

Cutting through the Confusion Of Managed Competition

BY JANE H. WHITE

Managed competition" has become the healthcare reform mantra of choice in Washington, DC. Promoted by President Bill Clinton during the campaign, the concept has led to much confusion in policy and healthcare circles, however. "Nearly everyone confuses managed competition with managed care," said Princeton sociologist Paul Starr at a December 17, 1992, hearing before the Senate Committee on Labor and Human Resources. In addition, "a lot of people mistake managed competition for a pure free-market proposal," Starr continued.

Not only are these concepts easily confused, disagreement exists about the actual definition of managed competition. Many variations of the strategy have been put forth in different reform proposals. For instance, some proposals do not ensure universal coverage; others include more regulatory features. "There is continued disagreement about what managed competition means even among those sympathetic to market forces," said Columbia University political scientist Lawrence Brown at a January 6, 1993, meeting on managed competition in Washington, DC, convened by the Alpha Center.

In an attempt to cut through some of the confusion and policy jargon, in this column I set out the key principles of managed competition espoused by the concept's leading architects and proponents. Although the definition of managed competition remains a moving target, one thing is clear: The policy debate in Washington has now shifted. As Clinton transition team Health Director Judith Feder explained at a January 14, 1993, conference in Washington, sponsored by United Communications Group, "The debate is no longer about which of the three approaches to reform we should follow. Now it is how should [managed competition] be implemented."

EVOLUTION OF MANAGED COMPETITION

The concept of managed competition has undergone a number of permutations since 1977 when



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Stanford economist Alain C. Enthoven presented it to the Carter administration. Back then, it was called "Consumer Choice Health Plan," and it built on the concepts of prepaid group practice plans developed in the 1930s and 1940s and on the health maintenance organization (HMO) strategy pushed in the early 1970s.¹ The Consumer Choice Health Plan was based on what Enthoven called "regulated competition." He then added to the concept "design proposals to deal with such issues as financing, biased selection, market segmentation, information costs, and equity."²

Although it did not develop into national policy at that time, Enthoven continued to promote the proposal, fine-tuning it over the years and helping experiment with pieces of it for such groups as Stanford University employees and California public employees. "As critics identified actual or hypothetical problems, I would often reply, 'I think that problem could be managed using the following tools,'" noted Enthoven.³ "This led me to believe that a more accurate characterization of what actually works would be *managed competition*," he explained.

In 1991 Enthoven's managed competition concept formed the backbone of a reform proposal developed by the Jackson Hole Group. This informal collection of policymakers, analysts, and industry leaders was convened by HMO architect Paul Ellwood of Excelsior, MN-based InterStudy. The group has met in Ellwood's Wyoming home to debate policy since the mid-1970s. As healthcare reform issues heated up and group members began to achieve some consensus around managed competition, they decided to publish their views for broader debate.⁴

A legislative assistant to Rep. Jim Cooper, D-TN, was at the 1991 meeting of the Jackson Hole Group. Cooper picked up on the Jackson Hole proposal and, with the Conservative Democratic Forum (CDF), introduced H.R. 5936—the Managed Competition Act of 1992—in September 1992. The CDF is a 65-member

group of conservative Democrats in the House and Senate. Their proposal caught Clinton's attention and formed the basis for his campaign-trail healthcare plan.

DEFINING MANAGED COMPETITION

Enthoven's dedication to fleshing out this proposal has earned him the titles of managed competition "architect," "father," and "pied piper" in policy circles. Earlier this month, he defined managed competition and its history as follows:

Managed competition is a purchasing strategy to obtain maximum value for money for employers and consumers. It uses rules for competition, derived from rational microeconomic principles, to reward with more subscribers and revenue those health plans that do the best job of improving quality, cutting cost, and satisfying patients. . . . The rules of competition must not reward health plans for selecting good risks, segmenting markets, or otherwise defeating the goals of managed competition. Managed competition occurs at the level of integrated financing and delivery plans, not at the individual provider level. Its goal is to divide the providers in each community into competing economic units and to use market forces to motivate them to develop efficient delivery systems.⁵

In a nutshell, managed competition hinges on three key concepts:

- Consumer choice of a competing healthcare plan
- Incentives to use the most cost-effective healthcare plan, primarily well-organized managed care plans
- Establishment of health insurance purchasing cooperatives (HIPCs) as regional purchasing agents with the economic clout to negotiate the best rates for individuals and employees of smaller firms

Many other elements are often discussed, such as a national health board to set standards, define a standardized benefit package, and oversee the HIPCs. Enthoven has also strongly pushed elimination of the tax subsidy on health insurance benefits. Currently, employer-provided healthcare benefits are purchased with pretax dollars; the higher an employee's income and more costly the benefits, the higher the "tax break." This is a perverse incentive to competition, he maintains.

Paul Starr, who achieved prominence in the healthcare policy community almost a decade ago with his book *The Social Transformation of American Medicine*,⁶ has again joined the health-

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care policy scene in the debate over managed competition. In his descriptions of managed competition at the December 1 hearing⁷ and in a *Health Affairs* article, he points to five key principles:

- First and foremost, there needs to be consumer choice and open enrollment among all the plans that are available through the purchasing cooperative.
- There has to be a standard, comprehensive benefit package.
- There has to be regular monitoring of the quality of care, and the purchasing cooperative must take the side of the consumers.
- For any given enrollee, the purchasing cooperative would pay no more than it pays the benchmark plan—that is, the plan providing the uniform benefit package at the lowest price and a satisfactory standard of care. Consumers who chose other plans would pay the marginal difference in cost.
- Finally, the purchasing cooperative provides a community rate to the enrollee. It doesn't charge older people or people with disabilities any more than it charges others. But when it pays the plans, it adjusts the overall payments to the plans in line with the risk of the population that enrolls in those plans, so that the plans are receiving additional payments for higher risk people.⁸

Starr sees managed competition as a system to "alter the organization of [healthcare] services, not just the flow of funds. . . . Managed competition does not merely make alternatives available; it is designed to clarify the true economic consequences of choice at several levels."⁹

DEFINING HIPCS

Many proponents of managed competition view HIPCs as a central feature of the proposal. Indeed some analysts would like to see employers of up to 1,000 employees or even all employers use the services of HIPCs to negotiate rates with approved, high-quality healthcare plans and thus achieve even greater economies of scale, lower administrative costs, and less chance for biases in signing up only the most sick (adverse risk selection). What form the HIPC would take is hotly debated. Most analysts see it as a not-for-profit, quasi-public entity whose main purpose is to help consumers get value for their money in choosing among competing healthcare plans and thus "manage" the competition.

California's insurance commissioner John

Garamendi put forward his own version of managed competition in February 1992.¹⁰ His plan would require *all* employers and employees in the state to contract for healthcare benefit coverage through a state-established HIPC. Although such a proposal would have some political difficulties, a model HIPC—the California Public Employee Retirement System (CalPERS)—is already in place. Currently, 754 public employers participate in the program, and 75 percent of the members are in HMO plans. CalPERS contracts with 22 HMOs to provide care to members and manages a self-funded preferred provider organization (PPO) for members who are unable to join an HMO because they live in a rural area or out of state or they simply want to pay more for the PPO option.

CalPERS was started in 1935 to run the retirement program for state employees. By the early 1980s, other public agencies in the state were allowed to join the healthcare benefits program. At the December 16, 1992, hearing before the Senate Committee on Labor and Human Resources, Tom Elkin, assistant executive officer of CalPERS, said few agencies joined the CalPERS at first. But as healthcare costs began to rise and management and administration of multicarrier programs became increasingly complex, more agencies joined CalPERS.

Elkin described four key reasons for the program's success:

- Aggressive premium negotiations for multiple employers
- A uniform benefit design for all members
- Cost and performance data collection
- Strong consumer and employer commitment

A 13-member board governs the model HIPC, the investment portfolio, and the healthcare benefits program. Six board members are elected by consumers, 5 represent employers, 1 is appointed by the governor, and 1 is appointed by the California state legislature. "This board has exclusive authority for the administration of our program and operates with a great degree of independence," said Elkin. Services include handling the enrollment process, collecting and distributing premiums, managing the open enrollment period, producing and distributing booklets to members explaining the different healthcare plan choices, conducting consumer surveys, monitoring quality, and negotiating premiums each year with the approved healthcare plans. All these functions are carried out for a fee of 0.5 percent of the premium cost.

Other examples that approximate the HIPC concept include the healthcare benefits program for public employees in Minnesota, as well as the Federal Employees Health Benefits Plan. Analysts

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have proposed many variations on the HIPC theme, from private to public entities with varying degrees of regulatory versus market negotiating power. Some argue that the design of HIPCs should allow for regional variations given the differing healthcare markets and levels of expertise across the states. In some areas such as California and Minnesota, the HIPC idea is virtually in place. In more rural states with fewer managed care options, development of HIPCs will take much longer and, indeed, may not be feasible.

CHALLENGES FOR MANAGED COMPETITION

As policy analysts and the healthcare community struggle to understand and reach consensus on managed competition as a framework for healthcare reform, numerous challenges loom. Just a few of the questions include:

- How will managed competition work in sparsely populated rural areas or inner cities, where provider choices are limited?
- How will we ensure enrollees receive high-quality care through these low-cost plans when our measurement tools for quality are still limited?
- How will chronically and seriously mentally ill patients fit into the system (for without regulatory protection or strong financial incentives, plans are likely to avoid these costly patients)?
- Will large self-insured companies be outside the HIPC, or will they be required to use the local purchasing cooperative's services?
- Who will define the basic benefit package, and what will it include?
- What will be done about malpractice liability reform?

Although pieces of managed competition are in place throughout the country, the overall strategy remains largely theory. A key question is: What will happen to an elegantly worked out economic theory once it hits the trenches of the political process, where bargains are struck and constituents appeased? As Columbia's Brown queried at the Alpha Center meeting, "Is managed competition too fragile a strategy to be ready for political prime time?"

Other questions of concern to policymakers were outlined by Rand economist Steve Long, also at the Alpha Center meeting:

1. Can we rely on managed competition alone to meet the cost containment needs of the constituents who supported health care reform?
2. What about the deficit?
3. Who are the winners and losers?
4. What about quality?

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PRIMARY CARE PROGRAM

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FQHC requirements.

Catholic-affiliated organizations typically seek tax-exempt status by applying for membership in the *Official Catholic Directory* (OCD) and qualifying for the exemption under the group ruling given to the Catholic Church. However, because the FQHC corporation cannot be construed as being under the control or auspices of another organization, it must attain an exemption independent of the OCD listing process.

Other issues to consider before implementing the FQHC program include analyzing licensure and other regulatory issues triggered by FQHC status, documenting the relationships between the FQHC and its medical staff and provider hospital, analyzing insurance aspects of the relationship, and addressing potential alienation of property and other canonical issues.

COSTS AND BENEFITS

Participation in the FQHC program can significantly improve Catholic providers' ability to deliver primary healthcare services to populations in need. However, sponsors should be aware that implementing the program often entails complex licensure and regulatory issues. In addition, hospital administrators must realize that, in creating an FQHC organization, they are required to give up direct control over the delivery of primary care services.

Before committing to the program, then, providers must ask whether they can meet FQHC requirements and whether the program's benefits justify the effort needed to create an FQHC. For organizations that can answer yes to both questions, the FQHC program presents an opportunity to improve the level and quality of primary healthcare services available in their communities. □

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5. What are the implementation details; how is it really going to work?

These questions and more will need to be addressed in the coming months as Clinton prepares to submit his plan to Congress. In the interim, Congress has planned a busy schedule of hearings and briefings so that when the plan comes down from the White House, they will be ready. For instance, in late January Rep. Pete Stark, D-CA, who chairs the House Ways and Means Subcommittee on Health, began a series of hearings on healthcare reform. Part of the hearing blitz (30 to 40 are planned) is to educate the large number of new committee members. But another reason is that the sheer complexity of the issues and the difficult policy decisions that lie ahead demand such intensive debate. □

NOTES

1. Alain C. Enthoven, "Consumer Choice Health Plan: A National Health Insurance Proposal," Memorandum to Health, Education, and Welfare Secretary Joseph Califano, September 22, 1977.
2. Alain C. Enthoven, "The History and Principle of Managed Competition," *Health Affairs*, Suppl., March 1993.
3. Enthoven, "The History and Principle of Managed Competition."
4. Paul M. Ellwood, Alain C. Enthoven, and Lynn Etheredge, "The Jackson Hole Initiatives for a Twenty-first Century American Health Care System," *Health Economics*, vol. 1, 1992, pp. 149-168.
5. Enthoven, "The History and Principle of Managed Competition."
6. Paul Starr, *The Social Transformation of American Medicine*, Basic Books, New York City, 1984.
7. Paul Starr, testimony before the Senate Labor and Human Resources Committee, December 17, 1992.
8. Paul Starr and Walter Zellman, "Bridge to Compromise: Managed Competition, Global Budgets, and Universal Coverage," *Health Affairs*, Suppl., March 1993.
9. Starr, testimony; Starr and Zellman.
10. John Garamendi, "California Health Care in the 21st Century: A Vision for Reform," State of California, Sacramento, February 1992.

ANALYSIS

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based on the attributes required for a GCN," Browne explained. Now 80 staff people from LGHS entities, as well as providers and community members, serve on 11 committees.

The committees, which meet every four to six weeks, coordinate activities in many areas, including finance, marketing, education, wellness, information systems, and research. The marketing committee, for example, eliminated separate brochures for each program and produced one brochure for all aging services in the system, Browne said. The education committee is creating training programs aimed at teaching employees to work effectively with older adults and instilling positive attitudes toward aging. The networking committee integrates external service providers into the GCN. And the central access/intake committee eliminates duplication in assessment.

Successful Cooperation "A spirit of collaboration" is integral to establishing a successful GCN, Browne said. "It is difficult for hospitals to treat others as equals," she said, but they must collaborate with consortium members and with outside providers. Also, all persons who work with older adults—no matter what hospital department they are part of—must function as part of a team to serve the chronically ill, she said.

"As we endeavor to reform the way services are financed, administered, and delivered to the chronically impaired elderly, we are asking people to plan and to eventually make some major changes in the way they operate on a day-to-day basis," Browne pointed out. She said that Lutheran General continues to incorporate into its daily operations the critical elements of successful internal and external collaboration. These include encouraging employees to work not only within the system but also with community players, ensuring that all stakeholders benefit from the arrangement, identifying effective processes and expected outcomes by allowing all players to speak freely about what they need to do their jobs, and evaluating processes to ensure accountability to the community.

—Judy Cassidy