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WHY MANAGED CARE HAS FAILED TO CONTAIN HEALTH COSTS

by Alain C. Enthoven

Prologue: Many legislative proposals to reform the health care system promote expansion of managed care as the best current hope to control health care costs. Private employers have in fact embraced managed care as their preferred approach to moderating the growth of employee health insurance premiums. Given the demonstrated potential of managed care plans to reduce costs, the expansion in their number of enrolled members over the past years seemingly should have resulted in a reduced rate of increase in national health care spending. Clearly there are other forces at work. In this paper Alain Enthoven examines the forces that have affected “elasticity of demand,” or consumer responsiveness to changes in price. He argues that certain factors—including employer coverage practices, the existing tax code, and the number of standardized coverage options per purchasing group—reduce purchasers’ sensitivity to price differences among plans and thereby decrease the plans’ incentives to cut costs. Several of the possible solutions that he advances are tenets of the Jackson Hole Group’s managed competition plan, which he coauthored with Paul Ellwood and Lynn Etheredge. “Some say that competition has failed,” he writes in this paper. “I say that competition has not yet been tried.” Enthoven, a champion of marketplace efficiency in a variety of fields, became interested in health care economics while serving as president of the medical products division of Litton Industries in California. As a consultant to Kaiser Permanente, the country’s largest HMO, he began to develop the ideas that would form the backbone of his own proposal for health care reform. It is generally believed that the Clinton administration’s eventual health care reform bill will rely substantially on Enthoven’s ideas. Enthoven is a professor at Stanford University’s Graduate School of Business; he received his doctorate in economics from the Massachusetts Institute of Technology.
Abstract: Much evidence points to the fact that managed care plans (health maintenance organizations and preferred provider insurance) reduce costs and offer value for money. Yet they apparently have not helped to slow national health expenditures. One explanation is that the practices of purchasers (including government and employers), the tax laws, and other market imperfections have reduced the demand for real cost containment, depriving managed care plans of an adequate incentive to cut cost and price. These market conditions can and should be corrected; the managed competition proposal being discussed at the national level is a comprehensive plan for doing so.

National health expenditures grew from 9.1 percent of gross national product (GNP) in 1980 to 14.1 percent in 1992. These rates of growth and spending are unsustainable and excessive. In the same years we heard a great deal of rhetoric about the superiority of “competition” and free markets over “regulation,” and we saw the proliferation and rapid expansion of health maintenance organizations (HMOs) and preferred provider insurance (PPI). However one wants to characterize the public policies and private employer cost containment strategies of the 1980s they clearly failed to bring health spending down to acceptable levels.

Some say that competition has failed. I say that competition has not yet been tried. This paper attempts to clarify what must be done if our nation is to try to solve the problem of health care spending growth based on incentives and competition in a decentralized private market.

The word competition as used by economists, if not qualified by some phrase indicating the contrary—such as nonprice competition—means price competition. When there is price competition, suppliers compete to serve customers who are using their own money or are otherwise motivated to obtain value for money. One of the striking features of the U.S. health care economy, as we have configured it, is how little price competition there is. Why is this the case?

The Traditional Theory Of Market Failure In Health Care

The traditional (and correct) answer given by economists is the effect of the presence of insurance on incentives.” The incidence of illness and the cost of treatment are uncertain. People are risk averse. So they want insurance. But for insured people, after they have exceeded their annual deductibles, the cost of more care is small, often zero. So insured people choose to buy more care—and their physicians acting as their agents recommend and provide more care—than they would buy if they were paying for it. Moreover, physicians paid fee-for-service have powerful incentives to resolve every doubt in favor of providing more services. Combine cost-unconscious demand with a growing supply of specialists, all searching for new ways to be more useful to patients, and a great deal of new technology development induced by the cost-unconscious demand, and it
is not difficult to explain rising per capita expenditures.

HMOs and PPI were developed to counteract cost-unconscious demand. HMOs integrate the insurance function and the delivery of care into a single organization, so that the premium paid reflects, among other factors, the ability of the HMO’s providers to organize and deliver care efficiently. Thus, the incentive effects of insurance and fee-for-service are attenuated or eliminated. Given this incentive framework, one would expect HMOs to do many things to improve quality and cut cost. And there is good evidence that some HMOs reduce cost substantially. From 1980 to 1992 HMO membership grew from about nine million to forty-four million.

PPI is an intermediate step from traditional coverage to HMOs. PPI as generally defined includes contractual arrangements with selected providers to offer comprehensive services for negotiated fees, formal programs of quality assurance and utilization review, and significant financial incentives for patients to use contracting providers. PPI was virtually nonexistent before 1982, the year in which the California legislature overturned provisions of the insurance code that were based on “guild free choice” principles and replaced them with a specific authorization of selective provider contracting by insurers. In subsequent years most other states followed California’s example. By one estimate more than sixty-six million people were covered by some form of preferred provider coverage by the end of 1992.

If HMOs and PPI do truly reduce cost, why have they not taken over the whole health care financing system? Of course, since legal barriers to their development were removed, their growth has been quite spectacular. Another decade like the last one is likely to see most Americans covered under such arrangements. A more important question is, Why hasn’t competition among HMOs and PPI noticeably attenuated the growth in total national health expenditures? I acknowledge that it has not. And does the answer to this question suggest some things that could be changed so that HMOs and PPI would slow spending growth?

In brief, the answer is that purchaser (that is, employer and government) practices (driven in part by union demands), the tax laws, and other artificial market imperfections have created conditions that reduce the demand for real cost containment and that make the demand curves for HMOs and PPI price-inelastic, thus depriving them of an adequate incentive to cut cost and price. These conditions could be corrected. Managed competition is a comprehensive plan for doing so.

Terms And Concepts

Demand curves and inelastic demand. To address these questions, it is necessary to use some basic concepts of economic analysis. (Readers who
know all about inelastic demand should skip this section.) First, the demand curve is a schedule relating the price a supplier charges and the quantity of goods or services it sells. Demand curves normally slope downward, reflecting the fact that if a supplier cuts price, it will attract more customers. Exhibit 1 shows a hypothetical demand curve for HMO membership in an employment group of 2,500. Assume, for illustration, that employees are offered a choice of a fee-for-service, “free-choice-of-provider” plan with a premium of $150 and an HMO with a variable but lower premium. The coverages are the same. Essentially, this HMO offers cost reduction in exchange for members accepting a limited set of providers and adherence to utilization controls. The curve is drawn to reflect an assumption that for every dollar of premium reduction, fifty additional employees choose the HMO. In deciding where to set its price, the HMO’s management knows that if it reduces price, two things happen: First, it loses revenue on the customers it has, and second, it gains more customers. The sum of these effects is described by the marginal revenue curve, the change in total revenue when quantity is increased by one unit.

Next, assume that this HMO can deliver services for a constant (average and marginal) cost of $100 per member per month. Economic theory tells us that this HMO can maximize its profit by choosing the price and

![Exhibit 1: Original Demand Curve, Marginal Revenue Curve, And Profit-Maximizing Price](on October 23, 2017 by HW Team)
quantity at which marginal revenue equals marginal cost. If marginal revenue exceeds marginal cost, the HMO can increase profits by cutting price and attracting more members. In this case the HMO maximizes profit by setting its premium at $125, in which case 1,250 employees decide to join.

To complete our analytical tool kit, every demand curve at every point has a property called price elasticity of demand: the proportional change in quantity sold (or number of subscribers) divided by the proportional change in price. It is related to but is not exactly the same as the slope of the demand curve.

Demand may be inelastic, meaning that at the point in question, the demand curve is so steep that the supplier can increase revenue by increasing price. That is, if demand is inelastic, the percentage loss in subscribers caused by a price increase is less than the percentage increase in price, so revenue increases. If a seller faces inelastic demand, its incentive is always to raise price because by raising price, it can realize more revenue, and total costs will go down if it sells less.

On the other hand, demand may be elastic, in which case, for example, a 10 percent increase in price would lead to more than a 10 percent loss in subscribers, so that the HMO would lose revenue by raising price. Elastic demand is necessary for there to be an incentive to lower price, but it may not be sufficient. In fact, for there to be an incentive to reduce price, marginal revenue must exceed marginal cost. The more elastic the demand curve, the greater the reward in increased revenue for reducing price, and the lower the price (relative to marginal cost) the supplier finds it in its best interest to charge.

Exhibit 2 illustrates inelastic and elastic demand. Total revenue-price times quantity—is measured by the area of the rectangle under the demand curve. In the case of inelastic demand, total revenue is greater when price is higher. For elastic demand, total revenue is greater when price is lower.

Readers of economics texts are likely to get the impression that the elasticity of demand is like a natural law, given by technology and consumer tastes. But, in fact, the elasticity of demand is something that suppliers, purchasers, and public policy can and do influence a great deal. If health care costs are a concern, it is in the interest of purchasers and the general public to take action to make the demand curve for health care more elastic, to increase the incentives of providers to reduce price and cost.

My basic contention is that various actions by suppliers, purchasers, and government and other characteristics of the markets in which HMOs and PPI compete have combined to produce inelastic demand. Many HMOs can raise price with little or no loss in revenue. However, there are policies that can be pursued by government and by purchasers that would make the demand curves faced by HMOs and PPI much more elastic and that would
Sponsors and managed competition. Markets for most goods and services are normally made up of suppliers on one side and individual purchasers on the other. That is the case in automobile or homeowner insurance and to a limited extent in health insurance. Some national health care financing reform proposals are based on that models. In my view, that model is unworkable in health insurance for a number of reasons, and it is not the model that actually works in most of the private health insurance market in the United States. The reasons for this were explained in a recent paper in Health Affairs.

The model of private health insurance that works—the one that covers most employed people—is group insurance. The best version of this model includes a sponsor: a collective purchasing agent that is large, active, and informed, which contracts on behalf of a group of insured people and which either buys one coverage for all or offers a selected menu of different health plans to individuals for their choice. Thus, my diagnosis of inelastic demand and my prescription for how to ameliorate it refer to sponsor behavior.

Factors That Artificially Reduce Demand For HMOs

If HMOs reduce cost and offer more value for money, why are not more people enrolled in them? The reasons are many and complex. Here I focus on reasons that are important today, that can be illuminated by economic analysis, and that can be changed.
Employers that do not offer HMOs. First, as noted above, the great majority of the private market for coverage is through sponsored groups, mainly employers. The HMO Act of 1973 required employers of twenty-five or more workers to offer their workers one group-practice HMO and one individual-practice HMO, if such organizations served their areas and asked to be offered. Still, many employers do not offer HMOs, while others offer only the required minimum.

Large employers. Large employers may choose not to offer their workers the opportunity to enroll in HMOs for the following reasons. First, some employers are concerned about administrative cost and complexity. Second, some find that HMO facilities are not convenient to where their employees live. Or, some believe that HMOs give lower-quality care, although they almost invariably lack the information needed to support that conclusion. Third, they do not know how to manage biased risk selection. Fourth, HMO benefits are tightly regulated by the federal and state governments, and some of the services they are required to cover are costly.

The fact that many large employers do offer HMOs suggests that there are workable solutions to these problems. For example, HMO facilities would be more convenient if more of them existed. Concerns over quality might be alleviated by better, publicly available, standardized information on health outcomes. Competition would work better if all competitors had to play by the same rules (that is, had similar benefit requirements).

Small employment groups. Nearly half of the U.S. work force is self-employed or employed in groups of 100 or fewer. Such groups—and even larger ones—are too small to spread risk, to achieve economies of scale in administration, to manage competition effectively, or to offer a choice of health plans at the individual employee level. For this discussion, the last is the key problem.

Consider a firm of fifty employees now covered by a traditional free-choice-of-provider insurance plan. The representative of an efficient group-practice HMO proposes that the HMO be offered as a choice for each current employee for a premium 25 percent below that of the traditional plan. The company’s chief executive asks its current insurance company for its reaction. Following the typical pattern in this situation, the insurance company refuses to participate in an individual-choice-of-plan arrangement for this employer. It argues that this would split the group, raising administrative costs to unacceptable levels, and that this would lead to poorly managed competition in which the healthy young people with no doctor/patient ties would choose the HMO and the insurance company would get the bad risks. So the executive finds that this is an all-or-none choice. Upon consulting with colleagues, the executive encounters strong resistance on the part of a few to the idea of switching to the HMO—and
so declines the HMO’s offer. A 25 percent price advantage cannot move this business!

One effective way to correct this problem would be to pool all small employment groups in an area into one large purchasing cooperative that would function like a very large employment group, offering a multiple choice of plans at the individual level to each employee. A working example of this is the California Public Employees Retirement System (CalPERS), which offers a multiple choice of plans to state employees and also to the employees of over 800 participating local government agencies, some of which have as few as two employees. The Jackson Hole Group initiative proposes covering all Americans with health insurance purchasing cooperatives (HIPCs) that would perform this function."

Executives of some insurance companies argue for choice of plan at the employment group level rather than at the individual level, on the grounds that individual choice makes the market more susceptible to the problems of biased risk selection. I see this as an effort on their part to block an important step toward opening this large market to HMOs and to creating price-elastic demand.

**Employer contribution policies.** Every employment group has its own story. Most employers’ policies are variations on what I call the “typical case.” Originally, employers offered employees a single traditional fee-for-service, free-choice-of-provider plan. Health insurance was cheap, tax-deductible to the employer, and tax-free without limit to the employee. Covered health benefits were a great source of bargaining prizes for unions. Health insurance fully paid by the employer became an entitlement in the minds of many workers. Unfortunately, traditional fee-for-service coverage and third-party payment create no accountability for cost in the health care system. The incentives for providers are cost-increasing.

HMOs began to proliferate in the 1970s and 1980s. The typical large-employer reaction was to offer HMOs and to pay their premiums in full as long as the premiums did not exceed those of traditional coverage. Thus, either way, coverage was free to the employee. The consequence of this was to put HMOs into the same state of cost-unconscious demand as fee-for-service providers were in. This employer policy made the demand curve faced by the HMO vertical, perfectly inelastic, up to the price of the traditional coverage. The HMO could not attract additional subscribers by cutting price; it would not lose subscribers by raising price, up to the price of the traditional coverage. The incentive in this situation is to “shadow price,” that is, to set price just under the price of the fee-for-service coverage and to spend much of the money on expanded coverage or improved service to attract customers.

In the 1980s some employers modified their policies in various ways,
usually without changing the essentials. Many adopted some form of PPI to replace the traditional free-choice coverage. But few made the different health plans compete on price. There are no good surveys that report this aspect of employer contribution policies. But my students and I have interviewed dozens of employers and HMO marketing managers. It is clear to me that as of 1993, although there are signs of change, the great majority of employers structure their health benefit offerings in such a way as to deprive the HMOs that serve their employees of the normal marketplace reward for cutting or restraining price (that is, more customers). There are some weak incentives to restrain cost and price. The employer might choose not to offer the HMO if it is not priced appreciably below the fee-for-service plan. Still, once offered, the HMO has only to keep its price a safe distance below the premium of the fee-for-service plan to avoid having its contract terminated.

The logical alternative to this policy would be for the employer to offer choices of plan, including the most efficient HMOs, and to make a fixed-dollar defined contribution toward the premium of the plan of the employee’s choice—a contribution that does not vary with choice of plan and that does not exceed the price of the low-priced plan. The employee pays the difference between that contribution and the premium of the plan of his or her choice. Then, if the employee chooses a less costly plan, he or she saves the difference in premium. More important, if the HMO cuts or restrains premiums, it can attract more customers. This policy has been adopted, for example, by the state of Minnesota and its employees and by Stanford University. By itself, this policy might or might not be enough to make demand elastic enough to motivate price reduction, but it would obviously be a large step in that direction.

Why do employers persist in an apparently irrational policy when an apparently rational alternative is available? Several factors enter in. For one, unions have won employer-paid traditional coverage as a bargaining prize, and union leaders who want to keep their jobs are understandably reluctant to suggest willingness to give it up. Many executives want the traditional free-choice coverage for themselves and fear that it would not survive in a competitive market, or they want to make their employer subsidize the extra cost of their chosen coverage. Employers look at health care financing as an insurance problem, not a problem in organization of medical care. Employees look at this as a labor/management compensation issue, not a health care purchasing issue. Employers considering the change in policy see a certain short-term cost in bad employee relations followed by an uncertain possible long-term gain in health care cost savings. But the most important factor is that this is a collective action problem. One employer acting alone cannot change the whole health care system. If one
employer in a market area converts to defined contributions while the rest stay on the “cost-unconscious system,” it will find that its health care costs will continue to rise with those of the inflationary system in general. For the policy of defined contributions to be effective in controlling cost, it is necessary that most—or at least a critical mass of—employers in a market area adopt the policy. Thus, collective action is needed.

There are many variations on inappropriate employer contribution policies. For example, one apparently equitable policy is for the employer to offer a choice of plans and to pay 80 percent of the premium for whichever plan the employee chooses. The trouble with this is that the employee acts on the premium differences he or she experiences and, in the case of this policy, pays only 20 percent of the true premium difference. Worse yet, the HMO considering cutting price by a dollar gets only 20 percent of the increased subscribers it would get if the employer had a defined contribution policy.

Suppose the HMO charged a premium of $125, while the fee-for-service coverage cost $150. Under this 80 percent policy, the employer would be paying $120 toward the fee-for-service coverage and $100 toward the HMO. The employee considering the choice would save only $5 per month by joining the HMO, even though the HMO was doing the job for $25 less. Compared to the original situation that would have occurred when employees were using their own money, HMO membership would now be only 250, one-fifth as great. The effect of this policy is shown in Exhibit 3. Demand Curve I represents the situation in which people are paying the premium difference with their own money. Demand Curve III reflects the employer’s policy of paying 80 percent of either premium.

**The Internal Revenue Code.** Because employer contributions to employee health care coverage are free of federal and state income and payroll taxes without limit, the Internal Revenue Code and its state counterparts distort employee incentives. Combining federal and state income and payroll taxes, many people are in the 35-40 percent marginal tax bracket, or even higher. I use 40 percent here for illustration. This means that when employers and employees are considering how to divide up an additional $100 of total compensation, they know that if they take it in taxable wages or salary, they will only receive $60 net after taxes. If they take it in additional health benefits, they will get whatever benefit the full $100 buys them. Section 125 of the Internal Revenue Code provides that employees can characterize their own premium contributions as “employer-paid,” for tax purposes (through the vehicle of “salary reduction”) and thus make premium contributions in pretax dollars.

For example, suppose the employer in Exhibit 1 makes defined contributions of $100 toward either the fee-for-service plan or the HMO. In pretax
dollars, the employee faces a price difference of $25. But in after-tax dollars, the difference is reduced to 60 percent of that, or $15. The tax code is, in effect, a heavy tax on cost containment, and its effect is to reduce significantly the demand for HMO membership. It means that the HMO that cuts its price by a dollar gets the increased membership that goes with a sixty-cent price cut, not the increase that would go with a one-dollar price cut. The effect of the tax code here is to reduce HMO membership by 40 percent, from 1,250 to 750. The effect is also illustrated in Exhibit 3 by Demand Curve II. In a nation with a health care cost crisis, it makes no sense to tax cost containment!

Demand Curve IV combines the demand-reducing effects of the tax code and the employer’s policy of paying 80 percent of the premium. In this case, if the HMO charges its profit-maximizing price, HMO membership becomes 150, 12 percent of what it would have been if undistorted consumer preferences ruled. Finally, Demand Curve V depicts the “employer-pay-all” case. Demand for this HMO’s product of cost reduction is reduced to zero!

Factors That Make Demand Curves For HMOs Inelastic

This brings us to the second major question: Why hasn’t competition among HMOs attenuated the growth in health expenditures? Why hasn’t
price competition forced HMOs to manage more effectively to innovate, to cut cost, and to restrain price? The answer is that many factors have worked to create price-inelastic demand for individual HMOs. These factors could be corrected. The aggregate demand for a good or service such as wheat, gasoline, or health care may be very inelastic, while the demand curve faced by an individual producer—a farmer, a gas station, or an HMO—can be very elastic because the products of other suppliers are on offer and are good substitutes. The elasticity of its own demand curve determines the incentive an HMO has to cut price. Why are HMO demand curves of low elasticity? Some of the factors already mentioned can reduce elasticity of demand.

Employers that restrict the number of HMOs offered. If a large employer offers two HMOs when it could offer four or six, it may be reducing the price elasticity of demand of the HMOs it offers. If the additional HMOs are perceived by employees to be good substitutes for the HMOs already offered, the elasticity of demand faced by the two HMOs on offer will be increased by offering the competitors.

In terms of the example, suppose the employer now identifies a second HMO that contracts with the same doctors, uses similar utilization controls, and is seen by employees as a perfect substitute for the first HMO. Neither HMO could charge a penny more than the other because if it did, all of its members would switch to the other HMO. While the demand curve for HMOs in general would slope downward, as in Exhibit 1, the demand curve for each HMO would become flat, and competition would drive each to offer a price of $100, equal to its marginal cost. In that case, with free consumer choice not biased by the employer’s contribution policy or the tax code, all 2,500 employees would join an HMO.

The present structure of the market for health insurance in small employment groups reduces the elasticity of demand for all carriers. Similarly, employer contribution policies and the provisions of the Internal Revenue Code can reduce the price elasticity of demand (although they do not necessarily do so). Other factors also work against elastic demand.

Product differentiation and market segmentation. Health insurance contracts cover a myriad of different goods and services, with various schedules and formulas as to what will be paid by the consumer and what by the insurer: deductibles, out-of-pocket spending limits, and limits on covered services measured in physical amounts or dollars. Some contracts cover, while others do not cover, for example, well-baby care; screening tests; allergy tests; vision exams and eye glasses; immunizations; prescription drugs; durable medical equipment; family planning and various infertility treatments; mental health services; speech, physical, or occupational therapy; acupuncture; dental care; and on and on. Contracts cover each of
these with varying copayments, coinsurance rates, or limitations.

A popular strategy among health insurers of all types is “product differentiation,” that is, offering a complex package that differs from that of any other carrier to make it difficult, even for an expert, to make side-by-side value-for-money comparisons, to get the consumer’s attention off the price and onto features that can be sold. The goal is to reduce the sensitivity of consumer choices to price. The Federal Employees Health Benefits Program (FEHBP) is famous (or infamous) for this. Segmentation refers to a similar strategy exercised when consumers’ tastes, needs, or wants are not all the same. The idea is for suppliers to divide up the total market into subgroups, each with different bundles of preferences, and to tailor different packages that appeal to different subgroups. The goal is to reduce to a minimum the number of people, as it were, standing in the middle, ready to change from one plan to another because of a change in price. The market for health insurance is easy to segment because there is great variability with respect to expected medical needs, and because in each market area there is likely to be room for only several HMOs and preferred provider plans.

A sponsor who wants to counteract product differentiation and market segmentation should do the following. First, the sponsor should standardize coverage contracts. In 1992 the board of CalPERS voted to standardize all HMO contracts for active employees and their dependents for the twenty-three HMOs serving its beneficiaries. This change so intensified price competition among HMOs that the average HMO premium for 1993-1994 is actually below the 1992-1993 level. Second, the sponsor should monitor each HMO’s capabilities in each medical specialty and require an adequate level of competence and access to specialty care. Finally, the sponsor should monitor geographic locations and require broad geographic coverage in a given service area.

The need for standardization for the purpose of combating market segmentation and making demand more price-elastic is at the level of each sponsored group. At least these reasons do not argue that every sponsored group must have the same package. Stanford employees could have their standard coverage, while California state employees have a different one.

Yet another reason why people may be reluctant to change from one health plan to another to save premium dollars, when coverage is not standardized, is fear of hidden “air pockets” in the new coverage. People understandably suspect that the lower-priced plan might have achieved its lower costs by excluding coverage for some costly services they might need one day. A standardized coverage contract can remove this uncertainty and increase consumers’ willingness to respond to price changes.

Biased risk selection. Health risks can fall unevenly when people are given a choice of health plan; this is known as biased risk selection. Some
HMOs might enroll a disproportionately high number of patients with medical conditions that are costly to treat. Selecting favorable risks, and especially avoiding bad ones, can be an important source of profit for a health plan. This possibility raises important issues of equity and incentives. From the present point of view, if Plan A gets the bad risks and Plan B gets the good ones, Plan A’s costs will be higher, and its price will have to be higher than Plan B’s because of adverse selection. That fact makes it easier for Plan B to raise its price. In effect, its demand curve is likely to be less elastic because of Plan A’s higher price.

The sponsor can correct for this by risk-adjusting the premiums. The essence of the idea is to measure the relative expected medical costs in each group, based on variables such as age, sex, retiree status, and diagnostic information, and to make compensatory payments in the form of surcharges on the premiums of those plans getting favorable selection and subsidies to those getting unfavorable selection. If the premiums are risk-adjusted, Plan B will find itself in much sharper price competition with Plan A.

Lack of comparative information on quality. Many people will be unwilling to switch from familiar and satisfactory HMO A to unfamiliar HMO B to save, say, $25 per month in premium costs if they lack information that assures them that the quality of care in HMO B is good. Thus, the availability of information can have a powerful effect on price elasticity of demand. This is especially true in medical care, where the stakes can be very high. Many people equate high price with high quality, and they are suspicious that reduced cost may be achieved by reductions in quality.

There is very little reliable information on the comparative quality of care in different hospitals and HMOs. In principle, one would like to have risk-adjusted measures of outcomes, that is, comparative data on such outcomes as mortality, restoration of function, and control of chronic conditions, adjusted to take account of the characteristics of the patients treated.” And such data should be collected for all providers and all health plans according to uniform definitions and standards.

Today, very little of such data is available. One example is an excellent ongoing study of perinatal mortality in California. The Pennsylvania Health Care Cost Containment Council recently published A Consumer Guide to Coronary Artery Bypass Graft Surgery with case-mix risk-adjusted mortality rates and charges. There are a few limited attempts to gather and report such data in other states. The problem is that providers-hospitals and doctors-fear the publication of such information, and they use their considerable political power to block it. Government action is needed to compel production of such data according to uniform standards.

Doctor/patient ties. Many people have established relationships with primary care physicians and specialists that they find satisfactory. Beyond
the bonds of personal trust, there is an economic dimension. A doctor/patient relationship can represent a substantial investment in searching, trial and error, and time for the doctor to acquire insight and understanding about the patient’s body, preferences, and values. People with strong ties to physicians in HMO A will be reluctant to switch to HMO B to save $25 per month, even in net after-tax dollars, even if they have good data that show that HMO B delivers high-quality care. However, not everyone, nor even a majority of consumers, needs to be willing to switch to police a market. Each year roughly 25 percent of Americans change residences; many of them have to change primary care physicians anyway. Many more have little or no investment in their doctors and are not deterred from switching. Moreover, in many areas HMOs and PPI plans have overlapping provider networks, so that people find that their preferred primary care doctor is in several networks. In that case they can comfortably switch to the lowest-priced network offering their doctor. If even 5 or 10 percent of consumers are willing to switch plans because of price, the market could be very competitive.

The Long-Run Effect Of Competition

So far, this discussion has used static concepts of economic analysis. How would a strategy of price competition with price-elastic demand affect rates of growth in per capita health spending over the long run?

First, HMOs would match the numbers and types of doctors they retain to the needs of the population served, so that all of their doctors would be busy and proficient. They would pay no more than necessary to retain these services. Market prices for services of specialists in excess supply would drop, discouraging young doctors from choosing those specialties. In the long run, market prices would reflect the costs of training and the alternative opportunities available to young people considering medical school. Incomes of highly paid specialists would fall. Much more care would be delivered by primary care physicians and their paramedical assistants who can provide good care for less money. There would be no excess of specialists looking for new ways to make themselves useful.

Second, doctors would examine practice patterns critically, gathering outcomes data systematically, to evaluate the effectiveness of alternative therapies. Today wide variations in practice patterns exist, with some therapies costing many times others to produce equivalent results. Gradually these variations would be reduced, and physicians would use the treatments that produce satisfactory outcomes at the least cost. This would be a continuing process.

Third, successful HMOs would adopt and practice continuous quality
improvement, the powerful management philosophy pioneered by W. E. Deming and J. Juran that enabled Japanese manufacturing companies to defeat their American and European competitors in world markets and that has been adopted by leading American companies. Continuous quality improvement would lead to continuing annual productivity gains that would help to offset such expenditure-increasing factors as expanding technology and an aging population.

Fourth, the customers for medical technology (that is, the HMOs) would become cost-conscious, informed purchasers who would make careful evaluations to determine when and how new technologies would be used. New technologies that reduce the total cost of care would be rapidly adopted. New technologies that increase total spending but produce significantly better outcomes would be adopted, but only after more careful scrutiny and for clearer indications than today (that is, more restrictive criteria of who can benefit enough to justify the cost). New technologies whose adoption would increase total spending without significantly improving outcomes would not be adopted. This new demand side would change the prospective profitability of investments in research and development of new technologies, making investment in expenditure-reducing technologies relatively much more attractive, whereas in the recent past their ability to reduce health spending has been considered irrelevant to purchasers.

Conclusion

Competition will not work to provide HMOs with effective incentives to cut cost and price unless demand is quite price elastic. Price-inelastic demand is not an unchangeable law of nature. It is an artifact of policies pursued by health care financing and delivery plans, providers, purchasers, and government. Most of the causes of price-inelastic demand can be addressed by purchasers and government. Employer and government sponsors need to convert to defined-contribution health benefit programs, limit tax-free employer contributions, standardize benefit coverages within sponsored groups, risk-adjust premiums, group small employers into large health insurance purchasing cooperatives, and require production of reliable data on quality, especially as measured by outcomes. A comprehensive strategy is needed, not merely one or two interventions. Competition needs to be tried in earnest before it is dismissed as a failure.

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