
The U.S. Experience with Managed Care and Managed Competition

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Managed Care Defined

To understand “managed care,” one needs to understand the traditional model of health care organization and finance that managed care was intended to replace. That model was aptly characterized “Guild Free Choice” by Charles Weller to indicate that “free choice” was being used as a restraint of trade to block the emergence of any form of economic competition among doctors (Weller 1983). Its principles were: free choice of doctor at all times, free choice of treatment, that is, nobody interferes with the doctor’s decisions and recommendations, fee-for-service payment, direct doctor-patient negotiation of fees, and solo (or small single specialty group) practice (Weller 1983). The model was widely accepted because of the pre-Wennberg view of most people that “the medical care they receive is a necessity, provided by doctors who adhere to scientific norms, based on previously tested and proven treatments” (Wennberg 1984). In combination with well-insured patients, there was no way that employers or insurers could control health spending in this model. Organized medicine is still fighting to hold on to parts of it.¹ Some people say that managed care is “anything other than Guild Free Choice.”

For purposes of this paper, I divide managed care into two types, while recognizing that the boundary is not clean. The first is the “integrated delivery system” (IDS), or “delivery system HMO,” that is, systems that are built on the core of a large multi-specialty group practice, often with links to hospitals, labs, and pharmacies, and usually with a significant amount of revenue based on per capita prepayment. Prominent examples include Kaiser Permanente, HealthPartners of Minnesota, the former

Harvard Community Health Plan, and medical groups such as the Leahy and Mayo Clinics. What is important about these systems is that the physicians accept accountability for quality and per capita cost, and are committed to work together to improve them.

The second category includes what I call “carrier HMOs,” that is, entities in which the chassis is an insurance carrier and the providers are large numbers of otherwise unaffiliated doctors, mostly paid on a fee-for-service basis (Enthoven and Tollen 2004). These carrier HMOs often serve as the sole source of health insurance for employers; therefore, in order to enable the employer to assure every employee insured access to all the doctors he or she might want to see, these HMOs are typically very large, often nearly all-inclusive, networks (Robinson 2004). Once the providers know that they must be included in the network, the bargaining power of the carriers is weak. Also, such arrangements are usually only a part of a doctor’s practice, and are unlikely to change practice patterns. Such arrangements can be a useful adjunct to an employer’s cost containment strategy, and possibly a useful transition device. But for purposes of this paper, they are not considered to be very effective at care management or cost containment. Indeed, fee for service (FFS) points doctors in the direction of resolving all doubts in favor of providing more, and more costly, services, whether or not more is beneficial to the patient.

From the point of view of the long-run prospects for an economical health care system, it makes a world of difference whether or not physicians work in a framework that rewards economical decisions.

What Happened in the 1990s?

In the 1990s, the market shares of all sorts of managed care increased greatly. The shares of these entities are difficult to discern, because the data are not reported in terms that I consider significant. Surveys usually report in the categories of conventional (that is, traditional fee-for-service indemnity insurance), HMO, PPO, and Point of Service (POS) [see the Kaiser Family Foundation (KFF) and the Health Research and Educational Trust (HRET) 2004]. (For the shares of these categories among employment-based insured people nationally, see Table 4.1.) As

Table 4.1
Market shares

	1988	1993	1996	1998	2001
Conventional	73%	46%	27%	14%	7%
HMO	16	21	31	27	24
PPO	11	26	28	35	46
POS	0	7	14	24	23

Source: The Kaiser Family Foundation and the Health Research and Educational Trust (2004).

Table 4.1 shows, the market share of conventional insurance plummeted, while the combined market shares of HMOs, PPOs, and POS providers nearly tripled, mostly without much fundamental transformation in the underlying delivery system. Most of the HMO members were not in integrated delivery systems. On the other hand, the members of the American Medical Group Association, which are actual or potential integrated delivery systems, care for more than 50 million patients, some through PPOs and POS plans (American Medical Group Association 2005). Most, but not all, are doing some care management. There are 468 multi-specialty group practices in the United States with over 100 physicians (Shortell and Schmittiel 2004). Under appropriate market conditions, most of these could partner with network model HMOs and become integrated delivery systems, as many in California have done.

Victor Fuchs presented the historical health care expenditure (HCE) data in a way that illuminates the impact of managed care. Using deflated, per capita data and three-year moving averages, he showed that health expenditures were growing nearly 6 percent in 1990, while GDP was growing by less than 1 percent. Between 1990 and 1995, the growth rate of HCE fell to 2 percent, while GDP's growth rate picked up to 2 percent and more. "Both private and public payers demanded restraint of HCE. [These data show] that managed care dramatically answered that call" (Fuchs 2000).

The growth rates in health insurance premiums over the 1990s are shown in Tables 4.2 and 4.3. Briefly, health insurance premium rates were growing in double-digit rates in the late 1980s and early 1990s. Then the

Table 4.2
Increases in Health Insurance Premiums in the 1990s

1989	18%	1995	3.5%
1990	14	1996	0.8
1991	12	1997	2.5
1992	11	1998	4.0
1993	8.5	1999	5.3
1994	6.0	2000	8.2

Source: The Kaiser Family Foundation and the Health Research and Educational Trust (2004).

Table 4.3
Percentage Change in Premiums from Previous Year by Plan Type

	1988	1993	1996	2000
Conventional	12.4	9.1	1.9	9.5
HMO	8.4	7.7	-0.2	7.6
PPO	20.3	7.2	1.0	8.5
POS	-	5.2	1.1	7.8
All	12.0	8.5	0.8	8.2

Source: The Kaiser Family Foundation and the Health Research and Educational Trust (2004).

growth rate fell sharply, down to 0.8 percent in 1996, but started rising back up to double digits in 2001. HMO premiums generally grew less rapidly than conventional insurance and PPO rates.

When the Clinton health plan collapsed in 1994, employers became desperate and herded many of their employees into HMOs without much explanation or choice and without visibly sharing the savings. Some 20 percent of insured employees were assigned to HMOs *as a single source of health insurance*. From 1993 to 1996, HMO market share rose from 21 percent to 31 percent. Employees were shifted to less costly HMOs, and the carrier HMOs took advantage of excess supplies of providers. They drove hard bargains on price, and also picked some of the low-

hanging fruit by driving hospital utilization rates down to approximate those of the delivery system HMOs.

Driving employees into HMOs without a choice was a most unwise policy. It is not surprising that it produced the managed-care backlash, that is, strong expressions of dissatisfaction and complaint by some consumers and patients (actually a minority) who felt that their access to care had been restricted by managed care, and by some (but not all) physicians who felt that managed care had limited their autonomy (and cut their fees). All these sentiments were expressed energetically to politicians, who felt pressure to respond, often with legislation restricting managed care. The media smelled blood in the water, fabricated some horror stories, exaggerated isolated incidents, and added to the general dissatisfaction (Blendon et al. 1998).

Research showed that dissatisfaction was concentrated among people who had no choice (Davis and Schoen 1998; Gawande et al. 1998; and Enthoven, Schaufli, and McMenamin 2001). This should not be surprising. People want to be able to choose their own doctors; therefore, in a world of selective managed care, they must be allowed to choose their managed care. The problem was, and is, that this conflicts with employer and insurer preferences for the single-source model. Further evidence that lack of choice was the key factor is that employers such as Stanford and those affiliated with CalPERS, most of whose employees were in HMOs by choice, experienced no backlash. A recent article reported that the backlash was not followed by a mass exodus from HMOs (Marquis, Rogowski, and Escarce 2005).

One of the ironies was that surveys found that in California about 10 percent of members were actually dissatisfied with their managed care (The California Managed Health Care Improvement Task Force 1998). Of course, even 1 percent of Californians still represents over 300,000 people. What should have happened is that employers should have told their employees, “We can no longer afford to pay the full costs of your traditional fee-for-service insurance and still raise your pay; so we will continue to offer it, but we will pay only up to the costs of the HMO, and then let you make the choice.”

The backlash led to weakened managed care. Restrictions on managed care triggered a “feeding frenzy” among state legislators, who passed

laws against “drive-through babies” in the absence of any evidence that the policy of 24-hour maternity stays (with exceptions for cases of medical need) were harmful to anyone’s health. In addition, some states passed “any willing provider laws” that destroy the bargaining power of managed care and prevent it from trading volume for price (Carroll and Ambrose 2002; Martinez 2002). Perhaps worse, however, the backlash led employers to reinvent “any willing provider” on their own, by insisting on very wide, all-inclusive networks to ensure that each employee could find his or her favorite doctors in the network. In most cases, this took the form of the wide-access PPO, a model incapable of really managing health expenditures.

Managed Care and Managed Competition Did Not Happen

One important thing that did *not* happen in the 1990s was *managed competition* on a large scale (Enthoven 1993). The employers of 77 percent of employed, insured Americans did not offer their employees a choice of carrier (Marquis and Long 1999). (Offerings of two or more plan designs from the same carrier, with each design offering mostly or entirely the same providers, is not managed competition.) Of the employers that do offer a choice, most contributed more on behalf of the employees who chose costlier health insurance programs (KFF and HRET 2004). These employers subsidize inefficiency, and tax efficiency. A frequent pattern is for the employer to pay a fixed percentage, such as 80 to 100 percent of the premium of the employee’s plan of choice. Such policies originated in the open-ended tax break for employer-provided health insurance and union demands, and may persist if they are seen as a crude form of risk adjustment. These policies deny managed care the opportunity to market its superior efficiency. The survey evidence points to the fact that fewer than 10 percent of workers at Fortune 500 companies have a choice of health insurance program and receive from their employer a fixed-dollar contribution (risk-adjusted or not), allowing them to keep the savings (Maxwell and Temin 2002). This combination is a minimal condition for the success of effective managed care.

It is a great irony that, contrary to the widespread belief that we have a market-oriented health system—a belief reflected in the announcement for this conference²—we do not have much of a market for effective man-

aged care. In most places, the market available for competing integrated delivery systems is just too small. So the answer to the brochure's question: "How has the U.S. health care system adjusted to the introduction of market-oriented medicine?" is that, for the most part, we have not introduced a market for effective managed care.

Someone might object that we see a great deal of "competition" among managed care organizations seeking to contract with employers. The problem is that this is a crippled competition. Effective managed care must *select* providers. But such selective managed care cannot (or should not attempt to) serve as a single source of care for an employment group because people want to be able to choose their own doctor, and many people will have good reasons for not wanting to belong to any particular delivery system HMO, or any HMO at all. Their reasons may include that they do not see their favorite doctors there, the facilities are not conveniently located, they do not like the institutional style, or they do not trust the incentives in risk-adjusted per capita prepayment. Since the choice of a managed care organization must be at the individual employee level, an effective market must be based on responsible choice at the employee level.

A local example of the effects of faulty market structure is the experience of Harvard Community Health Plan, a highly regarded "flagship" of the prepaid group practice movement. In the decades from its early 1970s startup to the mid-1980s, its membership grew very rapidly. Then in the mid-1980s, it hit a "glass ceiling" and growth practically stopped. I interpret that to be the result of the fact that they got as much market share as they could from the choice-offering employers, and most employment groups were not available to them.

Creating a Competitive Market

How might we create a truly competitive market in which effective managed care can compete to serve everyone? I have written about the possibilities, essentially building on limited but demonstrated practical successes. As one example, some large employers offer their employees several choices and a fixed-dollar contribution toward the plan of their choice: the University of California, Stanford, Harvard,³ Wells Fargo

Bank, Hewlett-Packard, and the State of California. At Stanford last year, the university saved \$44 million compared with what it would have cost if everyone had been in the PPO (Enthoven and Talbott 2004). Many others could convert to a market model simply by changing their fixed-percent-of-premium contribution to a risk-adjusted, fixed-dollar amount. But that would still leave out three-quarters of insured employees.

Another possibility is exchanges. For example, in California, the program that brokers care for state employees, CalPERS, was opened to local government agencies, and more than 1,000 belong. So, a California state agency is running an exchange for more than 1,000 employers. Employees are offered a multiple choice, including HMOs and PPOs. At least at last report, state employees received fixed-dollar contributions (alas, not risk-adjusted), below the price of the low-priced plan, toward the purchase of health insurance. (Some local agencies contribute more on behalf of costlier plans, so the whole of CalPERS is not a pure model of managed competition.) In California, we also have PacAdvantage, a nonprofit exchange for small employers, and California Choice, a model created and run by brokers for small employers that offers employees a choice from among six or eight delivery systems. California Choice is growing and now covers about 165,000 lives. (Unfortunately, employers are not required to offer fixed-dollar contributions in these exchanges.)

Another approach to exchanges is offered by BENU, a new company that offers employers the simplicity of a single source, while employees have a choice of two carriers and several plan designs (Closs 2004). BENU uses software to achieve administrative simplicity, and state-of-the-art risk adjustment to deal with biased selection. BENU has contracted with Kaiser Permanente and CIGNA in Portland, Oregon, and Washington, D.C., to be offered through their model.⁴ The carriers have agreed on the risk-adjustment model for post-enrollment allocation of premium revenues. Because the carriers are protected from adverse selection, employers can use a fixed-dollar contribution strategy.

I see no compelling or fundamental reason why the private sector cannot create exchanges of their own, to parallel CalPERS. There are significant barriers, such as the need for upfront investment; for employers to understand and be persuaded of the benefits of competition; for a willingness to accept standardized benefit designs offered to many employment

groups instead of designs particularized to each group; and for a long-term solution to appeal to a very short-term-oriented community. Perhaps this would be too much of a public good to expect private employers to fund the startup. However, software does exist to make risk-adjusted payments to each health plan and to require risk-adjusted contributions from each employer, so that employers would not have to subsidize one another in the exchange.

A legitimate and serious concern is that there will be adverse selection in a multiple-plan offering, leading to death spirals, to significant profits and losses that are attributable to risk selection rather than to quality and efficiency, and to such outcomes as failure to develop expertise in treatment of costly chronic conditions. Managed competition theory rests on the expectation that predictive modeling tools can be developed that will permit risk adjustment of premiums, enabling employees to see risk-neutral premiums and health plans to be rewarded for caring for bad risks. This is a very complex issue; this is not the time or place to review it.⁵ There are commercially available models that address it.⁶ A recent study sponsored by the Society of Actuaries found that some of these models get an R-squared fairly close to the 20 percent that Newhouse requires of an ideal risk adjuster.⁷ There will be inefficiencies from imperfect risk adjustments. The judgment on which all of this rests is whether or not the efficiency gains that result from competing integrated delivery systems are likely to be greater than the inefficiencies induced by imperfection in risk adjustment, or in any other payment system we might adopt.

Large regional exchanges could offer many advantages: people could retain membership in the HMO of their choice as they switched from one job to another—reducing wasteful turnover; large parts of the market could be opened up to real competition; and economies of scale could be great. The costs of administration in CalPERS are less than one-half of 1 percent of premium because they cover 1.3 million people. And carrier administration costs are also low: Kaiser Permanente signs one contract to cover some 400,000 people. A large regional exchange could accomplish risk adjustment, reinsure very-high-cost cases, and manage COBRA continuity for employers. And government could create subsidized groups (for example, poor people) and buy their way into the exchange. Also, such exchanges could greatly reduce the costs of market

entry for new managed care organizations. Without exchanges, a new HMO today faces a formidable barrier to entry, that is, the need to make a sale to and contract with hundreds of thousands of employers. A large regional exchange could cut through this. In fact, CalPERS played a major role in easing market entry for many HMOs in California in the 1970s and 1980s. The existing market entry barriers are another important reason why we cannot say that we have a functioning market for managed care in this country.

Did Managed Care Work as Expected?

Did managed care work as its advocates expected? Not as I expected. My first proposal for managed competition was for universal coverage in which government would pay a risk-adjusted amount set at the low-priced plan for everybody, the tax exclusion for employer-paid health insurance would be repealed, managed care would compete on a level playing field, and every person would have to make a responsible, cost-conscious choice (Enthoven 1978). I developed this proposal as a consultant to Department of Health and Human Services Secretary Joe Califano and the Carter administration, in response to Jimmy Carter's campaign promise to bring us universal health insurance.

Subsequently, I expected that the advantages of managed competition would become apparent to private-sector employers who were complaining that health expenditures were running out of control, and who, for a time, seemed to be embracing HMOs. I did not anticipate the scope and extent of employer unwillingness or the inability to create a competitive market at the employee level.

The Employment-Based System Is Failing

It is now apparent that the employment basis of health insurance is hopelessly flawed (Enthoven 1979). There are too many reasons why employers are incapable of being good sponsors of health insurance, although I do recognize the small minority who do a good job. For most, the reasons include their lack of understanding of health insurance and health care (after all, they are not in that complex business), their short-term

orientation in the face of problems that need long-term solutions, and their use of health insurance to further company (or union) goals, rather than to contribute to a rational and equitable overall health care system. Problems follow from the fact that some managed care companies see the employer, rather than the employee, as their customer. In the employment-based system, market forces work to undermine cross-subsidies of the costly patients. High deductibles are a step in that direction. Employers can outsource services provided by low-wage people (for example, janitors) to companies that do not provide health insurance.

The need for health insurance companies to deal with millions of employers and individuals creates market entry barriers and adds to administrative costs. The employer-based model has left out 45 million people under the age of 65, and the financing is regressive. This is becoming a very serious problem as the costs of health insurance become large relative to the earning power of many workers. People typically lose their health insurance when they lose their jobs (mitigated by COBRA, but still a problem)—just when they need it most, and are quite likely to have a difficult time paying for it—or when the breadwinner dies or becomes unable to work. Others lose their health insurance (Medicaid) when they get a job, creating a work disincentive and a very high implicit marginal income tax rate. Some people are locked into jobs that do not represent the best use of their talents, “job lock”; others become trapped in unsatisfactory marriages because they depend on their spouse for health insurance, “wed lock.” Many are forced to change their HMO when they change jobs, which may mean changing their doctors, or to make a new start on their annual deductibles. Many people simply do not fit into the employment model: pre-Medicare widows, many of whom are not poor, but who may become so as a result of medical costs (Himmelstein et al. 2005); the self-employed, including professionals and domestic helpers; and entrepreneurs starting new companies.

Implications for Reform

We need reform that replaces the employer-based model, which is failing (Enthoven 2003), with universal coverage based on managed competition in the private sector (Enthoven 1978). Ezekiel Emanuel and Victor Fuchs

recently pointed the way with publicly financed risk-adjusted vouchers for everyone (Emanuel and Fuchs 2005). Every person should have a wide choice,⁸ a responsible choice,⁹ an individual (or family) choice, an informed choice, and multiple choice where possible. Short of such universal coverage, we could approach a universal competitive market or transition to market-based universal coverage by creating large regional exchanges and encouraging the majority of employers (possibly with tax incentives), particularly small firms, to buy coverage for their employees through these exchanges. Compared with conventional insurance and wide-network PPOs, IDS HMOs do very well in such environments, even under present tax laws that subsidize employee choice of costlier coverage. For example, 75 percent of Stanford employees are in such HMOs; 78 percent of Wells Fargo California employees and 80 percent of University of California employees have chosen HMOs that are mostly “California delegated models,” based on multi-specialty group practices and individual practice associations. It matters little if some 20 percent want the costlier care that goes with PPOs if the extra cost is paid by the employee, and not by his or her employer or by taxpayers. In fact it is a good thing that non-HMOs exist. Nobody should be in an HMO against his or her will.

What could we expect to happen if we had a model of universal (managed) competition to serve cost-conscious consumers? All I can offer is speculation, because this would be a radically different environment from today’s.

The most important players on the field, at first, would be wide-network PPOs and integrated-delivery-system HMOs. However, we can be sure that a host of innovative models somewhere in between would emerge. Particularly, there would be selective network models created by insurance companies. There is little that wide-access PPOs can do to control cost. They can’t select providers; they can’t do much to influence care patterns; and they would have little influence on the deployment of new technologies. If and when they tried to negotiate lower fees, they would learn what CMS (the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services) knows about fee-for-service Medicare: that a fee cut intended to save \$100 would be followed by increased utilization that would take back \$30. As a result,

we would see doctors running around faster and providing more services to protect their incomes (Volume-and-Intensity Response Team 1998). Knowing that the doctor visit is very compressible, we would see a great number of very short follow-up visits.

On the other hand, there is a long list of actions that IDS could take, in response to long-term competitive pressures, that could reduce cost and expenditure and improve care.

To begin with, in the Health Insurance Experiment, RAND found that the Group Health Cooperative (GHC) provided high-quality care while generating 28 percent fewer relative value units than the fee-for-service sector in Seattle (Newhouse 1993). This does not give them credit for lowering total cost by better personnel utilization, or by more effective purchasing, as such an organization could do, relative to the performance of the fragmented fee-for-service sector. I think the importance of this result is that it was produced in the absence of cost-conscious customers (Seattle was a union town) and competition in kind.¹⁰ Here is a list of 12 actions that IDS could take to improve quality and cut cost:

- (1) Emphasize primary care, disease prevention, and early detection and treatment, practices that would generate positive externalities for our whole society.
- (2) Create or share in institutions like Minnesota's Institute for Clinical Systems Improvement, Kaiser Permanente's Care Management Institute, and the Veterans Health Administration's Quality Enhancement Research Initiative that form physician teams to translate science into up-to-date clinical practice guidelines (Committee on Quality of Health Care in America 2001).
- (3) Carefully select and train physicians and other health professionals for quality and willingness to work in teams. Have programs to ensure that they are proficient, well informed, and up-to-date. Train nonphysician personnel to maximize the services that they can perform appropriately, reserving physicians for where they are needed. Deploy health professionals in the appropriate numbers and specialties needed to care for enrolled populations. [Prepaid group practices use physicians and nonphysician professionals more efficiently than does health care in general (Weiner 2004).] Pay physicians both salaries and bonuses based on measured patient satisfaction, indicators of productivity, quality, and

teamwork, in order to align provider incentives with the interests of patients in high-quality, affordable health care.

(4) Deploy health information technology (HIT). Use it for electronic medical records, with diagnostic test results and procedures recorded and conveniently available for all doctors, so that they have a complete picture of the patient's medical history before seeing the patient. Also, use IT to create convenient caregiver support tools, such as reminders, alerts, and summaries of relevant guidelines, so that the value of each encounter can be maximized (Halvorson 2004). McGlynn et al. recently published an important study documenting that Americans are receiving barely half of recommended care. Errors of omission are widespread (McGlynn et al. 2003); this could be ameliorated greatly by computerized caregiver support tools.

(5) Continually evaluate and redesign work processes to improve efficiency and take full advantage of IT. It is worth noting that the IDS practices are far ahead of the solo-practice sector in the deployment of HIT (Shortell and Schmittiel 2004). It will be far more difficult for solo doctors to have comprehensive patient records. Information technology is the nervous system; to realize its potential, there needs to be a "brain," that is, a person or a team to regularly review and analyze the information and then feed the results back into practice improvement. Solo doctors are having a difficult time deploying HIT because they have not generated the capital to do so, and they lack a business case for it because they do not share in responsibility for total system cost and quality.

(6) Select and deploy equipment that has been evaluated for safety and effectiveness, in appropriate numbers for proficiency and economies of scale. Create training programs to be sure personnel are well trained in its use.

(7) Concentrate complex procedures in regional centers of excellence. Delivery systems may either create their own centers or subcontract the work to centers outside their systems, based on rational "make-buy" calculations.

(8) Back away from "flat-of-the-curve" medicine, that is, practices in which the marginal benefit in health outcomes is very small relative to the cost. There can be little doubt that today there is a great deal of "flat-of-the-curve" medicine, such as the large numbers of specialist visits of patients in the last months of their lives, as documented by Wennberg in Florida (Fisher et al. 2003a, 2003b).¹¹

(9) In general, IDS practices can, and do, practice “Continuous Quality Improvement” (Berwick and Jain 2004) to review and redesign care processes and to innovate with better practices (Enthoven and Keston 1998). Donald Berwick and Sachin Jain have written: “Prepaid Group Practices (PGPs) have the potential to deliver greater health care quality than is provided in the more prevalent, disaggregated, fee-for-service care system” (Berwick and Jain 2004).

(10) Integrate services through the continuum of care—at home, at the doctor’s office, and in the hospital inpatient and outpatient settings. Deliver care in the least costly, appropriate setting, taking into account total system costs, not just costs and revenues associated with one setting. IDS practices can engage in such planning in a way that is impossible for disaggregated providers. Also in the IDS sector, resources can be transferred smoothly from one setting to another within the system’s total budget. Some IDS practices own hospitals, while others develop close contractual relationships with hospitals. An important source of efficiency gain is the alignment of physician and hospital incentives, all oriented to the best total result.

(11) Improve care management for chronic disease; train and deploy teams of nonphysicians for this work. In the fee-for-service sector, insurers are now contracting with disease management companies that work separately from doctors. Integration of disease management into the whole medical care program must offer opportunities for greater efficiency as well as improved alignment of incentives.

(12) IDS practices can evaluate new technologies and use them only where beneficial to patients, and not otherwise. [For example, Kaiser Permanente has saved millions of dollars by using Cox-2 inhibitors and low osmolality contrast agents only where needed (Crosson 2005 and Eddy 1996).] Efficiently deploy new technologies to assure proficient use. IDS practices can deploy cost-saving technologies faster than the traditional sector, despite the fact that such technology use would not be in the economic interest of fee-for-service solo-practice doctors.¹² In general, salaried doctors have far less incentive than fee-for-service doctors to demand technology deployment to further their own economic interests. Genomics offers exciting opportunities for better care and also large challenges to the health care system. There are hundreds of genetic tests now available, some quite costly. Genomics offers opportunities to diagnose people at high risk for disease and to develop targeted therapies. To use these resources wisely and effectively, there will be need for organized

systematic approaches, including evaluation of who should be tested and what prevention strategies and therapies they should be offered. Thus, there will be a great need to educate and inform physicians and genetic counselors. The Kaiser Permanente Northern California Region genetics program already has more than 250 employees and performs more than 20,000 genetic tests a year (Arp 2005). It is difficult to see how the fragmented solo-practice sector will be able to deal effectively with this situation.

The total economic environment would contrast sharply with what exists in American health care today. Today’s health care economy rests on inflationary incentives, dominated by the cost-increasing incentives of FFS, the tax code, employers who subsidize more and costlier care, and barriers to market entry by efficient alternatives. In the model that I am describing, market entry for innovative, cost-effective, organized systems would be eased greatly, and everybody would be in a model of cost-conscious choice. The general standards of care would move in the direction of greater consideration of marginal cost versus benefit. The environment would legitimize cost-conscious medicine. Most people would no longer see cost reduction as unworthy, because it would be in their obvious personal interest. We could expect to see a large cultural change.

In its effort to moderate expenditure growth, this truly competitive market would be up against the relentless force of expanding medical technology. National health expenditures are rising because more and more people want and receive the benefits of costly technologies such as joint replacements and invasive cardiology (Fuchs 1999). And now, very costly drugs are emerging to correct enzyme deficiencies and to fight cancer. A *New York Times* article recently reported that Genentech’s new drug, Avastin, would be priced at \$8,800 per month; and for that, so far, it offers life extension of only a few months for some patients (Berenson 2006). Also, the benefits of competition will be attenuated by provider monopolies in many areas, and a vigorous anti-trust program will be needed.

But I also think that it is not unreasonable to believe that national health expenditures in a truly competitive market of the kind I have described would be half what they will be if we stay with the present system, a nontrivial difference. We cannot stay with the present system

much longer. Fundamental reform of some kind will happen. And it is reasonable to think that the reform most compatible with American culture would be a decentralized, competitive market model.

Notes

1. “Any willing provider” laws, for example.
2. Wanting It All: The Challenge of Reforming the U.S. Health Care System, June 15–17, 2005, Wequassett Inn, Chatham, MA. The announcement for this session says, “How has the U.S. health care system adjusted to the introduction of market-oriented medicine?”
3. Harvard converted from employer payment of 85 percent of the premium of the employee’s plan of choice to a fixed-dollar amount set below the price of the low-priced plan in 1995, without any risk adjustment. This put the Blue Cross Blue Shield PPO into a death spiral, and it was withdrawn in three years (Cutler and Reber 1998). Other managers of health plan competition have mitigated or prevented death spirals by plan design (for example, by raising the deductible). The Health Insurance Plan of California rescued its PPO by using diagnosis-based risk adjustment (see Shewry et al. 1996). Recently, practical, diagnosis-based risk adjustment has become available.
4. They also offer a combination of Group Health Cooperative and CIGNA in Seattle.
5. For what is probably the best analysis in depth, see Newhouse (2002).
6. The list includes Diagnostic Cost Groups from Boston University, Ambulatory Care Groups from Johns Hopkins University, and Episode Groupers produced by Symmetry.
7. See Newhouse (2002, p. 151). The actuaries’ results are for cases truncated at \$100,000. Dealing with very-high-cost cases is complex if one wants to maintain appropriate incentives to manage those cases efficiently and to keep people out of that category. See Cumming et al. (2002).
8. That is, not just IDS HMOs, but also PPOs, POS, or indemnity plans, if enough people want them.
9. That is, if one wants a plan that costs more than the base plan, one must pay the full difference with one’s net after-tax dollars.
10. GHC ran into the same glass ceiling of non-choice-offering employers that HCHP ran into in Boston: like HCHP, they had to establish an individual-practice network to be able to compete for single-source business. In the process, they lost their cost advantage.
11. David Eddy (1996) documented an example in which Kaiser Permanente, in Southern California, developed guidelines to identify patients who really needed low osmolality contrast agents, so that they could stop using them on

most patients who did not need them. A similar process took place for Cox-2 inhibitors. Kaiser Permanente used them sparingly and also followed the Cox-2 patients.

12. An example of such a technology is uterine artery embolization (UAE), which costs less and is less invasive than hysterectomy and works well for many women. OBGYNs do not tell their patients about it as an alternative to hysterectomy, perhaps because it is done by interventional radiologists (see Helliker and Etter 2004).

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Comments on Enthoven's "The U.S. Experience with Managed Care and Managed Competition"

Michael E. Chernew

The consensus among policymakers, business leaders, employees, and virtually anyone who has thought seriously about the issue is that the American system of financing health care suffers from serious deficiencies. Costs are high and growing, many Americans lack insurance coverage, and there is a pervasive sense that there are serious inefficiencies and quality deficiencies associated with the delivery of care.

The paper by Dr. Enthoven provides insight into these issues and traces the rise (sort of) and fall (sort of) of one proposed approach to improve the situation: increased competition in health care. I caveat the "rise" and "fall" with "sort of" because the system of managed care and competition that arose during much of the 1990s did not conform particularly closely to the system advocated by Dr. Enthoven, and therefore it is a bit unfair to assert that this system was tried and has failed. In any case, the premise behind Enthovenian competition is that consumers are not able to make appropriate economic decisions at the point of service because they do not have the necessary information, and because insurance distorts the incentives they face by reducing the price they must pay for care. To remedy this, competition is pushed to the point of health plan choice. Consumers choose health plans that, in turn, influence the care they receive (and the prices they pay for that care).

This competitive solution is not new. In fact, Dr. Enthoven has been associated with this approach for decades. So why has this system not come to pass? Dr. Enthoven focuses on the failure of employers to provide employees with the appropriate financial incentives at the time of health plan purchase, a situation that is exacerbated by the tax code, which subsidizes coverage and reduces the incremental costs of more

expensive plans. I agree with the fundamental premise of his work: the system would be better off if employees had a broad choice of plans and faced the incremental costs associated with more expensive plans.

Yet Dr. Enthoven believes (or, more accurately, I believe he believes) that, in such a system, the entities that would "win" in the marketplace are "delivery-system HMOs," which rely on relatively exclusive provider networks to organize and deliver care.

In the current system, many HMOs are "carrier HMOs" that have broad physician networks and less ability to manage care. Dr. Enthoven would likely trace these carrier HMOs and broad networks to the muted financial incentives put in place by employers. Yet I think that we cannot be so quick to dismiss the possibility that consumer demand for broad networks is high. What they will pay for this breadth is not really known, but clearly consumers seem to desire this breadth.

Breadth of networks offers three main benefits. First, it allows consumers to delay their choice of physician, particularly for specialist care, until they need a specialist. They may not want to commit at the time of health plan purchase because their preferences for physicians are unknown to them before they become ill. Second, closed networks require individuals to choose physicians from the system they selected for all types of care that they may need. They may prefer physicians in one delivery system for one type of care and physicians in another system for another type of care, and broad networks reduce the chances that their preferred physicians will be out of network. Third, in many markets, travel times might have to increase dramatically if providers were exclusively in one system. The density of many markets might not support competing delivery system HMOs.

Of course, the complaints about "carrier" HMOs and broad networks are not tremendously damning for a model of managed competition. Plans can and do have provisions for allowing out-of-network care, and much of the care delivered currently is in-network; so the demand for broad networks may not reflect a strong desire to see out-of-network physicians, but rather a demand to have the option to do so.

Moreover, in a dynamic setting it is not clear that premiums would be lower in a system of competing delivery-system HMOs relative to a

system of competing broad-network plans, even if the delivery system HMOs enjoyed a cost advantage. Although competing delivery system HMOs with relatively distinct provider networks would have a strong incentive to compete in a static model, the extent to which such a system would enhance competition in a dynamic model is unclear. Consumers are hesitant to switch physicians. Distinct physician networks could yield a system in which the elasticity of demand facing any given plan could be low because of this inertia. The system could resemble markets for durable goods in which there is extensive competition for the initial sale, but little competition for post-sale parts or service. The extent to which this inertia would result in higher premiums would depend on the willingness of consumers to switch physicians. With exclusive provider networks and meaningful travel costs, in some settings local monopolies may arise, further contributing to reduced competition among plans.

Ultimately, the premium differential between a system of competing delivery-system HMOs and one of competing carrier HMOs (or any other type of broad-network plans, for that matter) will depend on the cost advantages of an exclusive network of providers relative to any increase in premiums associated with inelastic demand facing closed systems. In any case, if the financial incentives were correct at the time of purchase, we might not be discouraged if broad-network plans “won,” because the premium advantages may not be as great as the cost advantages, and because such an outcome could be interpreted as reflecting consumers’ preferences regarding their care systems. With heterogeneous tastes, we might expect a range of plan types to survive, and more analysis is needed to understand better how the different systems affect one another and the market overall. Offering appropriate financial incentives at the time of plan purchase does not guarantee that there will be no inefficiencies in the functioning of the plans or the system overall.

Two other aspects of a managed competition model are worth mentioning. First, it is unlikely that a managed competition model, even if it worked as Dr. Enthoven envisions, would eliminate health care cost growth. Imagine the outcome from a competitive health care system if the main goal were the optimal delivery of care. Most observers would agree that such a system would be less expensive at any point in time

than the current system that contains incentives for excess consumption (although there is also evidence of underconsumption of certain services with the current system).

However, the optimal amount of health care spending rises over time as medical technology progresses; so even if we achieve optimal spending, we can still expect cost growth. This is depicted in Figure 4.1. Optimal care at time t is bundle A , and optimal care at time $t+1$ is bundle B . Inefficient care at time t is bundle C , and inefficient care at time $t+1$ is bundle D . Cost growth in an inefficient system is represented by movement from C to D . Cost growth in an optimal system is represented by movement from bundle A to bundle B . Which cost growth will be greater depends on the manner in which technology shifts demand. Movement from an inefficient system to an optimal one is represented by cost savings (movement from C to A), followed by cost growth (movement to B).

Of course, cost growth in an optimal system (from A to B) should be viewed favorably because, by the definition of optimal spending, the benefits would justify the expenditures. Yet policymakers and purchasers should not expect cost growth to disappear. Whether or not cost growth slows will depend on how medical technology progresses. While it is certainly true that a system of more-conservative health plans would encour-

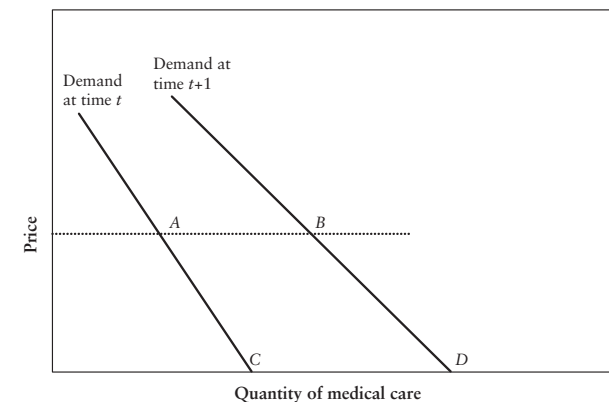


Figure 4.1
Cost Growth in Inefficient and Efficient Systems

age medical innovations that are less cost increasing, evidence about how the nature of technological progress would change in a managed competition system is scant.

For this reason, although the savings associated with a more efficient system may represent a downward shift in health spending, it may not alter the trajectory of health care spending over time. This is depicted in Figure 4.2. The trajectory of spending in an inefficient system is higher than that in an efficient system, but the slopes are not necessarily different. The rates of spending growth could be similar in both settings. Because we have not experienced an optimal system of care, we cannot assess easily the spending trajectory that we would experience in such a system. Existing evidence suggests that the introduction of managed care has reduced spending and lowered the rate of spending growth, but the reductions in spending growth have not been sufficient to stem the rising share of GDP devoted to health care (see Chernew et al. 1998 for a review).

Second, as we introduce a greater level of competition into health care markets, we may achieve greater efficiency. It is reasonable to expect more explicit tiers of care, with some individuals paying for plans with fewer restrictions on care (and maybe better outcomes), and other individu-

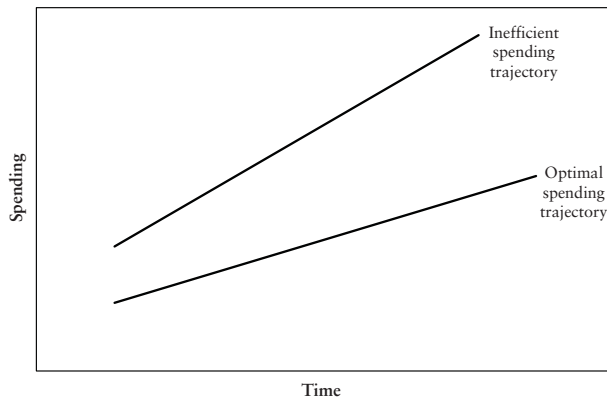


Figure 4.2
Spending Levels versus Trajectories

als enrolling in plans with less access to certain services. Such a system might not be worse than our current system, which exhibits considerable inequality in access, and evidence that the variance in costs is associated with meaningful variation in quality is not strong. Even if current variation in costs is related to inefficiencies, so that less expensive plans are not inferior, we should expect the possibility that as technology advances and costs grow, variance in costs will increasingly be related to quality differences. This is illustrated in Figure 4.3. When the system is inefficient (at bundle A), consumers could get more health and more of everything else if the inefficiency were eliminated by moving to a bundle on the production possibility frontier (such as bundle B). However, once on the production possibility frontier at bundle B, the only way to get more health is to give up some nonhealth consumption, by moving to another point of the production possibility frontier, such as bundle C. Thus, in an efficient system, the tradeoffs between health and nonhealth goods will be more salient, and different individuals will make different choices. Those choices will be based in part on preferences, and in part on income. Concerns about tiers of care that might arise by income group could be addressed with income subsidies or vouchers, but this raises a whole new level of policy response that would need to be defined.

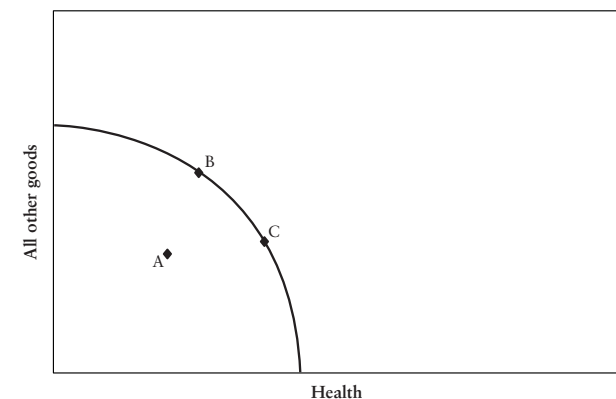


Figure 4.3
Production Possibility Frontier

There are several takeaway messages from this discussion. First, a system of competing delivery system HMOs, even if working as Dr. Enthoven envisions, would still be characterized by cost growth and tiered levels of care. From an economic perspective, these may not be suboptimal outcomes, but they will likely be important aspects of the system that policy-makers will need to address. Second, a richer understanding of why such a system has been slow to take off is needed. If imperfect risk adjustment is part of the explanation, more work is needed to improve risk adjustment methods. Similarly, if information imperfections are part of the explanation, additional research regarding information needs and dissemination approaches is particularly important. In this regard, I should note that Dr. Enthoven has been a strong advocate for informing consumers about the “quality” of care delivered in different systems.

Third, considerable uncertainty exists regarding the outcomes that would arise from a system of Enthovenian competition. I think it is likely that multiple types of plans would arise, and greater understanding is needed regarding how they might both impact and compete against one another. This requires more thorough knowledge of the connections between financing and delivery systems, including an understanding of how consolidation among providers might affect the desired outcomes. Connections between the commercial financing and provider systems and the analogous public systems must also be evaluated, and we must assess how the availability of charity care will affect the behavior of key players. Finally, as information systems evolve, new benefit design packages that combine the traits of integrated delivery systems and financial incentives for patients and providers will become more commonplace. If we can develop a system that encourages adoption of value-promoting benefit packages, which is the essence of what Dr. Enthoven proposes, we will at least be moving in the right direction.

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