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An In-depth Look at Managed Competition, Part I

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The model for the upcoming national health insurance plan being proposed in Washington is H.R. 5936, also known as the Managed Competition Act of 1992. The bill was presented in September 1992 by its key sponsors, Rep. Jim Cooper (D-TN), Rep. Mike Andrews (D-TX), and Rep. Charles Stenholm (D-TX). The bill was developed by the Conservative Democratic Forum's Task Force on Health Reform chaired by Rep. Cooper.

The Managed Competition Act is a modification of the plan drafted recently by the Jackson Hole Group, an informal organization of some of the nation's health policy experts. According to the Conservative Democratic Forum, founded by Rep. Stenholm, managed competition in health care will give all Americans the same clout to buy health care that only employees of the Fortune 500 companies now enjoy. Doctors, nurses, hospitals, and insurance companies will participate in more efficient, quality driven networks, eliminating the waste from the provider community.

The bill goes beyond current concepts of managed care (i.e., HMOs) to a system of managed competition between super-HMOs, while preserving maximum consumer choice and individual responsibility. To better understand the concept of managed competition and its impact on the chiropractic profession, the basic plan will be summarized, with the working details to follow.

The Managed Competition Act of 1992 provides use of strong tax incentives to encourage providers and insurance companies to form health partnerships, publicly accountable for costs and quality. Large regional purchasing cooperatives (Health Plan Purchasing Cooperatives or HPPCs) will give individuals and small business the benefits of greater buying power. A National Health Board will establish a uniform set of effective health benefits. To have tax-favored status, health plans will be required to offer those standard benefits, comply with insurance reforms and disclose information on medical outcomes, cost-effectiveness, and consumer satisfaction. To achieve tax fairness, the Democrat's proposal limits the employer's tax deductions to the lowest priced Accountable Health Plan (AHP) in their area, a concept similar to proposed reforms found in the Jackson Hole Plan.

At the present time, businesses are allowed to deduct the full cost of any health coverage they provide to their employees, no matter how generous, while self-employed individuals and certain small businesses are allowed to deduct only 25 percent of the cost of their health benefits. Individuals who buy coverage on their own currently do not get a tax break unless their health expenses exceed 7.5 percent of their adjusted gross income. In the Managed Competition Act, all individuals, including the self-employed, will be given a tax benefit for 100 percent of basic health plan costs.

Individuals and small businesses will be able to afford health coverage by joining Health Plan Purchasing Cooperatives, which will offer group rates with lower administrative costs. Individuals will choose from a menu of health plans, and their employees will choose the dollar amount, if any, that they wish to contribute. Health plans will be able to exclude coverage of pre-existing conditions and will not be allowed to use "experience rating" to charge higher rates for individuals

who have a history of higher medical expenses.

Additionally, the Managed Competition Act provides for a new federal program that details the purchase, or subsidy of health plan premiums for individuals and families below the poverty level. States will no longer have to finance Medicaid, and will gradually assume the responsibility for long-term (e.g., nursing home) care for the poor.

The key elements to the Managed Competition Act include the concept of the Accountable Health Plan, the Health Plan Purchasing Cooperative, the National Health Board and its sub-boards, and malpractice reform.

Accountable Health Plans (AHPs)

For the AHP to be eligible, the plan must provide for the coverage of a federally-defined, uniform set of effective benefits. The benefits will be specified by the National Health Board. Each AHP will be held accountable for medical outcomes. The AHP may offer more services if chiropractic benefits do not become part of the uniform set of effective benefits package.

Preemption of State Laws Restricting Utilization Review Programs

The Managed Competition Act mandates that no state law or regulation shall prohibit or regulate activities under a utilization review program. Under the Act, utilization review programs refer to systems which review the medial necessity and appropriateness of medical services (which may include inpatient and outpatient services) using specified guidelines. Types of utilization review include: preadmission certification; application of practice guidelines; continued stay review; discharge planning; preauthorization of ambulatory procedures; and retrospective review.

As the chiropractic representative to the Texas Workers' Compensation Commission's Medical Advisory Committee for the past two years, I have seen first hand the effects that unregulated utilization review programs have on the provider community. We have experienced many problems with the various utilization review agencies based on nonstandardized policies for their reviews. One example of this is seen consistently with one particular review company: It seems to be their standard practice to deny the patient chiropractic care if an MRI indicates disc herniation. I have personally received the reports from doctors who have had their care denied because the patient had a disc injury. Consistently, the patients were sent for "exclusive management by medical specialists."

It will become critical for the chiropractic profession to adopt a more sophisticated and reliable method for reporting case data. Present systems involving the traditional "SOAP" notes taught in all medical schools and chiropractic colleges are woefully inadequate in today's adversarial third party pay system. The traditional method of "SOAP" charting breeds conflict because the doctor's opinions concerning the case and the reviewer's opinions are, more often than not different. In the national health insurance system, with the provision of deregulation for the audit companies, it will become essential that the chiropractic profession adopt a standard of care, because the law concerning the practice of the review agency dictates that reviews will be done using specified guidelines. Many have cast stones at the Mercy Guidelines, but surprisingly, the ones casting stones have not read the document and rely on other people's opinions! The last thing the chiropractic profession needs at this point is to present another divided front to the legislators and to the carriers.

Health Plan Purchasing Cooperatives (HPPCs)

The Managed Competition Act provides for the formation of HPPCs which will enable the small

business and the individual to have the purchasing power of the larger corporations. Each state shall be considered to be a Health Plan Purchasing Cooperative area. States may subdivide so long as all portions of each metropolitan statistical area are within the same HPPC area. The number of individuals within a HPPC area will not be less than 100,000. Additionally, the law provides for HPPCs to be set up between states that share a common metropolitan area, so long as the entire metropolitan statistical area is within the HPPC area.

Each state shall provide, by legislation or otherwise, for the establishment of a not-for-profit Health Plan Purchasing Cooperative. Each HPPC will be governed by a board of directors that is appointed by the governor or other chief executive officer of the state. The duties of the board of directors will include entering into agreements with AHPs, entering into agreements with small businesses (employers with less than 1000 employees), receiving and forwarding premiums, and providing for coordination with other HPPCs. The HPPC will provide the following information to all: price comparisons on AHPs, outcome assessments of AHPs, enrollee satisfaction with AHPs, and other quality related information which will be received from the National Health Board.

The HPPC will allow the small employer to have a level playing field with the large corporations with respect to buying power, because the HPPC will collect all premiums from the small employers and function as a "broker" of insurance, buying in quantity from the AHPs in the area. Currently as much as 40 percent of premiums paid by small businesses and individuals goes towards administrative costs of health insurance as compared to less than 10 percent for large businesses. Additionally, small businesses do not have enough employers to spread the risk of insurance around, and even if one employee has high medical expenses, insurance can become quickly unaffordable. This problem is worse for the case of the individual purchasing health insurance.

National Health Board

The National Health Board will be comprised of five members appointed by President Clinton with the advice and consent of the United States Senate. The president shall designate one of the five members to serve as the chairman of the board, and not more than three members of the board shall be of the same political party. The board shall appoint an executive director and additional officers as needed to carry out the provisions of the Managed Competition Act.

Which Services Will Be Covered?

The National Health Board will be responsible for formulating the uniform set of effective benefits by not later than October 1, 1993, which will apply for the following one year period. The specified for health care conditions that will be covered are:

> The Board may exclude from the benefits such treatments as the Board determines, based on clinical information, have not been reasonably shown to improve a health condition as well!

Special note: It is possible that the uniform set of effective benefits may be formulated based on available scientific research across diagnostic codes in the ICD-9 classification system rather than on methods that have been traditionally followed across provider groups, allowing all groups access to the patient, with no controls on outcome or accountability for services rendered. Considerable attention will be given to the various treatments in each diagnostic code classification and to the cost effectiveness of each of the available treatments or procedures. Therefore, it is imperative that we work to include chiropractic benefits as a part of the uniform set of effective benefits available to the individual or small business. If chiropractic services are not included on the base policy, the decision for inclusion of chiropractic services will be left up to each AHP, or

super-HMO. In this case, the tax benefits will not be available for coverage of chiropractic care!

Except as specifically excluded, the actual specific treatments, procedures, and care (such as the use of particular providers or services), shall be left up to each Accountable Health Plan.

The National Health Board will judge medical treatments, procedures, and related health services based on the following criteria:

1. Effectiveness in improving the health status of individuals.

2. Long-term impact on maintaining and improving health and productivity and on reducing the consumption of health care services.

The National Health Board will also be in the position to determine if there are areas of "ineffective competition" in the provision of health care services included under the uniform set of effective benefits in a HPPC area of a state. If such an area is identified, the National Health Board can authorize the governor of a state to develop a plan for controlling the growth in premiums of AHPs in the area until the National Health Board finds that effective price competition is regained.

The National Health Board will also appoint two other five-member boards to assist in the task of administration of the program: the Health Benefits and Data Standards Board (Health Benefits Board) and the Health Plan Standards Board.

The sub-boards of the National Health Board and malpractice reform will be dealt with in Part II of this series in the March 12th issue.

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Editor's Note: The 16-member multidisciplinary Texas Workers' Compensation Commission's Medical Advisory Committee that Dr. McKechnie has been on the past two years as the chiropractic representative, is responsible for recommending changes to the workers' comp. system. Dr. McKechnie says his team has been "active in formulating standards of practice guidelines that will go beyond the Mercy Guidelines, by analyzing the top 100 ICD-9 diagnoses for chiropractic and then constructing a statistical data base for claims analysis." The data base they're using can assess length of care, modality usage, office visit frequency, and amounts billed and paid. These items are subjected to a bell-curve statistical analysis.

Dr. McKechnie also serves on groups responsible for the Physical Medicine Treatment Guide, spinal manipulation guides (for use by DCs, MDs, and DOs), impairment rating standardization, and a group that is responsible for recommending additions to the North American Spine Society Code Manual, which may replace the ICD-9 diagnosis system for spine related diagnoses in the Texas Workers' Compensation system.