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HEALTH POLICY BULLETIN

Managed competition is gaining steam now as a vehicle for health care reform, although President-elect Clinton has not completely embraced it. In this issue, we offer two perspectives on a concept that is likely to be the starting point for serious health care reform in the new administration. The first focus piece summarizes the proposal of a national coalition whose diversity is a sign that it should be taken seriously. The second focus piece offers PSC's perspective on the prospects for managed competition.

FOCUS: NATIONAL LEADERSHIP COALITION FOR HEALTH CARE REFORM

The coalition (a group composed of major corporations like Bethlehem Steel, Dayton Hudson, and Georgia-Pacific; nonprofit organizations like the Children's Defense Fund, the Christian Children's Fund, and the United Steelworkers of America; and professional organizations of providers like the American College of Physicians, the American Nurses' Association, and the Association of Minority Health Professional Schools) has proposed a plan for comprehensive health care reform that emphasizes both managed competition and global budgeting.

Their plan would require all employers to offer a health benefits package that provides coverage for the following services: hospital, hospital alternatives (home health care); surgery; X-ray and laboratory; prescription drugs; essential emergency, mental health, and substance abuse care; routine physicals and tests; and well baby and child care, including vision, dental, and hearing services through the age of 18. All services, with the exception of the well baby and child care services, would have a 20 percent copayment. People who are currently uninsured would receive their benefits through a program called Pro-Health; Pro-Health would incorporate the acute-care portion of Medicaid.

Employers could provide coverage for employees and their families or they could enroll them in Pro-Health; Pro-Health would be financed by a payroll tax paid by the employer and the employee. Businesses would be phased in over a three-year period. The coalition notes that the Pro-Health option would probably be most attractive to businesses whose wage costs are low; to prevent employers from flooding the Pro-Health plan, the payroll tax could be adjusted annually so that no more than 25 percent of the population was enrolled in Pro-Health at any time.

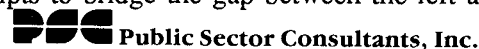
Why would this work? The plan would work because of cost controls, practice guidelines, malpractice and insurance reform, and heavy reliance on organized delivery systems. Systemwide targets would be set annually to limit the rate of expenditure increases to the rate of growth in the gross national product; payment rates for providers would be negotiated to come in below or at the expenditure targets; and annual targets would be set for capital spending. State targets would be arrived at by translating national targets; states could choose the method of keeping expenditures below or at the target level. Fee-for-service providers would face rate setting while organized delivery systems would not.

National practice guidelines would be used to make payment decisions and to serve as standards in malpractice cases. Use of the practice guidelines as standards of care in malpractice cases would also cut down on defensive medicine. A national board on health care quality would oversee the development of the practice guidelines and would fund outcomes research as well as encourage the use of continuous quality improvement. Insurers would be required to use community rating and would have to offer everybody the minimum benefits package, but they would be exempted from state-mandated benefits. Electronic billing, a universal claim form, uniform rates, universal coverage, and standard benefits would lower administrative costs.

The coalition says its proposal and managed competition are not alternatives to each other; rather, they are complementary because the proposal uses some of the features of managed competition, namely organized delivery systems on the provider side and organized groups on the consumer side (small business consortia and Pro-Health). Their proposal goes beyond managed competition, they say, because it includes universal coverage, quality-of-care initiatives, reform of insurance and malpractice law, and simplification of the administration of insurance. Managed competition by itself, they note, addresses neither these issues nor those of cost controls.

FOCUS: MANAGED COMPETITION

In the last few months, the debate on health care reform has changed fundamentally. A new idea—in truth, a three-year-old idea—has gained currency and received hosannahs from the press (*The New York Times*, *Business Week*). The idea, "managed competition," has a singular attraction: It is the first major health care reform proposal that attempts to bridge the gap between the left and the



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right—the poles, presumably, of government control and the free market.

Even if managed competition presents the first real health care reform proposal around which Democrats and Republicans can wrap their arms without coming to blows, pundits (like *The New York Times* editorial board on October 10) must not be too hasty in proclaiming it the champion. Health care is a very complicated business and managed competition is a complicated reform. Thus, selling it to the American people will not be easy. Furthermore, managed competition is a package deal, with a symmetry (equal parts market and regulation) that should appeal to Republicans and Democrats truly committed to the compromise necessary for reform; break off pieces and you are left with chaos and imbalance.

Managed competition has several major features:

1. Major consolidation—presumably "voluntary" (that is, through the force of the market)—of health providers into "integrated finance and delivery systems." These systems could be HMOs or other arrangements among physicians, hospitals, and insurers. The systems would be rewarded financially for controlling costs and providing quality health care. They would be paid a set fee per patient. While subject to global budgets set in the marketplace, the systems would not be forced to negotiate fees for providers, an important departure from Governor Clinton's plan.

2. Informed consumer choice, which, according to managed competition originator Alain Enthoven, "is designed to reward with more subscribers those organizations [that is, integrated finance and delivery systems] that do the best job of improving quality and cutting costs." Central to enforcing informed consumer choice is a limit on employer tax deductions for health insurance plans. At present, employers can deduct all their health insurance premiums; Enthoven would encourage cost consciousness by limiting the tax deduction to the cost of the "cheapest plan of acceptable quality."

   Informed consumer choice also extends to quality measurement. Each integrated finance and delivery system will be held accountable for reporting uniformly (so comparisons between systems can be made) detailed information on the quality of care, including patient satisfaction, treatment effectiveness, and risk-adjusted outcomes. Standards for reporting will be set by a national board.

3. Small-group insurance reform that will encourage thousands of small businesses to pool their workers in mammoth Health Insurance Purchasing Group Cooperatives (HIPGCs). Small businesses would lose the employee health insurance tax deduction if they did not join an HIPGC. With tremendous leverage in the market, HIPGCs would contract with multiple integrated finance and delivery systems, and employees would choose the plan best suited to their needs. Risk skimming and exclusions for preexisting conditions would be prohibited. All plans would be community rated.

4. A national board would decide on a uniform health benefits package. Systems could offer variations from the basic package, but the basic package would be a required offering that would allow for easier comparison shopping.

5. Employers must provide health insurance to all full-time employees. Part-time employees and all others not covered by Medicare and Medicaid would have public sponsors purchase insurance through the HIPGCs in the appropriate state.

Managed competition is not a mere tweak in the system. It rests on a mandate that guarantees universal access. This is not "play or pay," but simply "play." It does not levy a payroll tax; it forces employers to go out and find a good plan.

The mere promise of managed competition should accelerate health care providers' efforts to define and measure quality. The systems best able to quantify the value of their services—for individuals and populations, for inpatient and ambulatory care—will have a tremendous competitive advantage. Moreover, consumers of health care will not purchase the cheapest care if they are at all fearful that the differences in quality between providers may be the difference between life and death. As quality becomes more clearly defined and standardized—and understandable to the public—the best providers will be able to charge a premium.

The pressure for meaningful reform in our health care system is becoming irresistible. Every day, a new incident—General Motors shifting some of its health care burden to white-collar workers and retirees; the American College of Physicians, the second largest group in organized medicine, breaking ranks and calling for spending targets and negotiated fees for providers; outcry about the underwriting practices of some insurers; the unsustainable increases in Medicaid spending—suggests that we must tarry no longer.

Managed competition may not be the best alternative—it may be too complex to sell quickly to the American people, and it may not work—but that is no longer the issue. What matters is that it offers the possibility of compromise. Enthoven's plan may be only a painful step toward the system we really need (whatever that is), but we will not know what we really need until we try it first.

OF INTEREST

The legislature will return to Lansing on December 3 to adjourn *sine die*. All legislation that has not been acted on will die.

—Frances L. Faverman, Editor
and Peter Pratt, Consultant

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