Managed Competition: Maintaining Health Care Within the Private Sector

The health care reform debate has been effective in bringing visibility not only to cost containment issues, but to the need for expanded access to health care. The reform strategies that are currently under consideration are incremental changes that build on the transition in health care that has been underway for more than a decade. A hallmark of that transition is managed care arrangements, such as capitation (which involves a set fee per patient) and other alternative reimbursement methods, which now have become part of the norm (Miller & Luft, 1997). These arrangements are part of a larger strategy, managed competition, the details of which are under debate for expanding access to care and containing costs.

Health economics literature is replete with examples showing that health care cannot be competitive in a strictly profit-driven, single-payer system. Thus, managed competition is an effort to stave off a single-payer system. It is an alternative through which reforms of the health insurance industry can be accomplished and through which economic cloud can be redistributed among the various segments of the private health care industry.

Some of the strategies under managed competition are already being tried; others are still under debate. The most common strategies that could affect access to care, and that are currently debated by legislators, include employer mandates and community rating. These strategies likely to affect cost containment include capitation and other managed care arrangements, as well as benefit plan restructuring.

Expanding Access Through Employer Mandates and Community Rating

Although access to care is often presented as a financing dilemma, it is fundamentally an ethical problem that has yet to be resolved (Relman & Reinhardt, 1986). On the one hand, there is an intuitive sense among Americans that no one should be denied health care because of inability to pay. Health is basic to one’s ability to participate in the work force, to fulfill a social role in society, and to secure necessary goods and services. On the other hand, health care has been treated as a commodity from which an entire industry continues to profit and grow. The United States has held to a strong belief that health care is a commodity that, as is true with all goods and services, should be paid for through one’s participation in the work force or in a traditional social role such as the spouse of a worker. Managed competition straddles this ethical dilemma.
ma. It intervenes in the free-market system to expand access to care, but it does so without entirely challenging the belief that access to health care should be based on one's ability to pay for it.

The Medicaid and Medicare programs are a partial attempt to resolve the problem by providing care to those too old to work or those who are both very poor and unemployed, while having the employment-based, private health insurance system provide the bulk of funding and access to care (Rothman, 1993). However, the working but uninsured and the unemployed middle class can attest that the problem has not been resolved. To date, the largest segment of the uninsured are employed persons, particularly those who are working for small businesses, earning low wages, or working part-time. It is estimated that working Americans and their dependents constitute about 25% of the uninsured population (U.S. General Accounting Office, 1991). One managed competition mechanism to expand access for the employed but uninsured segment of the population is through employer mandates.

Mandates adjust the link between employment and access to health insurance so that more people have coverage from employee-based health insurance. Employer mandates, as they are being defined in many of the proposals, would require that all employers pay about 80% of each employee's health insurance premium costs for a basic benefits package (Stout, 1994). They are advocated as not directly adding to government spending and allowing business the tax advantage of deducting employee health benefit costs. Any real cost to the employer can be passed on to workers in lower wages, to consumers through higher prices, or to shareholders by way of smaller dividends.

The main opposition to employer mandates comes from small businesses, which say that the drawbacks far outweigh any tax advantage. They claim that they cannot afford the immediate costs of buying any form of health insurance. They warn that, before the costs could be passed on and equilibrium established, small businesses could be forced to close or would have to take other actions, such as requiring higher copayments from employees, eliminating retiree benefits, and replacing full-time employees with part-time employees (Battistella & Kuder, 1993).

Incremental approaches toward employer mandates have also been proposed, such as providing small businesses with government subsidies for the costs of providing health insurance, or legislating limited forms of mandates only for states that do not meet target goals for expanding access (Stout, 1994). In whatever way they are specifically implemented, the crux of employer mandates, as an intervention in the free market, is that employers would continue to be the route through which health insurance premiums would be paid and collected and through which access to care would be expanded. Using employer mandates is not the only option for expanding access to care, but it is the option that maintains the link between employment and health insurance. However, linking health insurance to employment raises an ethical question.

Under the current system, employment determines access to health care. This situation means that the criteria (personal and social attributes and circumstances) that allow one (or qualify one) to be employed are the same criteria that one must meet to have access to health care (Jecker, 1993). Employment is often awarded to a person for such attributes as intelligence, education, social position, or even health. Those who believe that access to health care should be based on the need for health care would thus argue that linking employment to health care is unfair. This ethical issue, however, is not addressed in the legislative arena, and every effort in health reform, such as employee mandates, appears to be aimed at maintaining the employment-insurance link.

Community rating of health insurance premiums is another strategy for expanding access to care. Community rating means that insurance companies charge the same rate for insurance premiums to all of their customers in a given geographic area, regardless of the health status of the population (Swartz, 1993). Health insurance began with community rating, where the risk and cost of illness was spread equally across a community. Since the 1970s, insurance companies have been using experience rating to sell insurance at lower premiums to categories of people who were expected to have a lower risk of illness. Using experience rating, insurance companies charge different rates to different customers (or groups of customers). Premium costs are adjusted on the basis of such individual variations as age, gender, previous claims experience, health status, and other such risks and predictors of health and illness. Thus, lower premiums based on experience rating were available to large employers, where working people are relatively healthy, where the risk can be spread over a greater number of people, and where the insurance company can collect greater profits from the greater number of premiums.

Insurers often point out that experience rating is fair because the healthy are not forced to subsidize the less healthy when each policy holder pays a premium that is consistent with his or her level of risk (Stone, 1993). However, this concept of fairness must be viewed in comparison to another, the solidarity principle, which is a social insurance concept that certain agreed-upon individual needs will be paid for by a community or group (Stone, 1993). Community rating, in the broadest sense, approximates the idea of the solidarity principle; experience rating is based on actuarial fairness.

Unfortunately, insurers exploited experience rating as a profit-generating mechanism (Joseph and Edna Johnson Institute, 1994). Experience rating became a competitive marketing strategy as insurers sought to gain a larger share of the market by offering the lowest-priced premiums to large employer groups (Stone, 1993). This stratification resulted in enormous inequities for small businesses and individuals, thus contributing to the problem of diminished access to health care and leading to small businesses and individuals being priced out of the insurance market. Additionally, experience rating led to absolutely denying health insurance or offering only exorbitantly expensive insurance to individuals who had preexisting conditions or were known to have other high-risk factors.

Although a move from experience rating back to community rating would promote greater access to health care, it could create other problems. Estimates are that community rating would increase the premium rates by 10% to 20% for employers that heretofore had low premiums (Jones, Doe, & Topodas,
Those employers might then look for strategies to decrease their costs, such as cutting back on covered benefits or terminating health care benefits entirely. Additionally, insurers might experience greater risk, which would ultimately increase the cost of premiums. As an alternative to pure community rating, some managed competition schemes have suggested that pure community rating be tempered by allowing insurance companies to use rating bands (Jones et al., 1993). Rating bands limit the annual increase in rates and establish a prescribed ratio of the highest to lowest premium rate for similar groups. Another alternative to pure community rating is rating by class, in which insurers can vary premiums only by actuarial data on demographic variables, such as age or gender, but not on claims experience, health status, or length of time since a policy was issued.

The main strategies to expand access to care, employer mandates and community rating, are offered as separate strategies in some proposals but are tied together in others, especially when health care alliances or purchasing cooperatives are proposed. Health care alliances or purchasing pools are larger health insurance pools of either small businesses or small businesses and individuals (U.S. General Accounting Office, 1994). Under some reform proposals, the alliances would control the premiums and benefits of insurance plans through negotiation with insurance companies. The alliances or cooperatives would negotiate the community rates that would be financed by employer mandates.

Employer mandates and community rating could expand access for the working population, but discussion of expanded access for low-income, self-employed, or unemployed persons has fallen by the wayside in reform proposals. However, if the subject again comes to the fore, access for these groups would most likely be financed by government funding, funneled through such structures as the alliances or cooperatives. This approach would provide access to the same health care even though some persons would have policies financed through employers and others would have policies financed through the government. However, universal access currently receives little support in legislative debates.

The goal of increased access to care cannot be separated from cost containment. Strategies that would expand access are presented in the next section, along with strategies for cost containment.

### Cost Containment

The two major strategies used to contain costs are (a) capitation and other managed care arrangements and (b) benefits plan restructuring. Capitation and other managed care arrangements affect the fees or reimbursement for services, whereas benefit plan restructuring defines what diagnostic and treatment services will be covered by health insurance. Both strategies address a basic distortion in applying a free-market principle to health care.

If health care was priced according to a pure free-market system, the patient would make a conscious (rational) decision to purchase health care at a price agreeable to both patient and provider. To make a rational decision, the patient would have to understand how the care would help him or her and would have to be aware of the prices that other physicians or hospitals would charge for that same care (same quality, same degree of usefulness to the patient). With this information the patient would then decide whether the care was useful enough to pay the price being charged, whether some aspects of quality could be sacrificed in order to pay a lower price, or whether to forgo the care entirely, either because it was not useful enough, given the price, or because it was unaffordable at any of the going prices. Clearly, patients do not make such rational decisions about purchasing health care. Patients cannot acquire full information because it can be too highly technical to grasp quickly; the benefits or effectiveness of care are sometimes unknown or can vary; the price of care, from one provider to another, is not easily accessible; and the pain or urgency of illness greatly limits the patient's ability to acquire information.

These limitations produce a distortion in the market that allows providers to set their fees independently and to affect the demand for services. Compensating for this distortion, third-party payers assumed the role of sponsors for patients in negotiating prices of services and defining the level of health care benefits. This action created a second conflict because at the same time that private third-party payers negotiate with providers on behalf of patients, they have an interest in their own profitability.

Insurance companies contained costs by limiting reimbursement to what the insurer determined as the usual and customary fee, as well as through patient copayments and deductibles (Institute of Medicine, 1989). Although the provider received lesser reimbursement from the insurance company, he or she was still free to charge whatever fee he or she determined was fair and could then bill the patient for the balance. The costs to the insurance company were lowered and the provider still received the full reimbursement through balance billing. However, the overall costs of care were not changed.

Under managed competition, the price of care is negotiated with the providers of care by the managed care organization. There are many schemes and variations on reimbursing professional services. In general, health maintenance organizations (HMOs) negotiate set fees with the provider, but the patient is usually not billed for the balance. The provider agrees to a capitation rate in which he or she is paid a set amount per patient or is paid a set salary to assume responsibility for the patients. In a slightly different managed care arrangement, such as preferred provider organizations (PPOs), the provider agrees to charge a discounted fee to patients covered by the given insurance plan. The patient may be billed for the balance, but on an already discounted fee.

The major problem with these arrangements, from the perspective of the provider, is that he or she cannot independently set fees and may share a level of financial risk with the managed care organization (Berenson, 1991). However, a benefit to the provider is that the managed care organization can usually guarantee the provider a certain level of income. This income is guaranteed as either a salary in some of the capitation plans or a guaranteed volume of patient referrals (Berenson).

To guarantee providers a certain volume of service and so give incentive for providers to join the panel, some managed care organizations limit the
number of providers on their panel. The ramifications is that some providers who are willing to accept the negotiated reimbursement are not accepted on the panel (Berenson, 1991). This situation essentially limits the ability of some providers to compete for patients and it has raised antitrust actions against managed care organizations. For example, providers in a small town, where a managed care organization covers a large segment of the town’s population, can be virtually driven out of business (or out of town) if they cannot join the panel of providers. The issue is still not resolved, but several states now have legislation with “any willing provider” clauses that require a managed care organization to accept any provider willing to practice under the terms of the managed care organization’s contract with providers.

Providers also encounter problems when signing on with a number of different managed care organizations. Each managed care organization might negotiate a different reimbursement rate with the provider; however, any of the organizations can specify in the contract to receive the provider’s lowest charge, which is termed a favored nation status. Thus, if the provider agrees to a lower rate with another managed care organization, the provider must then offer the same low rate to the organization that put the favored nation clause in the contract. If the provider receives a large number of patients from the favored nation organization, it can result in a substantial decrease in revenue for the provider. The evidence that managed care achieves cost savings is conflicting (Gabel & Rice, 1994; Miller & Luft, 1993; Petersen, 1994). One source of the conflict is that many cost studies cannot be compared. They differ in their definition of a managed care arrangement and in defining the level of benefits. Additionally, there is little account of the out-of-pocket costs that patients incur. Further, it is possible that cost savings are, in part, a shift in profits from the provider to the managed care organization.

The cost containment strategy that directly affects the patient is benefit plan restructuring. Insurance companies have played a major role in deciding what services and treatment would be part of a package of benefits. However, an inherent conflict is that insurance companies have an interest in keeping the costs of care to a minimum in order to maximize the company’s profits (Gabel, Formisano, Lohr, & Di Carlo, 1991).

For some time, insurance companies have been defining benefit plans with an eye to reimbursing only those services that are medically necessary. For example, services that are optional, such as cosmetic surgery and some preventive services, are rarely included in a benefits package; benefits for mental health and substance abuse treatment have been limited, if offered at all; and treatment or diagnostic procedures that are classified, by the insurer, as experimental are also not covered. With advances in technology and more diagnostic and treatment options available for a given condition, it has become increasingly difficult to define what constitutes medically necessary care. Making third-party payers even more cautious in designing benefit packages, health services research has documented that there are variations in medical care around the country, suggesting that some care may be overused or that there may be inefficiencies in the health care delivery system (Wennergren & Gitelson, 1982).

The problem with excluding specific benefits is that some patients truly need them. Those that can pay for them out of pocket can receive them, but those who cannot will not be able to obtain them. Sometimes such a denial of benefits is tantamount to receiving no care; at other times a result in a lesser quality of care for the patient. Benefits restructuring, in the extreme, merges rationing of care and rationing always raises the question of whose needs should shape rationing decisions. Managed competition, to date, has not offered much of a solution to the definition of benefits or cost containment problems. Ultimately, the profit motive, be it that of a managed care organization or that of an insurance company, can loom as a threat to the patient’s best interests (Reinhardt, 1986).

However, insurers and managed care organizations have become more sensitive to the negative press regarding their interest in cutting benefits or reimbursing only treatment alternatives with the lowest cost. They have increasingly marketed themselves by touting their quality improvement or quality assurance programs as evidence that they look after the quality of care and the patient’s interests. Through quality assurance and improvement programs, which now include outcomes research or medical effectiveness research, they attempt to justify their judgments about the level of benefits.

Because benefits packages often exclude those services whose effectiveness is not thoroughly substantiated or those that have an effective but less expensive alternative, the managed care organizations are in effect defining appropriate care for a given health condition. Alarmingly, their ability to define appropriate care is questionable. Typically, managed care organizations use report cards that provide data such as patient satisfaction and the number of enrollees who received mammograms or other health screenings. Although one would agree that health screenings and patient satisfaction are an aspect of quality, they are an incomplete report on quality. Thus there is ongoing concern about how managed care will affect the quality of care and the professional judgment and autonomy of practitioners.

Health care providers have attempted to counter this problem by developing guidelines for care, sometimes called practice parameters. Although managed care organizations express an interest in the professional guidelines, it is too early to say how or to what extent they will apply them.

It is notable that professions, for all their ire about infringements on their autonomy, are still reluctant to describe appropriate care; they fear that guidelines will be used to increase their exposure to malpractice liability and that insurers will distort the content of the guidelines to further limit reimbursable benefits (Institute of Medicine, 1992). Because of this reluctance on the part of providers and also because of the inherent methodological problems in developing guidelines, many of the current guidelines are not specific enough and fail to comprehensively document the literature. Thus, the move to define appropriate care is proceeding, but is hampered by the self-interests of both the payers and the professions.

Conclusion

The private insurance industry, which is the mainstay of financing the U.S. health care system, is under attack and
will be reformed, but is also being preserved as a viable option to a single-payer system. In a sense, the insurance industry is the target of reform in order to preserve it and its ability to manage health care within the private sector.

Private sector management of the health care industry will allow the many segments of the health care industry to grow and profit. However, some segments, such as direct providers, may experience a decline over their usual rate of return or increases in costs, at the expense of others. Some segments of the health care industry may reap a higher level of profits. With private sector interests in profits, it is difficult to imagine how the costs of care will actually be contained.

Currently, the private sector will neither support nor provide universal access to health care. The ethical issue of who should have access to health care and according to what criteria will be sidestepped. Thus, managed competition will need a fairly heavy dose of government regulation to provide for universal access.

It appears unlikely that managed competition will greatly enhance access to care or contain the costs of care. Universal access to health care and its relationship to a fair price of care are bound in ethical dilemmas that are rarely recognized and discussed in the legislative, policy-making arena. Even the health care industry prefers to avoid the debate for fear of the choices it would present. With such heady considerations lurking beneath the surface, it is no wonder that the health care reform debate is mired in political, congressional haggling, with special interest groups (the health care industry) vying for the best advantage in any redistribution of economic clout and profit.

References


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