

Alain Enthoven: An Outspoken Champion for the Prepaid Group Practice

Alain Enthoven describes the reforms needed in the health care marketplace to pave the way for a 21st-century health care system built around the strengths of prepaid group practices.

By Jon Stewart

“This book should be required reading by every physician in the United States Doctors could learn a tremendous amount about their own medical practice and its marvelous potential by reading this book.” — Rep Jim Cooper (D-TN), in a Health Affairs review of Enthoven and Tollen’s new book on prepaid group practice.

Alain C Enthoven, PhD, is the Marriner S Eccles Professor of Public and Private Management (emeritus) in the Graduate School of Business at Stanford University and a Senior Fellow in the Center for Health Policy at Stanford’s Institute of International Relations. He holds degrees in economics from Stanford, Oxford, and the Massachusetts Institute of Technology. In 1977, while serving as a consultant to the Department of Health and Human Services in the Carter administration, he designed and proposed the Consumer Choice Health Plan, a plan for universal health insurance based on managed competition in the private sector. The plan, based on the existence of integrated delivery systems such as Kaiser Permanente (KP) and Group Health Cooperative (GHC), provided the foundation for what became the Clinton administration’s proposed health care reform plan in the early 1990s. Dr Enthoven continues to publish and speak widely on the subject of the managed competition model and the value of integrated delivery systems. Most recently, he co-edited (with Laura Tollen of KP’s Institute for Health Policy) the book, *Toward a 21st Century Health System*:

*The Contributions and Promise of Prepaid Group Practice.*¹

The following interview was conducted by Jon Stewart, *The Permanente Journal’s* Editor for Public Policy.

The Permanente Journal (TPJ):



Dr Enthoven, you’ve been advocating the notion of “managed competition” built around competing organized delivery systems for many years as the best way to promote more efficient, higher quality health care. Yet today, in the wake of the rejection of managed care, the market seems to be moving in almost the opposite direction—toward loose, unmanaged networks of providers, less-than-comprehensive coverage plans, along with soaring health care costs. What went wrong?

Dr Enthoven: What went wrong



was that employers panicked. In the 1990s, after the Clinton reform plan was defeated, employers tried to impose managed care, meaning HMOs, without giving employees a choice and without visibly showing them the savings to be achieved. The whole thing appeared to employees to be a loss of freedoms they previously had, and without seeing

any savings personally. Research showed that the dissatisfaction with managed care was concentrated among those people who were there without a choice, which is not surprising. I think they made a terrible mistake. What employers should have done was what we do at Stanford University, where we say to employees, we’re going to offer you five plan choices reflecting different delivery systems and care models, and the university will pay for the low-priced plan and give you your choice among the alternatives, but you’ll have to pay the difference in price. In that case, the consumer is empowered and nobody is in managed care who doesn’t choose to be, because we include non-managed care options, and people reap the personal savings from choosing the managed care plan, which is typically the low-cost plan.

TPJ: You’ve noted that the health care marketplace today is not very conducive to the growth of prepaid group practices (PGPs), like KP. Can you describe the kind of market that would promote PGPs and the reforms that would be needed to make that happen?

Dr Enthoven: The first thing is that the markets need to be open to consumer choice. A big problem today is that most people in this country work for an employer who offers only a single carrier.

TPJ: That was once a foundational principle in KP’s genetic code, was it not?

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Dr Enthoven: Right. KP advocated that consumers should have a choice because doctors didn't want patients in the plan involuntarily because it would be hard to have a good doctor-patient relationship with someone who was suspicious and resentful and didn't want to be there—the same reasons people resented being forced into managed care plans in the 1990s. I think it's very important to remind Permanente physicians of that today, because there's been a bit of backsliding on that principle, and the only way you can get into some

small groups is to be a single carrier. That's why I like models like the KP-Health Net dual-choice model in California and the BENU dual-choice model with KP and Cigna in Oregon or with Group Health and Cigna (GHC) in Washington State, in which an HMO partners with a non-HMO-type plan to offer employees a range of coverage choices under what looks to the employer like a single organization. I think it's really important for people to have a choice—to be there because they want to be there.

TPJ: Besides choice, what are the other characteristics of a market that would help promote PGPs?

Dr Enthoven: The next thing would be to let the consumers keep the savings from choosing a lower-cost plan. At Stanford University, as I said, if an employee chooses KP rather than a preferred provider organization (PPO), s/he saves thousands of dollars. Besides that, there need to be comparable benefits offered by all the competitors so that the more comprehensive plans, like PGPs, don't attract all the sickest people with chronic conditions. It won't work if you have one policy with a \$2000 deductible, and the

competing policy offers first-dollar coverage (no deductible). Not only will you get adverse risk selection, but you'll get opportunistic risk selection because people will take the high-deductible policy with the low premium until they expect to need medical care, and then they'll switch to the no-deductible plan.

That leads to the next thing we need for a fair market, and that's risk adjustment of premiums, based on a diagnostic assessment. That's important because PGPs are strong in disease management, and it's important that they not be penalized in the marketplace because of that strength.

And then finally, there needs to be a single regulatory environment among the competitors. The problem is that, because of ERISA, states don't regulate employer self-funded programs, and so these plans have a lot a freedom that PGPs, which are regulated by states, do not have, such as freedom from state-mandated benefits.

So I think those five things—choice, financial incentives for exercising responsible choice, comparable benefits, risk adjustment of premiums, and a level regulatory playing field—define a market in which PGPs could grow and prosper.

TPJ: You mentioned as the second characteristic an arrangement that would allow employees to reap the savings of choosing a more efficient plan. Isn't it a fact that the structure of most employer plans represents an actual disincentive to choosing an efficient, lower-cost plan? In other words, aren't many employers actually encouraging their employees to choose more expensive plans?

Dr Enthoven: That's right. People just don't understand that. But I talk with a lot of employers who pay the whole premium for whatever

plan the employee chooses or pay 80% to 90% of the plan of the employee's choice, and each of those represents a very high tax on efficiency because there's little or no incentive for employees to choose an economical health plan. And the income tax laws don't help, because we can choose a more costly health plan and pay the difference with pretax dollars, which means that everybody subsidizes the more costly plans. On the other hand, among those few organizations that allow employees to keep the savings from choosing lower-cost plans, such as the big public employee groups like CalPERS (California Public Employees Retirement System), PGPs do very well.

TPJ: Why does this practice persist? How do these big employers justify benefit policies that give incentives for choosing the least efficient plans?

Dr Enthoven: Intellectually and in private, most employers agree with me, but they resist making the change because they fear that those employees who would lose the effective subsidy they'd been getting would make more noise than those who would reap a benefit.

TPJ: PGPs and other organized systems have staked their claim to what you call a level playing field and a fair market on their ability to deliver superior value in the form of greater efficiency and quality than the disaggregated system. But what's the evidence for that claim?

Dr Enthoven: The evidence is shown in two chapters in our new book, *Toward a 21st Century Health System*.¹ As for value and cost, I don't think anyone questions that PGPs can provide high-quality, comprehensive care at a lower cost. In my preface, I talk about the RAND experiment comparing GHC with its fee-for-service (FFS) competitors,

and they found that GHC provided high-quality care that achieved outcomes comparable with FFS outcomes but using 28% fewer resources. And they did that without any serious competition, which might have driven even better results. And a chapter by Steve Shortell from the University of California, Berkeley, shows that organized delivery systems have engaged and invested in more activities like prevention and disease management and information systems than the disaggregated plans. And then a chapter by Harold Luft, Adams Dudley, and Kenneth Chuang shows, through a literature review, that PGPs come out better on health outcomes but not as well on patient satisfaction, although they comment that those studies have not been adjusted for the issue of choice, in other words, whether the members were in a plan by choice or not, which affects satisfaction. But the main point they make is that most existing studies look at HMOs in general (including network models) versus FFS and don't isolate PGPs from other forms of HMOs; so, the PGPs get lumped in with forms that are based on FFS doctors who have FFS practice patterns. Other chapters show that PGPs have more effective management of the pharmacy benefit and more effective utilization of the medical workforce.

TPJ: We see the market today moving in the direction of these so-called consumer-directed health plans with high deductibles and higher copays and less comprehensive benefits. And, of course, KP is now offering these kinds of plans itself to remain competitive. But under these plans, can the core advantages of PGPs survive in an increasingly FFS environment?

Dr Enthoven: Yes, I think so, because their advantages are funda-

mental. They offer care that is much better organized and managed and has greater value for money. I'm sure many people in KP regret to see the arrival of the \$1500 deductibles in KP, and I hope and trust that KP will do that in a way that the preventive and disease management services are not lost but are covered before the deductible kicks in. I don't think that the high-deductible approach is going to be effective in controlling costs in the long run, because so much of the costs are incurred by people who have very high costs that go way above the deductible. So, the incentive effect for consumers in having to manage that first \$1500 in costs—that is, having to think twice before you go to the doctor—is all going to be lost when people find themselves in the hospital, which is where most of the costs are. On the other hand, the high-deductible plan is going to let the employer, who is facing a 15%-per-year upward trend in health costs, convert a greater share of that cost to the employee. So, employers will get some temporary relief, but they'll soon find that the rising cost trend will continue unabated, and they won't have done much good, but will have threatened the viability of preventive services. A better approach for employers would be to address the health status of their employees, working with their health plans, to keep the employees healthy by persuading them to live healthy lifestyles, to get them on the right medications if they're diabetics or asthmatics or whatever. In the long run, there's more hope for mitigating cost growth that way than by just making people pay for the first \$1500 of costs out of pocket.

TPJ: It seems today that many employers are more interested in

distancing themselves from health care than in engaging in their employee's wellness.

Dr Enthoven: It's very understandable for them to do that. But it's important to realize that employers are feeling pretty desperate and pretty burned, because they thought they were doing a good thing when they went to managed care, but it blew up in their faces.

TPJ: What's next in health care, beyond yesterday's managed care and the current cost-shift strategy? Do you see a chance, for instance, that consumers will get wise to what's happening and will eventually demand that the government step in and take action?

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Dr Enthoven: I think that's fairly likely. One scenario is that the winning candidate in November 2008 will have campaigned on the slogan "Medicare for all, now." And the Fortune 500 companies—as well as small business—and the unions will both strongly back that approach. It would be an understandable reaction. I would just regret that Medicare is still basically an FFS program except for the relatively small share of people in Medicare Advantage. So that could be very bad news for PGPs, because the federal government has done a very poor job of letting PGPs compete in the way they can in the federal employee health benefits program, for instance. But I can already see signs in the air for that direction.

TPJ: Can you envision a model of a national health system that would work for PGPs?

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Dr Enthoven: Two modest incremental proposals that I've been looking at would include government requiring employers above a certain size to offer their employees choices of delivery systems; and whatever the employee contributes would be in the form of a fixed dollar amount instead of a set percentage, so that the employee who makes the economic choice gets to keep the savings. Beyond that, we could buy access for the uninsured into the federal employee health benefits program. That would be good, if not perfect. Back in 1978, I proposed a model published in *The New England Journal*^{2,3} in which everybody would be in a consumer choice model, with the government paying their way into the low-priced plan and then running it on managed competition lines with risk adjustment of premiums and standard benefits. But the challenge today is how to get there, and I think incremental steps in which the government assumes more and more retiree care costs and more of the high-priced care is the most feasible pathway.

TPJ: Can you see a realistic roadmap that would take us in that direction?

Dr Enthoven: The boundaries of the roadmap are not clear, but the principles are pretty clear: Open the markets to consumer choice; let the consumers keep the savings of choosing the economical plan; apply risk adjustment; provide comparable benefits.

TPJ: Are you at all optimistic?

Dr Enthoven: I've put a lot of energy into getting employers to change over the years, and today I'm quite pessimistic about that. I just don't see the comprehension and the willingness to change. Then, if you look to the government for change, I don't see much wise public policy out of there either. All you see is government responding to well-financed special interests. The principles of the competition model took a beating in the new Medicare legislation. The Bush Administration started out with the idea that the tradeoff for government drug coverage would be a reformed, competitive delivery system, but they backed off when they saw the possibility of enacting the prescription drug cov-

erage as a way of enhancing the President's chances of reelection.

TPJ: Given your pessimism about change, do you still believe that the organized delivery systems, like GHC and KP and others, can have a healthy future?

Dr Enthoven: Yes, I think so. Society is not going to deal them out. But we have a big chore ahead of us in terms of public education, and that's why I felt that this book was such an important thing to do.

TPJ: Thank you. ❖

References

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The Permanente Physician

The Permanente physician practices in a stimulating professional atmosphere comparable in many ways to what is found in an academic community. His associates are colleagues who share his goals. There is open discussion, exploration and consultation among peers.

— Herman Weiner, MD, second Medical Director of SCPMG,
describing advantages of group practice in general and Permanente in particular.
This "Moment in History" quote collected by Steve Gilford, KP Historian