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Managed Competition: Revisiting Enthoven's Principles

Anjali Nambiar*

Abstract

The term "managed competition" was coined by Alain C. Enthoven in many of his early writings as a response to America's ailing healthcare system. The idea evolved from its conception as a means of regulation to a much more active and "intelligent" management of the healthcare market by what he calls a "sponsor". Scholars have identified the manifestation of managed competition in other jurisdictions, which adhere to some of Enthoven's principles but might deviate from others, especially in the characterisation of the sponsor's role. In this piece, we revisit Enthoven's principles and propose a broader definition of the concept of managed competition in order that it may encompass other countries' experiences that do not conform to a strict application of Enthoven's concept.

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*Author works with Dvara Research, India. Corresponding author's Email ID is anjali.nambiar@dvara.com

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1 The Emergence of Managed Care

Enthoven conceptualises managed competition in the context of managed care entities and emphasises their existence as a pre-requisite for such a competitive environment to yield favourable quality and efficiency outcomes. The market, thus created by the sponsor, is one of competing managed care entities. Hence, before delving into the principles of managed competition, it is necessary to discuss the managed care model and its merits.

The traditional health insurance system in the United States (US) provided free choice of doctors who were paid on a fee-for-service (FFS) basis[1] and were usually solo practitioners. The insurers acted as remote third-party payers who would reimburse patients for their medical bills (Enthoven, 1988). Called the "guild free choice" model, it provided significant advantage to the providers as they decided the course of treatment/s and the pricing of the same. Since the fees were negotiated by the doctors directly with the patients, the information asymmetry inherent in this interaction allowed provider-induced moral hazard to play out.

While the guild free choice model dominated the healthcare system, the multispecialty group practices pioneered managed care by providing plans that included prepayment and "limited provider" choice in the 1920s. Enthoven drew attention to the managed care organisations (MCOs) which were emerging in the market, for instance, health maintenance organisations (HMOs) and preferred provider insurance (PPI) plans (Enthoven, 1988). In such organisations, the insurers would contract providers into a network to provide care to their insured, a process called selective contracting (van den Broek-Altenburg & Atherly, 2020). The integration between the insurer/purchaser and providers facilitates an alignment of incentives. The degree of integration is determined by the nature of the contracts with providers which can be exclusive (e.g., HMOs) or non-exclusive (PPIs) (Ashraf, 2020). Nevertheless, selective contracting with provider networks increased the insurer's say in the coordination of care across the spectrum and in the terms of provider payment. The model also shifts the payment mechanism from the traditional FFS for each service to an annual premium amount[2] for such integrated health plans providing insurance cover and healthcare (Enthoven, 1993).

[1]The fee-for-service (FFS) model pays physicians based on the number of services or procedures provided to patients.

[2]Employing annual premiums is one of the necessary conditions of managed competition as it removes the perverse incentives associated with payments for each healthcare service provided (FFS). Later in the paper, we acknowledge that the payment mechanism by the insurers to the providers might however still rely on FFS payments leading to rising costs.

The core principles of managed care are the monitoring and coordination of care (primary through tertiary care), an emphasis on prevention, the provision of appropriate care, and the alignment of incentives between purchasers/insurers and providers (Sekhri, 2000). In essence, managed care seeks to burden providers with some part of the risk of insurance, and introduce gatekeeping, so as to address both consumers' moral hazard. In this piece, we argue that these functions can be performed by different actors in the health system, or even through regulation, in the absence of complete integration of the purchaser and the provider.

2 The Principles of Managed Competition

While MCOs addressed many of the flaws of the traditional FFS system, integrated entities could still compete to produce undesirable outcomes. Such market failure can occur through risk selection, product differentiation, discontinuity of coverage and entry barriers (Enthoven, 1988). To counter such tendencies of the market to fail, Enthoven emphasised the need to "manage" the market. He described managed competition as a purchasing strategy by the sponsor that leverages the mechanism of price competition to ensure efficiency and quality in the healthcare system (Enthoven, 1993). The strategy involves purchasing healthcare from a variety of plans on behalf of a group of people and then allowing individuals to choose which plan they'd like to opt for. Enthoven clarifies that price competition does not limit its scope strictly to price, but also includes quality and product features as factors influencing the customer's choice. He, therefore, prefers to use the phrase "value-for-money" competition (Enthoven, 1993). The sponsor "manages" the market of competing managed care entities by performing the following broad functions:

1. Establishing rules of equity in the market.
2. Selecting the participating plans to control quality standards.
3. Managing enrolment process.
4. Creating price elastic demand.
5. Managing risk selection.

In the next section, we take up these functions in more detail, along with examples of their application in different health systems.

3 The Application of Enthoven's Principles in Different Contexts

Written in the United States' context, Enthoven's early works are mainly concerned with the challenges faced by the American healthcare system in terms of rising costs and poor health outcomes. Consequently, the theory of managed competition that he posits, is mainly composed of a set of principles to address these challenges and is rooted in the conception of the sponsor as the employer, or a group of employers as seen in many states of the US. Enthoven does, however, observe that the sponsor could also be welfare trusts, Health Care Financing Administrations (HCFA), and state governments (Enthoven, 1988). We will argue that managed competition models can also exist at the national scale, as in the case of the social health insurance systems in the Netherlands, Israel, Germany and Switzerland (Table 1). To encompass such cases, we need to broaden the definition of managed competition to make fluid the characterisation of actors in the market environment while keeping the core principles intact and cardinal. What is common across the health systems in these jurisdictions is the role of the sponsor being assumed by the government or a public body. While the characteristics of the systems could vary, they embody most of the core principles of managed competition. The competing entities could be sickness funds (as in Germany and Israel) or private insurers with varying levels of contracting with providers (as in Switzerland and the Netherlands). For clarity, we hereon use the term health plans to refer to integrated entities in the market.

The functions of the sponsor as outlined by Enthoven are observed in these health systems in different forms. We reflect on each of those functions and their application in the health systems under study.

3.1 Establishing rules of equity

The principle of equity in healthcare envisions universal access to healthcare in terms of both affordability of care and entitlement to the same basket of care. Social health insurance systems provide universal health coverage to their citizens by addressing the affordability aspect through income-based contributions or community rating. While Israel and Germany use mandatory contributions, the Netherlands and Switzerland have employed community rating wherein individuals in a region pay the same premium regardless of age, sex, and pre-existing diseases. All systems use subsidies to cover those who cannot pay for themselves (e.g., unemployed and elderly members). Standardised benefit packages and the mandate to offer them to all consumers ensure equity in access to the same services.

3.2 Selecting participating plans

According to this principle, the sponsor is tasked with choosing plans in the market on behalf of the consumers (Enthoven, 1993). While the government puts in place regulations to ensure that standards of care are met, it does not actively select plans for its population. Instead, some health systems provide public information on the performance of health plans for consumers to exercise informed choices. In the Netherlands, the government provides information on the quality and price of care provided by different health plans (van Ginneken et al., 2011). Scholars have noted the absence of such quality information to consumers in Israel (van de Ven, 2016) and Switzerland (De Pietro et al., 2015) as a drawback in these health systems.

3.3 Managing enrollment process

Enthoven stresses the importance of active management of the enrolment process to ensure acceptance of all members by health plans and allowance of switching between plans (Enthoven, 1993). Such provisions are necessary for universal coverage as well as to ensure competition among the plans. In the social health insurance systems under consideration, the sponsor does not actively manage this enrolment process but uses other means to ensure that the desired objectives are met. While the universal acceptance of individuals is ensured under the rules of equity set by the government, switching between plans is another feature provided as an option to members at different points in the year. Members are allowed to switch plans twice a year in Israel (Rosen et al., 2015) and Switzerland De Pietro et al. (2015), once in 18 months in Germany (Blümel et al., 2020), and once every year in the Netherlands (Kroneman et al., 2016). Hence, regulations are established at the system level for customer protection, whereas a typical sponsor (like an employer in the US) would be actively involved in the enrolment of all his/her employees and monitoring of the plans they are subscribed to.

3.4 Creating price elastic demand

The purpose of the sponsor is to create price elastic demand so that health plans are incentivised to cut prices to gain market share from the competition (Enthoven, 1993). Enthoven describes the sponsor's role in this regard in terms of limited sponsor contributions, standard benefits package, providing quality information to consumers to make informed choices, individual choice of plans, and disincentivising risk selection (Enthoven, 1993). We have looked at the features of standard benefits packages and risk adjustment (to disincentivise risk selection) in terms of setting conditions of equity in the market. Limiting sponsor contributions is re-

quired to provide enough gap between it and the price of the lowest-priced plan so that there is price competition. In the contexts we have considered, instead of pure price competition, health plans compete with one another for members and are hence motivated to provide better quality care for the same price. Choice of plans by individuals and providing quality-related information are important features enabling an environment where plans compete for well-informed customers. This feature resonates with the "value-for-money" competition envisioned by Enthoven.

3.5 Managing risk selection

Since the absence of risk rating can induce risk selection by insurers, the governments in these jurisdictions mandate entities to accept all applicants. Further, risk adjustment in these health systems through capitated funds aims to compensate health plans for the additional risk they take on. The risk adjustment scheme was initiated based on factors of age and sex which would make some individuals "bad risks" for insurers leading to their exclusion from the system. It was realised later that these factors were insufficient to counter risk selection, necessitating the introduction of health risk-based adjustment taking into account the susceptibility to health shocks. Switzerland, for instance, considers previous hospitalisation events and expenditure on medicines to determine the risk adjustment to be provided to health plans (De Pietro et al., 2015). The health systems in Germany and the Netherlands rely on a morbidity-based risk adjustment scheme (Blümel et al., 2020), and risk-adjustment for the health risk profiles (Kroneman et al., 2016), respectively. Israel continues to use an age-based risk adjustment but has recently incorporated sex and region as factors requiring adjustment (Rosen et al., 2015) and is yet to incorporate risk profiles as a comprehensive measure to prevent risk selection.

Hence, the principles of managed competition have been adopted by all the health systems in consideration, albeit through regulations, with the government or a public body acting as the sponsor. In such cases, the management of the competitive environment by the sponsor i.e. the government/public body primarily entails the establishment of rules of equity, creation of price elastic demand, and management of risk selection. The active selection of plans in the market, on behalf of people as well as the enrolment process, is largely found to be absent in such systems indicating a passive role of the sponsor in this regard. Nevertheless, as seen above, providing information to consumers and instituting regulations serves the purpose of meeting the goals of managed competition. In this regard, the Netherlands and Switzerland are more active in the dissemination of information as well as regulation of plans in the market (see Table 1).

Table 1: Countries with Managed Competition

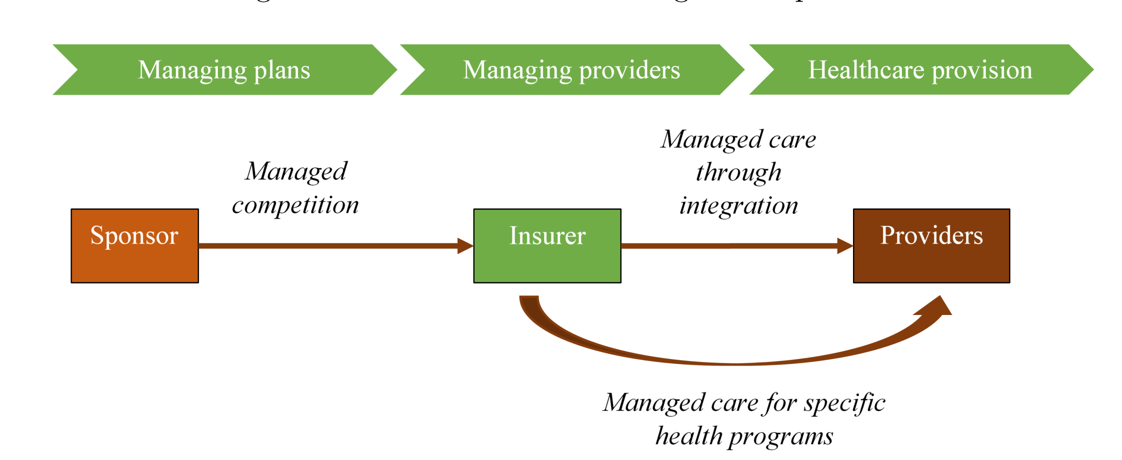
	The Netherlands (Social Health Insurance system)	**Switzerland (Mandatory Health Insurance system)**	**Germany (Statutory Health Insurance system)**	**Israel (National Health Insurance system)**
Insurer	Private insurers	Private insurers	Sickness funds	Sickness funds
Provider	Hospitals, physicians, & specialists are independent.	Cantonal hospital associations; Provider-payer associations	Regional association of physicians, Public hospital system	Provider networks
Managed care	Insurers negotiate contracts with independent providers & hospitals. Selective contracting with specialists.	Insurance plans with some restrictions of choice of provider.	Limited selective contracting seen in add-on programs (for instance, a diabetes management program).	Exists with ownership or contracts with providers.
Sponsor/ active or passive role	Dutch Health Care Authority/active	Federal Office of Public Health/active	Federal Ministry of Health & Federal Social Security Office/passive	National Insurance Institute/passive
Payment to hospitals	Diagnosis-related group (DRG)	Fee schedules (ambulatory care) & DRG (acute care)	DRG	Procedure-related group (PRG)
Payment to physicians	Combination of FFS, capitation, & pay for performance (P4P)	FFS	FFS	Capitation
Community rating	50% community-rated; 50% income-dependent	Yes, but premiums differ on age classes.	No, income-dependent (flat wage tax rate)	No, income-dependent (health tax)

4 The Essence of Managed Competition

As summarised in the previous section, the role of the sponsor and the associated functions are performed by a public body that is itself the government or acting on its behalf. As has also been noted, the form the sponsor's "management" takes is usually that of regulatory norms. The achievement of the objectives of managed competition can also be facilitated through negotiations at the regional/national level between provider and insurer groups instead of selective contracts between individual insurers and providers. Such an arrangement is observed in Germany with limited use of selective contracting mainly for the purpose of coordination of healthcare (Nambiar, 2021). The limited presence of such selective contracting in the German SHI system is the first sign of integration of not only care across levels but also integrated purchaser-provider networks in the market. In such systems, plans have the freedom to decide payment methods unlike the national level arrangement in the SHI system. While plans have experimented with pay-for-performance, capitation and FFS models of payment, the emergence of the former two as the dominant methods (to move away from traditional FFS payments) would be dependent on negotiations and bargaining between the insurers and providers. Not only Germany, but also the systems of the Netherlands and Switzerland employ FFS as the payment method for physicians (see Table 1). While this can be a drawback, the use of DRG payments for hospital care is an advanced form of FFS wherein the hospitals get paid a fixed cost for the treatment of the disease instead of each service provided in the treatment (Roberts et al., 2008). The insurers in the Netherlands and Switzerland also negotiate with providers on the fee schedules (for FFS) and budget ceilings to control costs (De Pietro et al., 2015; Kroneman et al., 2016).

Apart from the functions of managed competition being performed by the government as the sponsor, the functions of managed care in social health insurance settings could also be introduced by the government or a public body through particular programs (see Figure 1). Such a broader role of the sponsor is possible considering the common objectives of efficiency and equity in managed care and managed competition. In managed care models, the insurer contracts with providers and endeavours to create coordination, integration and the right incentives for efficiency and quality in healthcare provision. In the health systems of Germany and Switzerland, selective contracting is limited to specific health programs, either with add-on programs (in the former) or with specialist care (in the latter). However, the function being performed here is that of integration and coordination through regulations. Hence, the sponsor creates an environment where the principles of managed care are promoted through regulation despite the absence of integrated entities.

Figure 1: Manifestation of Managed Competition



Regardless of a public/private sponsor and the kind of integration, it is essential to align incentives between the purchasers and the providers in the market. This is also vital for managed competition to manifest wherein cost and quality metrics become the areas of differentiation from their competition (Shmueli et al., 2015).

Where the sponsor performs functions of managed care by creating incentives for providers, such regulation would likely be passive, as is seen in many social health insurance contexts. While we can broaden the role of the sponsor and increase the scale (national), the active "management" of the competitive environment is the prerequisite, which seems to be amiss in such systems. Nevertheless, there are examples within the US context itself wherein the manifestation of managed competition took a different form than what was envisioned. In the state of California, instead of competition between HMO (health maintenance organisation) units, Enthoven observes the presence of HMO carriers that contract with multiple hospital networks (Enthoven & Singer, 1996). Hence, the application of the principles of managed competition can take different forms depending on the contextual features and the role of the regulator in the health system.

5 Conclusion

The essence of Enthoven's idea of managed competition revolves around a balanced use of regulation to steer market forces towards the goals of efficiency and equity. Social health insurance systems exhibit these intentions through similar tools to manage the market. While functionally defining both managed care and managed competition lets us arrive at a broader understanding of the concepts in operation, it also carries the risk of diluting his principles or blurring the lines between indemnity and managed care. Hence, it is important to adhere to the principle of risk-sharing not only with the insurers but the providers as well, to move the burden away from the individuals. In such an endeavour, entities with some form of integration (multiple possible configurations) overseen by a sponsor or "manager" would be a viable pathway to customer-centric health systems. It is also evident that with the sponsor's role being assumed by the government, strong institutional capacity and regulatory will is required to steer the market towards favourable outcomes for the consumers.

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