

P E R S P E C T I V E

Market Forces And Efficient Health Care Systems

Market forces could be made strong enough to produce efficient health care systems, but it would take large changes.

by **Alain C. Enthoven**

ABSTRACT: The “market forces” to which economists ascribe the ability to motivate improvement in quality and efficiency are largely nonexistent in U.S. health care. One thus might ask, “Could market forces be made strong enough to deliver efficient health care systems?” There is some evidence to suggest that the answer is “Yes.” This paper offers a short list of some changes that would be needed to create such a health care economy. Continued increases in costs and in the numbers of uninsured people will likely make a universal coverage model based on Medicare a politically popular choice, but such a model would not deliver efficient health care systems because it lacks sufficient incentives for consumers to choose less costly options.

I DO NOT DISAGREE WITH the empirical findings of Len Nichols and his colleagues. But I do deplore the state of affairs their findings represent, particularly the confusion over the meaning of “market forces.” The “market forces” to which economists ascribe the ability to motivate continuous improvement in quality and efficiency are not just any old bunch of people buying and selling. Rather, such “market forces” meet certain fundamental conditions, including that the buyers are (reasonably well) informed, are using their own money (at least at the margin), and face a choice among competing alternative suppliers. We have little of such market forces in U.S. health care today. The forces that do exist are badly distorted or blocked by employers’ failure to offer employees responsible choices; by the tax treatment of “employer-paid” health insurance; by providers’ resistance to the collection and publi-

cation of quality-related information; by provider monopolies; and by laws and regulations that block the development of high-quality, cost-effective alternatives to fee-for-service (FFS) indemnity insurance. These are things that could be changed.¹

■ **When is choice of insurance really not a choice?** The employers of most insured Americans do not even offer a choice of health insurance carriers.² That usually means they have a wide-network, all-inclusive preferred provider organization (PPO), a model that is particularly incapable of managing quality or cost. FFS medicine is the most expensive kind of medicine: A single carrier offering three plan designs—a health maintenance organization (HMO), a PPO, and a point-of-service (POS) plan—all using essentially the same FFS doctors, is not “a choice of efficient health care systems.” The remaining employers offer choices, but most contribute much more toward the

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more costly PPO than toward the HMO. Many of them pay a flat 80–100 percent of the premium of the plan of the employee's choice, which means an 80–100 percent tax on efficiency.³ A really sad and disappointing story I hear these days is of the employers who offered choices, paid (practically) the whole premium, found that few people joined the HMOs (because they weren't allowed to keep any or much of the savings), and so dropped the HMOs because “nobody wanted them.”

The situation is ironic because many employers do follow a reasonably good approximation to the managed competition model.⁴ The list includes Stanford University, the University of California system, Harvard University, American Management Systems, Wells Fargo Bank, and Hewlett-Packard. I usually include the Federal Employees Health Benefits Program (FEHBP) and the California Public Employees' Retirement System (CalPERS) in this honor roll, but both of them need major tune-ups.⁵ And many small employers offer multiple choices to employees through exchanges such as California Choice.⁶ So it is not as though employers can't offer choices and make fixed-dollar contributions.

■ **Could market forces be strengthened enough to deliver efficient systems?** There is evidence that they could be: When given information and responsible choices, most people migrate to what they see as value for money, at least when choices are available as they are or can be in metropolitan areas. Efficient health care systems do very well in markets created by employers that offer responsible choices. In CalPERS, typically 80 percent of employees choose HMOs, and more would do so if HMOs served the rural areas where they live. (These are thinly populated areas where market forces may never be strong enough to support efficient health care systems.) At Stanford, only 14 percent of employees chose the PPO for 2004.

■ **What changes would be needed?** To create a health care economy in which market

forces are strong enough to deliver efficient health care systems, many changes would be needed. Here is a short list.

First, employers would have to offer their employees multiple, wide (not only HMOs), responsible (the employee who chooses the less costly plan gets to keep the savings), informed, individual choices. To make choices responsible, employers would need to make a fixed-dollar contribution, allowing employees who choose plans costing less than that to keep the savings. Congress could mandate choices and fixed-dollar amounts.

Second, competition would need to be managed. For example, there must be enough standardization in benefit packages, appropriate enrollment processes, and so

forth to create price-elastic demand. Sponsors of managed competition must risk-adjust the premiums so that health plans that enroll patients with chronic diseases are not punished for doing so and so that plans that attract bad risks but that would be attractive to consumers at actuarially fair premiums are not driven out of the market.

Third, there would need to be a renewed effort to apply antitrust laws to health care, to go after and break up provider monopolies that were created for the purpose of gaining market power, to correct the situations such as that in Boston described by Nichols and colleagues. Fourth, Congress would need to override states' “any-willing-provider” laws. Fifth, there would need to be a regulatory overhaul to create a level playing field.⁷

If this list is too daunting for U.S. employers and policymakers, then effective market forces will not exist, and what does exist will not be strong enough to deliver efficient health care systems. On the contrary, efficient health care systems will continue to languish or disappear, and the much more costly unmanaged FFS model will win out.

■ **Why not “Medicare for All”?** It is late, probably too late, to avert the inexorable progression to “Medicare for All.” U.S. employers

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would need to have an epiphany soon. But when it comes to health care, most of their horizons are so limited and their vision so constrained that such a change seems unlikely.

What is becoming most likely is that the winning candidate in 2008 will make “Medicare for All” a foundation of his or her platform. And employers, incapable of controlling costs and desperate to get medical expenses off their financial statements, will lead the candidate’s campaign finance committee. Labor and small business will join them. The large and growing numbers of uninsured, by then reaching well into the middle class, will consider the issue to be of top priority.

While I would welcome universal coverage as long overdue, I think it would be a tragedy to lock in FFS Medicare and deny people the opportunity to save money by choosing less costly options. The recent Medicare “reform” debate shows that it will be almost impossible to dislodge FFS from Medicare. FFS makes doctors and payers adversaries. It punishes doctors for innovating in ways that make their costly services less needed. The burden of chronic disease is growing rapidly, yet our FFS delivery system is oriented toward episodic, acute care. FFS promotes the wide variations in practice patterns documented by John Wennberg and colleagues.⁸ And it certainly does not motivate quality improvement in the sense of discouraging overuse, underuse, and misuse. Providers do not bear the costs of their poor quality.

MEDICARE FOR ALL will end up with an impasse like Canada’s, only much more costly. The Medicare model will not deliver efficient health care systems. A properly structured market model, based on existing demonstrated successes, could.

NOTES

1. A.C. Enthoven, “Employment-Based Health Insurance Is Failing: Now What?” *Health Affairs*, 28 May 2003, content.healthaffairs.org/cgi/content/abstract/hlthaff.w3.237 (18 December 2003).
2. M.S. Marquis and S.H. Long, “Trends in Managed Care and Managed Competition, 1993–

1997,” *Health Affairs* (Nov/Dec 1999): 75–88. Also see J. Maxwell and P. Temin, “Managed Competition versus Industrial Purchasing of Health Care among the Fortune 500,” *Journal of Health Politics, Policy and Law* 27, no. 1 (2002): 5–30.

3. Henry J. Kaiser Family Foundation/Health Research and Educational Trust, *Employer Health Benefits: 2002 Annual Survey* (Menlo Park, Calif.: Kaiser/HRET, September 2002).
4. A.C. Enthoven, “The History and Principles of Managed Competition,” *Health Affairs* (Supplement 1993): 24–48.
5. The FEHBP has a provision that if a health plan offers a premium below the government’s contribution level, the employee gets to keep only one-quarter of the savings. This is a strong disincentive to offering a premium below the contribution, a 75 percent tax on efficiency. This should be replaced by a pure fixed-dollar contribution, allowing the employee who chooses a less costly plan to keep all of the savings. In addition, the FEHBP needs regional pricing, diagnosis-based risk adjustment, and a minimum standard for benefit packages. CalPERS also needs regional pricing, a diagnosis-based risk adjustment, and a true fixed-dollar contribution policy among the participating local government agencies. In addition, CalPERS needs a way of designing and offering less costly benefit packages as market conditions change. And because CalPERS is a voluntary exchange, it probably needs to use risk-adjusted employer contributions to the pool as well as risk-adjusted payments to health plans. These government agencies have been models of managed competition, but the rigidities of the political process have prevented them from adapting to current market conditions and technology.
6. See the CaliforniaChoice home page, www.calchoice.com/default.asp.
7. A.C. Enthoven, “Open the Markets and Level the Playing Field,” in *Toward a Twenty-first Century Health System: The Contributions and Promise of Prepaid Group Practice*, ed. A.C. Enthoven and L.A. Tollen (San Francisco: Jossey-Bass, March 2004), 227–245.
8. J.E. Wennberg, E.S. Fisher, and J.S. Skinner, “Geography and the Debate over Medicare,” *Health Affairs*, 13 February 2002, content.healthaffairs.org/cgi/content/abstract/hlthaff.w2.96 (18 December 2003).