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MANAGED COMPETITION THEORY AS A BASIS FOR HEALTH CARE REFORM

by

CATHERINE T. DUNLAY & PETER A. PAVARINI*

INTRODUCTION

Health care reform, both nationally and at the state level, has been in the spotlight for several months, but it is clear that we are far from consensus concerning the appropriate plan for effecting reform. "Managed competition" has been heralded in the media as an approach most likely to be capable of developing consensus and, based on President Clinton's campaign materials and early reports from the White House Task Force on Health Care Reform (the "Task Force"), it was widely expected that the reform program proposed by the Clinton Administration would be a derivative of that economic model. More recently, the Clinton Administration has taken the position that its plan is not managed competition - but it is clear that many elements of that model remain a part of the Administration's plan.

In addition to the attention at the federal level, a number of states seeking to develop health care reform plans are studying managed competition. Florida, Minnesota and Washington have enacted legislation containing elements of managed competition, as discussed below.¹ Managed competition legislation has been considered in a number of other states. For example, in California the "Garamendi plan," which combines managed competition with a global budget, passed the state legislature but was vetoed by the Governor in 1992.²

In light of the large amount of attention it has received from federal and state officials, managed competition can be expected to have an effect on the evolution of the health care system, even if no pure managed competition reform proposal is legislatively enacted. In fact, the attention given to managed competition and the widespread expectation that a reform model based on managed competition would be enacted may have already had an effect in accelerating a movement among health care providers to form more integrated delivery systems. Thus, this article will seek to explain the fundamental principles of managed competition and the basic features of reform based on managed competition. It will also examine some of the criticisms of managed competition and the practical and legal impediments that will be faced in seeking to reform the health care industry based upon managed competition theory.

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¹ See *infra* pp. 26-33.

² See *California Considered Likely Model for National Reform, Conf. Told*, 1 HEALTH CARE POLICY REPORT 501 (May 17, 1993).

BASIC THEORY AND GOALS

The underpinning of managed competition is that the benefits of effective competition - whereby suppliers compete on the basis of providing maximum value for the consumer's dollar - are not present in the current health care system.³ Thus, the system must be reorganized and managed so that an efficient market promoting such "value-for-money" competition among health plans can be achieved.⁴ To achieve this goal, managed competition seeks to restructure the methods by which health care is purchased and paid for, and to do so in a way that causes the providers delivering health care to reorganize into more cost-conscious and quality-conscious delivery systems.⁵ To understand the rationale for such a reorganization, an understanding of the flaws of the current system from a competitive viewpoint is essential.⁶

WHY THE CURRENT MARKET STRUCTURE DOES NOT FOSTER VALUE-FOR-MONEY COMPETITION

Proponents of managed competition point to several reasons why the current market has failed to produce value-for-money competition.⁷ These criticisms apply primarily to the traditional system of fee-for-service providers receiving reimbursement through insurance plans paid for by employers.⁸ Although industry changes in recent years, including an increased tendency of employers to shift part of the cost of health benefits to employees, development of health maintenance organizations (HMOs), preferred provider organizations (PPOs) and other managed care organizations, and an increasing tendency of large employers to seek direct contracts with providers, may mean that the criticisms are not applicable to all aspects of the current market, the market has not changed to a point where these criticisms are no longer applicable. In fact, the changes cited above are precursors to the type of system managed competition would seek to create.

Advocates of managed competition have identified the following as sources of market failure under the current system:⁹

³ Alain C. Enthoven, *The History and Principles of Managed Competition*, HEALTH AFF., Supp. 1993, at 24, 25.

⁴ See *id.*

⁵ See Paul Starr & Walter A. Zelman, *A Bridge to Compromise: Competition Under A Budget*, HEALTH AFF., Supp. 1993, at 7, 11.

⁶ See Enthoven, *supra* note 3.

⁷ *Id.*

⁸ *Id.* at 25-26.

⁹ See, e.g., Paul M. Ellwood et al., *The Jackson Hole Initiatives for a Twenty-First Century American Health Care System*, 1 HEALTH ECON. 149, 155 (1992).

Cost-Unconscious Demand

One of the most fundamental problems under the current system is that the parties making decisions about utilization of health care services are not the parties who bear the economic risks of those decisions. Employees covered by indemnity insurance paid for by their employers have little incentive to be cost-conscious in their selection of health care providers. Further, the determination of services to be provided and choice of provider are often made by the employee's physician, rather than by the employee himself or herself. This is particularly problematic since the economic incentive for physicians paid on a fee-for-service basis is actually to provide more services and, thus, receive more payment, rather than to make careful cost-benefit analyses in choosing the services to be provided. The problem is exacerbated even further by the physicians' concern that they must practice defensive medicine to avoid malpractice liability. Last, the tradition of employers making payment for premiums under health insurance plans, coupled with the tax-free nature of those payments under federal income tax laws, results in a lack of cost sensitivity of employees, and reduced cost sensitivity of employers (who receive a deduction for the premiums regardless of their amount), in choosing health plans.

Lack of Information

To the extent that employees and employers seek to make price and value-conscious decisions concerning health plans and health services, they are hampered by a lack of information, particularly concerning the comparative quality of health outcomes. Thus, there is likely to be reluctance in choosing a lower priced plan because of the inability to obtain assurance that the plan provides adequate quality. In addition, the vast array of different benefit designs offered by insurers and managed care organizations makes comparison of different plans extremely difficult.

Limits of Individual Choice

Many employers are not large enough to offer employees a multiple choice of plans, thus limiting the employees to the limited selections made by the employer. An employer offering a less expensive managed care plan in addition to a traditional indemnity plan may find the employees choosing the indemnity plan because their physicians are not participants in the particular managed care plan selected by the employer. Further, a switch by the employer from a more costly to a less costly benefit plan is likely to be difficult since all of the employees will be affected by the switch.

Competition Among Health Plans Not Based on Value-For-Money

Competition among insurers and managed care organizations is characterized by factors other than value-for-money competition, most notably risk selection and market segmentation. Risk selection refers to the process by which insurers and managed care

organizations seek to enroll healthy people and avoid high risk enrollees who will generate high costs. Insurers seek, through underwriting practices and premium pricing, to avoid insuring those who will generate a disproportionately high amount of claims. Risk selection is also accomplished by designing benefits in a manner calculated to attract healthier enrollees and discourage the unhealthy. Market segmentation is accomplished primarily through benefit design. By offering different types of coverage, different plans may attract different types of enrollees, thus reducing the extent to which the plans compete based on price in attracting the enrollees.

Competition Among Providers Not Based on Value-For-Money

Because of the cost-unconscious nature of demand as described above, price often is not dominant in competition between providers. For example, hospitals compete on services and technologies available and on amenities offered to patients and physicians, even though this may cause increased costs, since patients and physicians are not the parties affected by the costs, although they are the parties making the decisions.¹⁰ With competition on this basis, it should not be surprising that there is duplicative expenditure by hospitals on expensive technology.

Proponents of managed competition also criticize the current methods of providing care to the uninsured through Medicaid and provision of charity care by health care providers.¹¹ Under these current methods, health care for the uninsured is likely to be delayed until health problems are more serious, and care is frequently provided in costly settings, specifically hospital emergency rooms.¹² Further, high administrative costs are incurred because of the need to determine eligibility of patients for such care, and the dollars lost by health care providers in providing such care are recovered through increased charges to insured patients, a process known as cost-shifting. Through cost-shifting, the cost of providing care to the uninsured is borne in an uneven, unregulated manner by the insured.¹³

BASIC FEATURES OF A MANAGED COMPETITION SYSTEM

Managed competition has been the springboard for many national health reform proposals - including the proposal of the Jackson Hole Group, the Managed Competition Act of 1992 proposed by the Conservative Democratic Forum, and the reform model outlined in President Clinton's campaign.¹⁴ These and other managed competition

¹⁰ Jonathan E. Fielding & Thomas Rice, *Can Managed Competition Solve the Problems of Market Failure?*, HEALTH AFF., Supp. 1993, at 216, 220-21.

¹¹ Enthoven, *supra* note 3, at 41.

¹² *Id.*

¹³ *See id.*

¹⁴ *See Insurance Industry Governors Adopt Health Care Policies: Debate Intensifies*, 1 HEALTH LAW REP. 351 (Dec. 10, 1992).

reform proposals contain varying provisions and, thus, if each proposal is viewed as constituting managed competition it will be impossible to define one cohesive theory. This may be one reason that there has been considerable public confusion over what managed competition means.

For purposes of this discussion, the elements of managed competition will be defined primarily as those identified by Professor Alain Enthoven, who developed the concept in the late 1970's (building on earlier efforts of Scott Flemming and others) and has refined the concept in various writings since that time.¹⁵ For this reason, when drawing upon a specific proposal for governmental health care reform, we will draw primarily upon the proposal of the Jackson Hole Group, in which Professor Enthoven participated, although contrary views of other analysts and elements of other reform proposals, including the September 1993 draft of the Clinton Administration proposal (hereinafter referred to as the "Clinton Proposal") will also be referenced.

For purposes of our analysis, we have grouped what could be described as many different elements of managed competition into three key features: creation of a cost-conscious purchaser of health plans with significant market power; organization of health plans and structure of their relationship with health plan purchasers so that the purchasers can most effectively manage competition among the plans; and provision of incentives to individual consumers so that they will make cost-conscious decisions in choosing health plans. Each of these key features, and their more-detailed components, are discussed below.

Sponsors and Purchasing Cooperatives

Purchasing cooperatives are probably the one element that is present in all proposals described as managed competition proposals. Before discussing cooperatives, however, the concept of a sponsor should be described since a purchasing cooperative is one type of sponsor. Sponsors are those who purchase health benefits on behalf of a group and assume the role of actively managing competition among health plans for that group.¹⁶ Examples of sponsors in the current market include employers and government agencies.¹⁷ The purchasing cooperative is the mechanism by which those purchasers without sufficient size or market power to act effectively as sponsors are represented by an entity with the necessary size and power.¹⁸ (Such cooperatives are dubbed health insurance

¹⁵ See *id.* at 24.

¹⁶ *Id.* at 30.

¹⁷ *Id.*

¹⁸ *Id.* at 35.

purchasing cooperatives, or HIPCs, by Professor Enthoven; health plan purchasing cooperatives, or HPPCs, by the Conservative Democratic Forum; and health alliances by the Clinton Administration. We will refer to them hereafter as HIPCs.)¹⁹

Sponsors, including HIPCs, would perform many important functions in a managed competition system: actively negotiating and contracting with health plans; gathering information on the health plans and disseminating it among customers in the HIPC; monitoring the behavior of health plans and HIPC participants to eliminate risk selective behavior, market segmentation and other noncompetitive practices; administering all of the health benefit contracts; and acting as the point of entry for managing enrollment.²⁰ Sponsors are the first level at which health plans would compete, since a contract with the sponsor would be necessary before the health plan would be available as a possible choice for consumers represented by that sponsor.²¹

Employers are the most prevalent purchasers of health benefits, but most are not large enough to effectively manage competition and efficiently perform the functions described above.²² Thus, HIPCs would be formed to represent those employers and their employees.²³ Such HIPCs must be "large enough to spread risk, achieve economies of scale, offer choice of plan at the individual subscriber level, and manage competition effectively."²⁴

HIPCs would not be risk-bearing entities and would not have their own plans, since they are intended to be impartial brokers promoting the interests of their participating consumers.²⁵ HIPCs would contract with employers and would be required to accept all employers in their area.²⁶ To avoid risk selection by the HIPCs, they would be prohibited from excluding groups or individuals based on health considerations.²⁷ Further, strong incentives or mandates would be provided for employers to participate in HIPCs.²⁸ Such incentives or mandates would be necessary to prevent adverse selection from saddling the HIPC with an unbalanced, poor risk pool as a result of employers that have favorable claims experience, and thus benefit from experience rating, opting out of the HIPC.

¹⁹ *Id.* at 37.

²⁰ *Id.* at 35-37.

²¹ *See id.* at 30-31.

²² *Id.* at 35.

²³ *Id.*

²⁴ Ellwood et al., *supra* note 9, at 150.

²⁵ Enthoven, *supra* note 3, at 36-37.

²⁶ *Id.* at 36.

²⁷ *Id.*

²⁸ *See id.* at 37.

Each HIPC would contract with a number of different health plans so that individual consumers sponsored by that HIPC would have the ability to choose among those plans. Thus, the individual would not be limited to the limited number of plan options that a small employer would provide and could exercise choice independently of other employees of his or her particular employer.

The appropriate structure for HIPCs is a subject for debate. Professor Enthoven and the Jackson Hole Group described HIPCs as nonprofit membership corporations with boards elected by the participating employers.²⁹ The Conservative Democratic Forum also would structure HIPCs as nonprofit corporations, but the boards would be appointed by the state governors.³⁰ Under the Clinton Proposal, states may determine whether their HIPCs will be non-profit corporations, independent state agencies or agencies of the state executive branch, and may establish the mechanism for selecting HIPC boards.³¹

The California Public Employees' Retirement System ("CalPERS"), as administrator of a health benefit program for employees of the State of California and other public agencies in that state, is cited as an example of an existing entity that functions much as an HIPC.³² CalPERS has over 750 public employers participating in its health benefits program, with a total of over 875,000 covered lives.³³ The CalPERS board consists of thirteen members: six elected by consumers, five representing participating employers, and two appointed by the governor and the state legislature.³⁴ Participating agencies are prohibited from restricting enrollment due to pre-existing conditions, age or sex, and there is no waiting period for coverage.³⁵ CalPERS negotiates and contracts with health plans, performs all administrative functions, collects data concerning cost and quality, distributes information to consumers, and conducts an annual open enrollment period for plan selection.³⁶ CalPERS contracts with a number of HMOs,³⁷ and offers self-funded PPO plans.³⁸

²⁹ *Id.* See also Ellwood et al., *supra* note 9, at 157.

³⁰ For a more complete discussion of governance and design of HIPCs, see Paul Starr, *Design of Health Insurance Purchasing Cooperatives* HEALTH AFF., Supp. 1993, at 58; Walter A. Zelman, *Who Should Govern the Purchasing Cooperative?*, HEALTH AFF., Supp. 1993, at 49.

³¹ See *Clinton Administration Description of President's Health Care Reform Plan*, "American Health Security Act of 1993." 1 Health Care Pol'y Rep. (BNA) 55 (Sept. 13, 1993) [hereinafter *President's Health Care Reform*].

³² See *California Retirement System Holds 1993 Premium Increases to 1.4 Percent*, 1 Health Care Pol'y Rep. (BNA) 21 (Mar. 8, 1993).

³³ See *Achieving Effective Cost Control in Comprehensive Health Care Reform: Hearings on S. 955 Before the Comm. on Labor and Human Resources*, 102d Cong., 2d Sess. 120 (1992) (testimony of Tom I. Elkin).

³⁴ *Id.*

³⁵ *Id.* at 121.

³⁶ *Id.*

³⁷ *Id.* at 123.

³⁸ *Id.* at 126.

CalPERS negotiates aggressively with health plans and uses cost data obtained from the plans in its negotiations.³⁹ Because it found multiple plan designs were adversely affecting its ability to provide understandable information to consumers and to negotiate premiums with the plans, it instituted a uniform benefit program effective for the 1993 - 1994 contract year, which it found has simplified the premium negotiations process and enhanced competition between health plans.⁴⁰ For the 1993 - 94 contract year, CalPERS was able to limit its overall health benefit premium increase to 1.4%, which is significantly less than the 12.1% projected increase in national health expenditures.⁴¹ HMO premiums actually decreased by 0.4%, which was offset by a 7.9% increase in rates for the PPO plans.⁴²

ORGANIZATION OF HEALTH PLANS AND STRUCTURE OF THEIR RELATIONSHIP WITH SPONSORS

Under managed competition, a number of devices would be used to enhance competition among health plans on the basis of price and quality, and to avoid risk selection and market segmentation.⁴³

Insurance Market Reforms

Under managed competition, certain restrictions would apply to all health plans offered to consumers sponsored by an HIPC or other sponsor. To prevent risk selection, all sponsored consumers would have to be given access to coverage in an annual open enrollment conducted by the sponsor.⁴⁴ The health plans would be required to accept all participating consumers who chose that plan.⁴⁵ Exclusion of coverage for pre-existing conditions would be prohibited, and the employees would receive continuous coverage; cancellation or nonrenewal for health reasons would not be permitted.⁴⁶ All enrollees would be charged a community rated premium, and experience rating would not be permitted. To discourage risk selection and ensure the viability of plans in which a disproportionately large number of high-risk consumers enroll, the HIPC would, however, impose a surcharge on health plans that receive the benefits of favorable selection and subsidize those that receive unfavorable selection.

³⁹ *Id.* at 122.

⁴⁰ *Id.* at 124-25.

⁴¹ See *President's Health Care Reform*, *supra* note 31.

⁴² See *Purchasing Cooperatives Report Success Using Uniform Benefit Packages*, 1 Health Care Pol'y Rep. (BNA) 300 (Apr. 19, 1993).

⁴³ See Enthoven, *supra* note 3, at 32-35.

⁴⁴ *Id.* at 33.

⁴⁵ *Id.*

⁴⁶ See *id.* at 36.

Standard Benefit Package

All health plans would be required to offer a standard benefit package, for several reasons. First, if universal coverage is to be achieved, as discussed below, it will be essential to establish the nature of the coverage to which everyone is entitled. Second, use of the standard benefit package will enhance comparability of the plans, thus enabling the sponsors to negotiate more effectively with the plans and making it possible for consumers to make informed choices between plans. Complex and varied benefit structures would make it very difficult for consumers to determine which plans provide the best value, and would require more time in decisionmaking than consumers are likely to be willing to spend. Last, a requirement for a standard benefit package is intended to prevent plans from using benefit design as a risk selection mechanism.

Provision of Cost and Quality Data

All health plans would be required to capture data on the quality and cost of services provided by them and provide that data to the sponsors. Sponsors would then gather that information, use it in their negotiations with health plans, and present it to consumers to enable them to make informed decisions. The intended result is that high quality, cost effective plans will be rewarded with increased enrollment and therefore, plans will be encouraged to develop quality and cost effectiveness.

Universal Coverage

Because the current methods for providing care to the uninsured are considered by managed care proponents to lead to delayed care, care in costly settings, costly eligibility determinations and cost-shifting, reform of this system is considered a necessary component of managed competition.⁴⁷ This is especially important since managed competition's restructuring of the market to increase competition would be likely to reduce the ability of providers to engage in cost-shifting to cover care for the uninsured. Thus, the pressure placed on providers to cut their costs could have the effect of reducing access to care for the uninsured. Further, some consider universal coverage to be necessary to prevent adverse selection from undermining the system because of the election by healthier individuals not to participate.⁴⁸

Reform proposals obviously need to address how universal coverage can be achieved and funded, and Professor Enthoven describes this as something that could be achieved in a variety of ways, including employer mandates, individual mandates and taxes.⁴⁹

⁴⁷ *Id.* at 41.

⁴⁸ William Custer, *Health Care Reform: Managed Competition and Beyond* EMPLOYEE BENEFIT RESEARCH INST., Issue Brief No. 135, at 9 (Mar. 1993) [hereinafter EBRI].

⁴⁹ Enthoven, *supra* note 3, at 42.

Under the Jackson Hole Group proposal, all employers would be mandated to cover all full-time employees with a defined employer contribution of 50 to 100 percent of the price of the lowest price standard benefit package available through the applicable sponsor.⁵⁰ Under the Clinton Proposal, employers are required to pay 80% of the average-priced plan for their employees and all individuals are required to purchase coverage, with subsidies for some small businesses and for low income individuals provided by the federal government.⁵¹

Division of Providers Into Competing Economic Units

One of the features central to Professor Enthoven's proposal, but highly controversial, is the division of providers into competing, risk-bearing economic units. Under the theories advanced by Professor Enthoven, providers can best be encouraged to develop higher quality and more cost effective methods of delivering health care if they are divided into competing, risk-bearing units. If all of the health plans offered by a HIPC have open panels and include the same pool of providers, the plans will have neither the necessary bargaining power with providers to hold down costs nor the necessary relationship with providers so that selection of one health plan over another is based on the quality of the providers in that plan. Because the competition focused upon by managed competition is the competition among the health plans, which is the level at which consumers are more likely to be able to understand costs and be motivated to reduce those costs, it is essential that the insurance and health care service functions be integrated. Otherwise, the desired effect on health care providers will not be achieved. Managed competition is intended to encourage creation of systems of providers that can monitor quality, have incentives to engage in cost-effective innovation, and match resources of personnel and facilities to meet the needs of the enrollees.

Under both the Jackson Hole Group proposal and the Conservative Democratic Forum proposal, accountable health plans would be created to fulfill these functions. These accountable health plans, or "AHPs", would be organizations that integrate insurance and health care delivery, deliver the full array of standard benefits and report cost and quality information. They would be required to register with, and would be regulated by, a national board. The Jackson Hole Group proposal envisions such AHPs as possibly consisting of either single, vertically integrated organizations of providers and insurers, or affiliations of independent provider and insurance organizations working collaboratively.⁵² Only coverage from AHPs would be entitled to favorable tax treatment under the Jackson Hole Group proposal.⁵³

⁵⁰ Ellwood et al., *supra* note 9, at 160.

⁵¹ *President's Health Care Reform*, *supra* note 31, at Supp. pp. 220-35.

⁵² Ellwood et al., *supra* note 9, at 153-54.

⁵³ *Id.* at 162.

Under the Clinton Proposal, only state-certified health plans would be permitted to provide health benefits to HIPCs, and those health plans would also be required to meet federal standards with respect to such matters as fiscal soundness, practitioner credentialing and utilization management, among other matters.⁵⁴ Fee-for-service health plans, which do not integrate insurance and health care delivery, are retained under the Clinton Proposal. In fact, HIPCs are required to make at least one fee-for-service plan available to their participants.⁵⁵

Professor Enthoven has criticized inclusion of indemnity plans as being irreconcilable with a managed competition system because of the lack of a contractual relationship between payer and provider under indemnity insurance.⁵⁶ Without that relationship, the quality of services could not form the basis of comparison for choosing between health plans as intended under the managed competition system.⁵⁷

Encourage Individual Consumers to Make Cost-Conscious Decisions

Under managed competition, the HIPCs would choose the participating health plans, but the final choice among those plans would be left to consumers. It is important, therefore, that consumers have an incentive to make cost-conscious decisions when choosing among those plans. To encourage such cost-consciousness, the tax-free employer contribution to premiums would be limited to the amount of the lowest priced plan in the HIPC offering the standard benefit package. Thus, enrollees would receive the full benefit of choosing the less expensive plan, unaffected by tax subsidies, and the incentive to plans for cutting prices would be increased. Further, because enrollees choosing a plan other than the lowest price plan would experience at least some economic cost in doing so, such a decision would presumably be made only if there was a quality feature of the chosen plan making that cost worthwhile. Under the Clinton Proposal, all employer contributions toward plans providing the standard benefit package are tax deductible to the employer and not counted as income to the employee, without limiting the tax deduction to the lowest-priced plan or to the 80% of average premiums that the employer is required to pay.⁵⁸

IMPLEMENTATION ISSUES AND QUESTIONS

There are a number of important details that need to be decided upon in structuring health care reform based upon a managed competition system. Accordingly, most

⁵⁴ See *President's Health Care Reform*, *supra* note 31, at Supp. pp. 73-77.

⁵⁵ *Id.* at 61.

⁵⁶ See *Clinton Should Scrap Plans to Allow Indemnity Insurance, Enthoven Urges*, 1 Health Care Pol'y Rep. (BNA) 296, 297 (Apr. 19, 1993).

⁵⁷ *Id.*

⁵⁸ See *President's Health Care Reform*, *supra* note 31, at Supp. p. 239.

reform proposals, including the Jackson Hole Group Proposal, the Conservative Democratic Forum proposal and the Clinton Proposal, require establishment of a national agency to make many of the determinations, provide oversight to the HIPCs and/or AHPs and otherwise to address implementation issues. Private sector boards that would advise this national agency with respect to matters in their areas of expertise are also contemplated under some of these proposals.

Certain of the issues that would need to be addressed by a legislature in passing health reform legislation based on managed competition and by any governmental agency established under that legislation are discussed below. Also discussed below are some of the impediments that will be faced in seeking to implement such reform in today's market.

Issues Relating to Sponsors and HIPCs

One of the important questions concerning HIPCs will be the question of which employers and individuals should be the subject of strong incentives or mandates for participation. The more employers that are given the option of staying out of the HIPC, the greater the potential is for adverse selection to negatively affect the HIPC.⁵⁹ The Jackson Hole Group proposal would make small group participation in a HIPC a condition for exclusion of the employer contribution from the employee's taxable income, but defines a small group as 100 or fewer employees.⁶⁰ The Conservative Democratic Forum proposal allows firms with 1,000 or more employees to opt out of the HIPC, but gives states the option of increasing that number to as much as 10,000.⁶¹ The Clinton Proposal allows employers with more than 5,000 employees to opt out of the HIPC, but such employers would then be regulated as "corporate alliances."⁶²

Another question concerning HIPCs is the number of enrollees that must be in the HIPC in order for it to obtain the desired economies of scale and operate effectively, but not be so large that it becomes unmanageable or excessively political. A different, but related question is the appropriate number of sponsors for any given geographical area, and the size of the area to be covered by one sponsor. If more than one sponsor is permitted in the same geographic area, the health plans may be able to engage in some risk selection by differentiating between the sponsors. The existence of more than one sponsor would also diminish the market power and negotiating strength of the sponsor. On the other hand, if there is only one HIPC in a geographical area, that HIPC will be

⁵⁹ Starr & Zelman, *supra* note 5, at 14-15.

⁶⁰ Ellwood et al., *supra* note 9, at 156.

⁶¹ H. R. 5936, 102d Cong., 2d Sess. §§105(a), 191(c)(2)(1992).

⁶² See *President's Health Care Reform*, *supra* note 31, at Supp. pp. 65-71.

a monopsony purchaser. Some see this as a benefit since the HIPC could then use its power to hold down prices, especially in sparsely populated areas where competition between providers is unlikely.⁶³ Questions are raised, however, about how to assure that such a HIPC will act in the public interest.⁶⁴ Theoretically, a HIPC as a monopsony purchaser could hamper competition among providers by conspiring with one or more providers, or could push prices so low that most providers are forced from the market, leaving a monopoly. The American Medical Association has taken the position that creation of a HIPC as a monopsony purchaser would result in deterioration of quality and access.⁶⁵

Under the Clinton Proposal, states may establish the geographic areas for HIPCs within their boundaries, but may establish only one HIPC in each area.⁶⁶ Thus, it appears that the Clinton Administration considers the benefit of establishing HIPCs as monopsony purchasers to outweigh the potential risks.

STRUCTURE OF RELATIONSHIP BETWEEN HEALTH PLANS AND HIPCS

Insurance Market Reform

One of the largest problems in restructuring the insurance market is determining how to risk-adjust premiums paid to plans so that plans with low-risk enrollees will be surcharged and plans with high risk enrollees will be subsidized.⁶⁷ There are currently no good models available for that process.⁶⁸ Questions that would have to be addressed in creating such a model include determining what factors indicate various risks and whether to make the determination prospectively, which would result in less accuracy, or retroactively, which is likely to lessen the effectiveness of managed competition as an incentive for the plan to be cost-effective. The Clinton Proposal provides for prospective adjustment of payments under a risk-adjustment system to be developed by a National Health Board.⁶⁹

Another potential problem is that because all employers would pay equally under community rating, the employer's incentive to maintain the health of its work force is decreased. The economic benefits of a better experience rating because of a healthier

⁶³ See, e.g., Richard Kronick, *Where Should the Buck Stop: Federal and State Responsibilities in Health Care Financing Reform*, HEALTH AFF., Supp. 1993, at 87, 90-91.

⁶⁴ See Henry J. Aaron & William B. Schwartz, *Managed Competition: Little Cost Containment Without Budget Limits*, HEALTH AFF., Supp. 1993, at 204, 209.

⁶⁵ *Applying Antitrust to Health Alliances*, 1 Health Care Pol'y Rep. (BNA) 559 (May 6, 1993).

⁶⁶ See *President's Health Care Reform*, supra note 31, at Supp. pp. 49-50.

⁶⁷ See Enthoven, supra note 3, at 34.

⁶⁸ See id.

⁶⁹ See *President's Health Care Reform*, supra note 31, at Supp. p. 83.

work force would not be obtained by employers under this system. Thus, the system may have a negative effect on employer-sponsored wellness programs.

Standard Benefit Package

The determination of what is included in the standard benefit package will have profound effects. This determination will affect directly the type of care that individuals obtain. If the standard benefit package excludes many types of medical care, the proposal will be subject to charges that it results in rationing health care, leaving care not covered by the standard benefit package available only to those financially able to purchase it. If the package is very inclusive, cost is likely to be a problem. This determination also will affect the income of various types of providers, favoring those whose services are included and disfavoring others.

A number of questions would have to be addressed in establishing a standard benefit package. These questions, which touch upon the areas of financing, consumer protection, governmental relations and quality maintenance, include what benefits are affordable, what information do consumers need to know about the benefits, at what level of government should the benefits be prescribed, and how will required treatments be defined and delivered.⁷⁰ Other countries have found the determination of the content for a standard benefit package to be difficult to make and have tended to push this decision down to local levels of government.⁷¹ The Clinton Proposal, however, establishes a fairly inclusive benefit package and provides for adjustments to that package to be recommended to the President and Congress by a National Health Board.⁷²

Information Gathering

Similar to the situation with respect to risk-adjusting premiums paid to plans, the collection of quality information necessary under a managed competition system is not feasible with current processes. Various groups have collected various types of quality data concerning health care, but that data is not currently collected in any uniform fashion and there is no broad consensus on what the pertinent information is for determining quality of health care. It is expected that the uniqueness of each patient situation is likely to make the determination of uniform quality measures difficult.⁷³

⁷⁰ Linda A. Bergthold, *Benefit Design Choices Under A Managed Competition*, HEALTH AFF., Supp. 1993, at 99.

⁷¹ EBRI, *supra* note 48, at 11.

⁷² See *President's Health Care Reform*, *supra* note 31, at Supp. pp. 19-42.

⁷³ See Shoshanna Sofaer, *Informing and Protecting Consumers Under Managed Competition*, HEALTH AFF., Supp. 1993, at 76 (discussing possible methods for providing information to consumers in HIPC).

Dividing Providers Into Competing Units

This aspect of a managed competition system, as envisioned by Professor Enthoven, has led many to characterize managed competition as a system leading to the creation of super HMOs and poor quality of care. These criticisms are further discussed below.

Further, as Enthoven envisions it, the most effective market will have totally separate networks of providers, without overlap. Such a system of providers will not be feasible in sparsely populated areas. One study concludes that a population of 1.2 million would be required to support three fully independent plans, and that 42% of the U.S. population lives in such markets.⁷⁴ This study further concludes that a population of 360,000 could support three plans that are mostly independent, but share some hospital facilities and contract for tertiary services.⁷⁵ U.S. markets with such populations would include 63% of the U.S. population.⁷⁶ Last, the study concludes that three plans providing primary care and many basic specialty services, but sharing in-patient cardiology and urology services, could be supported by a population of 180,000, which would include 71% of the U.S. population.⁷⁷

Professor Enthoven argues that in sparsely populated areas where there is not a sufficient market for competing provider networks, the HIPC could rely on competition *for* the field instead of *in* the field, an approach that clearly raises the monopsony issues discussed above.⁷⁸ As Professor Enthoven sees it, a HIPC in such an area might contract with an established organization to establish and operate networks in the area or might "reach through" the health plans and negotiate directly with the needed providers.⁷⁹

Another question regarding the ability of the current market to support competitive provider networks is the question of whether there are sufficient primary care physicians in practice, especially when one considers that universal coverage also will be sought.⁸⁰ It is the general consensus that there are too many specialists and not enough primary care physicians in the current market to support universal coverage under managed competition.⁸¹

Universal Coverage

Provision of universal coverage can clearly be expected to generate costs. One of the most difficult issues politically is how to fund these costs. The suggestions of

⁷⁴ Richard Kronick et al., *The Marketplace in Health Care Reform*, 328 NEW ENG. J. MED. 148, 150 (1993).

⁷⁵ *Id.*

⁷⁶ *Id.*

⁷⁷ *Id.*

⁷⁸ Enthoven, *supra* note 3, at 39.

⁷⁹ *Id.*

⁸⁰ See Fitzhugh Mullan et al., *Doctors, Dollars, and Determination: Making Physician Work-Force Policy*, HEALTH AFF., Supp. 1993, at 138, 140-41.

⁸¹ See, e.g., *id.* at 141.

Professor Enthoven and the Jackson Hole Group that taxes or mandates be used may be politically difficult to implement. Many question the effect of mandates on the financial viability of small employers, which at least one analysis has concluded would bear most of the cost of an employer mandate.⁸² The Conservative Democratic Forum proposal does not contain mandates and, while including provisions to increase the percentage of the population covered, does not provide for coverage of the entire population. The Clinton Proposal, however, relies upon an employer mandate and seeks to achieve universal coverage.

Encouraging Cost-Conscious Consumers

Many question whether the tax reform suggested under managed competition proposals would be sufficient to significantly affect consumer behavior.⁸³ It has been stated that the existing research on the relationship between tax policy and the demand for insurance, and on the relationship between insurance and the demand for health care would suggest that the proposed changes in tax policy are likely to have relatively minor effects, but the impact of insurance is not fully understood.⁸⁴

Some also argue that the imposition of costs through limiting employer contributions and taxing contributions in excess of the least expensive plans is inequitable because it will in effect leave the less well-to-do with no choice but participating in the lowest price plan. Arguably, this will create a two tier system with lower quality care of those of lesser means and high quality available for those who can afford it. In addition, the tax cap as a method is regressive since the provision of the same amount of excess health benefits to the poor and the wealthy would result in the poor paying a larger percentage of their income as taxes on those benefits than the wealthy.⁸⁵

Other Elements Necessary in Reform Based on Managed Competition

Some of the issues that are considered to have a negative effect on health care costs are not addressed by managed competition. Most notably, many consider physician over-utilization of services to arise from the malpractice explosion and the resulting need to practice defensive medicine.⁸⁶ Thus, tort reform is considered by many a necessary complement to health care reform based on managed competition.⁸⁷

⁸² EBRI, *supra* note 48, at 18.

⁸³ See, e.g., Aaron & Schwartz, *supra* note 64, at 208; Fielding & Rice, *supra* note 10, at 226.

⁸⁴ EBRI, *supra* note 48, at 20.

⁸⁵ *Id.* at 21.

⁸⁶ See, e.g., *Decreasing Defensive Medical Practices Could Save \$35.8 Billion Over Five Years*, 2 HEALTH LAW REP. 137 (Feb. 4, 1993).

⁸⁷ *Id.*

Funding of graduate medical education and research will also need to be addressed. Currently, these functions are financially supported by cost-shifting, with providers including the costs of such items in their charges for health care. Price competition under a managed competition system would make this practice unwise and thus it has been suggested that some new methods of funding for these functions, which are beneficial to society, will be needed.⁸⁸ Funding of graduate medical education should also take into account the need for more primary care physicians and fewer specialists, as noted above.

OPPONENT'S VIEWPOINT

Those who oppose managed competition as a basis for health care reform, in addition to raising the implementation issues discussed above, raise more basic questions about the feasibility and likely effects of a managed competition system.⁸⁹ Critics assert that managed competition is an unproven theory that has never been tested in practice, and that the economic pressures such a system would place on providers and consumers would lead to lower quality and reduced access to health care.⁹⁰ Doubts about the extent to which managed competition would be effective in controlling escalating health care costs are also widespread.

An Untested Theory

Representative Pete Stark, chair of the House Ways and Means Health Subcommittee, has referred to managed competition as a "fairy tale"; Representative Dan Rostenkowski, chair of the House Ways and Means Committee, has compared it to supply-side economics and the "Star Wars" defense initiative.⁹¹ The Congressional Budget Office also has taken the position that managed competition is "untried."⁹² Such concerns about the viability of managed competition arise from the inability of its proponents to cite the health care system of any nation or state as an example of a functioning managed competition system. Without such a functioning system to examine, it is impossible to be certain of the effects of such a system in practice.

Professor Enthoven has pointed to CalPERS' experience as evidence that managed competition will work,⁹³ and noted that the theory "is based on demonstrations of successful, high-quality, cost-effective, organized systems of care that have existed for

⁸⁸ Alan C. Enthoven, *Managed Competition in Health Care and the Unfinished Agenda*, 7 HEALTH CARE FINANCING REV. 105, 117 (1986 Annual Supp.).

⁸⁹ See, e.g., *Experts Clash on Managed Competition in Testimony Before Senate Labor Panel*, 1 NATION LAW REP. 421 (Dec. 21, 1992).

⁹⁰ *Id.*

⁹¹ Jill Wechsler, *So You Think Reform is Going Slow Now? Wait Until Congress Gets a Hold of It*, 3 MANAGED HEALTHCARE NEWS, No. 6, at 1, 52 (June 1993).

⁹² *CBO Rates Managed Competition*, 21 HEALTH LAW. NEWS REP., No. 6, at 3 (June 1993).

⁹³ See *President's Health Care Reform*, *supra* note 31, at Supp. p. 21.

years", including, for example, Kaiser Permanente and Group Health Cooperative of Puget Sound.⁹⁴ He argues, "All of the pieces of the managed care/managed competition model are in actual successful practice somewhere. The challenge is to put these best practices together into one complete managed competition system."⁹⁵

Effects on Access and Quality

Critics argue that managed competition will coerce consumers into "super-HMOs" and deprive them of physician choice.⁹⁶ Professor Enthoven counters that different types of managed care organizations are contemplated, including selective independent practice models in which solo physicians could participate.⁹⁷ Thus, managed competition is not intended to force all consumers into large clinic-model HMOs as many critics suggest.⁹⁸ Further, he argues that individual choice is enhanced since consumers could choose any plan offered through the HIPC in which they participate, rather than being limited to the smaller number of plans offered by their particular employer.⁹⁹ Nonetheless, managed competition as envisioned by Professor Enthoven would limit the consumer's choice to the physicians participating in the particular plan that the consumer selects.

Other criticisms of managed competition mirror criticisms that have been levelled at managed care organizations — generally, that the economic interests of such organizations will outweigh the patients' interests, leading to undertreatment and discrimination against consumers with costly problems. Practices commonly used in the managed care industry to incentivize physicians to control costs - such as risk pools, where a portion of the physician's fee is withheld for later distribution only if economic targets are achieved - are criticized for injecting economic concerns into treatment decisions and eliminating the ability of physicians to make such decisions based solely on the patient's needs.¹⁰⁰ An analysis of managed competition by the Congressional Budget Office supports these criticisms, concluding that the dramatic restructuring required to control costs under managed competition would mean less consumer choice, more limited access to providers, fewer services and slower access to technology.¹⁰¹

Managed competition proponents, however, point out that while charges "of undertreatment have been leveled at managed care . . . no systematic detrimental effect

⁹⁴ Enthoven, *supra* note 3, at 37.

⁹⁵ *Id.* at 45.

⁹⁶ See, e.g., Robin E. Margolis, *Health Care Debate in Washington: Hare Realities Lurk Behind Clinton Reform Hoopla*, 10 HEALTH SPAN No. 2, at 21 (Jan. 1993); see also Reonald Bronow, *HMO Physicians' Shared Risk Pools Are Dangerous to Patients' Health*, 10 HEALTH SPAN No. 1, at 9 (Jan. 1993).

⁹⁷ Enthoven, *supra* note 3, at 44.

⁹⁸ *Id.*

⁹⁹ *Id.*

¹⁰⁰ See, e.g., Bronow, *supra* note 96.

¹⁰¹ *CBO Rates Managed Competition, supra* note 92, at 3.

on quality [under existing managed care programs] has been documented."¹⁰² Professor Enthoven further argues that the most economical medical care is often the highest quality care since prompt diagnosis and proper treatment is both less expensive and better for the patient than delays, misdiagnosis or inappropriate treatment.¹⁰³

Effectiveness in Controlling Costs

Many who have analyzed managed competition, including the Congressional Budget Office, the Economic and Social Research Institute and the Employee Benefit Research Institute, have concluded that it is unlikely to significantly reduce spending, at least in the short term, unless other measures such as budget caps are also used.¹⁰⁴ Managed competition does not directly address some of the factors commonly blamed for spiralling costs, such as an increasing elderly population, proliferation of medical malpractice cases, and development of expensive new technologies. At least one analyst has concluded that the main impetus for increasing health care costs is new technology and, accordingly, that managed competition without cost controls will not slow the increase in health care costs.¹⁰⁵

Some argue that because the need to hold costs down is so important and the effects of managed competition are uncertain, a global budget should also be used to assure cost control.¹⁰⁶ Some of such proponents also argue that a global budget is compatible with managed competition if it is imposed by limiting premiums for health care plans rather than by regulating provider fees.¹⁰⁷ While conceding that setting rates for providers may be counterproductive under a managed competition system since this would tend to "[freeze] in place the current composition of expenditures and thereby retard progressive changes,"¹⁰⁸ and would give providers incentives to increase the volume and intensity of services to compensate for lower rates, they argue that limiting capitated payments to health plans would not cause such detrimental effects.¹⁰⁹ Rate-setting for providers is suggested as a backup, however, to be used if managed competition combined with premium limitations fails to adequately control costs and to be used for providers par-

¹⁰² Alan L. Hillman et al., *Safeguarding Quality In Managed Competition*, HEALTH AFF., Supp. 1993, at 110, 113-114.

¹⁰³ Enthoven, *supra* note 3, at 44.

¹⁰⁴ *See Reports Raise Doubts About Potential of Reform Proposal to Reduce Spending*, Health Care Pol'y Rep. (BNA) 547, 548 (May 24, 1993).

¹⁰⁵ *See* Joseph P. Newhouse, *An Iconoclastic view of Health Cost Containment*, HEALTH AFF., Supp. 1993, at 152.

¹⁰⁶ *See, e.g.*, Paul Starr & Walter A. Zelman, *A Bridge to Compromise: Competition Under a Budget*, HEALTH AFF., Supp. 1993, at 7, 14; *see also* Henry J. Aaron & William B. Schwartz, *Managed Competition: Little Cost Containment Without Budget Limits*, HEALTH AFF., Supp. 1993, at 204; *see also* Stuart H. Altman & Alan B. Cohen, *The Need for a National Global Budget*, HEALTH AFF., Supp. 1993, at 194.

¹⁰⁷ Starr & Zelman, *supra* note 106, at 18-21.

¹⁰⁸ *Id.* at 18.

¹⁰⁹ *See id.* at 18-20.

ticipating in any indemnity/fee-for-service options and for areas in which the market cannot support competition.¹¹⁰ The Clinton Proposal provides for a global budget limiting premiums and premium increases and provides for HIPCs to negotiate fee schedules with fee-for-service plans.¹¹¹

Professor Enthoven, however, argues that any global budgeting is inconsistent with managed competition.¹¹² He asserts that even if global budgets are imposed through capitation rates paid to health plans "they would focus the whole health services industry on political efforts to raise or maintain the ceiling," would require costly administrative procedures and hearings to be consistent with due process, and would dampen the interest of managed care organizations in making necessary investments.¹¹³ Rather than use of such budget mandates, Professor Enthoven favors use of "targeted interventions" such as reduction of covered benefits, increase of copayments and deductibles or changes in taxation of premiums after observation of managed competition in practice and determination of the preferred method for reducing expenditures based on such observation.¹¹⁴

CURRENT LAWS AFFECTING IMPLEMENTATION OF A MANAGED COMPETITION SYSTEM

A number of existing federal and state laws would affect, and could create obstacles to, the implementation of a managed competition health care delivery system. Accordingly, changes or developments in laws affecting the health care industry would likely accompany the institution of managed competition health care reforms. A brief discussion of some of these laws follows.

Antitrust

Federal antitrust laws include prohibitions against contracts, combinations or conspiracies in unreasonable restraint of trade (Sherman Act Section 1);¹¹⁵ monopolization, attempted monopolization and conspiracies to monopolize (Sherman Act Section 2);¹¹⁶ tying and exclusive dealing arrangements that may substantially lessen competition (Clayton Act Section 3);¹¹⁷ and mergers, joint ventures, consolidations or acquisitions that may substantially lessen competition or tend to create a monopoly (Clayton Act Section 7).¹¹⁸ State laws often prohibit similar conduct. Several activities by providers

¹¹⁰ *Id.* at 20-21.

¹¹¹ *See President's Health Care Reform, supra* note 31, at Supp. pp. 62, 93-99.

¹¹² Enthoven, *supra* note 3, at 42.

¹¹³ *Id.* at 43.

¹¹⁴ *Id.* at 43-44.

¹¹⁵ Sherman Act, ch. 647, § 1, 26 Stat. 209 (1890) (current version at 15 U.S.C. § 1 (Supp. 1991)).

¹¹⁶ 15 U.S.C. § 2 (Supp. 1991).

¹¹⁷ Clayton Act, ch. 323, § 3, 38 Stat. 731 (1914) (current version at 15 U.S.C. § 14 (1988)).

¹¹⁸ 15 U.S.C. § 18 (1988).

and payers in implementing a managed competition system could be subject to challenge as violating these laws.

As discussed above, a HIPC that is the sole purchaser of health plans in its market could be subject to a charge of exerting monopsony power in violation of Section 2 of the Sherman Act.¹¹⁹ Thus, if a legislature intends HIPCs to be exclusive purchasers in the markets and to exercise monopsony power, it will need to provide the HIPCs with immunity from this charge. Most likely any such immunity would be coupled with substitute regulation to avoid abuse of power by the HIPC. All three states enacting managed competition reforms, as discussed below, have sought to provide such immunity and substitute regulation.¹²⁰

Even if not constituting a monopsony purchaser, a HIPC and its member employers will have concerns under the antitrust laws. Most notably, since a HIPC will represent a number of health plan purchasers, its decision to refuse to contract with an available health plan could be challenged as an unlawful boycott under Sherman Act Section 1 and similar state laws.

There are also risks to AHPs and their participants under antitrust laws.¹²¹ If a network has market power or a dominant share of the providers who participate in other plans, it could be subject to a claim under Sherman Act Section 1.¹²² Thus, although Professor Enthoven envisions plans without overlapping panels of providers, plans may be wary of prohibiting providers from participating in other plans. Further, if one type of provider in an AHP, such as a hospital, is dominant in its market and directs referrals to another provider in the AHP, such as a home health service, thereby increasing the market share of the provider receiving the referrals, claims could be made that such activities are a type of illegal tying arrangement or a prohibited leveraging of monopoly power. In addition, providers in an AHP must be cautious that the activities in which they engage through the AHP cannot be characterized as resulting in an agreement among those providers to fix prices.

When states enact health care reforms they may seek to provide some immunity to prosecution under federal antitrust laws to HIPCs, AHPs or both, under the "state action" doctrine.¹²³ This doctrine provides private parties with antitrust immunity for their activities if there is a clearly enunciated state policy to supplant competition in favor of the subject activities and significant state involvement in the activities.¹²⁴ As discussed

¹¹⁹ 15 U.S.C. § 2 (1988).

¹²⁰ See *infra* pp. 26-33.

¹²¹ See *Blue Cross of Wash. and Alaska v. Kitsap Physicians Serv.*, 1982-1 Trade Cas. (CCH) para. 64588 (W.D. Wash. 1981).

¹²² *Id.*

¹²³ *Federal Trade Comm'n v. Tico Title Ins. Co.*, 112 S.Ct. 2169, 2176-77 (1992).

¹²⁴ See *id.*

below, states enacting health care reforms based on managed competition have included provisions intended to take advantage of the state action doctrine.¹²⁵ The effectiveness of such provisions in triggering application of the doctrine has not been judicially tested, however.

The Clinton Proposal contemplates publication of guidelines by the Department of Justice and Federal Trade Commission establishing "safety zones," exemplar of arrangements among providers that will not be considered violative of antitrust laws, and an expedited business review or advisory opinion procedure through which providers can get a response within 90 days concerning whether proposed ventures outside the safety zones will be challenged.¹²⁶ On September 15, 1993, a document entitled "Statements of Antitrust Enforcement Policy in the Health Care Area" was issued by those agencies establishing safety zones with respect to certain hospital mergers, hospital joint ventures involving high technology equipment, physicians' provision of information to purchasers of health care services, hospitals' exchange of price and cost information, joint purchasing arrangements and physician network joint ventures.¹²⁷ The Clinton Proposal also contemplates a narrow safe harbor for providers to establish and negotiate prices if they share financial risk and the publication of guidelines clarifying application of the state action doctrine.¹²⁸

Tax-Exempt Entities

Many participants in the health care industry, especially hospitals, are non-profit, charitable institutions exempt from federal income taxation under Section 501(c)(3) of the Internal Revenue Code. Such tax-exempt entities will have significant concerns that their relationships with AHPs not jeopardize their tax-exempt status. Further, it is expected that hospitals, physicians and other providers will become vertically integrated to an increasing extent so that they can offer a full range of services and bargain as a unit in formation of AHPs. Issues arise concerning tax exemption of independent, tax-exempt entities participating in such vertically integrated systems and concerning the ability of the system itself to obtain tax exemption.

The test applied in determining tax exemption of a hospital is the community benefit standard enunciated in Revenue Ruling 69-545.¹²⁹ Factors necessary to establish community benefit include maintenance of an open medical staff, with staff privileges available to all qualified physicians in the area; operation of a full-time emergency room treating all person regardless of ability to pay; provision of care to all persons able to pay

¹²⁵ *Id.* at 2175. See also *infra* pp. 26-33.

¹²⁶ See *President's Health Care Reform*, *supra* note 31, at 167-70.

¹²⁷ *Justice/FTC Antitrust Guidelines for Health Care Industry*, 2 Health Law Rep. (BNA) 1265 (Sept. 23, 1993).

¹²⁸ See *President's Health Care Reform*, *supra* note 31, at 170.

¹²⁹ Rev. Rul. 69-545, 1969-2 C.B. 117, 118.

directly or through private insurance or government programs; and use of surplus to improve quality of patient care, expand facilities and advance medical training, education and research.¹³⁰ This standard would pose a difficulty for a tax-exempt hospital seeking to participate in an AHP if the AHP is intended to have a separate pool of providers that do not participate in any other plans or accept referrals from physicians outside the AHP. Most notably, the requirement for an open medical staff is directly at odds with the managed care staff model structure favored by Professor Enthoven. Further, while the Internal Revenue Service has recently granted favorable letter rulings to two systems with integrated hospital and physician practices, it has sought to apply this community benefit standard in doing so, including application of the requirement for maintenance of an open medical staff.¹³¹

In seeking to form integrated systems, entities that are tax-exempt under Section 501(c)(3) also will need to be particularly mindful that their arrangements comply with the private inurement and private benefit restrictions applicable to them.¹³² Under these restrictions, no part of the net earnings of such a tax-exempt entity may inure to the benefit of a private shareholder or individual including, in the case of a hospital, any member of its medical staff.¹³³ In addition, if the private benefit to an individual of a tax-exempt hospital's transaction is more than incidental to the accomplishment of public benefits, the tax-exempt status of the hospital will be at risk.¹³⁴ Thus, transactions with physicians and with other for-profit entities will have to be undertaken carefully to assure those parties do not benefit inappropriately from the transactions.

Last, it should be noted that the Internal Revenue Service has recently taken the position that activities in violation of the Anti-Kickback Statute, discussed below, also jeopardize the tax-exempt status of entities involved.¹³⁵

Anti-Kickback and Self-Referral Laws

The Medicare Anti-Kickback Statute imposes criminal penalties on any entity which "knowingly or wilfully" pays or offers to pay, or solicits or receives, any remuneration (including any kickback, bribe or rebate) directly or indirectly, overtly or covertly, in cash or in-kind in exchange for the referral of patients for any item or service which is covered in whole or in part by Medicare or a state health care program, such as Medicaid.¹³⁶ The

¹³⁰ *Id.*

¹³¹ Letter from Marvin Friedlander, Chief, Exempt Organizations Rulings, Branch 1, I.R.S., to Peter N. Grant, attorney representing Friendly Hills HealthCare Network d/b/a Friendly Hills HealthCare Foundation (Jan. 29, 1993); letter from Jeanna s. Gessay, Chief, Exempt Organizations Rulings, Branch 2, I.R.S., to Facey Medical Foundation c/o Don Abramsky (Mar. 31, 1993) (on file with author).

¹³² I.R.C. § 501 (c) (3) (1988).

¹³³ *See id.*; Gen. Couns. Mem. 39, 862 (Nov. 22, 1991).

¹³⁴ *See* Gen. Couns. Mem. 39, 862 (Nov. 22, 1991).

¹³⁵ *Id.*

¹³⁶ 42 U.S.C. § 1320a-7b (b) (2) (1988).

existence of a valid business purpose for an arrangement is not sufficient to establish that the statute has not been violated, since a violation occurs if *one* of the purposes is to induce referrals.¹³⁷ Violation of the statute carries a criminal penalty, and civil sanctions also may be imposed.¹³⁸ Certain relationships and transactions specified in the statute or in regulations promulgated by the Department of Health and Human Services, including bona fide employment arrangements and personal service contracts meeting specified criteria, are immune from risk of civil or criminal prosecution.¹³⁹

The Ethics in Patient Referral Act of 1989, as amended by the Omnibus Budget Reconciliation Act of 1993¹⁴⁰ (the "Stark Bill") prohibits physicians from making referrals to entities in which they have an ownership interest or with which they have a compensation arrangement for the provision of certain enumerated items or services.¹⁴¹ The enumerated items and services currently consist of clinical laboratory services, and effective after December 31, 1994, will include physical and occupational therapy, radiology and other diagnostic services, radiation therapy, medical equipment and prosthetics, parenteral and enteral supplies, home health services, outpatient prescription drugs and inpatient and outpatient hospital services covered by Medicare or Medicaid.¹⁴² The Stark Bill provides exceptions to this prohibition for certain arrangements, including bona fide employment relationships and personal service arrangements meeting specified criteria.¹⁴³ Many states have enacted similar referral prohibitions that apply regardless of whether the service is covered by Medicare or Medicaid.

If a managed competition system is created in which providers are divided into vertically integrated, competing AHPs, physicians will undoubtedly be encouraged or required to refer patients only to other providers in their AHP. Thus, arrangements between physicians and AHPs or other providers in the same AHP will need careful structuring to meet the requirements of an exception to the Stark Bill and a safe harbor under the Anti-Kickback Statute. In addition, it may be necessary to qualify such arrangements for an exception from similar state statutes.

The Clinton Proposal would expand the Anti-Kickback Statute and the Stark Bill to cover all payers and all services, but would provide a safe harbor to the Anti-Kickback

¹³⁷ *United States v. Greber*, 760 F.2d 68, 72 (3d Cir. 1985), *cert. denied*, 474 U.S. 988 (1985).

¹³⁸ 42 U.S.C. § 1320a-7b (e) (1988).

¹³⁹ *See* 42 U.S.C. § 1320a-7b (b) (3) (1988 & Supp. III 1991); 42 C.F.R. § 1001.952 (1992).

¹⁴⁰ 42 U.S.C. § 1395 (1988 & Supp. III 1991); *as amended by* Omnibus Budget Reconciliation Act of 1993, Pub. L. 103-66, Title XIII, § 13562 (a), 107 Stat 596, 602, 604.

¹⁴¹ *Id.*

¹⁴² *Id.*

¹⁴³ *Id.*

Statute and an exception to the Stark Bill for payments made on an at-risk basis, such as capitated payments, to providers and health plans.¹⁴⁴

Employee Retirement Income Security Act

The Employee Retirement Income Security Act of 1974¹⁴⁵ ("ERISA") was enacted by Congress to establish minimum standards for private employee retirement and fringe benefit plans.¹⁴⁶ It does not mandate provision of any specific benefits or regulate the substantive content of benefit plans.¹⁴⁷ Because employer-sponsored health benefit plans are subject to ERISA, it may be expected that any federal health care reform based on managed competition would include changes to ERISA.

More importantly, ERISA contains broad provisions preempting state laws that "relate to" employee benefit plans, with the exception of a narrow listing of particular state laws (including insurance laws).¹⁴⁸ State attempts to mandate the benefits to be provided by plans subject to ERISA have been held to be preempted.¹⁴⁹ Thus, provisions of Washington's managed competition reform legislation, discussed below, which seek to require employers to provide health care coverage are subject to the state obtaining an exemption from ERISA permitting such a mandate.¹⁵⁰ Further, state efforts to obtain funding for expanding health care coverage have been subject to ERISA challenge.¹⁵¹ For example, a Louisiana District Court held that ERISA preempted application to ERISA plans of a Louisiana statute establishing a catastrophic health insurance program and providing for that program to be funded through collection of hospital service charges from insurance arrangements, insurers and self-insurers.¹⁵² Similarly, a tax assessed on hospitals under Minnesota's reform plans, discussed below, which the hospitals are initially permitted to pass on to third-party payers, has been challenged under ERISA on the grounds that it requires ERISA plans to fund the provision of benefits to people who are not plan participants.¹⁵³ Clearly, ERISA poses a significant impediment to states seeking to enact health care reforms based on a managed competition model.

The Clinton Proposal would establish a new chapter or title of ERISA regarding health benefit plans through corporate alliances and would not apply current provisions

¹⁴⁴ See *President's Health Care Reform*, *supra* note 31, at 173.

¹⁴⁵ Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, 88 Stat. 832 (codified as amended in 29 U.S.C. §§ 1001-1461 (1988 & Supp. 1991)).

¹⁴⁶ See *id.* § 1001 (c).

¹⁴⁷ See *id.* §§ 1001-1461.

¹⁴⁸ 29 U.S.C. § 1144 (a) (1988).

¹⁴⁹ *But see* Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 758 (1985).

¹⁵⁰ See *infra* pp. 26-33.

¹⁵¹ *Bricklayers Local No. 1 Welfare Fund v. Louisiana Health Ins. Ass'n.*, 771 F. Supp. 771 (E.D. La. 1991).

¹⁵² *Id.* at 776.

¹⁵³ Complaint, *Boyle v Anderson*, (D.C. Minn. June 3, 1993)(No. 3-93-359)(on file with author).

of ERISA to health benefit plans. The ERISA preemption provision would be modified to apply only to corporate alliances, permit non-discriminatory taxes or assessments on employers or health plans in corporate alliances, permit states to develop all-payer rates and permit states to require all payers to reimburse essential community providers.¹⁵⁴

State Laws

Insurance Laws

The regulation of insurance has been traditionally controlled by the states. There are a number of different state laws affecting health insurers and managed care organizations, including laws mandating provisions of various benefits in policies, requiring managed care organizations to permit participation of all willing providers in their plans, and affecting methods of underwriting and rating insurance policies. Federal health care reforms based on managed competition would preempt application of certain of these state laws and probably shift at least some traditionally state functions to the federal government.

Corporate Practice of Medicine

Laws in a number of states prohibit corporations (other than professional corporations owned solely by licensed physicians) from engaging in the practice of medicine.¹⁵⁵ Such laws may hamper vertical integration of providers by preventing health care entities from employing physicians to treat patients and, thus, requiring physicians to maintain independent entities. The Clinton Proposal would preempt application of corporate practice of medicine to arrangements between integrated health plans and their participating providers.¹⁵⁶

STATE LEGISLATION BASED ON MANAGED COMPETITION

Despite uncertainties concerning the nature of federal health care reform, states have been moving forward with their own reform measures. Some of those states have based their reforms on managed competition, at least in part. Although none of such legislation has been in effect long enough to provide insights into managed competition in practice, a brief review of such legislation gives some insights into the variations based on managed competition that are politically viable and the approaches that are being taken in addressing some of the implementation issues discussed above.

¹⁵⁴ See *President's Health Care Reform*, *supra* note 31, at 72-73.

¹⁵⁵ See Catherine Dunlay & Mark Peterson, *Corporate Practice of Medicine*, 2 HEALTH L.J. OHIO Issue 5, at 105 (Mar./Apr. 1991).

¹⁵⁶ See *President's Health Care Reform*, *supra* note 31, at 77.

Florida Legislation

To develop a program of managed competition, Florida's Health Care and Insurance Reform Act of 1993¹⁵⁷ (the "Florida Reform") uses Florida's existing eleven health planning districts as health care delivery regions.¹⁵⁸ Each region will have a Community Health Purchasing Alliance ("CHPA"), which will serve as a broker or facilitator to assist members in purchasing health insurance from Accountable Health Partnerships ("AHPs").¹⁵⁹ The CHPAs will be nonprofit, private corporations with board members appointed by the Governor, the Speaker of the House and the President of the Senate.¹⁶⁰ CHPA board members will be prohibited from having any connection with a health care provider or insurer.¹⁶¹

The CHPAs will establish conditions of alliance membership, provide alliance members with information on price, quality, patient satisfaction, and enrollee responsibilities for each AHP, and provide purchasing services for alliance members.¹⁶² Only small employers (with 50 or fewer employees) located within the boundaries of a CHPA are eligible to participate as purchasers, except that the state is authorized to participate for the purpose of purchasing health care for state employees.¹⁶³ Employer participation in a CHPA is voluntary; the Florida reform does not require any employers to offer insurance to employees or to participate in a CHPA.¹⁶⁴ Small employers participating in a CHPA are not required to pay any portion of premiums for their employees or their employees' dependents, but if an employer does contribute to their coverage, the employer must contribute the same dollar amount regardless of the AHP chosen.¹⁶⁵ Employers participating in a CHPA that have thirty or fewer employees must offer at least two AHPs, and such employers that have more than thirty employees must offer at least three AHPs.¹⁶⁶

CHPAs are required to offer their participating employees all health plans offered by AHPs that submit responsive proposals and provide all requested information.¹⁶⁷ CHPAs also are to ensure that any health plan reasonably available in their jurisdiction,

¹⁵⁷ Health Care and Insurance Reform Act of 1993, 1993 Fla. Laws ch. 93-129 (amending FLA. STAT. ch. 627 (1992)).

¹⁵⁸ *Id.* § 68.

¹⁵⁹ *Id.* § 66.

¹⁶⁰ *Id.* § 74.

¹⁶¹ *Id.*

¹⁶² *Id.* § 68.

¹⁶³ *Id.*

¹⁶⁴ *Id.*

¹⁶⁵ *Id.* § 69.

¹⁶⁶ *Id.*

¹⁶⁷ *Id.* § 68.

including PPO, HMO and other managed care organization products, *plus* indemnity products, is offered to their members.¹⁶⁸ In addition, CHPAs are responsible for developing a plan to facilitate participation of providers, especially minority physicians, in an AHP.¹⁶⁹

AHPs may be created by health care providers, HMOs and insurers.¹⁷⁰ An AHP must be licensed by the Florida Department of Insurance as either a health insurer or an HMO.¹⁷¹ Each AHP must report its cost and outcome data to the Florida Agency for Health Care Administration (the "Agency"),¹⁷² which will be responsible for certifying the CHPAs and AHPs, developing comparison sheets, and establishing a standardized data collection system.¹⁷³ For networks formed after July 1, 1993, an AHP must make offers to health care providers who have practiced for more than one year in the AHP's district for at least sixty percent of its available provider positions.¹⁷⁴ This provision, which precludes AHPs from satisfying their recruiting needs with recent graduates and physicians brought in from outside of the area, was lobbied for by the Florida Medical Association.¹⁷⁵

Under the Florida Reform insurers and HMOs issuing policies to small employers must issue those policies on a guaranteed issue basis, without regard to health status, pre-existing conditions or claims history, although benefits in addition to statutorily defined standard benefit plans may be offered through riders to such plans, and such riders may be medically underwritten.¹⁷⁶ In addition, the Florida Reform applies a modified community rating standard to small employer policies.¹⁷⁷ Rates may be adjusted based on age, gender, family composition, tobacco usage, and geographic location; however, rates may not be based on health status or claims experience of any individual or group.¹⁷⁸

The Florida Reform includes a provision requiring the Agency to actively supervise CHPAs to ensure that actions affecting market competition further the intent of the Florida Reform.¹⁷⁹ This provision is intended to provide the CHPAs with antitrust immunity, including immunity from prosecution under federal law pursuant to the state action doctrine.¹⁸⁰ Similar protection is not afforded to AHPs, although the Agency is

¹⁶⁸ *Id.*

¹⁶⁹ *Id.*

¹⁷⁰ *Id.* § 77.

¹⁷¹ *Id.*

¹⁷² *Id.*

¹⁷³ *Id.* § 70.

¹⁷⁴ *Id.* § 77.

¹⁷⁵ Terese Hudson, *Florida Health Care, HOSP. & HEALTH NETWORKS*, Aug. 5, 1993, at 38, 42.

¹⁷⁶ *Id.* § 65.

¹⁷⁷ *Id.*

¹⁷⁸ *Id.*

¹⁷⁹ *See id.* § 70.

¹⁸⁰ *Id.* § 71.

directed to study antitrust issues related to AHPs and cooperative arrangements among physicians.¹⁸¹

The Florida Reform also created MedAccess, a new state health insurance program for residents with incomes below 250% of the federal poverty level who have no private health insurance for the previous year.¹⁸² Premiums are to be paid by individuals and/or their employers without government subsidy.¹⁸³ Health care providers providing services to MedAccess patients will be reimbursed at applicable Medicaid rates.¹⁸⁴ MedAccess is intended to focus on primary care and prevention and to improve access to basic health care without waiting for federal Medicaid waivers and state and federal funding.¹⁸⁵ Federal approval to establish a Medicaid buy-in program for individuals below 250% of the federal poverty level will be sought.¹⁸⁶

Minnesota Legislation

In 1992, Minnesota enacted MinnesotaCare,¹⁸⁷ which created a new health care commission, instituted small employer and individual insurance reforms, set forth data collection initiatives and established an insurance program for low income residents and children.¹⁸⁸ MinnesotaCare also established a Private Employers Insurance Program, to be administered by a state agency, through which private employers would be given access to the purchasing power of a large pool.¹⁸⁹

Minnesota's 1993 health care reform law, the Minnesota Integrated Service Network Act,¹⁹⁰ provides for the creation of Integrated Service Networks ("ISNs") that will be responsible for arranging for or delivering a full array of health care services.¹⁹¹ An ISN may be organized as a separate nonprofit corporation or as a cooperative and can be formed by health care providers, HMOs, insurance companies, employers or other organizations.¹⁹² The networks can be established after July 1, 1994.¹⁹³

¹⁸¹ *Id.* § 75.

¹⁸² *Id.* § 41.

¹⁸³ *Id.* § 45.

¹⁸⁴ *Id.* § 47.

¹⁸⁵ *See id.* § 42.

¹⁸⁶ *Id.* § 41.

¹⁸⁷ Health Right Act, 1992 Minn. Laws ch. 549.

¹⁸⁸ *Id.* Art. I.

¹⁸⁹ *Id.* Art. III, § 1.

¹⁹⁰ Integrated Service Networks Act, 1993 Minn. Laws ch. 345 (will amend MINN. STAT. §§ 62A-62N).

¹⁹¹ *Id.* Art. I, § 2.

¹⁹² *Id.*

¹⁹³ *Id.* § 24.

Employers of any size may choose to join the purchasing pool established under MinnesotaCare, and no employers are required to participate.¹⁹⁴ Similarly, health care providers are not required to participate in an ISN.¹⁹⁵ Moreover, providers will be permitted to participate in more than one network and to serve both patients who are covered by an ISN and those who are not.¹⁹⁶

By January 15, 1994, the Minnesota Commissioner of Health (the "Commissioner") is required to submit to the legislature and the governor a detailed ISN implementation plan which includes rules and legislation.¹⁹⁷ The implementation plan must encourage competition among ISNs through the collection and distribution of reliable information on the cost, prices, and quality of each. Each ISN will be required to offer up to five standardized benefit plans which will be defined by the Commissioner.¹⁹⁸ The plans will vary in the amount of their premiums and enrollee cost sharing.¹⁹⁹

Cost control through global budgeting is a key feature of the Minnesota statutes. The Commissioner is required to establish an annual limit on the rate of growth of public and private spending in health care services.²⁰⁰ ISNs will be required to offer services at a capitated rate not exceeding a maximum rate to be established by the Commissioner.²⁰¹ Providers who do not participate in ISNs will become part of a regulated all-payer system to be phased in over two years beginning July 1994.²⁰² That system will include controls on payments to providers, such as fee schedules or rate limits, to be established by the Commissioner.²⁰³

MinnesotaCare requires carriers offering insurance to small employers to offer two plans specified in the statute and to issue plans to any small employer (with two to 29 employees) without regard to health status.²⁰⁴ Similarly, the ISNs will be required to offer health care services and coverage to all Minnesota residents and will be prohibited from refusing coverage to any individuals or groups because of pre-existing conditions or health status.²⁰⁵ The networks' enrollment standards must ensure that high risk and special needs populations will be included, and growth limits and payment systems must

¹⁹⁴ 1992 Minn. Laws ch. 541, Art III, § 1; *see also* Christine B Moore, *HealthRight: Filling the Gaps in a High-Access State*, NAT'L CIVIC REV., Spring-Summer 1992, at 137, 141.

¹⁹⁵ *Id.* § 6.

¹⁹⁶ *Id.*

¹⁹⁷ *Id.* § 1.

¹⁹⁸ *Id.* § 12.

¹⁹⁹ *Id.*

²⁰⁰ *Id.* Art. II, § 5.

²⁰¹ *See id.*

²⁰² *Id.* Art. II, § 2.

²⁰³ *Id.*

²⁰⁴ 1992 Minn. Laws ch. 549, Art. II, § 5.

²⁰⁵ 1993 Minn. Laws ch. 345, Art I, § 6, Subd. 3(d).

be designed to provide incentives for networks to enroll even the most challenging and costly groups and populations.²⁰⁶

The Minnesota statutes include provisions for review of proposed arrangements among purchasers or providers by the state and grant of antitrust immunity to arrangements found to further the legislative intent.²⁰⁷ Such immunity is intended to include immunity from prosecution under federal law pursuant to the state action doctrine.

The Minnesota reforms are intended to encourage small businesses to provide insurance to employees, but do not provide for universal coverage.²⁰⁸ A subsidized minimum benefit insurance package for low-income families was established, however, to expand coverage. Several approaches were used to pay the costs of the Minnesota programs, including a gross revenue tax on hospitals, physicians and other providers and a cigarette tax. Hospitals are permitted to pass the cost of the tax on to payers until 1994 and are prohibited from doing so thereafter.

Washington Legislation

The goal of Washington's Health Services Act of 1993²⁰⁹ (the "Washington Reform") is to cover all Washington residents under a basic package of health benefits.²¹⁰ The statute requires all persons living in Washington to purchase at least a Uniform Benefit Package ("UBP") by 1999 (subject to certain exceptions for religious objections). If Congress exempts Washington employers from ERISA, employers will be required to offer at least three Certified Health Plans and pay at least 50% of the premium for the UBP for each employee and their dependents.²¹¹ If Washington residents are low-income, the State will pay part of the premium.²¹² In addition, government-administered programs including a Basic Health Plan, First Steps and Medicaid will be expanded to enroll adults and children below 200% of the federal poverty level.²¹³

As part of the Washington Reform, the Health Services Commission ("HSC") is created to design the UBP, which will be the minimum level of coverage, the optional

²⁰⁶ *Id.*

²⁰⁷ 1992 Minn. Laws ch. 549, Art. I, § 14; 1993 Minn. Laws ch. 345, Art. IV, § 14.

²⁰⁸ 1992 Minn. Laws ch. 549, Art. II, § 3; 1993 Minn. Laws ch. 345, Art. I, § 6, Subd.(d); *see also* Barbara P. Yawn, M.D. et al., Minnesota Care (HealthRight) Myths & Miracles, 269 JAMA 511 (Jan. 27, 1993).

²⁰⁹ Health Services Act, 1993 Wash. Laws ch. 492.

²¹⁰ *Id.* § 102.

²¹¹ *Id.* § 464.

²¹² *Id.*

²¹³ *Id.*

supplemental benefit packages.²¹⁴ The HSC will also set the maximum premiums that a Certified Health Plan can charge for the UBP.²¹⁵

The law provides that after July 1995, only risk-bearing managed care organizations which are state-Certified Health Plans ("CHPs") will be permitted to offer insurance in Washington.²¹⁶ In order to be certified, a plan must offer the UBP through managed care arrangements for no more than the maximum premium set by the HSC, enroll anyone who desires to enroll (regardless of age or health status), and charge community rated premiums with modification for geographic and family size differences.²¹⁷ CHPs also will be required to publish selection criteria for providers and give every category of provider the opportunity to participate.²¹⁸ Health insurance issued prior to the July 1995 effective date of this requirement will be subject to similar reforms, including restrictions on the use of pre-existing condition limitations and prohibitions against cancellation or nonrenewal of policies because of health status.²¹⁹

Private employers will have several options to provide their employees with a UBP. First, employers with more than 7,000 employees could run their own CHP, called a registered employer health plan. Second, employers could contract directly with CHPs. Third, they could directly purchase coverage through the state's Basic Health Plan at the full cost if they do not already offer more comprehensive insurance.²²⁰ Finally, employers could join a Health Insurance Purchasing Cooperative ("HIPC") to reduce administrative burdens and to increase their buying power.²²¹ A Small Business Assistance Fund is created to assist employers with 25 or fewer employees meet their obligations.²²²

Larger employers will be the first to be phased into Washington's reform system. Businesses with more than 500 employees will have to provide coverage for employees by July 1995 and their employees' dependents by July 1996.²²³ Employers with between 100 and 499 employees will have until July 1996 for their employees and until July 1997 for their employees' dependents.²²⁴ Employers with fewer than 100 employees will have

²¹⁴ *Id.* § 403.

²¹⁵ *Id.* § 406.

²¹⁶ *Id.*

²¹⁷ *Id.*

²¹⁸ *Id.*

²¹⁹ *Id.*

²²⁰ *Id.*

²²¹ *Id.*

²²² *Id.*

²²³ *Id.*

²²⁴ *Id.*

until July 1997 to provide benefits; dependents of employees in these small companies will not have to be covered until 1999.²²⁵

The Washington Reform creates HIPCs, nonprofit organizations that are member owned and governed, in each of four geographic regions.²²⁶ The HIPCs will be regulated by the Insurance Commissioner.²²⁷ HIPCs must allow any group or individual in the region to join, offer every CHP in the region, collect information on CHPs, conduct enrollments, and collect premiums.²²⁸

A statewide health data system including information on cost, quality and outcome is to be created, and the Washington Department of Health is to develop reports for consumers based on this data.²²⁹

These reforms will be financed, in part, by phased-in tax increases on alcohol and tobacco products.²³⁰ Revenue will also be created by a phased-in business and occupation tax on nonprofit hospitals and new taxes on HMOs, health care service contractors, and CHPs.²³¹

The Washington Reform provides for regulation and oversight of providers and CHPs to protect competition and promote choice. Actions furthering the legislative intent are granted immunity from prosecution under state antitrust laws and, pursuant to the state action doctrine, under federal antitrust laws.

HOW THESE STATES HAVE USED MANAGED COMPETITION

Certain elements of Professor Enthoven's managed competition model are present in the reforms of all three of these states. All of them provide for creation of HIPCs and AHPs, although not necessarily in the form envisioned by Enthoven. All three also establish some type of standard benefit package.²³² Further, all three eliminate experience rating (at least in the small employer market) and require issuance of insurance without regard to health status.²³³ Last, all three establish programs for collecting cost and quality data and providing that information to consumers.

None of the state models reviewed, however, is entirely consistent with Enthoven's model and, in fact, all of them include features Enthoven describes as contrary to man-

²²⁵ *Id.*

²²⁶ *Id.* Part I.

²²⁷ *Id.*

²²⁸ *Id.* Part II.

²²⁹ *Id.*

²³⁰ *See id.* Part III.

²³¹ *Id.*

²³² *See supra* text pp. 26-33 and notes 157-231.

²³³ *See supra* notes 157-231.

aged competition and/or fail to include features Enthoven describes as critical components. The reforms in Minnesota and Washington are both characterized by government budgets and price restraints, which Enthoven considers incompatible with managed competition. Both Florida and Washington require HIPCs to give all AHPs the ability to participate, thus limiting the ability of HIPCs to negotiate selectively. Florida's program expressly includes indemnity plans, and none of the three programs appear likely to create mutually exclusive, competing provider groups. Finally, only one of the three, Washington, mandates universal coverage.²³⁴ It is reasonable to conjecture that the urgent need to control costs, the costliness of providing universal coverage and concern about the interests of providers, insurers and employers underlie such deviations from Professor Enthoven's managed competition model.

CONCLUSION

There is widespread agreement that the current health care system in the United States is badly in need of reform. The reform plan proposed by the Clinton Administration, while not a pure managed competition system, incorporates versions of some of its key components, including HIPCs, universal coverage, community rating and continuous coverage, a standard benefit package and dissemination of cost and quality information. Accordingly, the debate concerning the feasibility, effectiveness and cost of such measures can be expected to continue and to intensify.

²³⁴ See *supra* notes 157-231.