To Subscribe:  https://fulfillment.healthaffairs.org
One of Alain Enthoven’s many contributions to our understanding of health care economics is the insight that a perfectly “free” market in health care will not produce desirable results. As developed by Enthoven and others, the theory of managed competition posits that an “unmanaged” market for health plans, in which individual consumers make choices among health plans without having the benefit of a sponsor, will not reward physicians, hospitals, and health plans for high-quality, economical care. In an unmanaged market health plans can prosper more easily through risk selection, market segmentation, and the provision of biased information than they can by doing the hard work of organizing the delivery system for quality and economy.

The invisible hand proving inadequate, the theory of managed competition posits that a third party is required to manage competition among plans. The third party can overcome the tendencies toward market failure by following a variety of strategies, such as assuring that each health plan (1) charges community-rated premiums and accepts all applicants, without waiting periods or preexisting condition exclusions; (2) offers the same package of benefits (to prevent risk selection and market segmentation and to increase price-sensitivity by removing fears about hidden “air pockets”); and (3) provides comparative information on satisfaction and quality.

In addition, the third party should administer a system of risk-adjusted payments to plans, to ensure that plans that do a particularly good job of taking care of people with cancer or heart disease, for example, do not put themselves out of business by doing so.

This third party has been given many names; President Bill Clinton’s Health Security Act calls it a health alliance. Regardless of the name, the concept has remained the same: to create an organization that can overcome tendencies toward failure in the market for health plans.

There is, however, an inherent tension in the theory of managed competition. On the one hand, managed competition is meant to save markets in health care from failing, without substituting government allocation and political control for market-based allocation mechanisms. On the other hand, the third party—whether the health plan purchasing cooperatives of the Jackson Hole Group proposal or the health alliances of the president’s proposal—performs a variety of public functions and so must be organizations that can be held publicly accountable. To make a market for health plans work, we need a public sponsor with a substantial presence, even under the Jackson Hole proposal.

The existence of a public sponsor raises concerns that the actions of the sponsor will be influenced by political pressure from providers and health plans. The Health Security Act proposes a variety of protections to insulate alliances from such pressures; for instance, alliance boards must be composed of employers and consumers, and the power of alliances is circumscribed. Although

Richard Kronick is a senior health policy adviser for the Clinton administration. He is on leave from the Department of Family and Preventive Medicine at the University of California, San Diego.
some are not convinced that these protections will be sufficient to allow alliances to be “market makers” rather than “regulatory” agencies, there is little reason to expect that proposed alternative formulations of alliances would be more successful.4

Alain Enthoven and Sara Singer assert that the Health Security Act creates “weak market incentives and no real opportunity for market forces to work.” I strongly disagree. The provisions of the act create extremely strong market incentives and provide ample opportunity for market forces to work. There is every reason to expect that the president’s plan will lead to the creation of an environment in which providers are rewarded for adopting practices that improve quality and enhance efficiency.

Enthoven and Singer suggest that the act could be fixed if four primary changes were made: (1) limit mandatory participation in health alliances to individuals and employer groups up to 100; (2) limit tax-free employer contributions to the level of the lowest-price qualified plan in the region; (3) do not guarantee a limit on employer or individual premium contributions; and (4) eliminate the proposal for premium caps.

While some of these proposed changes might slightly increase the strength of the market incentives created by the president’s plan, they would create other large problems and would not greatly affect whether providers are rewarded for quality and economy. If providers can produce the kind of care that consumers want in the world proposed by the authors, they can also do so in the world proposed by the Health Security Act.

**Limiting Health Alliances To Small Employer Groups**

To remedy the alleged ills of larger alliances, Enthoven and Singer propose limiting alliances to individuals and employees in firms with 100 or fewer workers. Such an alliance would act as a sponsor for approximately half of the non-Medicare market and would do little to respond to the concerns that Enthoven and Singer raise: The alliance would represent a significant concentration of power on the demand side and would need to be held publicly accountable. Further, it is only the largest employers (at a minimum, those with more than 5,000 employees) that have shown any ability to be innovative as purchasers. Thus, smaller rather than larger alliances create little added opportunity for innovative purchasing among employers.

Further, smaller alliances would suffer from a number of disabilities. First, smaller alliances (limited to individuals and firms with 100 or fewer workers) will be disproportionately composed of poor people: approximately half of the members of Jackson Hole-style alliances will be in families with incomes below 200 percent of poverty, compared with approximately one-third of those in the alliances proposed in the Health Security Act. Programs for poor people are generally treated poorly, and it is not good policy to create an institution that perfects the market primarily for the poor. Second, since low-income persons generally have greater health care needs than do upper-income persons, requiring only small businesses to be in a community-rated group with unemployed individuals would put an unfair financial burden on these businesses and their employees. Third, smaller alliances will require more frequent changes of coverage as people move into and out of employment or change jobs. Fourth, in firms outside the alliance, the employer, not the consumer, chooses the menu of plans. Smaller alliances will result in fewer choices for many consumers. Fifth, many firms that are not required to be in the alliance will want the option of joining (as proposed in the Clinton plan). However, with a smaller mandatory alliance the adverse selection problems are extremely serious. The only feasible options are either prohibiting firms with more than 100 employees from joining, or burdening the firms and individuals that are required to be in the alliance with a significant additional liability as firms with 101 employees and high risks select into the alliance while firms with 101 employees and low risks stay out. Finally, alliances without public employees will be vulnerable to the charge that “if it is good enough for us, why...
isn’t it good enough for you?”

As discussed by Walter Zelman in this volume of Health Affairs, smaller alliances will require, in many ways, greater amounts of government intervention, bureaucracy, and regulation in other parts of the health care system, for the following reasons. (1) Any method for sharing financial responsibility among employers of workers in dual-earner families will be more complicated to administer when large numbers of employers are outside alliances. (2) Smaller alliances will require an alternative form of oversight to assure that firms outside the alliance are providing the minimum benefit package to their employees and complying with universal coverage requirements. This oversight is feasible for the relatively small number of firms with more than 5,000 employees but is not practical for the large number of firms with 100 or more employees. (3) Smaller alliances will require an additional form of regulation of the insurance market for firms of 100 or more. A department of insurance (or some other agency) will be required to enforce rules regarding guaranteed issue and renewability, permissible deviations from community rating, and so forth for medium-size firms that need such protection. It is unlikely that most insurance commissioners will have the resources or the ability to effectively enforce such rules. Far from translating into less government involvement in the insurance market, smaller alliances require multiple forms of government intervention. (4) Although it would be in the collective interest of employers outside alliances to successfully manage competition among plans, it will not be in the interest of any one employer to do so. The costs of overcoming this collective action problem will be substantial; unless these problems can be overcome, many mid-size employers will not contribute to the creation of a market that rewards quality and economy.5

### Limiting Tax-Free Employer Contributions

The Health Security Act proposes a variety of changes in the demand side of the market that will create powerful incentives for providers to search for quality and economy. In the current market 40 percent of employees with employer-sponsored insurance have only one type of plan available to them: typically, a fee-for-service plan. More importantly, among those employees with a choice, fewer than 20 percent have a fully cost-conscious choice; that is, fewer than 20 percent are required to pay the full difference in price between the least expensive plan available and the price of the plan they choose. The other 80 percent work for an employer that partially or fully subsidizes the premium difference between the more expensive and less expensive plans. In the current market many employees have no opportunity or weak financial incentives to choose a less expensive plan; hence, providers and health plans have weak incentives to lower prices. The Health Security Act proposes that all persons (except those living in a state that might choose a single-payer system) would have a choice of plans and that all persons would be required to pay the full difference between the price of the plan they choose and 80 percent of the average-price plan (which in most markets would be at or below the low-price plan). If an employer chooses to pay more than the 80 percent required contribution, and if the employee chooses a plan that is less expensive than the amount the employer is willing to contribute, then the employer must provide a rebate to the employee. These reforms will create extremely strong incentives for consumers to choose less-expensive plans and extremely strong incentives for plans and providers to lower their prices. Combined with other reforms-standardized benefits, provision of information on satisfaction and quality, risk-adjusted payments to plans-concerted efforts by providers and health plans to search for methods to deliver high-quality care economically are expected.

Enthoven and Singer argue, correctly, that the incentives would be even stronger if the voluntary employer contributions were treated as taxable income to employees. Under the Health Security Act, if an employer is willing to contribute more than
the required 80 percent of the average premium, this employer contribution is tax-free if used to pay for a health plan premium but is taxable if a lower-price plan is chosen and the voluntary contribution is received as income. This provides somewhat weaker incentives to choose a lower-price plan than under alternative tax treatments.

However, two factors attenuate the strength of this concern. First, many people will work for an employer that does not make a voluntary contribution above the 80 percent requirement. These people will be fully cost-conscious, making choices between health insurance and income with posttax dollars.

Second, the median marginal tax rate for federal income tax and the employee share of Social Security tax is 22 percent. If the median marginal state income tax rate is approximately 5 percent, then the median marginal rate for state and federal income taxes combined is approximately 28 percent. Thus, even among people whose employer is willing to contribute more than the required 80 percent of the weighted average premium, the median person will be choosing whether to trade seventy-two cents of after-tax income for a plan that charges an additional dollar premium. While some may make different decisions than they would if tax treatment were equalized, many will not. Seventy-two-cent dollars are not as valuable as one-hundred-cent dollars but are still attractive to many.

Enthoven and Singer assert that the “tax cap could make a difference between a market system that works and one that does not.” Although it is theoretically possible that the tax cap could make a difference, it is unlikely that it would work in practice. Most people will not have voluntary employer contributions and will be fully cost-conscious; even those with a voluntary contribution will still have strong incentives to choose lower-price plans.

If it were possible to implement a tax cap set at the level of the lowest-price plan available to each person, then one could at least argue that only those persons who voluntarily choose more-expensive plans would face additional tax liability. However, even with large alliances it is not possible to implement such a proposal, and with smaller alliances, as under the Jackson Hole proposal, the problems would only increase. For members of the alliance, a tax cap that varied with the price of the low-price plan in an alliance region would greatly increase the administrative burden on the Internal Revenue Service and on employers in determining taxable income. More importantly, for employers outside the alliance purchasing experience-rated (or self-insured) policies, the price of the low-price plan in the alliance might have little relationship to the price they must pay for insurance. This is a more acute problem with small than with large alliances. Further, if any deviation from community rating within the alliance is allowed (as it is in some legislative proposals), the difficulties of establishing an equitable tax cap are compounded.

The only practical option for a tax cap would be a flat amount for the whole country, or perhaps a tax cap that varied by state. If the tax cap were set low enough to create real cost-consciousness, it also would be low enough that many persons would face a tax increase even if they chose the least expensive plan available to them. This is likely to be perceived by many as unfair and may well mean the difference between a proposal that can be enacted and one that cannot.

**Discounts**

Enthoven and Singer argue that the discounts available to employers will reduce the pressure that employers otherwise would exert to keep costs down. But as they admit, most employers have not adopted effective cost containment policies. Further, it is not clear that any but the very largest employers (and perhaps not even they) can really do anything by themselves to change the incentives that providers face.

While the limitation on employer liability to 7.9 percent of payroll may slightly reduce political pressure from the employer community for effective cost containment, it is unlikely to materially affect the success of cost containment efforts. One of
Enthoven and Singer’s main points is that the government cannot restrain cost growth by fiat, but only by creating an environment in which individual choices lead to incentives for providers to be economical. Given this observation, even concerted political pressure from employers will have limited effects. Second, employers face today, as they will under reform, a substantial collective action problem in organizing for their interests on health care issues. The 7.9 percent payroll cap might slightly increase the difficulty of solving the collective action problem but will not fundamentally change its character. Further, the requirement in the Health Security Act that alliance boards be composed of employers and employees will help solve the collective action problem.

Even with the proposed discounts, most employees will be cost-conscious; approximately one-quarter of the population will receive a discount on the employee share. Many of these people will receive only a partial discount and will, at the margin, be required to pay more for a more expensive plan.

As the authors clearly realize, an employer mandate requirement (which they support) will have potentially large negative effects on the employment prospects and income of low-wage workers if not accompanied with some schedule of discounts. The most desirable schedule of discounts can be debated (and other entries in this volume of Health Affairs provide a variety of suggestions worthy of consideration), but a blanket suggestion to eliminate discounts entirely is surely not feasible or desirable.

### Premium Caps

Enthoven and Singer devote about a third of their paper to discussion of the premium caps that are proposed in the Health Security Act. They argue that premium caps will undermine competition, create the wrong incentives, and put quality at risk.

None of these dire consequences is likely. First, the premium caps are conceived as a “backstop” or “emergency brake.” The president’s plan proposes slowing the rate of growth in per capita expenditure increases for insured persons by approximately three percentage points per year. However, simultaneous with this slowdown, the act proposes a major increase in spending (approximately $80 billion per year) on behalf of currently uninsured and underinsured persons. National health expenditures are expected to increase slightly above the baseline projections through 1998 as universal coverage is phased in; a decrease in the rate of growth of revenues for services delivered to the currently insured will be balanced by increased revenues for services delivered to the currently uninsured.

In the reformed market created by the Health Security Act, this scenario is feasible even without premium caps. The elimination of the small-group and nongroup markets for health insurance will lead to lower insurance administrative costs; universal coverage, a standard benefit package, a single claim form, and common electronic data protocols will lead to lower physician and hospital administrative costs. Many newly cost-conscious consumers will have the option of moving to lower-cost plans, which will lower expenditures further. If, in addition, providers and health plans increase their productivity by 1.5 percent per year during 1996-2000, expenditures will be reduced by more than enough to meet the targets in the proposed premium caps.15

We can, however, consider the consequences if the anticipated savings do not occur and the premium caps become binding. In this situation, health plans and the providers in them still will be rewarded for using available resources efficiently. The plan that puts too many resources into high-technology tertiary care that produces little value and not enough into primary and preventive care will lose enrollees to its competitors. Enthoven and Singer suggest that providers will be rewarded for “shroud waving,” but the health plans that do so are likely to lose subscribers and revenue.

There are strong arguments in favor of the proposed premium caps. The Congressional Budget Office (CBO) and many others both inside and outside of Washington,
D.C., are skeptical of the ability of a reformed market to reduce health care expenditure growth. To persuade some employers to support an employer mandate, it is important to provide guarantees about the rate of expenditure increase.

To convince legislators to support a program of providing discounts to low-income persons and their employers, it is vital to provide guarantees about the rate of growth of these expenditures. Finally, in the absence of a guarantee on private-sector rate of growth, proposals to reduce the rate of growth of Medicare and Medicaid spending create serious concerns about cost shifting to the private sector and about access to care for Medicare and Medicaid beneficiaries.

Conclusion

The Health Security Act creates strong market incentives for quality and economy and gives them ample opportunity to work. The president’s plan proposes the minimal amount of government involvement that is likely to be sufficient to make a market work. President Clinton recently asked that the perfect not be made the enemy of the good. In health care we cannot allow the theoretically perfect to be the enemy of the practical good. That is why we have created a proposal that will work and one that can build the public consensus required for support.

NOTES


2. If some parts of the population are required to purchase through the alliances, then the alliances must be held publicly accountable. Further accountability is required if public funds are used to subsidize health insurance for some low-income persons purchasing through alliances.

3. For example, alliances are required to contract with all plans that are certified by the state (with the exception of those that are more than 20 percent above the weighted average premium with which alliances are allowed but are not required to contract). For further discussion of the narrow scope of alliance discretion, see W.A. Zelman, “The Rationale behind the Clinton Health Care Reform Plan,” Health Affairs (Spring I 1994): 9-29.

4. Some have suggested, for example, requiring alliance boards to be elected by their members. While this approach sounds attractive, it is likely that these would be low-salience, low-turnout elections and that providers and insurers would have disproportionate influence on the election outcome.


8. An exception to this requirement is made for collectively bargained agreements.

9. A.H. Lerman and J. Cilke, “The Distribution of Effective Marginal Tax Rates” (Proceedings of the 84th Annual Conference, National Tax Association/Tax Institute of America, Columbus, Ohio, 1991), 245-256. Except in the smallest of firms, the employer’s share of Social Security tax is not relevant to the individual-choice decision. Although an employer’s Social Security tax liability would be affected by an employee’s choice to use a voluntary contribution for health insurance versus taxable income, the employer is unlikely to adjust each employee’s pay depending on the decision that is made.