Economic Theory and Political Reality:
Managed Competition, the Clinton Health Plan, and the Future of Medicare

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Abstract

During the 1992 election campaign, candidate Bill Clinton made the strategic decision to embrace a largely untested economic model called "managed competition" in his approach to health care reform. Managed competition, exemplified by the work of Stanford health economist Alain Enthoven, promised to harness market forces to achieve social goals.

The ill-fated attempt to enact comprehensive health care reform was the most spectacular failure of the Clinton administration. But managed competition ideas did not die when Clinton's Health Plan expired. Instead, they informed the 1997 expansion of a Health Care Financing Administration demonstration project into the Medicare + Choice program, which, at its peak, enrolled 15 percent of Medicare beneficiaries in private managed care plans. "Quality and choice: these will be the hallmark of Medicare for the Clinton Administration as we move toward the 21st century," boasted Health and Human Services Secretary Donna E. Shalala in an optimistic press release announcing the Medicare Choices demonstration project in 1996.

While the penetration of the private plans into the Medicare market has fallen far short of early projections (dipping to12 percent in 2004), the managed competition model continues to form the basis for ongoing Medicare reform under the Bush administration. Thus, the Clinton Medicare + Choice legacy lives on in the rechristened Medicare Advantage program under the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

Shortcomings of the managed competition approach received surprisingly little attention during the debate leading up to the Medicare Modernization Act, despite the fact that the record of Medicare + Choice is disappointing in a number of respects.

First and foremost, the potential of the managed competition approach to control costs is unclear from a theoretical standpoint, and unproven in practice. Medicare + Choice certainly has failed to meet early expectations for cost control. In 1997, analysts at Bruce Vladek's HCFA expected the private plans to deliver a richer benefit package at a lower cost than traditional Medicare. In fact, however, the plans cost the government money, because they siphoned off healthier, lower-cost enrollees.

Nevertheless, initial premium levels, set at 95 percent of traditional Medicare's per capita costs, proved too low for many plans to turn a profit, given their richer benefit packages and higher administrative and marketing costs. Between 1998 and 2003, the number of participating plans dropped from 346 to 148, while most remaining plans trimmed benefits and raised enrollee premiums and cost sharing, disrupting care for hundreds of thousands of beneficiaries. "The General Accounting Office and other independent experts believe that managed care plans continue to be overpaid," complained a 1999 Clinton White House press release, even as it announced that Clinton had agreed to increase government payments in an effort to entice more plans to participate in Medicare + Choice.

On the other hand, traditional Medicare covers only about half of total health expenditures for its beneficiaries. Individual out of pocket expenditures, and payments from group retiree health plans or individually purchased Medigap policies cover the balance. The Medicare HMOs appealed especially to low and moderate income retirees

who lacked employer-provided coverage precisely because they offered a lower-cost alternative to individual Medigap coverage. It remains an open question whether the plans delivered care at a lower cost than the combined public and private costs that would have been incurred if enrollees had remained in traditional Medicare.

Nevertheless, it is fair to say, real world success stories in controlling health care costs thus far have been associated with governments exercising monopsonistic power – that is, with single payers and global budgets – rather than with "the magic of the market".

Furthermore, some features of managed competition add costs by their very nature. In particular, managed competition is inherently information intensive. Consumers must be provided the information they need to make good choices. In addition, plans must be constrained to compete on the basis of cost and quality rather than by selection of low-cost enrollees. The latter condition is difficult (perhaps impossible) to enforce. Although the 1997 Balanced Budget Act called for the government to gather the data to alter plan payments depending on the health characteristics of enrollee populations, methodologies for such risk adjustment remain elusive and expensive to implement.

Finally, while advocates have highlighted the potential for managed competition to create an array of health plans tailored to individual preferences, the approach also has created an array of options tailored to individual ability to pay. Rather than two-tiered health care, managed competition promises a rainbow of tiers of care, with the most Spartan reserved for the lowest income enrollees. Ironically, this problem is of greater concern the more successful the government is in providing the public with information about provider quality. Such public information will empower high quality providers to command higher fees, and thus the best doctors and hospitals may be accessible only to enrollees in the highest premium plans.

Given these shortcomings, why has the managed competition approach been so influential? For the Clinton Administration, the key is political feasibility. Efforts to overhaul US health care have foundered repeatedly because political pressures to control costs and expand coverage have been stymied by political pressures to protect vested interests. For Clinton, managed competition promised to deliver cost control (in theory) without requiring the government to specify which vested interests would be harmed. Furthermore, it explicitly created a role for at least the large insurance companies to continue in business. And Clinton cannily included a budget cap as a backup in his Health Plan.

For Bush, who backed the extension of the managed competition approach to the provision of retiree prescription drug coverage (together with steeply increased payments to participating private plans), the political calculus is a little different. While the private plans may cost the federal government more than traditional Medicare, they promise to ease the mounting burden of retiree benefits for influential large employers.