Can Multiple Choice Be Managed To Constrain Health Care Costs?
by Stanley B. Jones

The nation has reached a watershed point in its gamble that “competition” can constrain rising health care costs. Employers and policymakers either have to commit more resources to understanding and managing the discouragingly complex multiple-choice health insurance market, or have to find a new solution to rising health care costs. We tried “regulation” in the 1970s. Abandoning “competition” now would leave us facing a time of discontinuity—with only radical alternatives that have not grown out of our experience, such as the Canadian system.

Most policymakers and employers bought into multiple choice in the hope that offering employees the additional choice of health maintenance organizations (HMOs) would contain health care costs and ultimately constrain premium increases for employers and employees. The hope was based on several beliefs: (1) Employees would choose the health plan that gives them the best benefit for their premium dollar, forcing health plans to compete more vigorously. (2) HMOs are able to offer better benefits for premium dollars spent than traditional insurers because they organize physicians and hospitals to manage care more effectively. (3) The increased competition between insurers and HMOs would encourage both to work even harder to constrain physician and hospital prices and services.

I call this the domino theory of cost containment, where employees (first domino) put competitive pressure on insurers and HMOs (second domino), which in turn put competitive pressure on physicians and hospitals (third domino). The ultimate target of the pressure has always been physicians and hospitals, where most of the costs are incurred and where the savings potential is highest.

Most employers (and policymakers, for that matter) did not under-
stand the theory of how competition works to properly manage it, but they counted on HMOs and competition somehow to constrain their skyrocketing premium costs. In addition, HMOs gave employers an answer to employees wedded to comprehensive first-dollar coverage; they could offer them HMOs, in which excessive use of services could be better managed. HMOs also allowed employers to offer young families more comprehensive benefits tailored to their needs at a lower price.

Employers and policymakers alike have cause to be frustrated with multiple choice. Most have not seen the hoped-for reduction in premium costs. In fact, many employers find that, while some of their competing health plans’ premiums have been lower, others have been higher, and the health insurance premium cost for all employees has risen as fast as or faster than ever. At the same time, employers’ administrative headaches and costs have skyrocketed, leaving them with an expensive new fringe benefit for their employees called “choice” for its own sake.

Past Problem, Future Challenge

The problem in the past and the challenge for the future is “managing competition” to maximize and capture HMO savings. Alain Enthoven’s current thinking on multiple choice and on the Federal Employees Health Benefits Program (FEHBP) in particular is the best-reasoned and most systematic advice around on what is needed to make multiple choice work. He reaffirms that the ultimate goal of multiple-choice health systems and HMOs is to constrain employers’ health care costs. He is not resigned, as many are, to treating multiple choice as a complicated new fringe benefit, for which the best we can hope is to keep it from adding too much expense to an already costly system.

Enthoven also focuses on the fundamental question in multiple-choice systems: Can employers “manage competition” to make it work to save them money? While Enthoven focuses on the future, his position implies that up to now employers have not saved as much as they could have with their HMOs and multiple-choice systems. He does not admit that employers have in fact spent more.

Enthoven suggests that employers adjust their premium contributions to competing plans to take into account their favorable or adverse risk selection, standardize the plans’ benefits, reduce the number of competing plans (especially indemnity plans), and better inform employees so they can make choices based on relative prices. But, above all, he calls on employers to invest more sophistication, staff, and financial resources in data collection, research, and managing competition.

Enthoven particularly urges the federal government, which has sup-
ported competition for nine years as a matter of national policy, to invest more in managing competition in the FEHBP, thus putting its resources where its policy is. The question for today’s policymaker and employer is whether it is worth it.

In this essay, I begin by describing how “risk selection” is the fundamental and possibly fatal flaw in multiple choice’s potential to contain costs. Next, I review the recommended “fixes” of Enthoven and others for risk selection and how likely they are to work. Finally, I offer some views on the extent to which the employer can ever hope to make competition and multiple choice work to save money.

Risk Selection And Cost Containment

Risk selection can be defined, for our purposes here, as the process whereby employees with varying demand for health care distribute themselves among the health plans available to them. If a health plan gets a disproportionate share of the employees who use a lot of health care, the plan has experienced adverse risk selection. If a plan gets a disproportionate share of employees who use little care, the plan has experienced favorable risk selection. If a plan gets a representative share of all employees, the plan has experienced normal selection. A plan with favorable selection incurs fewer health care costs for its enrollees and therefore is able to set a lower premium or offer more benefits. A plan regards this as favorable because, with lower premiums and better benefits than its competitors, it has a better chance of competing successfully for still more enrollees. Adverse selection makes a plan less competitive.

The effect of risk selection on plans’ premiums can be much greater than the effect of efficiency and cost containment. In the FEHBP, for example, Towers, Perrin, Forster & Crosby note that some plans with comparable benefits have premiums twice as high as others, due to selection. Because of the way the government’s contribution is calculated, the employee premium share can be four times as high for essentially the same benefits. Private employer systems in which multiple choice is three years old or greater have shown comparable risk selection effects. The HMO efficiency savings of up to 28 percent for the strongest HMOs, to which Enthoven refers, pale in comparison to these risk selection effects.

For multiple choice to save the employer money, the fundamentally destructive effects of risk selection must be eliminated. Risk selection discourages insurers and HMOs from organizing physicians and hospitals and managing their care. A plan can quote a low price, offer high benefits, and capture a good share of employees without organizing a tough managed care system. Perhaps this is why less efficient independent
practice association (IPA)-type HMOs have flourished in multiple-choice systems, and why more efficient group and staff models have not grown in number. However, organizing providers is the tough and only real way to cut costs—risk selection at best just moves costs around, and at worst costs the employer money.

Risk selection also discourages health plans from developing cost-reducing innovations. For example, a plan may find it can offer a home care benefit that keeps people out of the hospital or nursing home and saves money. But, if the benefit attracts a lot of employees who need such care, the plan will find that the costs of taking care of this disproportionate share of sicker employees will push up its premium more than its efficiency can save. This plan must therefore avoid becoming the place to go for such innovative and needed services.

Third, risk selection discourages plans with strong managed care from seeking out sicker employees, whose placement in such plans could save employers the most money. Many employers have correctly surmised that sicker employees, or at least those who use a lot of care under comprehensive first-dollar coverage, should be in HMOs, where their care is better managed. But, risk selection discourages the HMO from such action. The strongest HMO’s 28 percent efficiency advantage can not begin to offset the increase in premiums that could result from enrolling sicker employees. If the HMO marketed itself to those using the most care, its premium would be forced up and it would become non-competitive with other plans. So HMOs, like other plans, must attempt to enroll a normal share of well employees and avoid a disproportionate share of the sick. This is a great loss of potential savings and a fundamental flaw in multiple choice.

Fourth, risk selection can cost the employer money. If a plan is more efficient than another, it can offer a lower premium or richer benefits to employees without costing the employer anything. However, if a plan has employees who typically use 28 percent less care than the average, and if it offers this selection windfall to the employees in the form of richer benefits or lower employee premium share, it usually costs the employer money. In calculating their premium contributions, many employers pay for these new benefits and lower premiums (for some employees) by paying higher employer premium contributions to plans with adverse selection. I have seen employers for whom 20 percent of total premiums are excess payments to fund this selection windfall. However, in the long term, the lack of enthusiasm for efficiency and innovation mentioned above compounds the costs.

Finally, risk selection can cost some employees an arm and a leg. If employees are very old or otherwise ill-equipped to understand plan
choices, they may stay in a plan that has become exorbitantly expensive to them because of adverse selection. The extreme case in the FEHBP is that of the Medicare-eligible person who persists in paying several thousand dollars a year more (five times as much!) for a high-option plan today whose benefits are virtually the same as a low- or standard-option plan. Why is the price so high? The employee and employer alike pay for the added benefits and lower premiums of employees who are knowledgeable enough or brave enough to choose the plans with favorable selection. This seems a high human price to pay for a system that is not saving money for the employer or the average employee!

**Recommended Fixes To The Risk Selection Problem**

Enthoven offers a variety of fixes to invigorate price competition among health plans in multiple choice. I focus here on fixes for the problem of risk selection, because if it is not “fixed,” all other fixes are fruitless and even counterproductive. For example, if the premiums of competing health plans in the FEHBP and other employer systems continue to be influenced more by risk selection than by plan efficiency, employers cannot better inform and motivate employees to make cost-conscious choices among plans. A cost-conscious choice in many or most multiple-choice systems today takes the employee into the plan with the best selection—not the greatest efficiency. Encouraging such choice is more likely to cost the employer money than to save money.

**Fix one: adjust employer premium contribution.** Enthoven proposes to (1) calculate the standard employer premium share in an employer’s multiple-choice system based on a weighted average of all plans’ premiums, and then (2) adjust this employer premium share down or up for each plan to reflect the plan’s favorable or adverse selection.

The first step is an improvement over the current practice. Most employers still base their premium contribution on a percentage of the original indemnity insurance plan’s premium. This amount is then paid to all plans. In the FEHBP, a percentage of the average premium of the “Big Six” plans is used. The new approach recommended by Enthoven and others would keep adverse selection in the employer’s original indemnity plan, or in the FEHBP’s Big Six, from forcing up the employer’s premium contribution to all plans. In Enthoven’s approach, the adverse selection in some plans’ premiums would be offset dollar for dollar by the favorable selection in others through the weighted averaging process.

I do not think, however, that step one eliminates all the added cost to the employer from risk selection. Over and above the added adminis-
trative costs of multiple choice, I have observed in the FEHBP what might be called “benefit creep.” As plans with favorable selection wind-falls offer more benefits, other plans are obliged to do the same to stay competitive, raising their total premiums and pushing up the average employer’s contribution. Enthoven proposes to stop this by prescribing the standard benefits all plans must offer (see below).

The critical step two in this approach—adjusting the weighted average premium for favorable and adverse selection—is the key to making multiple choice work to cut costs. However, it is far more problematic than step one. As Enthoven points out, the existing approaches to this adjustment used and being tried by Medicare adjust for only a small portion of the selection problem; the private sector also has shown little sophistication in this area.

While research is under way to improve this adjustor, there is nothing on the horizon that will allow a meaningful premium adjustment to control selection other than prior health care use. As Enthoven rightly points out, using prior health care use to predict likely future use is fatally flawed. It creates an incentive for a plan to allow utilization for its enrollees to increase, knowing they will qualify in subsequent years for a higher premium payment as a result.

The FEHBP could produce a somewhat more powerful adjustor than most employers can by adjusting the Office of Personnel Management (OPM) premium contribution to account for the annuitant status and Medicare eligibility of employees. It is not necessary to have a separate plan for annuitants with Medicare to accomplish this. Unfortunately, there is no adjustor in the works for employers, including OPM, that corrects anywhere near enough of the selection problem to encourage pressure on hospitals and physicians, plan innovation, and marketing of HMOs to sicker employees to maximize their capacity to cut costs. Without such a fix, the basic domino theory behind multiple choice breaks down.

In addition, even if step two worked, it would not capture a share of actual HMO or other efficiencies for the employer. It attempts to take back the selection windfall for the employer, which the employer should never have paid in the first place. But, the employer should also take a share of the real efficiency savings. Without a further reduction in the employer’s premium share to capture such savings, the HMO would continue to use all of its efficiency savings to fund increased benefits for the employee. If the employer does not share in the efficiency savings, the employer has no incentive to work harder to invest more resources to manage multiple choice.

Enthoven proposes giving the employer a share of the efficiency
savings over time by standardizing benefits. The ceiling on benefits would force the HMO or other efficient plan to convert its savings into lower total premiums -or take them in profits. If the employer is setting premiums as suggested by Enthoven in steps one and two above, standardized benefits should result in lower premiums for both the employer and employee. Enthoven argues that, over time, as more employees enroll in the lower-premium plans, the employer’s average premium (step one) will go down.

**Fix two: standardize benefits.** Enthoven proposes to standardize benefits of all competing plans, such that they could offer no more and no less than the prescribed package, unless an employer determines a new benefit is completely innocent of selection effects. This will ease the selection problem some— but not much. It will constrain attempts by plans to attract low users by their benefit design. However, the experience in most systems and in the FEHBP seems to indicate that a great deal of selection is the result of lower out-of-pocket premiums to the employee, the resistance of those who are sick to changing doctors or plans, and other nonbenefit factors.

Unfortunately, to standardize benefits may cost more in the long run than it will save because it eliminates any remaining likelihood that plans will innovate in benefit design to contain costs. For example, a plan would have no incentive to insure nonmedical support services in the home as an alternative to more costly medical care. Such innovations are desperately needed to break the dominance of the acute care medical model.

Enthoven’s approach would allow such innovation only if the employer required it of all plans in the multiple-choice system or decided it would have no influence on selection—which is unlikely. This would destroy all or most of the competitive advantage of individual innovative plans. The burden of research or experimentation will fall back on employers in Enthoven’s approach—a burden they are not likely to assume.

**Fix three: return to one insurer offering multiple choices for an employer.** One idea not suggested by Enthoven, but under consideration by many employers, is to have managing insurers or HMOs compete to manage all of an employer’s multiple-choice plans. The insurer or HMO might offer all of the options itself, or through a joint venture with other insurers or HMOs, or even through subcontracts with other insurers or HMOs. The employer would deal with only the managing insurer and pay one premium for all employees. The employer might even partially or totally abandon the self-insurance approach and insist on a prospective rate from the managing insurer for a year or more, such that the insurer will profit or lose based on the insurer’s ability to contain costs.
This widely discussed approach transfers the risk and burden of managing multiple choice to the insurer or HMO. All of the problems of risk selection remain; however, the managing insurer or HMO, not the employer, must work these problems out. Here it is necessary for the managing company to distinguish between efficiency and risk selection in each of its competing plans so the plan can be rewarded for efficiency and deprived of any gains from risk selection. Otherwise, the insurer/manager will lose the money from adverse risk selection that employers are currently losing. These new multiple-choice managers will need to use the same advice and fixes reviewed here. Nothing about the new management automatically solves the problem. This approach has the advantage, however, of leaving the management burden to institutions whose business is insurance and health care and whose future hinges on investing the resources needed to handle the sophisticated task.

Pitfalls do exist, however. First, if all the health plans are offered by the same insurance company, situations might arise in which the managing insurer’s interest might be served by doing less than the most efficient job for the employer. Second, it will be difficult for employers to require the managing insurer to compete for the employer’s business on a periodic basis. Changing managing insurers may mean that all employees would have to switch plans and doctors. Third, the HMOs that managing insurers are forming to offer these multi-option arrangements are almost exclusively the less-efficient IPA types. IPAs could displace more efficient staff- and group-model HMOs already operating in the employer’s pool.

Can Employers Manage Multiple Choice?

It is not clear that multiple choice and competition can contain health care costs. More specifically, it is not clear that present and future tools for correcting risk selection can equip employers, or managing insurers, to manage multiple choice so as to save money. It is clear to me, however, that most employers’ current multiple-choice systems are not saving money—and indeed are costing them more, often a great deal more.

This conclusion is unwelcome to all parties, because it implies that more effort, more investment of resources, and more time will be needed if we are to try to make multiple choice and competition work. Most would like to think of the problem more simply and dismiss Enthoven’s demanding recommendations as going further than necessary.

But, if one thinks Enthoven’s recommendations go too far or demand too much, one is not in touch with the gravity of the problem. As I have indicated, I would change some of the elements of Enthoven’s recommendations, but the level and systematic nature of the reforms he
proposes are right. If employers or OPM, or the consultants who serve them, take only the less demanding of Enthoven's recommendations and try to fix the problem "on the cheap," they are heading for inevitably higher costs and disappointment. If an employer, including OPM, is not willing to make the investment or pay a managing insurer or HMO to do it, the employer should probably abandon multiple choice. It is costing the employer a lot more money than it would to offer a single health insurance plan, and a whole lot more than it would to offer only strong HMOs. Smaller employers really have no choice but to look to managing insurers or HMOs for help—or get out of multiple choice altogether.

The stakes for employers, managing insurers or HMOs, and the nation in this decision are very high. For one thing, it is not clear how we can preserve the proven cost containment potential of staff- and group-model HMOs without a multiple-choice system. Whatever employers and managing insurers do in the next few years, they need to look for ways to collaborate or enter joint ventures with such HMOs to take maximum advantage of HMOs' capacity to reduce costs for them. Above all, we cannot afford to throw out the HMO baby with the multiple choice bath water.

For another thing, it is not clear that anyone but the employer or managing insurer can ever hope to manage multiple choice. If government were to try, it would be faced with the same intractable risk selection problem (and already is in Medicare's adjusted average per capita cost, or AAPCC). In addition, there will be political pressures to treat multiple-choice systems more as troughs at which all plans should be allowed to feed than as systems to be tightly managed.

However, there are roles for government. There is a need for investment in research and data collection, and perhaps in licensing health plans, that goes beyond the capacity of employers and managing insurers. There are also enormous problems of uninsured and poorly served Americans that go beyond the scope of the employer-based multiple-choice systems and that demand government attention.

Can employers and managing insurers meet the challenge? Or is a Canadian-type system the answer we will turn to? Only time, effort, and money will tell.

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