

Good Managed Care Needs Universal Health Insurance

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Although the increase of corporate managed care has helped to reduce excesses and costs, continued gains in cost-effectiveness depend on good clinically managed care. Benefits of clinically managed care depend on stable contracts and universal coverage. Instead, employers are decreasing coverage and creating a market of “lemons” in which low-cost plans are rewarded for cost-cutting tactics. These tactics have spawned movements that demand rights for patients and providers. Choosing to shore up those rights, however, will increase the number of uninsured persons. This tragic choice, which no other industrialized nation has permitted, will not be resolved until some form of universal health insurance is implemented.

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During the past decade, the reorganization of medical services by managed care corporations has contributed significantly to the remarkable slowdown in health care costs. At least one third of this slowdown resulted from a large reduction in general inflation (which is now only 1% to 2%); another third resulted from employers reducing health insurance coverage and shifting costs to employees or the government (1). Observers agree that managed care achieved its share of the reduction in cost by driving hard bargains with physicians, hospitals, and other providers, forcing them to work harder for discounted payments—a one-time savings (2, 3). Relatively few managed care provider groups have done much to realize the potential of what can be called *good clinically managed care*—that is, the use of evidence-based measures to prevent, maintain, and restore the function and well-being of individuals in a stable population for which a particular health care plan is responsible. As predicted some years ago, “MBA managed care” is a temporary solution to increasing costs (4).

In contrast, good clinically managed care is a real solution that can improve health at lower cost for years to come. It has captured the imaginations of medical leaders for decades and requires four elements of stability: continuity of care, stable teams to develop and deliver integrated care programs, a patient population that remains in place long enough to develop working relationships with providers, and health insurance coverage that does not change or

evaporate for the entire population. This last element supports the other three. Without it, all four are compromised.

Unstable, risk-rated, and changing coverage undermines good clinical managed care and rewards its opposite: pernicious managed care. *Pernicious managed care* can be defined as tactics used to save money by obstructing access to specialists, tests, and procedures; underpaying providers and rewarding them for doing less; stalling or refusing to pay bills for services already given; and driving away patients with serious medical problems. The practices of pernicious managed care have roused the anger and disgust of the nation, inspired hundreds of television reports and front-page newspaper articles, prompted numerous lawsuits by injured patients, and led legislators to introduce hundreds of bills to stop such practices. These practices have damaged the reputation of the entire managed care industry, instilled distrust, and made good clinical managed care difficult to practice. Administrators of some managed care plans report that when they try to save patients from unnecessary procedures, recommend a better referral, or present a superior treatment plan, patients distrust their motives and suspect that they are just trying to save or make money.

The number of managed care organizations that are truly pernicious is probably small. However, the constant downward pressure by employers to lower costs in a voluntary risk-rated insurance system with competitive, short-term contracts sometimes makes good health care plans behave in less enlightened ways than they wish they could. A market for “lemons” prevails, in which often undetectable inferior care drives out good clinical managed care. This market dynamic leads to the “ethics of managed care”—namely, the strategies used by pernicious managed care to block, stall, and frustrate access to specialty services; skimp on services given; and muzzle or fire staff members who complain. The moral outcry and the large amount of legislation proposed to stop these practices almost never mention that these practices are influenced by risk-rated voluntary health insurance and the tragic choice it poses: Choosing to shore up patients’ rights would increase the number of uninsured persons (5). Strengthening

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rights for some means decreasing the rights of others. Yet leaving the ethical problems of managed care unaddressed has already injured the reputation of managed care and rendered it less effective.

Consider, for example, the coverage or insurance problems faced by clinical teams in the United States who are committed to orchestrating good clinically managed care. Patients who have cardiac problems within a plan will be under different contracts from different employers; each of these contracts may provide different coverage or copayments that may be more than some patients can afford. In addition, these employers may change the amount and kind of treatment that they will pay for. The stable financial base for doing good clinically managed care simply does not exist.

Approximately 100 000 persons lose their health insurance coverage each month; this guarantees that a portion of a managed care plan's population will become uninsured (6–8). Despite a \$100 billion government subsidy to induce employers to offer health insurance (9), 50% of all U.S. employers do not offer this benefit (10). Nearly 44 million persons now lack health insurance—one out of six Americans overall and one out of five living in large, urban areas (11, 12). This \$100 billion subsidy paid to employers alone would be “much more than it would cost for every uninsured American to afford the type of coverage enjoyed by insured Americans” (9).

Another portion of a managed care plan's population loses some of its coverage when employers who do offer health insurance limit their policies. They are saying, in effect, “I'll provide health insurance, but less than last year.” Out-of-pocket payments can be increased in a dozen ways, all of which discriminate against sick persons and the average worker (13, 14). When serious illness strikes, the health insurance provided by some employers will underpay the managed care plan or force the patient to pay. These same employers also shift their contracts from plan to plan, creating still more discontinuity. Managed care plans accommodate the limits and changes in coverage demanded by employers but then are blamed for these limits and changes. When you add those with inadequate policies to the 44 million who have no health insurance, fully one fourth of persons in the United States face personal impoverishment if they become seriously ill or injured (12).

Employers in the United States seem tired of providing health benefits; it is a burden that their international competitors do not have to bear (15–17). When Motorola competes with Nokia in the fierce market for digital telephones, it faces a company that does not have to pay for a health benefits department. However, Nokia's employees are cov-

ered by a comprehensive, effective health care system that costs less than half as much per person than does the U.S. system (18). The same sort of handicap impedes Ford when it competes with Volkswagen or Procter & Gamble when it competes with Unilever. Employers in the United States pay health benefits consultants \$3000 to \$4000 per day to custom-build their health care plans. Executives in most other industrialized nations consider this a costly practice because the resulting complexity compounds the expense of claims, forms, billing, and monitoring. A uniform national system also includes mechanisms to control costs; for the past 20 years, these mechanisms have kept the cost of most advanced health care systems in industrialized nations at 8% to 10% of the gross national product. Other countries are not impressed that the United States' unique managed care strategy has only been able to preserve the cost of a system that is already 40% to 60% more expensive than their own.

The “American way” of providing voluntary health insurance through employers is falling apart (3, 8, 15). The half of all employers who do provide health insurance, including all those who provide only partial coverage (19), are the primary payer for only 43.1% of the U.S. population, and these employers pay for only 21% of all health care expenditures. Moreover, the social contract between most employers and their employees is breaking down. Employers hire more temporary, contract, and part-time workers, to the point where about 29% of persons working in the United States have non-standard jobs.

Employers have also shifted large proportions of premiums and payments for medical services to their employees. This form of backdoor disinsurance discriminates heavily against those who most need medical services and reduces the chance that clinicians will be paid for treating them (3). Half of all full-time workers with incomes below the poverty line have no health insurance because their employers do not provide it and because buying an individual policy would cost them 26% to 40% of their income (20). As Kuttner explains:

By cost shifting, employers effectively price many lower-income workers out of economically meaningful access to health insurance. This, in turn, saves employers what would otherwise be their share of coverage for such workers, reducing employers' costs even further—and displacing those costs onto the portion of the system that bears the expense of uncompensated care or forcing these employees and their families to go without care altogether (1).

If the economy slows down or profits decrease, still more U.S. employers will limit or discontinue the health insurance that they now provide. In fact, The Lewin Group (5) has estimated that for every 1% of real increase in premiums, 400 000 more

Table. Benchmarks of Fairness*

Benchmark 1: Universal access—coverage and participation
Mandatory coverage and participation
Prompt phase-in: coverage and participation not held hostage to cost control
Full portability and continuity of coverage

Benchmark 2: Universal access—minimizing nonfinancial barriers
Minimize maldistributions of personnel, equipment, facilities
Reform education in the health professions
Minimize language, cultural, and class barriers
Minimize educational/informational barriers

Benchmark 3: Comprehensive and uniform benefits
Comprehensiveness. All effective and needed services deemed affordable, by all effective and needed providers. No categorical exclusion of services, such as mental health or long-term care
Reduced tiering
Increased uniform quality
Benefits not dependent on savings

Benchmark 4: Equitable financing—community-rated contributions
True community-rated premiums
Minimum discrimination through cash payments

Benchmark 5: Equitable financing by ability to pay
All direct and indirect payments and out-of-pocket expenses scaled to household budget and ability to pay

Benchmark 6: Value for money—clinical efficacy
Emphasis on primary care
Emphasis on public health and prevention
Systematic assessment of outcomes
Minimization of overutilization and underutilization

Benchmark 7: Value for money—financial efficiency
Minimize administrative overhead
Tough contractual bargaining
Minimize cost-shifting
Anti-fraud-and-abuse measures

Benchmark 8: Public accountability
Explicit, public, and detailed procedures for evaluating services, with full public reports
Explicit, democratic procedures for allocation decisions
Fair grievances procedures
Adequate privacy protection

Benchmark 9: Comparability
Develop a health care budget so that health care can be compared with other programs

Benchmark 10: Degree of consumer choice
Informed choice of primary care provider
Informed choice of specialists
Choice of other health care providers
Choice of procedure

* Adapted from Daniels N, Light D, Caplan RL. Benchmarks of Fairness for Health Care Reform. New York: Oxford Univ Pr; 1996.

persons will become uninsured (5). There is a particular irony to a system in which patients lose coverage because premiums are increased to pay for the implementation of “patients’ rights.”

Patching Up the Voluntary System

One way to address these problems is to increase the number of employers who offer insurance on a voluntary or semiregulatory basis. The Robert Wood Johnson Foundation and other organizations have spent years and donated millions of dollars to design more attractive health insurance packages in an effort to get more employers to sign up. A small percentage do, but the data show that far more keep discontinuing health insurance coverage year after year, even during times of economic growth, high profits, and low unemployment. When the economy slows down or premiums increase, more employers will discontinue health insurance cover-

age or cut it to a shadow of its former self—an extension of what is already happening (21).

Another way to provide health care coverage to more persons has been to establish rules and special programs to cover politically fashionable groups. Congress has passed, for example, legislation for persons who are laid off; those who change jobs; those with mental health problems; those with disabilities; children; and old, poor persons with serious illnesses. The results are always the same. For example, the Federal Health Insurance Portability Act, which was supposed to protect as many as 25 million citizens from losing their insurance, in practice benefits only a few hundred thousand (3). Far fewer enroll in these programs than are eligible because lobbyists get exceptions, complexities, and loopholes inserted into the legislation; agencies offer incentives to minimize enrollments; and patients need a Stanford law degree to thread their way through the resulting procedures (22). New legislation proposes using the billions of dollars from tobacco company settlements to offer health care coverage to more of those in need, but it will require yet another thicket of rules and regulations interwoven with all the others. Why not combine all these funding streams into a single universal program? A single program, it should be noted, does not have to be “single payer,” although that is the most efficient administrative model. Universal programs in many countries use multiple insurance pools or companies, and many include private practitioners.

Making Health Insurance Fair

This quagmire of bad choices and failed stopgap measures leads one to ask what the criteria are for a fair health care system. The Robert Wood Johnson Foundation funded a serious effort to answer that question. The resulting study by Daniels and colleagues (23) included the 10 Benchmarks of Fairness outlined in the **Table** (23). It became clear that a fair health care system would have to provide universal health insurance (benchmarks 1 and 3) charged to persons by their ability to pay (benchmarks 4 and 5). Without this, all players are rewarded for gaming the system and for exploiting the most vulnerable persons, and enlightened managed care cannot realize its potential. Eliminating waste and inefficiency before rationing, a major goal of managed care, is important (benchmarks 6 and 7). Daniels and colleagues analyzed the experiences of other nations and concluded that the policy of saving money through cost containment in order to finance universal health insurance is illusory and, in fact, backward. A universal system, in fact, is critical to large-scale savings, and as the U.S. experience in

recent years has shown, a nation never feels it has saved enough to afford universal coverage, even if it has saved billions and the economy is booming.

What enlightened managed care needs, and what every other industrialized country provides, is a universal health insurance system for everyone. This is what Alain Enthoven, the father of managed competition, concluded when he designed managed competition between managed care organizations. Managed care will not work if it does not provide universal health insurance with uniform benefits. Otherwise, the vulnerable and the ill can be exploited in too many ways (24, 25). Good clinically managed care is not possible without substantial trust between patients and providers and between providers and managed care plans.

Other countries once had a mixture—similar to that of the United States—of private insurance plans, government programs, and millions of uninsured persons, but, one by one, they all decided that this kind of mixture was inequitable and inefficient. It is. A voluntary system costs at least three times as much to administer and is less likely to cover sick and poor persons and persons from minority groups (18). To put this more practically, under a voluntary system, the bills for physicians, nurses, hospitals, and clinics that treat these persons may not be paid. Workers in every other service industry are paid for their work; why shouldn't clinicians be? Ironically, physicians and patients in countries that have sophisticated health care systems also enjoy more choice, less micromanagement, less corporate socialism, and more individual care than do U.S. physicians and patients who belong to managed care plans. In addition, physicians in countries with universal health care plans are not made to risk their take-home pay against their best clinical judgment.

Universal health insurance can be a partner of managed care plans in controlling costs. It provides some powerful tools for efficiency and cost containment. Managed care plans work best in a national system that can set firm but fair budgetary limits for everyone and provide free professional training for clinicians as part of a national work force plan. Managed care also works best if it can use the clout of large insurance pools to negotiate low prices for pharmaceutical products and equipment. The limited ability of U.S. managed care plans to control these forces is well described by national experts (26, 27). For example, drugs are poorly managed by most plans, and some plans report that they now pay more for drugs than for physicians.

For these reasons, the efficiency and quality of good clinically managed care for whole populations

can be attained only in a system that provides universal, stable coverage. In the absence of universal coverage, the "patients' rights" movement to ensure choice for those who have health insurance will only drive employers to increase the number of persons who have none and thereby reduce the meager amount of available charity care.

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