REMAPPING DEBATE
Asking "Why" and "Why Not"

The role of the New Democrats in the explosion of managed care

Original Reporting | By Meade Klingensmith | Corporate influence, Health care, Insurance

Feb. 20, 2013 — The "New Democrats" of the 1990s — those who thought the Democratic Party should move further to the right and position itself as a "centrist" alternative to the GOP — promoted a model of health care reform called "managed competition." Fundamental premises behind the strategy — such as the idea that the interests of insurers would be aligned with the interests of those needing a doctor and that Americans, if anything, were getting *too much* medical care — were much more faith-based than evidence-based. And some of the negative consequences of the greater reliance on "managed care" created a short-term backlash. Nevertheless, the assumptions and rhetoric of the New Democrats live on, embedded in the architecture of the Affordable Care Act (ACA) and in the rhetoric of a wide range of politicians and journalists, as well as many of the experts who study the health care industry.

COST CONTROL ÜBER ALLES

This is the second in a series of articles examining the phenomenon by which health care policy has come to be dominated by a single-minded desire for cost control, while concerns about maximizing the quality of care have been downgraded or ignored entirely.

The first article in the series described the origins of the Health Maintenance Organization (HMO) model, the modern incarnations of that model, and the evolution of HMOs into the vehicles through which a for-profit health insurance industry came to dominate the market by the 1990s.

This article describes the crucial role that the Clinton-era "New Democrats" — played in promoting the view that the principal problem to be addressed was cost control, and that the best and *only* solution to providing health care was through a for-profit, market-based system of insurance (albeit a regulated one), *not* a single-payer or not-for-profit HMO model.

— Editor

Will Marshall was a co-founder of the Democratic Leadership Committee (DLC), for more than two decades the heart of the New Democrats (the DLC shut its doors in 2011). He was also the founder and is still the president of the Progressive Policy Institute (PPI), the organization that provided the blueprints for many of the policies advocated by the DLC.

In an interview with Remapping Debate, Marshall described managed competition as "a system of private provision, competing health care providers who are under the supervision of public law and regulation that protects patients." The idea, he said, was to create marketplaces in which health insurers sold their products, either to companies or directly to enrollees. (In the 1990s, these marketplaces were called "purchasing alliances"; in 2010, they were later incorporated into the ACA as "exchanges.") The marketplaces would be the only way to purchase health insurance in the United States, and all products sold within them would be required to meet certain standards of coverage. Under the Clinton plan, every employer in the U.S. would have been required to provide health insurance to its employees. And, crucially, managed competion models in general assumed that for-profit managed care organizations would become the dominant actors in the system, as their lower cost would naturally attract purchasers.

Theoretically, adoption of the model would achieve three things: (1) it would control health care costs by guiding patients into managed care organizations, forcing insurers to directly compete over customers, and enabling mass-scale group purchasing; (2) it would ensure universal coverage; and (3) it would do these things through regulated market mechanisms rather than a national health program, thereby appealing to what Marshall views as "the American economic and cultural outlook."

Aligning incentives?

A central claim of managed care is that it aligns the incentives of health care providers with those of their patients. In the original formulation by Paul Ellwood (the "father" of managed care), found in his 1971 article for the journal Medical Care, the argument went as follows: "Since the economic incentives of the contracting parties [provider and patient] are identical [to keep the patient healthy], both would have an interest in maintaining health."

Remapping Debate asked Marshall whether, even if managed competition and managed care could control costs and provide some form of universal coverage, it would do so by denying medical services to patients who need them. Marshall insisted managed care would theoretically not deny useful procedures. Its goal, he said, was to "eliminate unnecessary procedures, root out waste, and, when it's done right, try to bring together specialists and general practitioners to take a holistic approach to the health care of the patient, rather than parceling them out by body part or disease and never communicating with each other."

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When asked whether PPI ever worried about the potential for managed care to deny necessary services, Marshall said it did. "If you can get away with dropping coverage and denying services," he said, "some actors will do that, and did." Then why would a for-profit managed care organization *ever* prioritize quality of care over making a profit? "The customers leave," Marshall responded. "We have exit…I remember being in several HMOs that I didn't like, and I left them and got into something that I thought was better care for me. Choice and exit are powerful forces."

According to Dr. David Himmelstein, a professor of public health at the City University of New York School of Public Health at Hunter College and a co-founder of Physicians for a National Health Plan (PNHP), however, the argument does not stand up. Because managed care is a profit-driven enterprise, he said, "The incentive…is to recruit the healthiest patients you can, to make them look on paper as sick as you can, and to avoid giving them care as much as you can." Or, more simply, "if you deliver less care, you profit. If you deliver more care, you lose."

Dr. Jim Scott, president-elect and vice president of internal affairs at the National Physicians Alliance, a physician advocacy organization, agreed. He told Remapping Debate that from the perspective of a for-profit managed care organization (as opposed to the doctors who work there), "what you want to do is manage the population. You want to have the healthiest population you can, deny the most care you can, and get away with it. That's about managing cost. That has nothing to do with managing care." Calling such organizations "managed care," he said, is "a lie."

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> — Will Marshall

Remapping Debate pointed out to Marshall that most people in the United States receive health insurance through their employers, whose incentive is to control their own costs. How were those employees supposed to "exit?" "That constrains choice," he said. "We're not dealing with a perfect marketplace here. It's got all kinds of peculiarities. And most people can't afford to forgo the group purchasing functions of their employers."

Where then, were they supposed to go? At that point in the interview, Marshall acknowledged that choice and exit alone were not powerful enough to prevent managed care from denying necessary services to patients. "That's why you have to have legal protections. Aligning the incentives of health care providers with the interest[s] of patients cannot be left to the market alone." For that reason, he said, having regulated "purchasing alliances" that would increase the negotiating leverage of health insurance "consumers" was an important part of the managed competition theory — but one that was not realized in the 1990s.

Cost, cost, cost

Managed competition was at the heart of President Clinton's health care reform proposal, the Health Security Act (HSA), which was formulated by a group of health insurance insiders known as the Jackson Hole Group. The HSA died in 1994 of what Ida Hellander, the director of policy and programs at PNHP, called "political asphyxiation." Neoconservative political commentator William Kristol, through his organization called Project for the Republican Future, spearheaded the opposition.

But records of the public debate around the HSA provide a window into how health care was discussed in the New Democrat era. Upon examining a range of speeches and testimony given during this period by politicians, health insurance lobbyists, and think tank representatives, and comparing those with the rhetoric of the last major health care debate in the 1970s, it is clear quality concerns took a back seat to a focus on controlling cost in the 1990s. As Will Marshall acknowledged, "The assumption [in the 1990s] was that quality wasn't a huge problem…The assumption was that cost inflation was the problem."

The text of President Clinton's 1993 speech on health care encapsulates the general trend of the 1990s. Its underlying assumption was that the quality of American health care was already excellent and needed little improvement: public policy should focus on quality health care only insofar as it does not *harm* quality; the priority was controlling cost, not *improving* quality. "We're blessed with the best health care professionals on earth, the finest health care institutions, the best medical research, the most sophisticated technology," Clinton said. However, "medical bills are growing at over twice the rate of inflation, and the United States spends over a third more of its income on health care than any other nation on earth, and the gap is growing, causing many of our companies in global competition severe disadvantage."

President Clinton's speech was just the vanguard of what became a stampede of calls for controlling the cost of health care, with quality as an afterthought. For example, on November 8, 1993, Kenneth Thorpe, deputy assistant secretary for health policy at the Department of Health and Human Services, in testimony at a hearing on health care reform held by the Housing Energy and Commerce Committee, said, "Why must we remain committed to a strong cost containment strategy? Because the total costs of health care are high and rising…The rising costs of the current system harm businesses, government, and households." The only mention of quality was as a factor for health insurance plans to compete over as part of a market-oriented bid at controlling cost.

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> — Prof. Robert Brook

And on March 10, 1994, Joan Simmons, the vice president of the Healthcare Leadership Council, an association of CEOs from several health insurers, pharmaceutical companies, hospitals, and other corporations in the health care field, testified to the House Education and Labor Committee, "People from across the globe come to the United States to receive the highest quality care. In this respect, our health care system is the envy of the world. It is proof that our system does more for its patients…Our delivery is undoubtedly the best in the world…Yet the financing system does require swift legislative reform…Congress must pass and the President must sign a bill that contains health care costs and makes coverage affordable and accessible to all."

There were a number of key reasons that might have caused lawmakers and policy advocates to appreciate some cost increases as appropriate. These included the increased availability of demonstrably improved and necessary medical technology, the population growth, and the beginning of the aging of the population. But, in general, this view was not expressed or explored, with the rising cost of health care seen as exclusively a negative that needed to be thwarted.

And quality?

There were, of course, some voices calling for quality as well, but even those often explicitly acknowledged they were swimming against the tide. For example, in testimony to the House Education and Labor Committee on November 8, 1993, Samuel Havens, board chairman of the Group Health Association of America, said, "We want to emphasize that while much of the impetus for reform comes from the need to reduce the inordinately high rate of increase in the overall health care costs, an even greater emphasis on assuring appropriate care and on maintaining and continuously improving the quality of care will be necessary if reform efforts are to succeed." A call for "continuously improving the quality of care" was rare indeed, the record shows.

In testimony that pointed directly to the risk posed to quality of care by a strategy that focused entirely on cost control, given before the House Committee on Ways and Means on March 21, 1995, Robert Brook, a professor of medicine and health services at the UCLA Center for the Health Sciences, said, "If we are going to contain the growth of health care costs in the United States, as most people insist we must, mechanisms that rely solely on economic and administrative principles will result in the indiscriminate elimination of care that is both beneficial and not beneficial to the patient…We must work toward ensuring that quality, not just cost and access, is considered when the structure of the health system is altered by forces such as managed care and competition."

Consequences of cost control fever

Near-relentless focus on cost and access, said Theodore Marmor, a professor emeritus of both political science and public policy and management at the Yale School of Management, will generally "put pressure on quality." Marmor believes a basic health care policy dictum: "If you push for any two of the following three aspirations, you put pressure on the third. That is, if you put pressure on access and on cost, you're going to do something to quality. If you put pressure to expand quality and to increase access, you're going to put pressure on cost. If you put pressure to get cost under control and to maintain quality, you're going to have real pressure on access." This rule, he said, generally holds true "for anything other than vaccinations." According to Marmor's rule, then, by focusing the debate of the 1990s so strongly on cost and access, the New Democrats guided the way toward pressure on quality.

The health care debate in the 1970s was different. There, Marmor said, "the scope of reform was much broader." Democrats, led by Senator Ted Kennedy, pushed for a national health program as a means of improving cost *and* quality, with both factors seen as equally in need of improvement. In a speech on health care at the 1978 Democratic National Convention, Kennedy said, "One of the most shameful things about modern America is that in our unbelievably rich land, the quality of health care available to many of our people is unbelievably poor, and the cost is unbelievably high."

According to Marmor's rule, wouldn't a focus on quality and cost put pressure on access? "Allocating care has got to happen," Marmor said, "and allocating it by ability to benefit and the seriousness of the medical need is a just, in my view, way of talking about this, as distinct from allocating it by ability and willingness to pay. That's the central philosophical issue in medical care."

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Marmor insisted that it was not possible to provide "unlimited" highest-quality care for everyone: "You cannot do all the things that are possible and live within a reasonable budget," he said, adding in a follow-up interview that doing so was also logistically impossible.

But what about trying to identify the highest standard of care currently available, estimating the cost of delivering that care universally, and only then deciding what compromises were necessary (rather than simply starting with the judgment that current expenditure levels are the appropriate place from which to start cutting)?

Marmor acknowledged the possibility that one could "imagine extending to everybody suffering [from an] illness the quality of care that is [provided] at very good places," and derive, at least in broad terms, the cost of doing so. He was skeptical, however, because of what he described as practical impediments to the delivery of such care on a universal basis (including the difficulty of replicating universally best-practice care now being delivered by a self-selected population of doctors to a self-selected population of patients), and did not weigh in on the question of whether cutting should precede or follow the identification of, and cost associated with, universal best practices.

Fallout and backlash

Despite the failure of the HSA as a piece of legislation, the principles behind it had an enormous impact on American health care. Its ideas — and the bipartisan acceptance of those ideas — sent a signal to the for-profit health insurance industry that no one would stop a scramble for profit, and scramble they did.

Hellander, noting that previous Democratic administrations had consistently aimed at creating a national health program, said, "That's what capital and business and everyone thought was eventually going to happen, so they weren't going to invest too much money in the health sector as a for-profit industry. Health insurance at that point was still mostly not-for-profit," despite the steady growth of the for-profit sector over the previous two decades.

"Once it became clear that they [the New Democrats] were on the side of big business," she said, "there was an all-out rush of insurance companies to merge…There were a lot of billionaires made during that period. Before that we'd seen people get rich in medicine, they'd have a few million dollars, but we'd never seen the creation of these billionaires."

During this same period, the percentage of American workers in some form of managed care plan exploded — from 27 percent in 1988 to 90 percent in 1999 — primarily because employers favored them as a means of cost control. Managed care transformed from a niche market that catered largely to self-selecting enrollees into the primary way that Americans received medical care. “We got the market reorganization without the superstructure of public law and regulation,” PPI’s Marshall said, referring to the fallout from the New Democrats’ support of a market-based system, combined with the failure to pass the HSA.

This was most Americans’ first taste of managed care, and many found it bitter. The result was what is often called “the managed care backlash,” a period in which newspapers filled with horror stories about patients being denied care by their HMOs, or made to jump through so many hoops that when care finally came, it was at a grave cost. A 1996 op-ed column by Bob Herbert in The New York Times that excoriated a North Carolina HMO for forcing a three-month-old girl with leukemia to receive treatment in a different state for several months, away from her family, is a typical example.

What motivated the New Democrats on health care?

Will Marshall said the PPI’s approach to health care policy was based on “the failure to achieve universal coverage after eight decades of agitation around that on the progressive end…We were trying to figure out how to get the goal of universal coverage in a new way, since the old ways didn’t seem to be yielding any progress.”

Chris Jennings, one of President Clinton’s primary health care advisors and a congressional liaison for Hillary Clinton, told Remapping Debate, “The motivator was [that] they wanted to have a successful effort to pass and enact legislation, and they felt that single payer was never going to pass.”

And Theodore Marmor, the Yale professor emeritus, said that some New Democrats “were advancing these [ideas] not because they thought this was the best way to go, but because they thought the institutions of American government made it so easy to block things that the only way you could do anything would be to provide a conception of health reform…that could draw Republican votes.”

But Dr. Ida Hellander rejected the idea that New Democrats were just seeking a practical way to achieve greater access to and affordability in health care: “The New Democrats were all about an alliance between Democrats and business…They were looking for a way to regain power, and they figured that moving to the right a whole lot was the way to do it.”

Were the New Democrats “all about” such an alliance? Marshall denied it, but in language remarkably similar to that used by those who are pro-business: the New Democrats, he said, had a “pro-growth agenda,” were “pro-market,” and tried to create policy solutions “that went with the grain of market logic.”

According to Marmor, some New Democrats did indeed have “a faith in market instruments, if not markets, that was practically theological in their fundamental orientation.” Marmor said Alain Enthoven, an economist formerly associated with the RAND Corporation (not himself a New Democrat), was the “quintessential example” of the beliefs of this faction.

When asked where the PPI got its ideas for health care reform, Will Marshall cited the work of Alain Enthoven.

Of course, not every managed care enrollee had to deal with denials of service. Enough did, however, and enough newspapers reported about such cases that in a 1997-1998 survey of consumer satisfaction, only tobacco companies were seen as providing worse service than managed care companies and health insurance companies. Banks and oil companies both received higher satisfaction ratings.

Though demands for more access remained a resonant political theme, and ultimately resulted in the increases in access promised by the ACA, demands for improving the "gold standard" of care have not been heard in force for 20 years. Indeed, rather than engaging in a process of first determining what the gold standard is, then making that standard of care available to all (in other words, the provision of care that would be "the envy of the world"), the ACA adopted a very different concept: it speaks in the language of "minimum essential benefits," with each state being able to define that standard by matching it to the level of coverage currently provided by one of the largest health insurers or managed care organizations in the state (as long as certain broad categories of coverage are met).

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