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HEALTH POLICY BULLETIN

FOCUS: UP TO OUR EYEBALLS IN POLICY WONKS

Lansing and the state have been up to their eyeballs in health policy wonks this past month. In town on January 25 was Lawrence Brown, Ph.D., dean of the School of Public Health, Columbia University. Brown was the principal speaker at the Michigan Health Policy Forum sponsored by Michigan State University. In his address entitled "National Politics of Health Care Reform: What Can We Expect in 1993 and Beyond?" Brown discussed the pros and cons of major change, what is unfolding in Washington, and what successful reform might require—"another way of asking," said Brown, "are we ready for major reform?" He is not sure that we are.

The arguments *for* major change lie in electoral, group, and national and state politics. Electoral politics reflected the rising discontent with the health care system, most notably in Pennsylvania where Harris Wofford survived a special election challenge from Richard Thornburgh, a popular former governor of Pennsylvania and a well-respected moderate Republican. Interest groups are now endorsing reform—not even the Health Insurance Association of America is saying that it cannot be done or that it must be done through the private sector. Finally, Brown commented, "National and state capitals have been put on notice that health care is a front-burner issue."

The arguments *against* major change are not so much arguments against change as they are disagreements about the nature of the change that is coming. Brown cited the fact that the electorate is fed up with the current American health care delivery system but is divided on what should be done. The tradeoffs and sacrifices necessary to change are also unknown, he pointed out. Interest group positions reflect strategic postures—a desire to position themselves as part of the solution rather than the problem. The postures, according to Brown, are easiest to maintain before the details of change become visible. All of these factors create a very volatile situation, he observed.

"Change in leadership is not a clear indicator of change in ideology," commented Brown. There is still concern over big government—but, he wondered, "How does big change occur without big government? Perhaps it cannot." A five-fold coalition is pushing for change: the uninsured, the business community, the rising cost of Medicaid, organized labor, and probably the most important group of all, the uneasily insured. "We are in the process of moving from crisis to chaos," he noted.

Brown thought three basic reforms are necessary: (1) the government would have to create a basic benefits package with caps, (2) the business community would have to play or pay, and (3) the solution would be market based. Hence, the appeal of managed competition. Managed competition is politically appealing, according to Brown, because it offers a palatable way to back into universal coverage through a market mechanism. The greater government presence required to make managed competition work is acceptable because of its apparent reliance on market forces.

Will it work? Brown is not sure. Some basic questions need answers. How much management of care will be required? His guess is the system will require more micromanaging to ensure the achievement of gains. How much money is really saved from managing care? The assumption that managed care will squeeze out excess and achieve savings that are sustainable over time is questionable, he said. Finally, will the American people be willing to leave their health care up to market forces? Brown thinks success will depend on President Clinton's political philosophy, the amount of political capital he is willing to invest in health care, and his sense of what people want and where he can lead them. Brown observed that Americans as a people "lack the vision thing. We need some vision of social solidarity."

Among the panelists responding to Brown were Raj Wiener, former director of the Michigan Department of Public Health; Gary Kushner, Kushner Associates; H. Darlene Burgess, Henry Ford Health System; and Robert Asmussen, Blue Cross and Blue Shield of Michigan.

Wiener noted that President Clinton had put on hold ideas about including Medicare, Medicaid, and long-term care in health care reform. Gary Kushner observed that fiscal decisions, particularly the deficit, would drive health care reform. The addition of Ira Magaziner, a consultant who believes there is an enormous amount of waste in government, to the health care team suggests to Kushner that the administration will focus on cost cutting before it presents a reform plan. Kushner also said that managed competition is not a solution for rural and inner city areas where the number of providers is not large enough to ensure competition. He also does not believe that Congress is willing to put enough money on the table to pay for the cost of change. H. Darlene Burgess commented that the biggest problem is how to get the savings from managed competition in the private sector to those people who do not have coverage. Robert Asmussen noted that the key to any health care reform is universal access, but he was fairly

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certain that the Canadian and British approaches to reform are not acceptable to most Americans.

FOCUS: ALAIN ENTHOVEN

The originator of the concept of managed competition spoke to a packed room at the annual Michigan Department of Public Health Director's Conference in Dearborn on February 11. Unlike many economists, Enthoven was witty and comprehensible. The topic, of course, was managed competition.

There are two ways to control health care costs, Enthoven informed his audience: managed competition or federal price controls and volume standards (setting a number for instances of care in a defined period and penalizing the offending provider group by reducing compensation in the following period). "Federal price controls," he said, "will lock in the fee-for-service, free choice, third-party payer system forever—a system that has perverse incentives, no accountability, and no quality controls."

His solution? Managed competition. According to Enthoven, managed competition would provide an integrated financing and delivery system that puts providers at risk for the cost and quality of care. Incentives for physicians and the interests of patients would be aligned and would produce high-quality, economical care. Physicians would be selected on the basis of quality and efficient practice patterns; the numbers and types of doctors would be matched to patients' needs. Costly procedures would be concentrated in regional centers, and total quality management would be practiced every inch of the way. Noting that "too many surgeons are bad for your health and your pocket," Enthoven observed that managed care systems hire more primary care physicians and actually remove barriers to care. More outreach would be done, and physicians would practice population-based medicine rather than specialty-based medicine.

True managed competition provides consumers with quality and cost information on providers and gives them a choice. The ingredients are standard benefit packages, risk-adjusted premiums, standard outcomes reporting, the pooling of small groups into health insurance purchasing cooperatives (HIPCs) with individual choice of plans, periodic open enrollment through a single point of entry, and informed active management. The HIPCs would contract with integrated health care delivery systems known as accountable health partnerships (AHPs) to enroll all the employees of contracting employers and would offer uniform basic benefits. No group could be turned down. Rates would be community-based and quality would be monitored by the HIPC. Enthoven cited the California Public Employees' Retirement System (CALPERS) as an example of an HIPC providing a managed competition setting. He said "the key issue is the incentives for the good risks to join and remain in the pool."

A procompetitive regulatory framework would be created through the formation of federal boards for health standards, outcomes management standards, and health insurance standards. Universal health insurance would be mandated—"there are no free rides; everybody must pay," he said. His approach would also have the advantage of keeping coverage in the private sector as much as possible. Universal health insurance would not be tied to schemes to redistribute large amounts of income. People not covered through employment would be covered publicly if poor. Those who were not covered but had money would be required to pay a portion of their premiums themselves.

Perhaps the best way to summarize the advantages of Enthoven's approach is to say that managed competition would create an equitable playing field. The groups (HIPCs and AHPs) would be large enough to fight on reasonably even terms. A plan that did not deliver would lose its customers. A purchasing group that was not efficient and economical would fall to another organization that was leaner and hungrier.

While his plan is attractive and suggests a way to achieve universal health insurance that is more acceptable politically to many than employer mandates or the expansion of government programs such as Medicaid, it has its critics. One of the most prominent is Paul Starr, the noted health care commentator, who thinks managed competition will work only if it is tied to caps or global budgets for services. Other critics wonder about the place of long-term care and mental health and substance abuse services in a managed competition system. It is true that it is easiest to design the system if those services are left out. It would appear that one of the questions policymakers must answer is, What gets included in universal coverage?

OF INTEREST

A spate of bills has been introduced in both houses. Many of them are reintroductions of legislation from the 1991–92 session. Medical liability (SB 270) and no-fault auto insurance reform (HB 4156) are on a fast track; SB 270 is expected to clear the Senate by the end of February, and HB 4156 will probably be reported out of the House Committee on Insurance rapidly. It is also likely that the health professionals' licensing and disciplining packages (HBs 4076–4082 and SBs 334–343) will move quickly.

One of the consequences of the shared-power agreement in the House is the change in committee chairs each month. For February the chairs are Democrats, and in March the chairs are Republicans. All inquiries about particular bills should be directed to the office of the chair of the committee for that particular month.