
Perspectives

Challenges For Managed Competition From Chronic Illness

by Mark Schlesinger and David Mechanic

Many health system reform proposals fail to recognize chronically ill Americans. Most of the proposals introduced in Congress over the past year make at most passing reference to long-term care for physical and psychiatric disabilities. Those that specify coverage of mental illness rarely cover more than thirty to forty-five inpatient days and twenty to thirty outpatient visits. Most explicitly exclude coverage for extended mental illnesses. The failure to address issues of chronic illness is no less noticeable in reform proposals that fall into the category of “managed competition.”

A major appeal of managed competition, as with all systemic reforms, stems from its promise to place all Americans on roughly the same terms in access to health insurance and health care.¹ This promise is often made in ignorance, with little awareness of how service needs vary for different conditions. But we believe that ethical, political, legal, and administrative considerations all dictate that such a promise must include Americans with chronic illnesses as full participants under the future health care system.

Why Include Chronic Illness And Disabilities?

Although many Americans have some chronic illness, most chronic conditions are not necessarily impairing and often do not require more than conventional care. The special implications of chronic illness for health system reform derive from a somewhat smaller, but still substantial, group. For the purposes of this paper we use the concept of “disabling chronic illness” to refer to physical and mental conditions that seriously impair a person’s ability to function in some major activity over time. We believe that these individuals have the largest needs, pose the most formidable challenges, and are most likely to be neglected in reform efforts. It should be understood, however, that this narrow focus very much understates the prevalence of chronic conditions and thus underestimates the centrality of

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this issue for health system reform.

There are a number of reasons for addressing chronic illness in health care reform. First, roughly thirty-four million Americans, 40 percent of them under age sixty-five, have chronic conditions that limit them in what are considered to be normal activities for their age group.² As the baby boomers age, the prevalence of chronic conditions will increase.

Second, there are tremendous disparities in access to care and insurance coverage among persons with chronic disabling illness. There are disparities in private insurance, but they are most apparent in Medicaid: Average medical expenditures per disabled Medicaid recipient in fiscal year 1990 ranged from \$2,711 in Mississippi to \$15,841 in Minnesota.³ It is unlikely that any comprehensive health care financing reform can ignore such disparities. In fact, the Americans with Disabilities Act (ADA) likely has made it illegal to exclude particular disabling conditions from public programs or to exclude individuals because they have certain conditions.⁴

Some managed competition plans would exclude Medicaid and Medicare, reducing the number of people with chronic illness in managed competition. However, experience with the treatment of chronic illness in mainstream health maintenance organizations (HMOs) suggests that major problems are likely when enrollees with chronic illness represent only a small proportion of plan members. Reducing the number of chronically ill persons who participate in the program thus makes it more likely that the needs of those who do participate will be neglected by the plans.

Goals In The Care Of Persons With Disabling Illness

We recognize that uncertainties in the political process can hamper ideal reform. We believe, however, that certain principles should guide any reform plan that purports to address chronic illness. These principles would emphasize functional outcomes and quality of life, comprehensiveness and balance in services, continuity of care, and appropriate distribution of responsibility and accountability.

Social function and employment. For chronic conditions, reforms must encourage arrangements that allow people to maximize the retention of social function. One important aspect involves encouraging work among those who are able. But employers, who are liable for their health expenses, have an incentive to discourage employment of workers with chronic conditions. Medical expenses for persons with moderate chronic disabilities are two to three times higher than for persons of the same age without disabilities.⁵

Comprehensiveness and balance of services. Medical providers and delivery systems must have the capacity to oversee comprehensive care.

Beyond appropriate triage and case management of complex needs, they should be responsible for restoration and recuperation services ranging from the direct provision of nursing and home care to successful referrals to an array of social and rehabilitative agencies. By balance we refer to the appropriate mix of medical and sociomedical services needed for the longitudinal care of chronic illness. Historically, financing systems have been biased toward inpatient treatment of chronic illness, bias replicated in states' purchase of services for the mentally ill, in Medicaid financing of long-term care, and in private coverage for treatment of substance abuse.⁶

Continuity of treatment. Chronic illness extends over many years, often for a lifetime. Continuity of care and providers makes it more likely that the providers will understand the complex psychosocial dynamics associated with people with chronic impairments.

Responsibility for appropriate treatment. In the prevailing system of care, no one is responsible for ensuring that patients receive, in a timely fashion, the range of services they need to ensure functioning and limit disability. Patients and their families typically serve as their own ombudsmen, piecing together an array of services deemed suitable for their perceived needs. However, many people with chronic illness—including some economically disadvantaged and socially isolated elders, as well as many persons with serious and persistent mental illness—lack the resources needed to effectively pursue self-empowerment. In these cases appropriate care may extend well beyond traditional medical services, requiring aggressive case management and assistance in obtaining access to housing or disability benefits, supervision of daily activities, and psychosocial rehabilitation.⁷

Responsibility for cost containment. Any effort to extend care to cover a wider spectrum of services must be linked to an effective cost containment strategy. For patients with chronic illness, cost sharing is likely to impose barriers to care that are unselective and that deter individuals from seeking beneficial services.⁸ For these reasons, we believe it more appropriate to control cost primarily by relying on incentives for providers and oversight by institutional purchasers, rather than efforts to reduce demand by cost sharing. The primary complication associated with chronic illness involves the relatively large variation in costs of treatment among patients with apparently similar conditions.⁹ Under these circumstances it is difficult to design payment systems that carefully balance incentives for cost saving with protections against inadequate care.¹⁰ Any system responsive to chronic illness must operate within budgetary constraints to achieve reasonable levels of cost containment. At an operational level, there must be some management of care, whether by a primary care physician, a professional case manager, or an interdisciplinary team.

Paradoxes Of Policy Making For Chronic Illness

Experience with financing and delivering services for the chronically ill suggests a number of patterns in needs, service use, and program design. As guideposts for reform, these often point in seemingly conflicting directions. We can summarize these conclusions in the form of three “paradoxes.”

Paradox 1: Incentives for patients and moral hazard. Policy analysts suggest that patient cost sharing is most appropriate when the demand for services is sensitive to price and initiated by the consumer (as opposed to physician-determined use). Much of long-term care seems to fall into this category. The threat of moral hazard (for instance, families forgoing their roles as caretakers) makes some cost incentives for patients seem both appropriate and necessary. Yet cost sharing is least effective and equitable when applied to chronic illness. Unless extremely large, deductibles have no influence on behavior for the chronically ill, for whom expected costs will invariably exceed the deductible. Copayments that are large enough to deter initial use become excessively burdensome with extensive use. Those who can will insure against them, eliminating any deterrent effect.

There are several alternative approaches to this dilemma. If cost sharing is used, it could be scaled to income to avoid likely inequities. Or cost sharing could be introduced in relation to the expected moral hazard. On this principle, cost sharing would be higher for say, psychotherapy, than for medication visits.¹¹ Our view, however, is that any clinically sensitive cost-sharing arrangement is likely to be administratively cumbersome and costly. Given the availability of supplementary insurance policies, cost-sharing requirements for chronic illness will tend to be either inequitable or ineffective. Thus, we believe that investment is better placed on fine-tuning case management incentives and strategies.

Paradox 2: The push for parity. Advocates for people with chronic illness have argued that it is unfair that certain health conditions are apparently given greater priority (and greater access to societal resources) than others. Efforts at creating parity in private insurance are unlikely to expand current acute coverage to the broader scope of services needed by persons with chronic illness and are more likely to push the coverage of chronic illness back into the acute care mold. The current push for parity replicates a mistake made by advocates for the elderly in 1965. Medicare was rationalized in part by the claim that elders who had worked hard all their lives deserved insurance just as good as the coverage working-age Americans could obtain. Indeed, Medicare coverage was explicitly modeled on benefits for federal employees at the time. But this overlooked the fact that the needs of elders, particularly those involving chronic illness, were different from those of younger people. Equality is not the same as equity.

Paradox 3: The two faces of Medicaid. Medicaid has become central to the provision of services for the chronically ill and disabled. Medicaid simultaneously serves as the long-term care system for the poor elderly, the major program for persons with severe and persistent mental illness, the primary program for care of the mentally retarded, and the basic insurance program for selected groups of indigent persons. It covers approximately 40 percent of persons with acquired immunodeficiency syndrome (AIDS).¹²

In several states Medicaid has developed a benefit structure far better fitted to the needs of persons with persistent illness and special needs than is found in any private insurance plan. States have the option to incorporate up to thirty-four services into the program, including case management, hospice, transportation, personal care, rehabilitation, and speech and hearing therapies. Further, the waivers authorized under Section 2176 provide opportunities to develop innovative delivery systems geared to the needs of highly disadvantaged and disabled populations. However, in part because of administrative hurdles and financial limitations, few states have taken full advantage of these opportunities.¹³ Consequently, reforms that result in “folding” Medicaid into a more universal package might significantly assist those living in states with the least adequate programs, while at the same time resulting in a contracted, less responsive package of benefits for those living in the most generous and innovative states.

Chronic Illness And Managed Competition

Although the details of managed competition approaches differ, all proposals share three common features: (1) managed care (typically in the form of prepaid health care plans); (2) consumer choice among these plans; and (3) a public, quasi-public, or private agency that acts as a “sponsor,” regulating the system and assisting beneficiaries in their choices. The performance of each of these features can be affected by the distinctive nature of chronic illness, as we show here.

Managed care: Potential problems. Prepaid plans hold considerable potential but some risks as a system of insuring people with chronic illness. Their potential stems from the discretion that capitation gives to providers to allocate services, freed from the administrative restrictions that are incorporated into fee-for-service insurance. Such discretion allows a shift in treatment away from institutional settings to community-based services.¹⁴ For many of the chronically ill, the lower cost of community-based care provides an additional incentive to prepaid providers, since they must keep treatment costs within an annual budget. The plan provides an infrastructure for incorporating case managers, so that benefits can be added without uncontrollable increases in costs. Since capitated plans generally avoid

extensive use of copayments, enrollees are shielded from the financial threat that copayments represent for people with chronic illness.

These potential benefits may not always be realized in practice. The same incentives that favor lower-cost treatments also discourage the provision of some services for which the norms of appropriate treatment are vague. This may lead to inadequate care. To stay within their budget, plans also have an incentive to shift costs to other providers, such as social service agencies, that are also responsible for the needs of people with chronic illness.

Over the past decade we have had experience with the care of chronic illness in mainstream HMOs (which have a small number of chronically ill enrollees), in HMOs participating in Medicare (where the prevalence of chronic illness among enrollees is significantly higher than in the general population), and in special demonstration projects. Most of the latter have focused on persons with chronic mental illness. A small number of plans have enrolled more seriously disabled elders under the social health maintenance organization (SHMO) demonstration project. Although none of these settings has been fully or rigorously assessed as yet, these experiences point toward several broad conclusions.

There appears to be a significant difference in the treatment of chronic illness between plans that “specialize” in chronic conditions (for example, SHMOs, capitated plans for the chronically mentally ill) and those that treat a relatively small proportion of enrollees with chronic illness. The former plans, which have had their scope of services defined more broadly than is true of the typical HMO, tend to be more responsive to long-term care needs and more likely to use case managers to monitor those needs.¹⁵ Evaluations of these plans suggest that prepayment leads to modest shifts in the amount and nature of services for chronic conditions, compared with fee-for-service coverage of similar individuals, although some plans have experienced significant increases in acute care spending.¹⁶

There are striking contrasts with plans in which the chronically ill are only a small proportion of enrollees. Serving only a few persons with disabling chronic illness, many plans fail to develop services such as case management, leaving this responsibility to the primary care physician. Screening programs for the early detection of chronic illness appear to be no more common in prepaid settings than in fee-for-service practice.¹⁷

Treatment for some chronic illness is significantly reduced in mainstream plans. While illnesses having well-defined professional norms of treatment are treated in roughly the same manner in prepaid and fee-for-service arrangements, incentives under capitation can lead to substantially reduced levels of treatment when norms are more vague. Additional costs of treating chronic illness are shifted to other community agencies.¹⁸ Mental health care expenditures in prepaid practices, for example, are one-third

to one-fifth as large as for comparable populations under fee-for-service insurance.¹⁹ It is incorrect to assume the services are unnecessary simply because norms of treatment are poorly defined.

Because norms of appropriate treatment are ill defined for many chronic conditions, it is difficult to determine if reduced spending or shifts in the nature of service have led to poorer outcomes. Those enrolled in prepaid care in the RAND Health Insurance Experiment had no observable increase in adverse outcomes, but they were studied over a limited period of time, and the study group included few people with serious mental illness. Most HMOs provide limited mental health benefits and may discourage the enrollment of people with these conditions. Although studies of patient satisfaction in prepaid plans have not focused on enrollees with chronic illness, anecdotal reports suggest considerable dissatisfaction with treatment—particularly for mental illness—in mainstream HMOs.²⁰

The capacity of a prepaid plan to provide appropriate treatment to enrollees with persistent and severe illness depends to a considerable extent on the way the plan is organized.²¹ Certain types of prepaid plans appear to be more problematic for enrollees with chronic illness. A significant number of plans rely on primary care physicians as “gatekeepers,” controlling access to other providers. There is significant evidence that primary care physicians lack expertise in diagnosing or treating some chronic conditions, particularly psychiatric conditions.²² Even such common problems as depression are identified only approximately half the time. For reasons not clearly understood, prepaid physicians are even less effective than are fee-for-service doctors in detecting depression.²³ More appropriate case management under these circumstances requires a multidisciplinary team.

Other problems may be created by the physician payment methods in the plan. A significant number of plans make primary care physicians’ personal income highly dependent on meeting utilization targets for their patients. These arrangements encourage some physicians to reduce the health care use of the enrollees for whom they are responsible.²⁴ Given the relatively small panel of enrollees for each physician, the great variability of costs associated with chronic illness create considerable risk that these providers would exceed their utilization targets. This could lead to inadequate treatment; physicians might work hard to avoid such enrollees, dump those that become chronically ill, and disrupt their continuity of treatment.

Managed care: Possible solutions. In our assessment, managed competition arrangements can integrate the chronically ill more successfully by defining a more comprehensive benefit package than is commonly provided through private insurance. The broader the scope of services for which plans are responsible, the less likely they would be to dump enrollees or shift costs to other agencies. The breadth of services that are currently funded

under Medicaid's optional coverages and its 2176 waiver program provides some sense of an appropriate norm. Because most HMOs currently offer only limited social services, sponsors may need to help them to gain expertise in managing these areas.

A second potentially useful measure would encourage plans that specialize in the care of chronic illness. Although in principle it is desirable to make all plans and providers sensitive to the needs of enrollees with chronic illness, developing specialized services may be too costly for plans without, a large number of potential users. In addition to encouraging the formation of some specialized plans, it may be necessary to discourage participation by others. It might be best not to include plans that rely on capitation of individual practitioners, in which personal income is closely linked with utilization targets.

Capitated primary care gatekeepers are most common among individual practice associations (IPAs), the fastest-growing form of HMO.²⁵ This creates a serious challenge for adapting managed competition to the broad and complex needs of people with chronic illness. It is important that plans have the capacity to supplement the primary care physician with other appropriate professionals. However, decentralized plans such as IPAs are least likely to have this potential. People with chronic illness would almost certainly be served better by group plans, but in more rural areas IPAs may be the only administratively feasible model. It may therefore be difficult to enforce strict prohibitions against decentralized plans. In such instances sponsors must assume greater responsibility to protect against inadequate or inappropriate treatment. It may prove more appropriate in some cases to retain some form of fee-for-service insurance, albeit with extensive case management provisions for services associated with chronic illness, than to enroll people with chronic illness into prepaid settings that are ill equipped to provide appropriate care.

There may be some aspects of enrollee well-being that are particularly difficult to support in a system relying on managed care. Over the past two decades there has been an increased emphasis on maintaining the independence of people with chronic conditions.²⁶ The philosophy underlying the independent living movement is in many ways antithetical to the use of case managers, particularly when those case managers act as gatekeepers to needed services.²⁷ Allowing people to choose among gatekeepers (or plans) only partially reduces this conflict. Enrollees are still forced to give control over their condition to someone else. We see no way within traditional notions of insurance for health care services to avoid this difficulty, given the specter of uncontrollable costs. It is our hope that within a broad array of services, individual enrollees will have sufficient flexibility to negotiate with case managers over the appropriate provision of services. But this issue

is likely to remain salient and potentially politically volatile.

Consumer choice: Potential problems. One response to the concerns we have raised is consumer choice. By this logic, if the chronically ill wish to avoid physician gatekeepers or to seek out plans that specialize in chronic illness, they are free to do so. But this presumes that they are given reasonable options. Without explicit subsidization, specialized plans may be slow to develop. The experience with SHMOs, for example, suggests that start-up costs are quite high for plans of this sort.²⁸ Without substantial subsidies, several of these plans would have failed in their initial years.

The positive outcomes predicted for managed competition proposals presume that the participating plans are competing on cost and quality, not simply selecting lower risks. This in turn presumes that capitation payments are effectively risk-adjusted. One can certainly imagine plans being paid more, on average, for enrolling chronically ill persons. Given the state of the art in risk adjustment, however, it seems unlikely that capitation payments will reflect accurately the variation in use and costs among the chronically ill.²⁹ At a minimum, chronically ill enrollees will be more risky and thus less desirable.

Requirements for open enrollment can limit discrimination in who can join a plan. However, HMOs participating in Medicare have demonstrated great resourcefulness in developing enrollment methods that legally do not discriminate but that in practice discourage enrollment by infirm elders.³⁰ Moreover, research on risk selection for HMO enrollees suggests that plans achieve a more favorable enrollee mix primarily by encouraging disenrollment, rather than by discouraging enrollment.³¹ This would be particularly likely with those chronically ill patients who prove more expensive than average, since these costs persist over time. Selective disenrollment is harder to regulate than selective enrollment, since it typically results from subtle influence by providers on patient choices.³²

With imperfect risk adjusters, a system of prepaid care in which there is substantial chronic illness can be unstable. Plans that face persistently high uncompensated costs will either withdraw from managed competition or go bankrupt.³³ As plans get in trouble financially, their first step is to try to dump chronically ill patients, severely disrupting continuity of care.³⁴

Consumer choice: Possible solutions. Incentives for selective enrollment and disenrollment would be reduced by mechanisms that buffer the risk that participating plans would face. In the (likely) event that effective risk adjusters cannot be developed for the capitation payment, an alternative approach is called for. Reinsurance has the potential to moderate the risks facing participating plans. In this context reinsurance represents a type of “blended” payment system that has been proposed in other contexts.³⁵ To achieve the appropriate blend, however, it is necessary to retain some

financial incentives for plans. Without these incentives, plans might revert to the prevailing fee-for-service tendency to overemphasize institutional treatment, since it is often easier (albeit more costly) to “manage” the care of chronically ill patients in institutional settings.

Conventional reinsurance for HMOs is inappropriate for this purpose. It generally reinsures plans that have either high costs for enrollees in any one year or extremely high lifetime expenditures. Chronically ill enrollees are likely to have moderately large annual expenditures that persist over a number of years. They would therefore commonly fall below annual caps, leaving the plan exposed to persisting high costs. Once the patients passed over the lifetime caps, the plans would no longer have any financial incentives to reallocate services away from institutional care.

To provide more appropriate incentives, we propose a hybrid form of reinsurance. This would be triggered once an enrollee has reached a moderate level of lifetime expenditure. Once the reinsurance was triggered, the plan would still be responsible for enrollees’ annual expenditures up to some predefined limit. (The appropriate level for the reinsurance would need to be determined by experimentation.) This two-stage cap maintains some incentives for the plan. But it also protects against accumulating losses associated with moderately expensive, persisting service needs.

Reinsurance of this sort would protect plans that developed specialized programs for the chronically ill; this was exactly the mechanism used to buffer financial risk for the SHMOs during the initial years of the demonstration project. But we believe that additional steps must be taken to develop capacity in plans that specialize in enrollees with chronic illness. The experience with demonstration projects designed for people with chronic physical and mental impairments suggests that the necessary network of providers is difficult to establish and maintain. Some of these demonstrations required more than a decade to organize. Although we believe that subsequent efforts can learn from this initial experience, we anticipate the need for special developmental grants to group HMOs that specialize in the care of the chronically ill, akin to the initial capital subsidies awarded under the federal HMO Act of 1973.³⁶

Form and role of sponsors: Potential problems. The role of sponsors in managed competition models involves regulating the system to ensure appropriate forms of competition and assuring that individuals have access to the full array of managed care options. Chronic illness introduces two types of complications. The first involves maintaining an appropriate level of competition among managed care plans. To do this, the sponsoring agency must include enough plans with appropriate services, so that participants have options. They must also be able to weed out plans that are of low quality or that try to “game” the system through selective enrollment.

Chronic illness presents several challenges to this role. The typical managed competition proposal invokes as a norm for participating plans that they provide all services that are “medically necessary.” This is a problematic standard for chronic illness, judging treatment in narrow medical terms. It may be too vague as well, since physicians’ norms for chronic conditions tend to be ill defined. But if medical norms are inadequate, it remains unclear what criteria should take their place.

The oversight role for sponsors also runs into conflict with the goal of continuity of care. To weed out inadequate plans, the sponsor must be willing to discontinue their participation, severing relationships between patients and providers. Experience with competitive bidding systems for services to the chronically mentally ill suggests, however, that those managing the system often feel compelled to maintain relations with marginally qualified providers, to avoid disrupting continuity of treatment.³⁷ This reduces the ability of sponsors to eliminate plans that are performing badly.

The second complication involves the choice of sponsor. Most managed competition proposals maintain a role for employers (particularly large ones) as sponsors. Large firms’ employees would continue to be experience rated to provide incentives to contain health care costs. Arrangements of this sort are almost certainly undesirable from the standpoint of potentially employable chronically ill persons. Experience-rated employers have a powerful financial incentive to avoid hiring chronically impaired workers. Antidiscrimination legislation exists but has been difficult to enforce. The Americans with Disabilities Act was designed to further combat this problem, but it continues to allow medical testing of job applicants and has unclear requirements for medically related job costs.³⁸

Form and role of sponsorsPossible solutions. To maximize the potential for people with chronic conditions to fully participate in society, it is essential to eliminate any financial incentives for employers to discriminate. At a minimum, employers who are sponsors should be community rated. Because this may make it difficult to provide employers with the appropriate incentives to contain health care costs, it is probably most appropriate to shift the sponsor role to entirely different auspices.

Proponents of managed competition typically emphasize the importance of enrollees’ ability to switch from one plan to the next, and of sponsors’ ability to eliminate plans that are behaving inappropriately. For the chronically ill, the benefit of choice must be weighed against the benefit of continuity of care. Because chronically ill enrollees will be less able to switch plans, sponsors must adopt a somewhat different role in supervising the managed competition system for the chronically ill.

Measures must be taken to strengthen the ability of individual enrollees to complain about inadequate treatment and for sponsors to act on those

complaints. To achieve this, a readily accessible grievance process should exist within the managed competition system, complemented by an independent ombudsman program.³⁹ Experience suggests that these grievance procedures should remain relatively informal and flexible, to encourage their use by enrollees and their acceptance by plans.⁴⁰ Alternative approaches have relied on effective client-tracking systems, combined with networks of advocates drawn from the communities in which enrollees live. This model was effectively developed in the On Lok program for severely disabled elders.⁴¹ The primary caregivers of most chronically impaired individuals are families or neighbors. To the extent that a plan inappropriately limits access to services, costs are shifted to these informal providers. They can thus provide timely feedback on practices within managed care settings and should be allowed access to grievance procedures.

Conclusion

Managed care has considerable potential for improving the array of services available to people with chronic conditions. The potential benefits of managed competition, however, appear less compelling. The claimed benefits rest primarily on the potential for switching from one plan to another, an alternative that is less available or desirable for many persons with chronic impairments. In much of the country outside of large metropolitan areas, little potential exists for developing competing plans that specialize in the care of chronic illness. To obtain care from plans equipped to meet their special needs, many people with chronic illness may therefore have to effectively forgo choice. Nonetheless, we believe that the managed competition framework, in particular the role of sponsors, could be adapted to encourage favorable changes in the financing and delivery of services for the chronically ill.

Modifying the model. More specifically, we believe that if managed competition is to incorporate enrollees with chronic illness, plans should include the following features: (1) The benefits package in (at least some) participating plans must include an array of services much broader than that in traditional private insurance (to guard against adverse selection, we anticipate that all plans must offer an equally broad array). (2) A special subsidy program must be established to encourage the formation of (group) plans that specialize in the treatment of chronic illness. (3) The development of sophisticated case management models should be encouraged. Where possible, plans that rely on decentralized arrangements and physician capitation should be discouraged from participating in the program. (4) Plans must be reinsured against the costs of moderate but persisting health care costs. Such reinsurance should maintain incentives for prepaid

providers to avoid overuse of institutional care. (5) To reduce discrimination in the hiring of employees with chronic conditions, at a minimum, all experience rating should be eliminated; employers should probably be excluded from roles as sponsors. (6) Because of the reduced opportunities for chronically ill enrollees to transfer among plans and for sponsors to weed out less effective plans, sponsors should develop accessible mechanisms for identifying and responding to enrollees' complaints.

These modifications to the basic managed competition model are intended to address each of the policy paradoxes discussed earlier in this essay. Integrating people with chronic illness into managed competition will not be easy. It will produce a form of managed competition that is more expensive and less competitive than would otherwise be the case. But policymakers have a strong moral, legal, and political obligation to extend this system to be truly universal.

We also believe that the benefits of this inclusive approach extend well beyond the personal well-being of the chronically ill. A health care system that has clear mechanisms for allowing people to voice their dissatisfaction and that encourages specialization in needs that might otherwise be neglected will be a system that is more responsive to all needs. Returning people with chronic illness to the mainstream of the health care system will produce a system that is better and more caring today, as well as more adaptable to the emerging needs of tomorrow.

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NOTES

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