompensated care is defined as the sum of charity care and bad debt. See American Hospital Association, "Uncompensated Hospital Care and Medicaid Shortfalls, 1980-1991: A Fact Sheet Update" (Chicago, November 1992).

viding insurance.) In turn, group insurance policies would charge premiums based on the average expected costs for the individuals composing the group. Thus, less healthy individuals would be charged higher premiums to reflect the higher expected costs of caring for them. It is basically this practice, known as "experience rating," that has led to significant variation in the rates charged to insure individuals and groups of employees--especially small groups. Other practices such as medical underwriting, limitations on the scope of coverage (for example, exclusions for preexisting conditions), and refusals to renew policies also stem from the same approach to insurance.

Whether it is desirable to sort consumers of health insurance by health status is, however, a contentious issue that depends on fundamental social judgments about who should pay the costs of health care. On the one hand, some people argue that each person should pay the full bill for his or her own expected health care use. In this view, cross-subsidization of relatively sick people by relatively healthy people through insurance arrangements is both inefficient and inequitable--inefficient in the sense that subsidies may encourage unhealthy lifestyles (such as smoking), and inequitable because the people who do lead healthy lives must pay more to help insure those people who do not. Implicit in this view is one of two beliefs: either people can to a large extent control their health; or if they cannot, social policy should try to offset innate or random differences in health status to no greater a degree than it offsets differences in the wealth and income levels of the families into which children are born.

On the other hand, some argue that a person's health is influenced by factors, including genetics and luck, that are beyond his or her control. In this view, discriminating against those who are unhealthy is wrong, just as discriminating on the basis of factors such as race or height is wrong. Moreover, advocates of this view point out that if risk sorting is pervasive, the chronically sick would be unable to obtain insurance except at exorbitant rates and, without insurance, would receive less medical care. In this view, people who are lucky enough to be healthy have a social obligation to take care of those who are less fortunate. Inevitably, this debate will intensify.[6] Advances in biotechnology are likely to bring new ways to test for genetic predispositions--and new and more effective ways to sort people into risk categories.

A further policy issue is whether the social responsibility for financing care for sick people should be allocated partly according to "ability to pay." Under both experience rating and its alternative--"community rating"--low-income people who buy insurance but remain healthy help to pay the health care costs of higher-income people who buy insurance and become sick. One view is that this subsidy is a natural consequence of using the insurance mechanism to redistribute the costs associated with an adversity that only some people experience. In that view, because people at all income levels voluntarily purchase insurance of many kinds, this outcome is not a problem. Another view is that, although the insurance mechanism is a useful way to share the costs of illness, a complementary mechanism should vary the net premiums with the incomes or resources of those purchasing insurance. The latter mechanism might involve financing insurance through income-related premiums, for example, or some form of income-related tax preference.

What Is Managed Competition?

The managed competition strategy for reforming health care seeks the efficiency, flexibility, and innovation that characterize competitive markets without the undesirable cost and cov-

6. See, for example, Katherine Swartz, "Community Rating: An Idea Whose Time Has Come (Again)," *Journal of American Health Policy*, vol. 3, no. 1 (January/February 1993), pp. 34-37; and Mark V. Pauly, "The Welfare Economics of Community Rating," *The Journal of Risk and Insurance*, vol. 37, no. 3 (September 1970), pp. 407-418.

erage problems of the present system. Similarly, much decisionmaking could remain decentralized under managed competition, providing opportunities for more individual choice and more regional variation than under some other approaches to health care reform. The managed competition strategy would also pursue expanded--and, under some proposals, universal--access to health insurance coverage. It would do so both because that is an objective in its own right and because shrinking the pool of uninsured people would enhance the effectiveness of the changes designed to contain costs.

To accomplish these goals, the strategy would restructure the incentives that the health care financing system creates for consumers, insurers, providers, and the medical technology industry. In doing so, it would rely heavily on eliminating existing sources of market failure in the health care sector except, for example, when the efficient market outcome might not be the socially preferred one. In particular, managed competition would reject the approach of sorting purchasers of health insurance by health status and then charging them different premiums.

Incentives for Consumers

Managed competition would eliminate, reduce, or measure the nonprice differences among insurance plans--for example, differences in their coverage or in the quality and efficiency of the care they fund. It would then make individual consumers use their own after-tax incomes to pay the additional costs of purchasing insurance plans other than the least expensive one within their region. In these ways, managed competition would encourage consumers to be more price-conscious in making decisions about their health insurance. In turn, that would give insurers, and through them providers, incentives to become more cost-conscious and efficient.

Competition has been advocated for at least two decades as a way to slow the steady climb of health care costs. Over that time, competition in health care markets has increased. More choices of insurance are available--traditional insurance, health maintenance organizations, preferred provider organizations, and other arrangements--and there are also more physicians and other health professionals, and increased advertising by providers and insurers. Consumers have presumably benefited from having more choices available, but most of the competition has been on the basis of amenities and perceived quality rather than price. As a result, there is no evidence that increased competition has restrained the growth in health spending to date. Managed competition is intended to shift the focus of competitive behavior from amenities and perceived quality to price. As the spur to efficiency, the strategy would rely on competition among networks of providers that are organized by insurers (referred to in this study as "insurer/provider networks"), and it would focus that competition on price and reduce existing sources of market failure.

Incentives for Insurers

Under managed competition, insurers would find it harder to compete by attracting relatively healthy consumers or by emphasizing unmeasured, nonprice advantages of their plans. If individuals were induced to be price-conscious when choosing among standardized health insurance plans with designated networks of affiliated providers, then insurers wishing to set lower premiums would need to compete by arranging for care to be delivered to their policyholders in a more cost-effective manner than competing insurers could achieve. Moreover, if insurers were accountable for the quality of the care delivered under their plans--either because of legal liability or through the market discipline of well-informed consumers--then they would also need to accept a degree of managerial responsibility for the quality of the care delivered by the providers affiliated with them. Consequently, insurers would gain incentives to develop networks of affiliated providers who delivered high-quality, cost-effective care. They

would also have incentives to pay providers the lowest acceptable prices for their services.

Incentives for Providers

In this new environment, providers too would face new incentives to find more cost-effective ways to deliver clinically effective care of high quality. They would be rewarded for adopting conservative practice styles where these achieved equally effective clinical outcomes and for introducing clinical innovations that were cost-effective. Providers might also have incentives to form groups to negotiate with insurers.

Incentives for Medical Technology

The increased emphasis on cost-effective forms of care would in turn alter the incentives for those developing new medical technology. Innovations in prevention, diagnosis, and treatment that reduced total health care costs would be relatively more attractive to providers and insurers under managed competition than under the present system, where new technology tends to be adopted regardless of its costs. Similarly, technological innovations that achieved better medical outcomes than present methods but at significantly greater cost could face more stringent restrictions on the clinical circumstances in which their use would be reimbursed than is the case under the present system.

Changes Under Managed Competition

Managed competition--an approach that has not been tried anywhere in the world--would involve fundamental changes. It would require new kinds of institutions, information and analyses, and patterns of behavior among health care providers, insurers, and consumers. Furthermore, the success or failure of managed competition would hinge on the interaction of its many parts. As a result, relatively little evidence is available to estimate the potential effects of managed competition proposals.

Managed competition could increase access to insurance and thus to health care services. It could also reduce spending on health care for those who are currently insured. To accomplish the latter, however, managed competition would have to restructure the health care market dramatically. Consumers would face less choice, as well as reductions in the quantity of services that they would obtain. The number of insurance companies would be dramatically reduced, and access to many providers would be limited to enrollees of specific insurers.

Although some of the services eliminated would be of little or no benefit, others that would be of medical value might no longer be provided. The pace of technological change and access to new technologies might also slow. Because most physicians would be exclusively affiliated with specific insurers, they would have less independence of practice arrangements and would be subject to guidelines affecting their clinical decisions. In other words, however cost containment was achieved, the types of health care people received and how the care would be delivered would differ significantly from the current system.

Opponents of managed competition criticize it on various grounds. First, they are skeptical that it would work and note that the proposals rely on various elements whose feasibility or effectiveness are unproven. Thus, they point out that the effectiveness of managed competition in containing health care costs remains a matter of conjecture. Furthermore, the changes required to establish the system would be major and often disruptive. Finally, the basic managed competition model would not work satisfactorily in many rural areas, where density of population is too thin to support multiple insurer/provider networks, or in those inner city areas where providers are sparse.

Chapter Two

Designing a Managed Competition Plan to Achieve High-Quality Health Care at Minimum Cost

Proposals for managed competition have two goals. One is to restructure competitive processes within health insurance and health care markets so that the preferences of consumers for preventive and acute care of high quality would be satisfied in a way that makes the most efficient use of resources within the health care sector. Doing so could achieve savings in spending on health care. The other goal, which relates to access to health insurance and hence to health care services, is that everyone be able to obtain affordable, renewable, private health insurance at a price that does not depend on whether the person's health status is better or worse than average.

Most models of managed competition generally aim to achieve:

> . . . the gradual transformation of the health care financing and delivery system, through voluntary private action, into an array of managed care plans, each competing to attract providers and subscribers by finding ways to improve the quality of care and service while cutting costs.[1]

Overview of Managed Competition

How would managed competition proposals change the health care landscape? First, a health insurance purchasing cooperative (HIPC) would be created in each region to manage the competition among insurers within the region.[2] In some proposals, all health insurance would be arranged through the HIPCs; in others, large firms and public programs would operate outside the HIPCs.

Next, regulators would require standardized health insurance plans--that is, a standard benefit package with uniform rules for cost sharing by participants. These plans would be offered on an open-enrollment basis without medical underwriting, exclusions in coverage, or restrictions on renewal. Premiums would be based on community rating for a small number of categories (for example, single individuals, couples, and families with children). That is, for each community rating category, a uniform price would be set at which anyone in the region could purchase the product. Each such insurance plan offered through a HIPC would also be required to designate the network of providers from whom

1. Alain C. Enthoven and Richard Kronick, "Universal Health Insurance Through Incentives Reform," *Journal of the American Medical Association*, vol. 265, no. 19 (May 15, 1991), p. 2,533.

2. Others sometimes use different names--for example, health plan purchasing cooperative or health alliance--for essentially the same concept.

care could be obtained--possibly all available providers in the case of some indemnity (that is, conventional) insurers. In some proposals, regulators would permit only standardized plans of this kind, precluding supplementary insurance.

In addition, regulators would develop a new system to measure the performance of providers. Each health care provider and each insurer/provider network would be required to compile, and provide to regulators for public dissemination, standardized--and thus comparable--data about costs, quality, and outcomes for the care provided.

Moreover, each consumer would choose among the plans of the available insurer/provider networks in an informed and price-conscious way. He or she would pay--in after-tax dollars--all of the additional costs of choosing insurance that is more expensive than the lowest-priced standard plan available through the HIPC. For this reason, employers' contributions to the health care costs of each of their employees would be capped at no more than the premium amount for the lowest-priced plan in each family-unit category. Public subsidies would be provided to assure access to health insurance for people who could not otherwise afford coverage.

Suppose, for example, that an indemnity insurer offered the standardized plan for an individual for $200 a month and that the least expensive plan within the region cost $175 a month. Then employers in the region would be permitted to contribute no more than $175 a month toward the health insurance costs of their employees, and any individuals purchasing the indemnity plan would have to pay at least $25 a month from their after-tax income. Individuals who chose the lowest-priced plan, however, would have no out-of-pocket premium costs if their employers made the maximum permissible contribution.

Features of a Plan to Achieve Health Care of High Quality at Minimum Cost

A look at one hypothetical plan for managed competition might illustrate how such plans could work. Its design incorporates those features that the Congressional Budget Office believes would be needed in managed competition proposals if they are to realize managed competition's full potential to reduce total health spending while maintaining a high standard of care. The analysis examines a "stand-alone" managed competition plan--that is, one that does not incorporate additional cost containment features such as an overall national limit on health expenditures.

This discussion is not intended to imply that the particular model of managed competition described below could achieve appreciably greater savings than all other models. Nor does it imply that implementing that specific approach would necessarily result in major savings. Much would depend on the specific details, such as the definition of the basic plan. Furthermore, knowledge of how managed competition proposals would affect health care spending is too limited to support such claims for any model.

Moreover, the model described here should not be interpreted as the "correct" way to carry out managed competition, if policymakers wish to adopt that strategy as a basis for health care reform. Reducing spending is only one of the many objectives of managed competition proposals; policymakers would need to choose what weight to give to each of these partly conflicting objectives.

The key features in the approach to managed competition described in this chapter fall into four groups. The first group would reduce the number of people without insurance. It is discussed first because these features in the plan dictate the need for a number of the subsequent features.

The three other groups are designed to restructure competitive processes within the markets for health insurance and health care services to achieve an efficient pattern for using resources. One group would help consumers identify differences in efficiency between competing health plans and respond to these and other differences in a price-conscious way. Another group would establish the basic framework for HIPCs. The remaining group would establish requirements for networks of participating insurers and providers.

Increasing Access to Insurance Coverage

This pair of features--open access and some mechanism for assuring universal coverage that would incorporate public subsidies for low-income people--would address several sources of market failure noted in Chapter 1. These shortcomings include the barriers to participation in insurance markets that are experienced by small groups of employees and by individuals with large, predictable needs for health care; uninsured people who become free riders receiving uncompensated care; and spillover effects when care provided to one person (for example, a vaccination) enhances the health or welfare of others.

Open access and universal coverage would also reinforce features that improve the efficiency with which resources are used in health care. For example, open enrollment would make it harder for insurers to enroll only the healthiest consumers and, in this way, would induce insurers to compete by organizing more cost-effective systems for delivering care. Universal access would also facilitate cost containment because the entire population would have strong incentives to make their choice of insurers on the basis of price.

Open Access. Five aspects would together create open access to health insurance for all individuals on an essentially equal basis. They are:

- Regular open-enrollment periods during which each individual or family would have an opportunity to change from the current insurance plan to any other plan available through the HIPC;
- Individual consumers choosing for themselves which of the plans offered through the HIPC they preferred, rather than permitting an employer to select one plan for all employees;
- A ban on medical underwriting, limitations on coverage, and exclusions from coverage for preexisting conditions within plans offered through the HIPC;
- Guaranteed renewal of insurance; and
- A requirement that premiums for all insurance policies be based on community rating by category, with the number of categories kept small (for example, single individuals, couples, and families with children).

Universal Insurance Coverage and Associated Subsidies. For managed competition to work most effectively, open access would not be sufficient. Some mechanism would be required that achieved insurance coverage for each individual, and that would almost certainly have to include subsidies for those with low earnings or limited resources.

The choices for policymakers among alternative ways to achieve universal coverage and to structure any subsidies would involve complex trade-offs and design issues. They are beyond the scope of this study, which focuses primarily on managed competition's effect on national health expenditures. For the purpose of the study, however, the specific choices made

are not critical, although alternative choices would affect government outlays differently.

Helping Consumers to Evaluate Differences Among Plans and Respond in a Price-Conscious Way

Currently, health insurance premiums can vary because of differences in coverage, the average health status of enrollees (and thus in the expected costs of their care), the quality of care, the profitability of insurers, and how efficiently providers use resources when providing care. Under managed competition proposals, however, consumers would be expected to make informed choices among insurance plans based on their relative efficiency in delivering care of a given quality. Consequently, the proposals would need to eliminate, or otherwise address, the current confounding differences in coverage and average health status and to quantify any differences in the quality of care and in profitability.

Three features of managed competition proposals are designed to do precisely that. They would eliminate, or quantify, the differences in coverage, health status, quality, and profitability so that consumers could identify when price differences between plans reflected more efficient care. A further feature would make consumers' choices among plans more sensitive to price differences than is currently true for most consumers.

These features would therefore respond to additional sources of failure in health insurance markets. In particular, they would correct some of the gaps in information facing today's purchasers of health insurance. They would also reduce the price distortion whereby, because of the open-ended nature of employer contributions, some employees can purchase more costly health insurance plans without paying a higher effective price.

Standardized Benefit Package and Coinsurance. A standard benefit package that is relatively comprehensive would be established for all insurance plans offered through the HIPC. This feature would require all the plans to cover the same specified range of health products and services. These might resemble those covered under typical health maintenance organization (HMO) plans today. In addition, organizations offering plans through the HIPC would not be allowed to sell supplementary insurance.

Standardizing the coverage of services under the benefit package and prohibiting balance-billing by providers would eliminate differences in covered benefits as a source of price differences among plans.[3] It would also make it harder for plans to achieve favorable risk selection--that is, to attract as policyholders people whose average health status is better than that of the insured population as a whole. Eliminating supplementary insurance would reinforce this outcome.

However, two standard plans that had the same coverage of services but different copayment structures would be permitted. One could have provisions modeled on the low deductibles and copayments typical of HMOs, while the other could have provisions modeled on the higher deductibles and copayments typical of indemnity insurance plans. Currently, indemnity plans usually allow enrollees to choose any available doctor, whereas HMOs limit enrollees' use to a network of affiliated providers; indemnity plans also accept greater variability in the practice styles of their physicians. Partly to discourage the higher rates of use of services that are apt to occur when enrollees choose their doctors under these reimbursement arrangements, indemnity plans also impose higher copayments than HMOs. Consequently, allowing two patterns of coinsurance to be combined with stan-

3. Insurers usually set maximum payment amounts for specific services and base their share of the payment to the provider on these, after allowing for any coinsurance amount that the patient must pay. Providers' actual charges sometimes exceed these maximum amounts. If providers do not agree to accept the insurers' maximum amounts as full payment, then patients must pay the difference--or the balance of the bill--as well. This process is known as balance-billing.

dardized coverage of services within standard plans would enable people who selected indemnity insurance to pay higher copayments to retain the right to have a greater choice of providers.

Some critics of managed competition dispute the need for a standard benefit package at all. Moreover, some proponents would permit supplementary insurance coverage if it were purchased solely by the individual from after-tax income. (The relevant arguments are discussed in Chapter 4.)

Risk-Adjusted Payments from HIPCs to Insurers. This feature has two aspects. One would require each insurer to quote a set of premiums for its plan--one premium for each category of enrollees--on the assumption that the insurer could enroll an average cross section of HIPC members. The quoted premiums would apply to any individual in the HIPC who is covered by the plan. If the plan in fact enrolled an average cross section of HIPC members, the quoted premiums would also be the amounts of the HIPC's capitation payments to the insurer--flat payments per enrollee--to cover the expected costs of enrollees' care.

The other aspect would be a mechanism to adjust the capitation payments to those insurers whose enrolled groups differed from the HIPC's average health status. The adjustment would, for example, raise the capitation payment to insurers whose enrollees were in poorer health and who would therefore have higher expected costs of care than for the HIPC as a whole.

An important objective of managed competition proposals is to create a new basis for competition among insurers--namely, how efficiently they arrange for their affiliated providers to deliver care of high quality, which would enable them to charge the lowest possible price. Both aspects of this feature would help achieve that objective. If premiums were quoted for the whole HIPC population, consumers could assume that differences in premiums among insurers were not attributable to risk selection. Also, to the extent that it was accurate, the mechanism for adjusting risk would eliminate the incentive for insurers to pursue enrollees who are healthier than average, and it would protect insurers from the financial disadvantage that would otherwise accompany random, unfavorable risk selection.

New Uniform Data to Measure Quality and Outcomes. Another important step would be to develop and establish a new system to collect comparable, uniform data, for individual providers and plans, that provided timely measures of the quality of health care services and the medical outcomes for the patients receiving them. That process would allow another potential source of price differences between plans to be measured. Consumers could then take account of any such differences in outcomes and quality when interpreting the significance of the differences in premiums among plans. In the longer term, if all plans achieved essentially the same standards because those data led to uniform practice guidelines, enrollees could be confident that choosing a lower-cost plan would not adversely affect the health care that they and their families received.

Along with data on quality and outcomes, providers would be required to report to HIPCs standardized financial data that permitted the profitability of competing insurance plans to be compared and made public. Knowing which insurers had above-average rates of profit in recent preceding years would enable consumers to quantify another source of premium differences among plans.

Limit on Employer Contributions. Information that enabled consumers to interpret differences in the prices of competing plans would be of little use if they had no incentive to respond to the information. Under the present arrangements for employment-based group health insurance, employers frequently pay all or most of their employees' premiums. Moreover, such contributions are not included in the employees' taxable incomes. Consequently, employees have little incentive to

consider premium differences when choosing among the insurance plans available to them.

To create an incentive for employers to make price-conscious choices, another feature of managed competition would limit the contribution that employers could make to cover the health care costs of each employee (and the employee's dependents). For each type of family unit, the cap would be no greater than the premium amount for the lowest-priced plan offered through the HIPC. Such a limit might be enforced in one or more ways: for example, making excess payments illegal; making them subject to an excise tax; making nondeductible, for corporate income tax purposes, all of the health care expenses of employers that make any excess contributions; or requiring that excess employer contributions be treated as taxable income of the individual for income tax and Social Security payroll tax purposes.

Establishing the Framework for HIPCs

Four additional features would establish the framework for managing competition through HIPCs. By supporting the creation of HIPCs that would establish a single insurance pool for each region and that would lead to fewer insurers, these features would reduce another source of market failure--the barriers to entering health insurance markets that flow from economies of scale in both the purchase and supply of insurance.

Creating a HIPC with Specified Functions in Each Region. By federal or state statute, one HIPC would be created for each geographic region. In general, regions would be large enough to support at least two competing insurer/provider networks, and the regions would not arbitrarily divide urban areas that straddled state boundaries.

HIPCs would have specified functions designed to enhance the efficiency of markets for health insurance and health services. They would:

- Establish standards for the region's health insurance plan and its providers;
- Apply these standards to determine which insurer/provider networks could offer the qualified insurance plan through the HIPC;
- Contract with individual insurer/provider networks for the insurance products they would offer to all employees and other individuals who are affiliated with the HIPC;
- Collect and analyze comparable information about cost, quality, and outcomes for each provider of health care services within the HIPC region and for each insurer/provider network as a whole;
- During the open-enrollment period, provide everyone who could be insured through the HIPC with a summary booklet comparing the cost, quality, and outcomes of the care that each network--and perhaps also each provider--offered during the past year, as well as the premiums for each network during the coming year;
- Collect premiums from, or on behalf of, individuals who are insured under plans approved by the HIPC; and
- Remit to insurers the capitated amounts to which they are entitled for the individuals they insure, after adjusting the premium payments received from those individuals for differences between their average risk status and the average risk status for all individuals insured through the HIPC.

To exploit economies of scale, a national body might undertake responsibility for some of these functions. In particular, the national body might set standards for the insurance plans, develop a consistent national data system as a basis for specifying what information each insurer and provider would be obligated to report, and develop a uniform risk-adjustment process.

Number of Insurance Plans Offered Through Each HIPC. The maximum number of insurance plans within a HIPC would not be arbitrarily limited. Rather, the number of qualified insurer/provider networks wishing to offer plans through the HIPC would determine how many there would be. Because price competition would be fostered by the potential for new competitors to enter an industry, an arbitrary limit would create an anti-competitive barrier for additional networks that wished to offer plans within a HIPC.

Nevertheless, many proponents expect that a much smaller number of qualified insurer/provider networks would choose to operate in any HIPC than the existing number of insurers. They see this as the probable outcome of market dynamics under managed competition (see Chapter 5). Other proponents would specify a more activist role for HIPCs than that described above (see Chapter 4).

Regulation by Each HIPC of All Health Insurance Coverage Within Its Region. For managed competition to achieve the maximum savings, all health insurance coverage would need to be arranged through the HIPCs. In principle, this would include health coverage currently provided by the significant number of large employers who self-insure their health plans as well as care currently funded by Medicaid and Medicare. Nevertheless, most proponents of managed competition envisage that, in practice--at least initially--Medicare would remain a separate program, and larger employers could continue to offer self-insured plans outside the HIPC system.

Arrangements to Hold HIPCs Accountable for Their Performance. HIPC boards would consist of members nominated by independent consumer organizations, groups of employers (if they remained a significant funding source for health care), and federal or state governments. Board members could not have financial interests in insurance companies or in health care providers. This feature would help to keep separate the interests of those on the demand and supply sides of health insurance markets, thereby increasing the likelihood that managed competition would succeed in achieving a more efficient health care system. HIPC boards might contract with professional management organizations, however, to undertake the technical and administrative work involved in running a HIPC.

HIPCs would also be required to report annually to the federal government or relevant state governments on trends in premiums, quality, and health care outcomes for their HIPC region as a whole. These data would enable the performance of HIPCs to be compared across the country, thus providing the basis for each board to modify its policies or personnel if needed.

Establishing Who Would Qualify to Operate an Insurer/Provider Network Within the HIPC

To qualify to offer an insurance plan through a HIPC, an organization would need to demonstrate:

- Sufficient financial resources to protect insured enrollees if the organization's insurance operations generated significant losses;
- Sufficient managerial, professional, and technical resources to operate an organization that is responsible for providing insured enrollees with care of high quality and that is financially responsible for the total costs of covered care (other than standardized copayments); and
- The capacity, through its employees or through a network of affiliated providers, to deliver to its insured enrollees the full range of health care services covered under the standard benefit package.

Qualifying organizations would also be required to contract with the HIPC to meet certain conditions. One condition would be to

provide the standard coverage, with standard coinsurance provisions, to any individual in the HIPC who requests coverage through the organization at a uniform annual premium for everyone in an approved rating category. Two more would be to designate who would provide care under the plan and to conform with the HIPC's open-enrollment arrangements, including a requirement--designed to preempt favorable selection through selective marketing--that only the HIPC could provide information about insurance plans to potential enrollees within the HIPC. Another condition would require qualifying organizations to provide to the HIPC all required data about the costs, quality, and outcomes of care for the organization as a whole and for each individual provider and to impose a similar requirement on each such provider under the plan.

Other conditions would require that providers accept responsibility for the quality of the care provided under the organization's plan--possibly including legal liability under malpractice arrangements, if a fault-based liability system were retained--and that they refrain from offering supplementary health insurance or additional health insurance products within the HIPC region. Finally, they would have to agree to cooperate with the HIPC in other matters affecting the smooth operation of the HIPC, including the arrangements for open enrollment. These contractual obligations would enable each HIPC to manage the competition within its region.

Other Issues

Many other issues would need to be addressed in developing a managed competition proposal for actual implementation.

Combining Managed Competition with Overall Expenditure Limits

Most proponents of managed competition think that changes such as those described in this chapter would greatly expand incentives for providers to offer only necessary care and in this way would accelerate improvements in the efficiency and quality of health care delivery. Consequently, they expect that health spending would grow more slowly than under the current system.

Other proponents of managed competition suggest, however, that this strategy on its own would take a long time to produce significant savings and may not be able to slow growth in health care expenditures sufficiently. They agree that managed competition should therefore be combined with an overall limit on national health expenditures. But whether managed competition and overall limits on health spending could be successfully combined is controversial. Some advocates of managed competition think that the two could not be satisfactorily merged, since an important function of managed competition would be to help determine the appropriate level of health care spending through regulated market processes. Others acknowledge, however, that even a well-designed system of managed competition could not guarantee a rate of increase in total health care spending that policymakers would find acceptable. Such proponents have offered different possible responses.

Alain Enthoven--one of the major authors of the managed competition strategy--has suggested, for example, how a global limit on health care spending might be structured within a managed competition system if such a limit were considered necessary.[4] In that case, he recommends focusing on the total premium cost that would be incurred if everyone in the United States purchased insurance coverage at the rates for the lowest-priced plans available through their local HIPCs. If this total cost grew faster than the gross domestic product, the National Health Board that is a

4. See Alain C. Enthoven, "Managed Competition in Health Care Financing and Delivery: History, Theory, and Practice" (revised paper presented at a workshop sponsored by the Robert Wood Johnson Foundation under its Changes in Health Care Financing Initiative, Washington, D.C., January 7-8, 1993).

feature of his proposal could be directed to recommend specific changes--for example, in covered benefits, coinsurance, or premiums--that would reduce health care spending accordingly. He would not limit spending by consumers, however, on "excess" premiums for more expensive insurance plans.

Others, like Paul Starr--a Princeton sociologist and health care analyst--argue that a limit on expenditures would be the most efficient way to control overall spending on health care.[5] An aggregate spending limit, if it were effective, would imply an average level of spending per person on health care services. A system of managed competition within each region might then be assigned the role of helping to allocate that spending efficiently. Under this approach, the purpose of managed competition would be to achieve the best health system consistent with that level of spending per person. This strategy would use the expenditure cap as the policy instrument to contain health care costs and managed competition as the instrument to allocate resources efficiently within the health care sector. Accordingly, the Starr proposal raises a different set of issues about cost containment, quantity of care, and quality of care that go beyond the scope of this study.[6]

Other Problems Not Specifically Addressed

Proposals for managed competition would need to address many other issues that this study does not discuss. They include funding graduate medical education and financing teaching hospitals; the roles of the Veterans Affairs and Department of Defense health care systems; whether the current fault-based liability system should be modified; the health needs of special groups, including poor people and drug-addicted individuals; and other services funded indirectly through Medicaid, such as school-based clinics.

5. See, for example, Paul Starr, *The Logic of Health Care Reform* (Knoxville, Tenn.: Grand Rounds Press, 1992).

6. For a discussion of some of these, see the statement of Robert D. Reischauer, Director, Congressional Budget Office, before the Subcommittee on Health, House Committee on Ways and Means, February 2, 1993.

Chapter Three

Incorporating Features That Would Promote Lower Health Spending

Proposals for managed competition contain many separate but mutually supportive features that are designed in combination to achieve the proposals' goals for access and efficiency. Often, however, omitting particular features would significantly weaken a specific proposal's capacity to achieve those goals.

The Congressional Budget Office considers eight specific features to be critical to achieving the full savings in health spending that managed competition could potentially deliver. Each feature is important to the overall plan, and indeed omitting any of them would weaken a proposal's effectiveness in expanding access or containing health expenditures.

Of the eight important elements, one is the creation of health insurance purchasing cooperatives. Three more would reinforce price-consciousness by limiting employers' contributions to their employees' health expenditures; standardizing benefits and copayment rules; and collecting new data on quality, outcomes, and costs. The next three elements--universal coverage and universal participation in health insurance purchasing cooperatives, open enrollment and community rating, and risk adjustment of payments to insurers--would be crucial to eliminating the effects of selection.

Unlike the first seven elements, which are structural features of managed competition plans, the last element is of a different kind--it is really a characteristic of how managed competition plans would need to function if they are to achieve substantial savings. Specifically, to be effective in reducing the growth rate of health spending, a managed competition system would need to result in a relatively small number of insuring organizations that had networks of affiliated providers--or at least primary care physicians--that did not overlap to a substantial degree and that competed on the basis of their efficiency in delivering care of high quality.

HIPCs

Creating a HIPC in each region is a crucial, defining element of the managed competition strategy. Without HIPCs, it would be much more complicated, within a market framework, to integrate--and thereby enlarge--each region's currently segmented market for health insurance. When dealing with organizations that sell health insurance, consumers would continue to lack both the power that flows from being part of a large group of purchasers and good information about why premiums differed among insurance plans.

Moreover, open access to health insurance would be difficult to enforce because insurers, unless otherwise prevented, would continue to pursue nonprice competition based on selection of favorable risks. Nor would insurers face the same incentives to form networks of affiliated providers or to reduce their premiums by delivering high-quality care in more

cost-effective ways. Also, even if community-rating were imposed on insurers within some other framework, it would be hard, within that framework, to establish a mechanism that could compensate insurers whose enrollees' average health status and use of services were atypical of the population's.

Elements to Promote Price-Conscious Choice

Consumers would be encouraged to make price-conscious choices by three critical elements of managed competition.

Limit on Employers' Contributions to Employees' Health Care Expenditures

Managed competition would be ineffective unless employees faced a clear incentive to assess their options for health insurance. Unless employers' contributions toward employees' health care costs (including contributions through tax-preferred flexible spending accounts and "cafeteria plans") were capped, some firms would continue to pay more, thereby avoiding pressure on their employees to consider cost in their choice of insurance plans. Omitting the limit on employer's contributions might also prolong the apparent impression among many employees that employer-provided health benefits are costless to them--when, instead, employees can be presumed to pay for them in the form of lower wages and salaries or less generous nonmedical fringe benefits.

However, merely capping the amount of employers' deductions for tax purposes, rather than capping the contributions that they can make for health insurance expenses on behalf of their workers, would not necessarily create the intended incentive for all employees. Some employers, for example, might accede to the demands of workers or unions that they pay more than this amount in spite of the tax penalty, knowing that they could recapture the additional costs by reducing other components of employees' compensation.

Standardized Benefits and Coinsurance Rules

If managed competition proposals did not require that benefits and coinsurance rules be standardized, savings in health care spending would be smaller than otherwise for three reasons.

First, differences in coverage among plans could continue to cause premiums to vary. That would make differences among premiums more difficult to interpret and would lead consumers to give less weight to them when choosing among plans.

Second, insurers would have greater opportunities than otherwise to design their plans in such a way as to pursue favorable selection--a phenomenon for which risk adjustments would offer only an imperfect remedy. This course of events would exacerbate a further source of premium differences among plans and would also diminish the pressure on insurers to compete by developing more cost-effective ways to deliver care.

Third, failing to standardize covered benefits and to eliminate balance-billing could decrease the differences in premiums that would otherwise arise between traditional indemnity insurers and health maintenance organizations. For example, suppose indemnity insurers were permitted to cover fewer services than HMOs. In that case, the differences in premiums would be smaller than with uniform coverage because part of the additional costs of receiving care under indemnity arrangements would be offset by the more limited coverage of indemnity plans. If balance-billing were permitted under indemnity plans--and premiums and standard copayments did not need to cover the full costs of

care provided under the plan--then premiums could be set at lower levels than if plans had to finance most of the higher charges of providers who used balance-billing. Moreover, enrollees in such plans would probably have incomplete information about the likelihood of balance-billing and its amount. Consequently, a smaller difference in premiums would result if balance-billing were permitted. This would tend to protect the market share of indemnity insurers that did not adopt cost-effective forms of managed care and so would reduce the savings in overall use of resources.

New Data on Quality, Outcomes, and Costs

Consumers would have little basis for distinguishing whether premium differences resulted from differences in quality or efficiency unless managed competition gave rise to operational and valid measures of costs, efficiency, quality, and outcomes that were collected in a comparable way among all providers and provider networks.

How satisfactorily and how quickly such information systems could be developed and adopted on a nationally uniform basis is, however, unclear. In particular, developing satisfactory measures of quality and outcomes that could be used in this way would be technically challenging. Moreover, the costs of undertaking this task would be considerable and would be concentrated in the early part of a transition to a managed competition system. A further technical difficulty is that, currently, many HMOs do not organize their data systems in ways that identify the resources used in specific encounters between each enrollee and the HMO's providers. Some HMOs would need to make significant additional investments in their data systems to be able to provide the level of detail on costs and quality of care that would permit comparisons with other insurers.

Eliminating Selection Effects

Effects of selection would be eliminated or offset by three other critical elements of managed competition.

Universal Coverage

To eliminate the effects of selection, everyone would need to be covered by health insurance. Having access to insurance, on its own, would not be sufficient: people who anticipate relatively high health care costs would be more likely to exercise their option to obtain insurance than people who anticipate relatively low costs. Moreover, many uninsured people still require health care, and providing it results in costs for the system because of associated patterns of inefficient use of resources and uncompensated care.

For managed competition to realize its potential savings fully, however, all health insurance coverage would need to be arranged through the HIPCs. This requirement would apply to health coverage currently provided by those large employers who self-insure their health plans as well as those that purchase coverage from insurance companies. It would also include coverage through Medicare and Medicaid. The roles, under managed competition, of the health care systems operated by the Departments of Veterans Affairs and Defense would also need to be considered. Similarly, participation in the HIPC arrangements would be mandatory rather than voluntary for any individual seeking insurance coverage.

Without comprehensive inclusion of all insurance within HIPC arrangements, uniform data on providers and insurer/provider networks for the entire health care system would

be much harder to collect. Partial collection would, in turn, detract from the quality of the information available to consumers choosing among insurance plans. Opportunities would also increase for insurers to pursue favorable selection systematically. In turn, that would heighten the pressure on the mechanism used to adjust capitation payments to insurer/provider networks for differences in the average health spending expected for their enrollees. Even without that added pressure, this mechanism would be imperfect. As a further consequence, pressure for insurers to compete by arranging more cost-effective care of high quality would lessen.

Self-Insured Firms. In 1990, among full-time workers with health care coverage who are in establishments with fewer than 100 employees, about 28 percent were in firms that self-insured their health care plans.[1] In 1989, for establishments with 100 or more employees, the corresponding proportion was about 36 percent.[2]

Some proponents suggest that all self-insured firms should be allowed to opt out of the HIPC system. If firms were given the option of whether to self-insure, however, those with above-average health costs would be likely to join the HIPC system in order to enjoy the benefits of community rating based on a healthier overall population. In contrast, those with below-average health costs would continue to self-insure rather than pay higher premiums under a community-rated system. Allowing bad risks to join the HIPC system and good risks to stay out would conflict with establishing regional risk pools whose members would be offered community-rated insurance plans.

Other proponents have suggested that all firms with more than a specified number of employees should be excluded from the HIPC system, as large firms tend to be self-insured. Excluding these firms, they suggest, would avoid disrupting agreements about health care benefits that employers and unions have negotiated, often with difficulty. Currently, about 40 percent of employees are in firms employing more than 1,000 people, and 60 percent are in firms employing more than 100 people.

If overall spending under managed competition is to achieve its potential savings, self-insured employers would need to be incorporated within the HIPC system for three distinct reasons.

First, a change in incentives would only affect the behavior of those consumers and providers who were subject to the change. Groups of employees left outside the HIPC framework would have weaker incentives to use health care in price-conscious ways than those included. Nor would the incentives for providers be altered when negotiating with self-insured employers.

Second, little evidence exists to show that large employers have been more successful than small employers at controlling their health insurance costs.

Third, if a sizable market remained outside HIPCs, providers might respond by continuing to manage their revenues through a combination of price differentials and increases in volume for those not included in the HIPC. Consequently, exempting self-insured firms above some specified size could appreciably reduce the savings in health care spending that would accrue from adopting managed competition.

Medicaid. Managed competition proposals typically assume that Medicaid would be superseded by whatever arrangements were introduced to cover low-income people who are currently uninsured. An incidental benefit of including Medicaid could be to cut down on disincentives to work, and consequently increase average earnings, among people whose eligibility for Medicaid is linked to their eligibility for the Aid to Families with Dependent Children (AFDC) program. Under man-

1. Department of Labor, *Employee Benefits in Medium and Large Firms, 1989* (1990), Table 38, p. 50.

2. Department of Labor, *Employee Benefits in Small Private Establishments, 1990* (1991), Table 37, p. 44.

aged competition, the subsidy that such people received for health insurance might be cut less sharply when their earnings increased.

Medicare. The role of Medicare under managed competition, however, would be less straightforward. Most proposals for managed competition assume that Medicare would be excluded, at least initially and often indefinitely. To do otherwise, proponents presume, would be politically infeasible and technically complex. On the technical side, for example, the average health care spending for Medicare enrollees is several times higher than that for nonelderly people. Merging the two groups into a single risk pool subject to community rating and a uniform risk-adjustment process would therefore entail a major--and geographically variable--redistribution of health care costs and would also be technically difficult.

Alternatively, treating the Medicare population as a separate risk pool for which separate plans would be offered, separate premiums quoted, and a separate risk-adjustment process established would make the system more complex in other ways. Moreover, if Medicare enrollees were included in the scope of managed competition and supplementary insurance were prohibited, then "medigap" insurance would be eliminated.

Nevertheless, Medicare accounts for a significant share of health care spending (see Table 2). Moreover, if Medicare enrollees were included in a managed competition system, all of their health care spending--and not just Medicare's direct outlays on their behalf--would be affected by the new incentives. For example, if people are classified by their primary source of health insurance, Medicare enrollees accounted in 1990 for about 23 percent of total spending on personal health care services of the kinds that insurance policies typically cover.[3]

Consequently, excluding Medicare enrollees from the scope of a health care reform designed to promote more cost-effective care would presumably significantly lessen the total savings in health spending that could be attained. Nevertheless, if Medicare were included and the higher level of savings therefore occurred, those savings might not all accrue to the federal government. That outcome could result because existing patterns of cost shifting by providers--from the Medicare and Medicaid programs to the insurers of other categories of patients--would probably be changed as well.[4]

Open Enrollment and Community Rating

Another critical element of the managed competition strategy is the open-access feature--requiring periods of open enrollment, prohibiting limits on coverage or on renewing insurance, and community rating by a small number of categories. Without this feature, it would be relatively simple for insurers--as they do now--to break the population into groups with different average health statuses and to market their policies to those people who are least likely to need care. The result would be that, in insurance pools whose average health status was relatively poor, the healthiest individuals would switch to healthier insurance pools where premiums were lower, leaving the sickest people in insurance pools that had increasingly poor health status and increasingly high premiums. In time, either insurance coverage would again become entirely unavailable to many individuals or people with the worst health status would pay many times more for insurance than relatively healthy people.

Requiring that community rating be undertaken for a small number of categories based on family composition would promote fairness

3. See Congressional Budget Office, "The Potential Impact of Certain Forms of Managed Care on Health Care Expenditures," CBO Staff Memorandum (August 1992, revised), Table 3.

4. See Congressional Budget Office, "Responses to Uncompensated Care and Public-Program Spending Controls: Do Hospitals 'Cost Shift'?" CBO Paper (May 1993).

Table 2.
Actual and Projected National Health Expenditures, by Source of Funds, Calendar Years 1990 to 2000

Source of Funds	Actual 1990	Actual 1991	Projected 1992	1993	1994	1995	1996	1997	1998	1999	2000
					Billions of Dollars						
Private											
Out-of-pocket	136	144	153	163	172	183	194	206	218	229	240
Private health insurance	222	244	266	288	313	339	368	400	432	465	499
Other	31	33	36	38	41	44	47	51	54	58	61
Total Private	390	422	455	490	526	566	610	656	704	752	800
Federal											
Medicare	111	123	138	156	178	200	223	246	272	301	332
Medicaid	43	56	70	82	94	106	119	133	148	165	184
Other	41	44	46	48	51	53	56	59	61	64	67
Total Federal	195	223	255	286	323	360	397	438	481	529	583
State and Local											
Medicaid	33	45	56	66	75	85	95	106	118	132	147
Other	58	62	66	70	74	78	83	87	92	97	102
Total State and Local	91	107	123	136	149	163	178	194	210	229	249
Total National Health Expenditures	675	752	832	912	998	1,089	1,185	1,288	1,395	1,510	1,631
					Annual Percentage Change from Previous Year Shown						
Private											
Out-of-pocket	n.a.	5.7	6.2	6.5	5.2	6.3	6.4	6.2	5.6	5.2	4.8
Private health insurance	n.a.	10.0	8.8	8.4	8.6	8.4	8.6	8.4	8.1	7.7	7.1
Other	n.a.	6.0	7.8	7.6	7.2	7.1	7.0	7.2	6.8	6.5	6.3
Total Private	n.a.	8.2	7.8	7.7	7.4	7.6	7.7	7.6	7.2	6.8	6.4
Federal											
Medicare	n.a.	10.9	12.7	12.7	14.4	12.1	11.3	10.7	10.4	10.4	10.5
Medicaid	n.a.	30.6	25.8	16.8	14.4	13.2	11.7	11.7	11.4	11.5	11.5
Other	n.a.	7.8	4.3	5.1	4.9	4.9	4.8	4.7	4.6	4.5	4.4
Total Federal	n.a.	14.6	14.3	12.5	12.8	11.3	10.5	10.1	9.9	10.0	10.1
State and Local											
Medicaid	n.a.	36.6	26.0	16.8	14.4	13.2	11.7	11.7	11.4	11.4	11.4
Other	n.a.	7.9	6.1	5.8	5.6	5.8	5.7	5.6	5.3	5.2	5.0
Total State and Local	n.a.	18.3	14.4	10.9	9.9	9.5	8.8	8.8	8.7	8.7	8.7
Total National Health Expenditures	n.a.	11.4	10.7	9.6	9.4	9.1	8.8	8.6	8.4	8.2	8.0

SOURCE: Congressional Budget Office.

NOTE: n.a. = not available.

between insurance units of different size. For example, single individuals would not be asked to pay the same rates as families.

Risk Adjustment of Payments to Insurers

In a health insurance system that required open enrollment, competing insurance plans would be likely to enroll groups that differed in their average health status and hence in the expected average costs for the care they would require. Differences in average health status would stem from random factors and could be exacerbated by insurers that acted deliberately to attract the more favorable risks. If such a system also required community rating of premiums but did not include a mechanism to neutralize the financial effects of risk selection, the main factor determining profitability for insurers would be how lucky they were or how effectively they could achieve favorable risk selection. To do the latter, they could manipulate their marketing and the selection and location of their affiliated providers. The resulting system would retain the present health insurance system's emphasis on competition through risk selection rather than through the efficient provision of care.

These issues would be of heightened importance during any transition to a managed competition system, since the current distribution of consumers among health insurance plans already reflects the impact of systematic selection by insurers and enrollees. Insofar as consumers showed a preference for remaining with their most recent insurers when choosing among plans during the transition, past selection patterns would tend to be perpetuated. Consequently, accurate methods to adjust payments to insurers for differences in the average health costs expected for their enrollees would be particularly important during the initial phase of the transition.

Mechanisms to adjust for risk selection in an accurate and unbiased way are essential but not yet available. Those under development would not work unless applied to large groups of insured individuals. Even then, they could be expected, at best, to adjust partially and imperfectly for the effects of selection on costs and to do so in a way that improved fairness among providers only on average and over time. Thus, some organizations that enrolled a disproportionate number of high-cost individuals might experience poor financial outcomes for essentially random reasons. In short, where risk adjustment is concerned, it is unclear how good is "good enough" and whether adjustments that are good enough could be achieved in the near term. During any transition to managed competition, interim approaches to risk selection are likely to be tried. Although useful, they would probably be less than fully effective.

Creating Incentives to Induce Competition Among Substantially Nonoverlapping Groups

To realize fully the potential savings from managed competition, any proposal would need to bring about a comparatively small number of insurer/provider networks that proved, in practice, to be substantially nonoverlapping. (If networks were not to overlap, each provider would have to be affiliated with only one insurer.) This outcome would be especially important for the networks of affiliated physicians--primary care physicians in particular.

If most providers were instead affiliated with several insurance networks, then price differences among the networks would largely reflect differences in the price discounts that

the various insurers had negotiated with these providers. In other respects, the providers in any particular network would essentially be competing with themselves as they wore the different hats of other networks. Consequently, they would have few incentives to change the way they practice to be more cost-effective and to adopt the practice styles sought by insurers. (Highly specialized physicians, as well as specialty or sole community hospitals, however, are examples of providers that might be expected to affiliate with more than one organization.)

More uncertain is whether such nonoverlapping networks of providers would come about, and if so how. One possibility is that managed competition could result in organizations that offer an insurance plan through the HIPC being held accountable for the quality of care provided under the plan. This accountability could be based on legal obligations, if a fault-based liability system were retained and if insurers as well as providers were made legally accountable under liability standards for malpractice. Alternatively, accountability might be achieved financially through the discipline of an effective market in which consumers were well informed about differences in the quality of care from providers affiliated with each network.

In either case, effective accountability for the quality of care provided under their plans would substantially change the incentives faced by insurers. In particular, they would have to monitor or manage both the quality and the cost of the care from each provider under the plan, which would entail much closer involvement with providers in their plans.

Some proponents of managed competition argue that these changes would require traditional indemnity insurers to become much more like those HMOs that contract with a network of affiliated physicians and use financial incentives, comparative information about each physician's performance, and other management techniques to encourage practice styles within the network that achieve efficient, high-quality care. As a result, the number of indemnity insurers wishing to offer plans through any given HIPC could be lower than would otherwise be the case. Some proponents anticipate that the market share of traditional indemnity insurance would fall sharply.

It is not clear, however, to what extent these or other incentives within a managed competition system would succeed in engendering a relatively small number of insuring organizations that all employed cost-effective forms of managed care, had substantially nonoverlapping networks of affiliated providers, and competed without collusion on the basis of their relative efficiency in delivering care of high quality. Such an outcome is more likely for networks of physicians than for hospital providers. For demographic reasons, it would also be more likely in some geographic areas than in others (see Chapter 5).

Chapter Four

Managed Competition Plans with Alternative Features

Many features of the approach to managed competition already discussed could be constraining compared with the current health care system. As a result, strong political pressure would build to ease them. Moreover, for analytic reasons, the approach illustrated in Chapters 2 and 3 was deliberately crafted to achieve the full potential of managed competition for reducing the total cost of high-quality, universal health care. In contrast, policymakers could seek to balance the priorities accorded to containing costs and attaining other health policy objectives--for example, retaining a degree of choice for consumers and providers, achieving rapid progress in medical technology, and minimizing disruption of the health care system during any transition to a new one.

Permitting Balance-Billing

The approach to managed competition described in Chapter 2 would proscribe balance-billing, leaving insurers to pay the full cost of health care services provided through their plans, except for the standardized copayments. Imposing this responsibility on insurers in an environment that fostered price competition would create a strong incentive for insurers to encourage providers to adopt cost-effective practice styles and to select, as members of their networks, providers who exhibited such styles. Advocates of managed competition see such incentives for providers as a primary source of savings; at the same time, omitting the requirement would reduce the savings from managed competition.

In addition, eliminating balance-billing would make premiums and standardized copayments the only health care expenses for covered services for which consumers were liable under plans offered through a health insurance purchasing cooperative. Knowing that there were no hidden differences in charges between plans would enable consumers to interpret premium differences with greater confidence.[1]

Some who favor managed competition, however, would relax the proscription of balance-billing (see Chapter 2). Permitting balance-billing, they suggest, would allow providers whose costs are higher because they try to offer a higher quality of service to retain their current practice styles. Moreover, the additional charges levied under balance-billing would be paid fully by the users from their after-tax incomes, which would lessen the extent to which the incentives for consumers to make price-conscious choices would be eroded. The trade-off for policymakers would be between greater freedom for providers and consumers and greater savings in health care spending.

1. Eliminating balance-billing would also create an additional trade-off for insurers to consider when developing their networks of providers. By raising the maximum charges they would reimburse, insurers might retain in their networks providers whom their enrollees use and who currently use balance-billing. But doing so would tend to raise the insurers' premiums, worsening their competitive position on the dimension of price.

Allowing Supplementary Insurance

The approach in Chapter 2 would, in addition, prevent insurers who offered plans through a health insurance purchasing cooperative from also offering supplementary insurance products. The rationale for this proscription involves different issues depending on whether the supplementary policies would cover the standard copayments, additional services, or alternative coverage entirely outside the HIPC framework. In each case, a policy tradeoff would arise between greater consumer choice, on the one hand, and greater savings in expenditures and a potentially more effective managed competition system, on the other.

Supplementary Coverage of Copayments

Permitting supplementary policies that covered copayments in the standard plan would defeat the cost-containment purpose of the coinsurance. Moreover, people purchasing such insurance could be expected to increase their use of services covered by the standard policy. Consequently, supplementary insurance covering copayments would increase the total costs for which primary insurers would be liable, although only the supplementary insurers would receive additional premium income. In short, insurance of this kind would considerably lessen the potential for managed competition to contain health care spending and would drive up premium costs for indemnity insurance.

Supplementary Coverage of Additional Services

Permitting supplementary policies that covered additional services not included in the standard plan would also raise broader issues. Some advocates of managed competition would permit this insurance, provided it was sold separately and was paid for from the after-tax incomes of consumers. The argument for doing so is that people could then obtain insurance coverage against the possibility of large expenses for services not covered by the basic package.[2] In this way, it would accommodate consumers' varying medical circumstances and preferences concerning risk.

All else being the same, this kind of supplementary insurance would raise health care spending, because broader insurance coverage would result in greater use of the additional covered services than without supplementary insurance. For a prohibition on supplementary insurance to be sustainable, however, the standardized benefit package would need to be relatively comprehensive. Otherwise, the demand for supplementary insurance covering services excluded from the package could be considerable. In this respect, permitting supplementary coverage might reduce the political pressure to have extremely generous benefits in the basic plan.

Allowing supplementary coverage could also affect the accuracy of the proposed system of risk adjustment and the achievement of HIPC-wide risk pools that were free from the effects of systematic selection. People choosing to buy supplementary policies would probably prefer to buy them from the same insurer that provided their standard health care coverage. They could then deal with only one insurer rather than two when filing claims and coordinating benefits.

Unless precluded from doing so, insurers could therefore be expected to design supplementary policies and to market them in ways that would result in favorable risk selection--that is, that would induce relatively healthy purchasers to enroll--in order to achieve similarly favorable selection under their basic plans as well. Thus, given the current limited ability to "risk adjust" payments from the HIPC to insurers, permitting supplementary policies would reduce the ability of managed

2. It is presumed that the standard package would protect against catastrophic expenses for covered services.

competition to reward insurers who were more efficient and would substantially lessen the incentives to provide more cost-effective care.

The adverse outcomes relating to systematic selection and risk-adjustment mechanisms might be mitigated or avoided if companies were not allowed to sell both basic and supplementary insurance policies. Even then, similar effects of selection might be engineered if legally separate subsidiaries of a single corporate group were permitted to sell basic and supplementary policies that used the same network of providers to deliver care. In that case, the subsidiary selling the basic policy could also benefit if the subsidiary offering the supplementary policy sold it to enrollees with better-than-average health; the financial advantage would still be captured within the corporate group. Moreover, collusion among insurers offering basic and supplementary health policies could achieve similar financial benefits.

Hence, the adverse effects of permitting supplementary insurance could be minimized through further regulation by prohibiting insurers from selling basic and supplementary policies within the same HIPC region, extending this prohibition to pairs of insurers with corporate links, and outlawing collusion among legally separate insurers that was designed to achieve favorable selection by coordinating their policies.

An alternative approach might be to require people purchasing supplementary insurance to do so through a pool, with purchasers assigned randomly to insurers. In that case, however, supplementary policies would also have to include standardized coverage.

Alternative Health Insurance Outside HIPCs

The approach described earlier assumes that all health insurance would be offered through HIPCs. Some proponents consider that it would be neither possible nor appropriate to prevent the sale of health insurance policies outside the HIPC framework. These proponents assume, however, that any expenditures on such insurance would be ineligible for preferential tax treatment. Thus, for example, employers could not make tax-deductible contributions toward its cost, nor would any payments by employers for such insurance be excluded from the employees' taxable incomes.

Even the additional cost of such "double taxation" might not prevent a market for such insurance from developing. Two groups might be particularly attracted to insurance outside the HIPC--people with significant resources who wanted more flexible insurance than managed competition might offer, and young healthy people. For the latter group, experience-rated policies that offered catastrophic coverage only and that were medically underwritten might be available at premiums substantially lower than those for community-rated policies offered through HIPCs. In that case, however, opting out by young healthy people with low expected health care costs could raise community-rated premiums for the rest of the population.

Unless otherwise prevented from doing so, members of the young healthy group could rely on experience-rated insurance until they developed a significant need for health care, at which time they could purchase a comprehensive policy through their HIPC to cover the costs of that care. To prevent this kind of self-selection into or out of the managed competition system, a lengthy waiting period--for example, five years--for entry into the managed competition system could be imposed on anyone who did not choose to join it when the opportunity first became available.

Permitting Variation in the Benefit Package

Some proponents of managed competition dispute the need for any standard benefit package at all. They contend that consumers frequently make complex, multidimensional

choices about expensive products. Purchasing insurance, they say, should be no more difficult than purchasing a house, a car, or a college education.

Health insurance differs from those products, however, in two ways. First, through the tax treatment of employers' contributions, health insurance purchases by most individuals have been heavily subsidized, encouraging people to base decisions on factors other than price, such as coverage and perceived quality differences. That difference would be reduced but not eliminated under managed competition. Second, none of the other products involves insurance, where insurers could use small differences in the fine print of coverage statements--especially in a community-rated system--to manipulate risk selection and affect premiums in ways that consumers could not reasonably ascertain. Similarly, the potential for unrecognized differences in coverage creates uncertainty for consumers about what they are buying. Standardized benefits could therefore promote informed choice by consumers while also minimizing intentional risk selection by insurers. Preventing risk selection is important to maximizing savings, given that the ability to adjust for risk selection is limited.

Proponents of managed competition have suggested two ways to standardize covered services that would be less complete than the approach outlined in this study. One would permit two standardized benefit packages--one for indemnity insurers and another for health maintenance organizations. The other would allow each HIPC region to determine what would be covered in its standardized benefit package(s).

Permitting Indemnity Insurers and HMOs to Offer Different Coverage

Some advocates would allow one standardized plan for indemnity insurers and another standardized plan for HMOs. Doing so would permit the present pattern of more comprehensive coverage of services under HMO plans to be maintained, with the additional coverage emphasizing preventive services. These proponents consider that offering two standardized plans would provide greater choice for consumers in ways that reflect differing preference patterns to which the market has already adapted. Yet this modest expansion of the options available should not, in their view, unduly complicate the decisionmaking process for consumers, many of whom already make this choice.

Permitting two standard plans could detract in several ways, however, from how effectively managed competition could realize the fullest potential savings in health spending. For example, uniform data would be harder to collect. Systematic differences in average health status would probably also occur between consumers choosing indemnity insurers and those choosing HMOs. These differences would presumably favor HMOs, which appear historically to have experienced favorable selection among their new enrollees.

Widespread systematic selection of this kind would reduce the ability of the risk-adjustment process to compensate insurers accurately for departures from the average in the expected use of services by their enrollees. In turn, the incentives for insurers to compete by developing more cost-effective systems for delivering care would be reduced. Particularly in less densely populated HIPCs, it might encourage instead a perpetuation of the pattern of competition in which, according to some advocates of managed competition, HMOs now undercut the premiums of indemnity insurers by just enough to establish a market niche but then have no further reason to pursue more cost-effective patterns of care.

Permitting separate standardized plans for indemnity insurers and HMOs would also reduce the savings in health care spending that managed competition could achieve. With separate standardized plans, HMOs would probably cover more services, and indemnity insurers less, than if there were a single stan-

dardized plan. HMOs would also probably still offer the lowest premiums within a HIPC. Consequently, the lowest premium within the HIPC would be greater if two plans existed than only one and if employers' contributions would be capped at a higher level. Thus, the benefit of the favorable tax treatment for employer contributions would apply to a higher volume of health care spending, and overall health care spending would therefore be reduced by a smaller amount.

Permitting Regional Variation in the Scope of Coverage

Another possibility that some managed competition proponents favor would be to permit the scope of standardized coverage--whether in one plan or two--to be determined at the regional level. Thus, coverage might vary from one HIPC region to another. This approach would allow variation in the health care system that might reflect regional differences in income levels, health care needs, health care prices, and social preferences. Once again, proponents consider that this variation would enhance choice and flexibility within a managed competition framework.

The approach would have costs for the system as a whole, however. Administrative costs would be higher nationwide, because of the different coverage rules in each region, and it would be harder to develop nationally comparable data on the use, costs, quality, and outcomes of health care services. Moreover, employers that operated in multiple regions, and their employees, could face differences in health care coverage from one HIPC region to another. These differences might reduce the willingness of large self-insured employers to join the HIPC system and could therefore reduce the universality of participation within the managed competition framework.

Role of HIPCs

The analysis in Chapter 2 assumed that the maximum number of insurance plans within a HIPC would not be arbitrarily limited but would instead be determined by the number of qualified insurer/provider networks wishing to offer plans through the HIPC. This approach would avoid creating an anticompetitive barrier for additional networks that wished to offer plans within a HIPC.

Some proponents of managed competition, however, would specify a more activist role for HIPCs. In their view, each HIPC should have some discretionary authority and should use it to permit only a small number of insurer-sponsored networks to offer plans--no more than perhaps five to eight. These plans, however, should exhibit some diversity--for example, including a staff or group model HMO, an IPA (independent practice association) model HMO, and an indemnity plan. One responsibility of the HIPC would be to select the insurers whose plans would be offered. In doing so, HIPCs might negotiate with potential insurers about the premiums, quality of care, and availability of providers that their plans would offer consumers. In this way, the HIPC would pursue what it judged to be the most favorable set of choices. Proponents of this approach seek to achieve a reduced number of insurers per HIPC by regulation, rather than as the outcome of market processes.

Chapter Five

Effect of Managed Competition on National Health Expenditures

Whether or not managed competition would be successful at holding down health costs depends on whether it could wring inefficiencies out of the current system and whether it would push technological development in a cost-saving direction. Adopting managed competition in the form outlined in this study would affect national health expenditures and their rate of growth in numerous and complex ways.

Extending insurance coverage to people currently without it would tend to increase health spending. So would new costs from creating and operating health insurance purchasing cooperatives and meeting requirements for additional data collection. In contrast, creating incentives that would encourage an expanded role for managed care and more widespread adoption of cost-effective approaches to medical practice would tend to reduce spending. Some of the effects on costs would be apparent quickly, while others would emerge or build over time. Although the overall effect could be to reduce national health expenditures in the longer term, the available evidence does not permit one to forecast changes in magnitude or timing with any precision.

Five questions highlight key factors determining the potential effectiveness of managed competition in reducing health spending.

- What scope does medical practice have to be more cost-effective, now or in the future?
- To what extent would incentives within a system of managed competition induce consumers to accept more cost-effective styles of practice?
- To what extent would these incentives induce providers to adopt more cost-effective practice styles, initially or over time?
- How long would it take to create a system incorporating such knowledge and incentives?
- Could the process by which technological change occurs in health care be structured so that, on a continuing basis, innovation would take on a more cost-reducing bias than in the past?

Scope for More Cost-Effective Medical Practice

Three key factors will help to determine potential savings in health spending: the criterion for appropriate use of resources within health care, the degree to which existing knowledge would enable providers to practice medicine more cost-effectively, and the extent to which further knowledge of this kind could be obtained.

Alternative Criteria for Judging When the Use of Resources Is Appropriate

The scope for reducing health care spending depends in part on the criterion adopted to judge when resources are used appropriately in the health care sector. Traditionally, the medical and legal systems expected clinicians to do what would most benefit their patients. Failure to observe this standard could constitute professional malpractice. Broadly speaking, that standard of care was often interpreted as requiring clinicians to provide their patients with all services expected to confer a medical benefit.

Today, the legal standard for appropriate care has become less clear as the health care environment and ethical perspectives on medical practice have changed. The changes include insurance policies that sometimes limit coverage for expensive care, recognition that decisions about what care is best for an individual can depend on the person's values as well as on technical judgments, and uncertainty about the probable outcomes of particular clinical approaches. Moreover, because some demographic groups are clinically more difficult or expensive to treat, considerations of fairness can also influence what standard of care to adopt.

Nevertheless, the criterion adopted for judging when care is appropriate has important implications for how resources are used within the health care sector. For example, if the traditional medical-legal standard were to be accepted as the criterion of the appropriate use of resources, then the potential for savings would depend on whether current medical practice is cost-effective--that is, whether it achieves a given level of health results using the combination of resources that costs the least.

Improvements in cost-effectiveness might result from simple changes, such as having all of a hospital's surgeons use instruments of the same design, that would allow existing services to be provided less expensively. Alternatively, savings might result from new ways to treat medical conditions that attained lower-cost outcomes that are at least as satisfactory. Under that standard, savings would be possible to the extent that some health care services or spending yield no medical benefits. Because it focuses only on benefits, however, the standard would treat the cost of services as irrelevant. Thus, it would be indifferent to whether large additional costs would need to be incurred to provide a service that would confer a small additional medical benefit.

In contrast, economic theory implies that, for resources to be used in an economically efficient way, the value of the additional benefits derived from providing a service must be as great as the additional costs incurred to provide it. At issue is whether this general standard of economic efficiency in using resources, which is typically applied in other sectors of the economy, should also be applied to the health sector. Requiring medical care to be economically efficient would apply a more stringent standard of using resources than merely requiring care to be cost-effective. If policymakers were to judge that the criterion of economic efficiency should be adopted, additional resources could be saved by not providing services whose benefits were considered to be less than their costs. New issues would be raised, however, about how the benefits of additional services should be valued.

Could Current Medical Practices Be More Cost-Effective?

Three factors--the unused potential of managed care, the apparent extent of inappropriate care, and the existence of duplicate capacity--suggest that health care spending could be reduced without compromising the quality of care. Although not discussed in this

study, another potential way to save on expenditures could be for providers to engage in additional discounting from their listed charges.

Managed Care. Moving people from fee-for-service medicine into staff- and group-model health maintenance organizations reduces health care spending.[1] Based on past performance, the Congressional Budget Office would expect the prices of staff- and group-model health maintenance organizations to be 10 percent to 15 percent below the prices of similar fee-for-service plans. CBO estimates that, if everyone with health insurance were to enroll in these kinds of HMOs and all of them achieved that level of cost reductions, national health expenditures could decline by up to 10 percent. In 1992, this amount would have represented a reduction of up to $83 billion. Expanded use of some other forms of managed care could achieve smaller savings. If the use of staff-model and group-model HMOs were expanded within the framework of managed competition, the potential savings might be larger because the HMOs would have stronger incentives to achieve savings than they currently do.

Inappropriate Care. Another rationale for claiming that savings in health care spending are possible stems from evidence that patterns of practice for particular conditions vary dramatically among providers and among regions. This evidence has prompted research on the appropriateness of the care that is actually being provided.

Hospitalization and surgery rates vary significantly among small geographic areas. The most recent study reported twofold variation in 1989 on several measures of physicians' services to Medicare beneficiaries--hospital admissions, payments per admission, and outpatient care costs.[2] Earlier studies using other measures found even greater variation.

Evidence of substantial variation among regions or providers in the average resources used to treat similar people with similar medical conditions does not necessarily imply that either more parsimonious or more resource-intensive practice styles are preferable. Variation of this kind, however, does raise the question of whether one practice style is medically more appropriate than another.

According to studies of the appropriateness of medical care, certain procedures have been performed unnecessarily or in questionable cases. For example, one study of selected medical procedures provided to Medicare beneficiaries in eight states found that 17 percent of coronary angiographies, 32 percent of carotid endarterectomies, and 17 percent of upper gastrointestinal tract endoscopies performed were inappropriate.[3] More generally, a review of this literature concluded that, in a wide variety of contexts, a significant portion of current medical care is inappropriate and that the most important factor explaining the amount of inappropriate care seems to be the practice style of the individual physician.[4] The authors cautioned, however, that the number of relevant studies was limited. Some were based on data from the early 1980s; medical practice had, of course, changed since then, and the authors did not know whether inappropriate care had increased or decreased.

More recent studies of three cardiac procedures, using 1990 data for New York State, found that only 2 percent to 4 percent of the procedures were inappropriate--much lower

1. For a summary of the evidence, see Congressional Budget Office, "The Effects of Managed Care on Use and Costs of Health Services," CBO Staff Memorandum (June 1992); and Congressional Budget Office, "The Potential Impact of Certain Forms of Managed Care on Health Care Expenditures," CBO Staff Memorandum (August 1992, revised).

2. W. Pete Welch and others, "Geographic Variation in Expenditures for Physicians' Services in the United States," *The New England Journal of Medicine*, vol. 328, no. 9 (March 4, 1993), pp. 621-627.

3. See M. Chassin and others. "Does Inappropriate Use Explain Geographic Variations in the Use of Health Care Services?" *Journal of the American Medical Association*, vol. 258 (November 13, 1987), pp. 1-5.

4. Robert H. Brook and Mary E. Vaiana, "Appropriateness of Care: A Chart Book" (prepared under contract for the National Health Policy Forum, The George Washington University, Washington, D.C., June 1989), p. 1.

proportions than earlier studies for two of these procedures had found.[5] The authors noted reasons why New York might have lower rates of inappropriate use than other states. Nevertheless, if similar results should be found for other regions and other procedures, indicating that the incidence of inappropriate procedures has decreased or is less nationwide than earlier research had indicated, then the best estimates of the extent of unnecessary medical care nationwide might be lower than previously thought.

Duplicative Capacity. Differing judgments are to be expected about how fast new technology should be introduced and about how much physical infrastructure is needed within the health care system; the underlying questions involve value judgments as well as technical ones. Nevertheless, many analysts consider that capacity within the health care system is at times duplicative and that reducing this redundancy might offer savings.

Nonfederal community hospitals, for example, had only two-thirds of their beds in use, on average, in 1990. In addition, the number of physicians, as a proportion of the population, grew by one-half between 1970 and 1990; considerable consensus exists that too many physicians specialize relative to the number of primary care providers.[6]

Medical equipment embodying advanced technology is also much more readily available in the United States than in other countries, where in some cases governments control the capital acquisition of hospitals in ways that have led to lower rates of introduction of medical equipment than in this country. A comparison of the availability of six technologies in the United States, Canada, and former West Germany, based on data for 1987 and 1989, showed much greater capacity in the United States. For example, the numbers of open-heart surgical units per million people were 0.7 in former West Germany, 1.2 in Canada, and 3.3 in the United States.[7]

If medical equipment is underused, unit costs for the services it provides are higher than they would otherwise be. If competition within markets for these services were based on price, one would expect the capital value of duplicate equipment to fall. Because insurance coverage for such services is extensive, the facilities that offer them tend to compete on quality and access to specialty services rather than price. Accordingly, they have considerable ability to set prices that cover the higher unit costs of underused equipment.

Expanding the Knowledge Base for More Cost-Effective Medical Practice

Developing strategies that would discourage only medically unnecessary care could be difficult; such care would be hard to target if inappropriate care remains as pervasive as earlier studies indicated. Three possible strategies for targeting are to conduct research on outcomes, develop practice guidelines, and--as foreseen within proposals for managed competition--systematically collect new data on the costs, quality, and outcomes of medical care.

Research on Outcomes. Systematic research on outcomes is under way for certain medical conditions or procedures, and the scope of this research could be expanded. By identifying the circumstances in which par-

5. See Lucian L. Leape and others, "The Appropriateness of Use of Coronary Artery Bypass Graft Surgery in New York State," *Journal of the American Medical Association*, vol. 269 (February 10, 1993), pp. 753-760; Lee H. Hilborne and others, "The Appropriateness of Use of Percutaneous Transluminal Coronary Angioplasty in New York State," *Journal of the American Medical Association*, vol. 269 (February 10, 1993), pp. 761-765; Steven J. Bernstein and others, "The Appropriateness of Use of Coronary Angiography in New York State," *Journal of the American Medical Association*, vol. 269 (February 10, 1993), pp. 766-769.

6. See Congressional Budget Office, *Rising Health Care Costs: Causes, Implications, and Strategies* (April 1991).

7. See Dale A. Rublee, "Medical Technology in Canada, Germany, and the United States," *Health Affairs*, vol. 8 (Fall 1989), pp. 178-181.

ticular procedures or patterns of treatment result in improved health outcomes, this research clearly can help greatly to identify when the use of particular procedures and treatments is appropriate.

Currently, Congressionally mandated research studies are in process to examine variations in clinical practice and associated patient outcomes for health conditions affecting large numbers of Americans for which optimal treatment is unclear, costs are high, and data are available. Conditions and procedures being addressed include acute myocardial infarction, cataracts, low back pain, prostate disease, total knee replacement, hip fracture and hip replacement, pneumonia, diabetes, ischemic heart disease, biliary tract disease, childbirth, congestive heart failure, and stroke prevention.

Research on outcomes is complex and costly, however, and technological change in health care is rapid. So results from such research are always likely to lag behind the technological frontier in medicine and to be available for only some procedures and treatments. Moreover, although research on outcomes can advance the appropriateness, and thus the quality, of medical care, it does not necessarily reduce its total cost.

Practice Guidelines. Although practice guidelines are available for some medical conditions, the profession lacks consensus for many others on what medical care would constitute "best practice." Research on outcomes is one way to expand the scope of this consensus. Guidelines developed on the basis of judgments by panels of experts, who consider research on outcomes along with any other available information, can be another. Recently, the Agency for Health Care Policy and Research issued practice guidelines for 6 conditions, and it is working to develop guidelines for 13 more conditions. Practice guidelines are intended partly to improve the average quality of care and partly to ensure that resources for health care are used appropriately and effectively. In these ways, they also respond to the evidence, summarized above, that practice patterns for particular conditions vary dramatically among providers and among regions.

Nevertheless, it remains unclear whether developing and adopting additional practice guidelines would reduce or increase the average cost of care for the conditions they covered. Because inappropriate use includes underuse and misuse of medical services as well as overuse, the widespread adoption of guidelines for medical practice might expand use for some services and reduce it for others. The net effects on health expenditures are uncertain.

Collection of Additional Data. Under proposals for managed competition, collecting new data on costs, quality, and outcomes from each provider and each network might help consumers to make better-informed, price-conscious decisions. It might also help to identify more cost-effective approaches. Key issues are how effectively the data would do so, whether the resulting data base would enhance the potential for research on effectiveness based on regional variation, and whether it would promote the development of additional practice guidelines.

Collecting uniform data based on national standards to measure the costs, quality, and outcomes of health care services would add greatly to the information base available for analyzing the nature, clinical effectiveness, cost-effectiveness, and quality of health care services that are currently provided. Such analyses could focus on selected services, care for particular conditions, care for certain kinds of patients, and care provided by specific providers, provider networks, or types of provider. Some states, providers, and insurers have developed a number of prototype information systems of the kind envisaged. These prototypes could help in developing a national data system.

If such a system were successfully established, the potential for research on effectiveness that examined regional or other sources of variation in practice patterns could improve. Using a national data base, such re-

search could investigate how outcomes of health care varied among regions with different characteristic patterns of treatment, including different levels of resource use. Research of this kind on effectiveness could not substitute for controlled trials with random assignment, but it might nevertheless provide a useful source of additional information that certain differences in patterns of treatment appear to have little impact on the outcomes of health care. In this and other ways, an accurate national data base could also promote the development of additional practice guidelines.

Nevertheless, to create a comprehensive set of measures, based on agreed national standards, and to put a system in place that would collect the required data accurately and consistently from all providers and insurers and from representative consumers throughout the country would be a major undertaking. Even assuming that agreement could be reached on the design of this system, the task of developing and establishing it could be expected to be lengthy, technically challenging, and costly. Moreover, providers and insurers who had to change their existing information systems to conform with the national system could find it disruptive. Although a national system might be implemented in stages and could be valuable before it covered all states or all data items, it would presumably be years before the complete system would be fully in place. Overall, it remains uncertain whether an accurate, comprehensive, and nationally uniform data system could be established at an acceptable cost within a managed competition framework.

The Willingness of Consumers to Accept More Cost-Effective Medical Care

The managed competition proposal described earlier would incorporate incentives for consumers to make more price-conscious decisions about insurance coverage as well as features to help them make such choices more easily (for example, a standardized product, community rating, and new data on differences in quality and outcome). The changed incentives for consumers would result from limiting spending by employers for each employee's health care to a defined contribution that is no greater than the cost of the least expensive plan offered through the HIPC and from requiring any additional spending to be from the consumer's after-tax income.

Of course, incentives would only apply to the extent that consumers were subject to them. Introducing managed competition would have little impact on health care costs if its scope and coverage were severely limited--for example, by excluding Medicare beneficiaries and also employees (and their dependents) in firms that self-insure their health plans, and by limiting coverage to a relatively modest set of acute care services. In that case, managed competition would represent little more than reforming the market for small-group health insurance.

The willingness of consumers to accept styles of practice that are more cost-effective is apt to reflect their perceptions of the extent to which choosing more cost-effective care would also restrict their choice of providers and options for treatment or reduce the quality of the care they received. Insofar as consumers perceived such trade-offs, their willingness to accept more cost-effective styles of practice (at some cost in terms of a choice of provider or quality) would presumably increase with the price advantage of insurance for the more cost-effective care. Healthier people and those new to an area, who would be less likely to have strong attachments to specific providers, would be relatively more likely to choose the more cost-effective forms of care. Switching to a staff- or group-model HMO, or to certain other forms of managed care, would itself be a choice of more cost-effective care that--according to the evidence--entailed no cost in terms of quality but some cost in terms of provider choice.

The Willingness of Producers to Adopt or Develop More Cost-Effective Approaches to Medical Care

If adopting managed competition led consumers to choose among health insurance products in a more price-conscious way, it should create incentives for providers to adopt or pursue more cost-effective approaches to health care delivery. To what extent these incentives for providers would prove to be effective is unclear, however. Accordingly, the likely impacts on the level and growth rate of health care costs are also uncertain.

Mechanisms That Might Increase the Cost-Effectiveness of Care

Proponents envision that managed competition would result in significant changes in patterns of practice--initially as insurer/provider networks adopted known possibilities for delivering care in more cost-effective ways and, subsequently, as the networks institutionalized a continuing search for cost-reducing innovations.

A critical question, therefore, is whether any mechanisms within the competitive process would be likely to spark these changes. Two possible mechanisms exist, which are not mutually exclusive. One would involve managers and providers of health care within an organization cooperating to identify more cost-effective ways to deliver care. The other would involve the emergence of additional networks of providers that have substantially nonoverlapping memberships.

Cooperative Innovation Within Health Care Organizations. Anecdotal accounts suggest that, within hospitals or hospital systems, reviews of current medical practice for particular conditions that are initiated or supported by a hospital's management and that involve the cooperative participation of its medical staff sometimes achieve significant savings in health care costs. The accounts come both from individual providers commenting on their own experience and from business purchasing coalitions describing their interactions with providers. Frequently, these performance reviews are precipitated by evidence that patterns of practice vary significantly among providers and that, in certain respects, the particular hospital's performance compares unfavorably with the average for the industry.

Managed competition, if it resulted in effective price competition, would provide an incentive for insurer/provider networks as a whole, and for individual health care facilities such as hospitals, to evaluate their comparative performance and the patterns of practice underlying that performance. Innovations in the delivery of cost-effective care might flow from such evaluations. Cooperative efforts involving both management and physicians represent one possible approach to this process. Reviews of this kind need not threaten physicians' incomes and could indeed avoid adversarial relationships between physicians and hospital managements.

Substantially Nonoverlapping Networks. Another mechanism to foster innovations in cost-effective care could be available if managed competition led to competition among a number of insurer/provider networks whose memberships did not overlap to a large degree. The likelihood that this outcome would result from market processes would depend on how both insurers and providers responded to the incentives facing them.

Some proponents suggest that insurers would have two strong motivations to form largely exclusive networks of providers. One would arise because an insurer that wished to compete by providing high-quality care more cost-effectively than competitors would need to monitor and to influence both the costs and

the quality of the care delivered by affiliated providers. To monitor costs and quality adequately, the insurer would need data about costs and care patterns for each provider's entire practice. Providers, however, would presumably be unwilling to provide such comprehensive information unless the insurer were the principal source of their business. Similarly, an insurer would be apt to have significant influence over a provider's practice style and detailed patterns of care only if the insurer were the provider's principal source of patient referrals.

The other motivation would arise because innovations that make care more cost-effective would confer a significant advantage in market share on the innovating insurer/provider network only if the innovations did not immediately benefit all insurers. Establishing a separate, nonoverlapping network would be one way in which an insurer could minimize the adoption of its innovations by other insurers' networks.

A further incentive for insurers, however, would operate in the other direction. The disincentive for an insurer to develop an exclusive provider network is that doing so would make it more difficult for potential customers to switch to that insurer. To do so, consumers would have to change all of their health care providers.

Whether insurers and providers would affiliate in substantially nonoverlapping networks under managed competition would depend on the impetus for providers as well as for innovative insurers. The self-interest of physicians, hospitals, and other providers might sometimes point to less exclusive arrangements. For example, affiliating exclusively with a single insurer could entail some reduction in a provider's professional autonomy and financial independence that would need to be weighed against the benefits of being self-employed (for physicians) or independent (for hospitals), having a larger or more stable flow of patients, and enjoying the administrative simplifications that go with a single source of private insurance funding.

Both physicians and hospitals would surely vary in how they evaluated these trade-offs. In the case of physicians, substantially nonoverlapping networks would probably emerge in many areas as physicians responded to the stance of insurers that sought to develop them. Possibly, physicians would form groups to enhance their bargaining position when negotiating with insurers. Because it is widely considered that there is an excess supply of specialists in many areas, new and underemployed providers, including some specialists, could be the most likely to enter into exclusive contractual arrangements with a single insurer.

For hospitals, the probable market outcome is murkier. Regions vary considerably in the number of efficient hospitals that their populations could support, the number and specialties of existing hospitals, and the geographic size of the market areas over which the population is spread. In areas where hospitals typically formed relationships with a number of insurer-sponsored networks, the extent to which hospitals competed for the business of these networks by discounting fees would be an important additional indicator of competitive performance.

Scope for Competition and Possible Outcomes

More generally, the performance of markets with small numbers of buyers and sellers is theoretically unpredictable. Although aggressive price-based competition is one possibility, overt or tacit collusion among insurers or providers are also possibilities. These possibilities raise the issue of how HIPCs or policymakers could measure whether competition was proving effective and how they might respond if it were not.

Scope for Competition. One primary factor determining the scope for competition in any geographic area is the size of its markets for health services. Multiple, competing insurer/provider networks are least likely to arise in

geographic regions where the population density is too low to support a large number of providers or where the neighborhood environment and conditions of practice attract few providers. Consequently, managed competition is unlikely to work satisfactorily in many rural and inner-city areas, where alternative or complementary arrangements would need to be developed.

One recent study based on 1989 data, for example, used the ratio of physicians to enrollees in large staff-model HMOs to estimate the population needed to support health organizations with various ranges of specialty services.[8] It found that:

- A health care services market with at least 1.2 million people could support three fully independent plans; 42 percent of Americans lived in such areas.
- A population of at least 360,000 could support three plans that independently provided most acute hospital services, but the plans would need to share hospital facilities and contract for tertiary services; 63 percent of Americans lived in such areas.
- A population of 180,000 could support three plans that provided primary care and many basic specialty services but that shared inpatient cardiology and urology services and engaged in substantial sharing of inpatient facilities with other plans; 71 percent of Americans lived in such areas.

By these estimates, therefore, more than one-quarter of the population lives in areas that would not support three networks of the last kind. Clearly, managed competition proposals would need supplementary or alternative arrangements to address the problems of health care delivery and costs in rural and inner-city areas.

Possible Outcomes. Various kinds of market structure could emerge from proposals for managed competition. Moreover, different geographic regions are all unlikely to experience the same outcomes, even when they have large populations. Possible outcomes include competing nonoverlapping networks, price leadership by a dominant and innovative network, the present system but with stronger incentives to compete on price, and price leadership by a dominant but noninnovative network. If substantially nonoverlapping networks of physicians, affiliated with insurers, did not emerge reasonably soon in most urbanized HIPC regions, however, it could represent an early warning signal that managed competition was unlikely to succeed in delivering major savings in expenditures.

The Time Required to Establish a Managed Competition System

As the preceding discussion makes clear, establishing a system of managed competition would involve a large number of discrete changes, many of them of considerable complexity. Some of the changes would require legislation; many would involve extended planning, prior or ongoing research, and an implementation phase. Further lags are probable before the changes would have their full impact on the behavior of consumers and providers and on health care spending.

As such, specifying the time required to "establish" a system of managed competition is exceedingly difficult. Rather, a complex series of changes would have to be introduced progressively and refined over time. Even if necessary legislation were passed this year, it could easily take two or three years before significant changes in the functioning of the health care system began to be apparent, and

8. Richard Kronick, David C. Goodman, John Wennberg, and Edward Wagner, "The Marketplace in Health Care Reform: The Demographic Limitations of Managed Competition," *The New England Journal of Medicine*, vol. 328, no. 2 (January 14, 1993), pp. 148-152.

it could require five or more years to establish completely the structure for managed competition. In fact, the full benefits would probably not accrue until the next century.

Impact of Technological Change on Health Care Costs

In the longer term, how managed competition affected health care costs would also hinge on whether it influenced the rate at which technological change increases costs. One perspective on this issue is the contention of Burton Weisbrod, a health economist at Northwestern University, that the relative importance of cost-reducing and cost-increasing innovations in health care technology should be viewed as a rational outcome of how health care financing is structured rather than as the result of chance factors.[9] In particular, the innovations selected for development and introduction reflect expectations about two issues: how readily future health care insurance arrangements would be extended to cover new treatments or cost-increasing improvements to existing treatments, and whether health care providers would be paid prospectively or retrospectively when the innovations were introduced.

Managed competition could make the incentives for technological innovation more favorable to changes that reduced costs, although to what extent is unknown. Specifically, managed competition could slow the contribution of technological change to growth in health care costs if its design included two features. One is criteria for coverage for the standard plan that excluded expensive new treatments for previously untreatable conditions until their clinical efficacy had been demonstrated. Similarly, where innovations involved improved, but more expensive, methods for diagnosing and treating conditions for which treatments existed, the criteria would exclude coverage until favorable benefit-cost ratios or greater cost-effectiveness had been demonstrated for specific applications.

The other feature is payment of health care providers by insurer/provider networks on a prospective, rather than a retrospective, basis. Under prospective payment systems, providers are compensated at a prespecified rate for the services they provide. The compensation may be fixed, as it is for HMOs that agree to provide necessary care in exchange for a fixed periodic payment.

Alternatively, it may take the form of specified payments for the treatment of particular conditions. Medicare's prospective payment system, which reimburses hospitals on the basis of the diagnosis-related groups to which patients are classified, provides one example. In either case, the payment for a particular individual, in general, does not depend on the costs incurred to treat that individual, although the payment rates reflect the average costs of treating such people or of providing care of that kind. Consequently, prospective payment systems remove the incentive for providers to offer additional services so as to increase their incomes.

In contrast, retrospective payment systems reimburse providers on the basis of the costs they actually incurred while treating an individual. Under retrospective reimbursement systems, higher costs--for example, for additional services or because of higher charges per service--will lead to larger incomes for providers.

Prospective payment systems, Weisbrod suggests, would encourage technological innovations that reduce the costs of treating a particular condition. Retrospective payment systems, however, provide a stronger incentive for improvements in medical technology that would also raise total health care costs.

9. Burton A. Weisbrod, "The Health Care Quadrilemma: An Essay on Technological Change, Insurance, Quality of Care, and Cost Containment," *Journal of Economic Literature*, vol. XXIX (June 1991), pp. 523-552.

The Uncertainties Involved in Managed Competition

Although making consumers more cost-conscious would clearly reduce spending on their health care, the impact that managed competition would have on total health spending is highly uncertain. Even if the all of the features described in Chapter 2 were included, the overall effects would still be difficult to predict, since the details of the policy would affect the outcome. Moreover, behavioral responses to these changes play an important role. For many of those behavioral responses the evidence is insufficient to permit their impact on the health care system to be assessed with any precision. Eleven questions highlight the source of many of these uncertainties:

- How much of the health care market would be covered by managed competition?
- Would the standardized benefit package be set at a minimum level, at the average currently available, or at a more generous level?
- What would be the difference in health insurance premiums between efficient HMOs and other insurers, in the initial period and over time?
- How much would spending increase to cover the uninsured and to cover expanded use by insured people if a package were adopted that provided more generous benefits than many people have now?
- How would consumers respond to having to pay more of their insurance premiums from after-tax dollars?
- How would consumers, providers, and insurers react to more and better information about insurance choices and about the quality and costs of individual providers?
- Could guidelines on practice and research on outcomes improve the efficiency of health care markets over time by paring inappropriate and unnecessary care?
- Would technological change slow under managed competition? Alternatively, would its impact change toward cost-reducing rather than cost-increasing innovation?
- How would administrative costs change under managed competition?
- Would the market coalesce into a small handful of insurers affiliated with specific, largely nonoverlapping networks of providers--especially physicians?
- Finally, over what time period would all of these changes occur?

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