Cite this article as:
U E Reinhardt
Publications and reports: health reform.
Lineage of managed competition
*Health Affairs* 13, no.2 (1994):290-292
doi: 10.1377/hlthaff.13.2.290

The online version of this article, along with updated information and services, is available at:
http://content.healthaffairs.org/content/13/2/290.citation

For Reprints, Links & Permissions: http://content.healthaffairs.org/1340_reprints.php

Email Alertings: http://content.healthaffairs.org/subscriptions/etoc.dtl

Not for commercial use or unauthorized distribution
To Subscribe: https://fulfillment.healthaffairs.org
III. PUBLICATIONS AND REPORTS: Health Reform

Lineage Of Managed Competition

"Success has many fathers, while failure is an orphan," goes an old saying. Now that managed competition appears to have the presidential seal of approval, there may be growing interest in its lineage. Who actually is the true parent of the concept?

Paul Ellwood and Alain Enthoven frequently are called the fathers of managed competition, and rightly so, as they did prodigious work nurturing and marketing the concept now known as the Jackson Hole Plan. The distinguishing feature of that plan is that it eschews a top-down budget, but instead calls for total national expenditures to be determined by bottom-up competition among health plans on the basis of both premiums and quality.

A radically different strand of managed competition was set forth in August 1992 by California Insurance Commissioner John Garamendi.¹ The distinguishing feature of that plan is that it constrains the process of competitive bidding among health plans by a top-down global budget. This constraint eventually will lead to accountable health plans' competing mainly on the basis of quality, rather than on both quality and premiums. Evidently, President Clinton's concept of managed competition slouches heavily toward the Garamendi concept, which inspired the president's design.

Both the Jackson Hole and the Garamendi versions of managed competition, however, can be traced to a much earlier version of the idea presented by Herman M. Somers and Anne R. Somers to the Sun Valley Forum on National Health in June 1971 and published in the Milbank Memorial Fund Quarterly in April 1972. Their paper precedes by more than half a decade Alain Enthoven's seminal Consumer Choice, his first version of managed competition.

The Somers design bears an uncanny resemblance to today's version of managed competition. For example, their plan calls for a federal National Health Insurance Board; a standard benefit package; and understandable, meaningful information on the competing plans. It provides for tightly supervised competition among a select number of insurance plans (preferably prepaid group-practice plans) and top-down global budgeting via fixed prepaid capitation payments to the plans, a feature in the Clinton plan, too. It is all there, and as early as 1971!

It is interesting to note that the Somerses called their concept "pluralistic and regulated competition in underwriting and administration." Enthoven himself also referred to the concept as "regulated competition" in his earlier papers. "Regulated competition" may be a more accurate description of the concept than "managed competition." It would be appropriate, and downright courteous, to acknowledge the Somerses' significant contribution to the concept in reporting on it. Sadly, that contribution has never been properly acknowledged in the scholarly literature.) Perhaps the press can do better than the policy wonks.

Uwe E. Reinhardt
Princeton University

NOTES

1. The Garamendi plan was penned by the commissioner with major assistance from Walter Zelman (and Larry Levitt), then working with Commissioner Gatamendi, and now leading members of the White House Task Force on Health Reform.

2. Paul Starr's version of managed competition, presented in The Logic of Health Care Reform, draws heavily and explicitly on the earlier Garamendi plan and differs from it mainly in nuances.


Health Reform Analyses

The Congressional Budget Office (CBO) unveiled its cost estimates of the president's health reform plan in the February 1994 report, An Analysis of the Administration's Health Proposal. For 1995-2000 the CBO predicts that the plan will increase the deficit by more than $70 billion, while the administration predicts the deficit will fall by...
about $60 billion. However, “CBO believes that the proposal holds the promise of reducing the deficit in the long run,” testified CBO Director Robert Reischauer 9 February before the Senate Finance Committee. The CBO projects that national health spending under the plan would fall $30 billion below the current CBO baseline trend by 2000 and would be $150 billion (or 7 percent) below the CBO baseline by 2004. Part of the difference stems from the estimate of how much the average insurance premium would cost under the president's plan. The CBO estimates this cost at 15 percent higher than the administration does.

In addition to cost estimates, the CBO report discusses how elements of the president's plan should be treated in the federal budget. For instance, the CBO says that “the financial transactions of the health alliances should be included in the accounts of the federal government, but they should be distinguished from other federal operations and shown separately, as is the practice for the Social Security program.” Whether payments to alliances by employers and individuals should be considered “on budget” has been a matter of heated political debate in Washington.

This long-awaited “scoring” of the president's plan by the CBO touched off a new round of debate in Washington about the “true” cost of reform and claims that the president's plan was dead. Anticipating this response, Reischauer testified before the House Ways and Means Committee 8 February: “I have considerable foreboding that the information contained in my statement and in the CBO report might be used largely in destructive rather than constructive ways—that is, it might be used to undercut a serious discussion of health reform alternatives or to gain some short-term partisan political advantage.” Reischauer added, “We should be designing health care reform according to what makes sense for health care policy, not according to how it's going to show up in the budget.”

The Joint Committee on Taxation, U.S. Congress, issued a report in February 1994 entitled Description and Analysis of the Employer Mandate and Related Provisions of H.R. 3600 (“The Health Security Act”). It consists of four parts: an overview of the Health Security Act, a description of the employer mandate and related provisions, examples of premium calculations, and an analysis of the economic effects of a coverage mandate. The analysis evaluates possible employment effects of three of the act’s components: (1) the individual mandate; (2) the employer mandate; and (3) government subsidies.

The report presents a number of rationales both for and against uniform pricing and individual and employer mandates. Some of the more compelling arguments for employer mandates are based on the assumption that health care reform must proceed, leaving the existing health care delivery system largely in place, and recognize that large changes in organization may be costly.

The report also finds that while most aspects of the mandates in the Clinton proposal are not likely to have a major impact on hours worked, output, or employment levels in the aggregate, some significant changes in income and employment decisions likely would occur at the individual level. It suggests that the partial employer mandate stipulated in the act holds cost implications for different family employment structures.

Finally, while the mandates in the act may remove some inefficiencies in individual employment decisions (such as “job lock”), they are likely to add other inefficiencies arising from subsidies to employers and individuals. For example, certain individual subsidies likely would reduce incentives for the unemployed to reenter the labor market. Also, certain business subsidies effectively penalize firm growth. Businesses may respond to this penalty either by refusing to grow or by hiding growth. This forces businesses to react to regulation rather than to market forces. Copies are available for $3.75 each from the Congressional Sales Office, Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402-9325; 202-512-4700.
The Health Security Act: Who Would Pay?


The study shows that, overall, the Clinton proposal would have only "modest effects" on the distribution of health care financing requirements. For instance, spending would decrease from 20 percent to 17 percent of income for the poorest fifth of the population. Spending by the rest of the population would "be largely unchanged, despite the major changes in coverage and financing that occur. No single income group would bear substantially different financial burdens under this proposal," the authors explained in a summary.

The total cost of health benefits for the study population would rise from $422 billion under the current system to $431 billion under the Clinton plan, but most of this increase would be offset by savings from the Clinton plan's spending caps in 1998. The biggest financing change would be elimination of the $32 billion "hidden tax" that now finances uncompensated care, which would not exist under the Clinton plan.

Direct per capita health spending (premiums and out-of-pocket spending) would decline from $810 per year under the current system to $670 per year under the Clinton plan. Direct costs for low-income families would fall from 14 percent of income to 6 percent under reform.

"These results should not be surprising," the authors state. "The Health Security Act essentially retains the employer-based system. Families' out-of-pocket contributions would decrease, but their employer insurance contributions would increase. Since families will pay for employer contributions through lower wages, their total contributions for health care remain generally the same." An individual mandate, however, could lead to substantial redistribution of income, they explain. Copies are available for $11 each from The Urban Institute, 2100 M Street, NW, Washington, DC 20037; 202-833-7200.

The Council on Graduate Medical Education (COGME) was created by Congress to provide recommendations on health care workforce issues. In its Fourth Report, issued in January 1994, COGME said that recent data reinforce the conclusions of its Third Report that "the nation has too few generalist and minority physicians, too many specialists, and poor geographic distribution of physicians." Given future needs, COGME believes that the following physician workforce goals should be attained by the year 2000: (1) First-year residency positions should be limited to 10 percent more than the number of U.S. medical school graduates. (2) At least 50 percent of residency graduates should enter practice as generalist physicians. (3) The number of underrepresented minority students should be doubled. (4) Primary care shortage areas should be eliminated. For a copy of the report, contact the Council on Graduate Medical Education, Health Resources and Services Administration, Department of Health and Human Services, Room 4C25, Parklawn Building, 5600 Fishers Lane, Rockville, MD 20857; 301-443-6190.

The Physician Payment Review Commission (PPRC), created by Congress to monitor Medicare's interactions with physicians, devoted fifteen of the twenty-two chapters of its Annual Report 1994 to health system reform, placing "a high priority on achieving substantial reductions in the rate of increase in spending on health care." The commission favors the application of both market mechanisms and expenditure limits to control costs. "Combining these two approaches would both limit the chance of failure and leave the system in a position to emphasize the more successful approach," the commission states in the executive summary of its report. It continues: "Policies to limit physician supply, reform the medical malpractice system, support outcomes research and practice guidelines, and pursue a national data strategy would support efforts by health plans and providers to deliver care in a more efficient manner." For a copy of the report, contact the Physician Payment Review Commission, Suite 200, 2120 L Street, NW, Washington, DC 20037-1527; 202-653-7220.