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MANAGED COMPETITION: LESS CHOICE AND COMPETITION, MORE COSTS AND GOVERNMENT IN HEALTH CARE

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INTRODUCTION

While the Clinton Administration continues to shape its health care proposal, several key Members of Congress—in both parties—have been developing comprehensive health care reform proposals loosely based on the concept of "managed competition." These lawmakers are drawn to managed competition because they believe that market incentives and competition, rather than government regulation and bureaucratic control, are the best means for addressing America's health care problems. Some also see managed competition as a middle ground between government-financed national health insurance and consumer choice health care proposals. But, in reality, managed competition would involve so much heavy-handed, unnecessary, government regulation and control that it would evolve into the bureaucratic system its advocates wish to avoid.

As a result, rather than solving America's health care problems, adoption of managed competition as the basis of reform would create many new problems, seriously harming the nation's health care consumers.

First, it would sharply restrict consumer choice and control over health care. This would happen in several ways. It would effectively require almost all consumers to buy a one-size-fits-all package of benefits determined by the federal government. It would force most workers to buy their health insurance from insurers chosen by government-run regional cooperatives rather than from any insurer of their choice on the open market. It would in practice force consumers into health maintenance organizations (HMOs) and other similar managed care systems. These networks of designated providers would preempt consumers' choice of alternative physicians and hospitals. Ultimately, under the raft of restrictions and controls inherent in managed competition, consumer choice of doctors, services, and treatments would be greatly curtailed.

Second, it would mean less competition. Ironically, managed competition would sharply restrict competition between health insurers, effectively leaving consumers in each area to face a cartel which would be dominated by a few large insurers operating managed care systems. With such restricted competition, insurers would be able to use the power of their managed care systems to deny consumers access to some of the care they want and ultimately to reduce the quality of care to save costs. The introduction and availability of new technology and innovative procedures, for example, would be retarded.

Third, many Americans with good coverage would be dumped into inferior plans. Employees of large companies with generous corporate health plans today are likely to be reassigned by their employers into the same regional managed care systems as other workers, sharply reducing their current broad access to the highest quality care. Moreover, many of these workers would be forced to pay higher deductibles and copayments for inferior coverage.

Fourth, the proposal would not significantly reduce health costs. Indeed, managed competition likely would accelerate, rather than reduce, today's skyrocketing health care costs. Managed competition proposals would do little or nothing to address the root cause of rapidly rising health costs—the third party payment problem. Because of the way most plans are designed and paid for today, consumers, doctors, and hospitals are left with little incentive to control costs because a third party insurer is paying all of the bills, no matter how large or small the claims.[1] Managed competition, in fact, would preclude plans with higher deductibles, as well as medical savings accounts and other approaches to reduce third party payment. Instead, it would force even more consumers into virtual first-dollar third party coverage, adding to the problem.

Fifth, there would be more bureaucracy. Managed competition would add several new federal and state bureaucracies and regulatory burdens, further increasing costs. Most damaging of all, the single, standard plan of coverage specified in detail by the federal government, through the political process, inevitably would cover numerous expensive benefits supported by politically powerful interests, whether or not individual consumers wanted to purchase such additional benefits. These benefits likely would include abortion on demand, open-ended mental health counseling, drug and alcohol treatment, open-ended treatment for AIDS and similar diseases, prescription drugs, dental benefits, and possibly long-term care. The addition of such politically driven benefits would make the standard health policy for most Americans under managed competition more costly, adding to the financial burdens on employers and employees, and raising national health care expenses.

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1 Stuart M. Butler, "A Policy Maker's Guide to the Health Care Crisis, Part I: The Debate Over Reform," Heritage Foundation *Talking Points*, February 12, 1992; Edmund F. Haislmaier, "A Policy Maker's Guide to the Health Care Crisis, Part III: What's Wrong With America's Health Insurance Market?" Heritage Foundation *Talking Points*, August 14, 1992.

Sixth, managed competition would destroy jobs. Because employers would face extra costs in hiring labor, some workers would lose their jobs. Under one version of the proposal, as many as one million jobs in small firms could be lost.

While failing to solve America's health care problems, managed competition would be successful in adding more government to health care. Managed competition plans also would sharply increase taxes, and use those funds to expand spending through increased means-tested subsidies for the purchase of health coverage by low-income recipients.

At the same time, these proposals include no broader reforms to ensure that welfare increases would not add to the counterproductive effects of America's welfare system. Because managed competition envisions a standardized benefits package for every American, the managed competition system would make it easier for special interests to succeed in mandating private spending on their favored activities by pressing Congress to add items to the standard, government-specified health plan, with the premiums that virtually everyone must pay for the plan effectively used as a tax to fund the benefits.

Finally, managed competition would establish a new regulatory framework that would make adoption of a full-blown Canadian-style national health system much easier, with the rationing and decline in quality that would result.

Instead of managed competition, Congress should build upon the principles of genuine consumer choice and market competition, principles present, though imperfectly realized in their own federal employee health care system, and developed more thoroughly in the Heritage Foundation's Consumer Choice Health Plan.[2]

The Heritage Plan, in contrast to managed competition, would put the consumer at the center of power and control over health care decision-making and funds, rather than insurance companies, the government, or doctors and hospitals. It would allow workers to direct the funds their employers currently pay for health insurance into any competing health plan of their choice. Workers would, in addition, receive a substantial tax credit for any direct out-of-pocket expenses, as well as for any insurance premiums or medical savings account contributions they paid, encouraging workers to reduce reliance on third party coverage for routine medical care.

Workers also could direct funds into a medical savings account. Contributions would be eligible for the same credit. These so-called medisave funds could be used to purchase a low cost, high deductible catastrophic insurance policy, or any other degree of coverage. Unused funds would remain in the account, tax free, to pay directly for any future uncovered medical expenses.

As a result, the Heritage plan would greatly expand consumer choice and control, forcing sharper competition among insurers and providers. It would maximize access to and quality of care, allowing consumers to purchase services and quality they prefer. At the same time, it would reduce costs most effectively by directly addressing the third party

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2 See Stuart M. Butler, "A Policy Maker's Guide to the Health Care Crisis, Part II: The Heritage Consumer Choice Health Plan," Heritage Foundation *Talking Points*, February 28, 1992.

payment problem—giving consumers direct market incentives to control costs, and creating cost competition among insurers, providers, and innovators to satisfy this new consumer cost sensitivity.

WHAT IS MANAGED COMPETITION?

The concept of managed competition has been developed and advanced most prominently by Professor Alain Enthoven of Stanford University and Dr. Paul Ellwood, a physician and leader of a group of scholars called the Jackson Hole Group.[3] A bill based on the concept (H.R. 5936) was introduced last year in the House of Representatives by Representative Jim Cooper, the Tennessee Democrat, who is a prominent member of the Conservative Democratic Forum, an informal caucus of conservative Democrats. In the Senate, managed competition has been embraced by Senator John Chafee, the Rhode Island Republican and chairman of the Senate Republican Task Force on Health Care Reform. The task force is said to be developing legislation based on managed competition. The Clinton Administration's health care reform proposal is said to be based loosely on the concept of managed competition, although statements by Administration officials suggest the White House is leaning toward a system with features more like Canada's.

Among the key elements of the managed competition idea:

1) A standardized benefits package would be determined by a national board.

Under the managed competition concept, Congress would establish a new federal National Health Board. This board is meant to be independent of the general public, like the Supreme Court or the Federal Reserve Board. The Board would determine the benefits to be included in a standard health insurance policy that everyone in the country would be required to obtain. The Board would specify these required benefits in detail, including what treatments and conditions would be covered, and the amount of the deductible and co-insurance payments in the standard plan. In one version of managed competition, all health insurers would be prohibited from offering any insurance policy that did not include all of the specified benefits and provisions in the standard government plan. In another, buyers would bear heavy tax penalties for purchasing such a plan. Moreover, insurance policies that offered additional benefits besides those in the standard government plan would, at a minimum, not enjoy the tax advantages available to standard plans. Similarly, if a patient directly purchased a service not in the standard plan, that patient would have to pay in after-tax dollars. Under the Cooper bill (employers purchasing policies for their workers that offered benefits beyond those in the standard government plan would be subject to a 34 percent tax on the cost of those benefits.[4]

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3 See, *inter alia*, Alain Enthoven, "The History and Principles of Managed Competition," *Health Affairs*, Supplement, 1993, Vol. 12, pp. 37-39; "Managed Competition and Its Potential to Reduce Health Spending," Congressional Budget Office, May 1993.

4 H.R. 5936, Section 101.

2) Cooperatives would organize plans in each area.

Managed competition envisions a Health Insurance Purchasing Cooperative (HIPC—usually pronounced "hippic"), either for an entire state or for each specified geographic area within the state. Under the Cooper bill, these HIPCs would be public, government-run, not-for-profit corporations. Insurers selling the government-specified standard insurance policy and otherwise acceptable to the government would be allowed to offer such policies to the public through the HIPCs. These standard government-licensed plans generally have become known as "Accountable Health Plans" (AHPs). Professor Enthoven and other managed competition advocates would grant each HIPC additional discretion to accept or reject insurers who wanted to offer health insurance through the HIPC.

3) Employees would be assigned to a HIPC, or their company might become its own HIPC.

All "small" employers would be required to arrange for the purchase of health insurance by their employees through the HIPC. "Small" is defined in H.R. 5936 as employers with 1,000 employees or less, which would cover about 60 percent of all workers. Other proposals would set the level much lower. Under H.R. 5936, each state would have the option to increase the requirement to participate in HIPCs to employers with up to 10,000 employees. "Small" businesses that fail to comply with this requirement would be subject to fines of up to $500 per day.[5]

Employees of these small businesses could choose only among the insurance companies offered by their HIPC, each of which would be offering the same government-specified, standard insurance plan. The choice would be on the basis of price, method of delivery of benefits, and quality. Employers thus could not pick a plan with a different set of benefits if they wanted such an alternative.

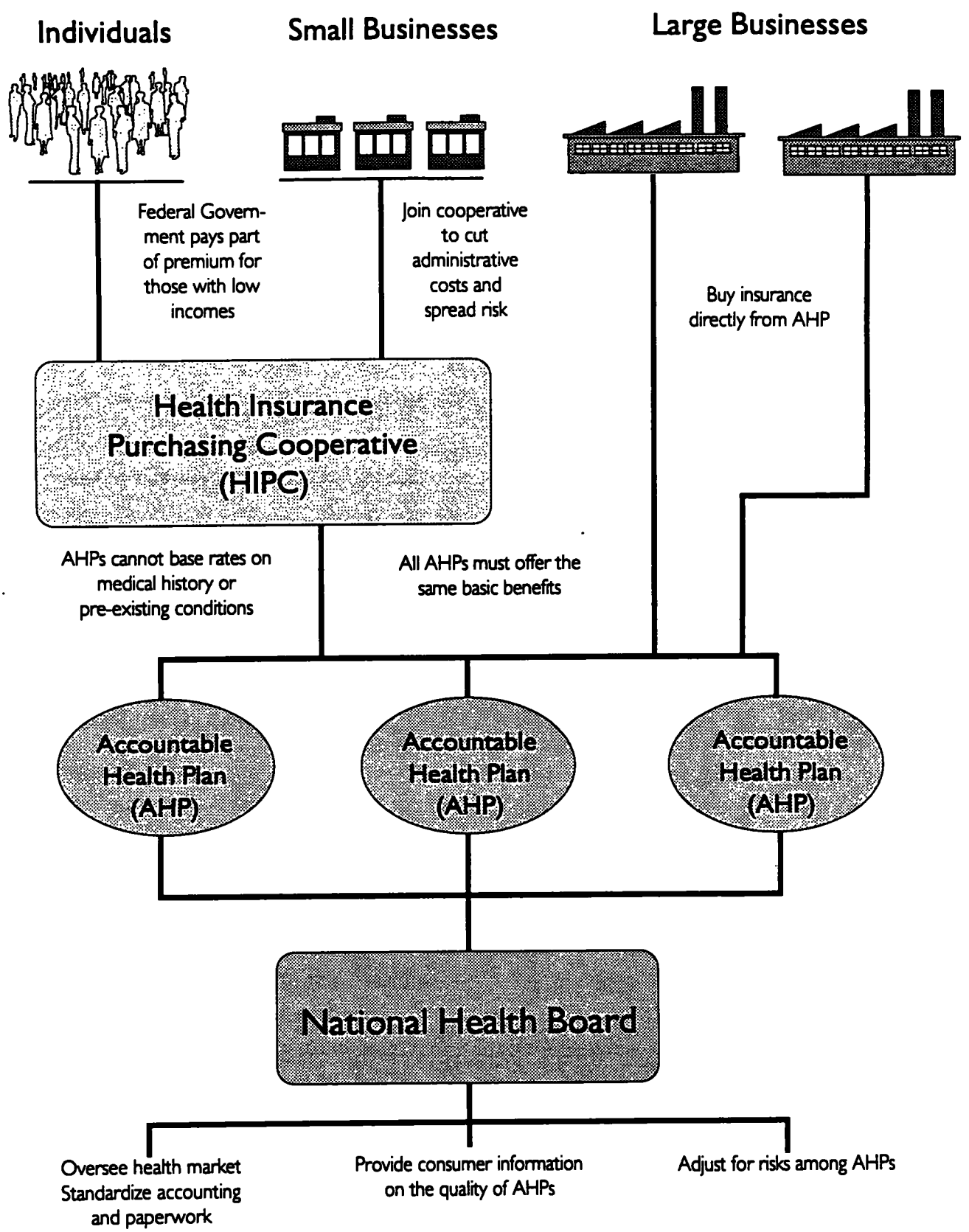
Employers would not necessarily be required to make any contribution to the plan chosen by each employee. The employees would have to accept whatever contribution their employer did make. Each employee would have to cover the remaining premium of their chosen plan. This amount, along with employer contributions, would all be paid to the HIPC covering the area. The HIPC would then distribute the funds to the insurance plans chosen by each worker.

Self-employed workers and individuals not actively employed similarly would have to buy any health insurance policy through the HIPC in their geographic area, in order to receive a tax deduction for their health insurance. If they wanted an alternative plan more to their liking, they would have to pay for the entire plan in after-tax dollars. This would amount to a potentially crippling cost on the purchase of any other plan.

Larger employers and their workers would not have to purchase insurance through the HIPCs. They could purchase their coverage from government-approved Accountable Health Plans outside the HIPCs, but they still would have to buy the same government-specified, standard insurance plan from these insurers. Thus, in effect, these large employers would be their own HIPCs. Under H.R. 5936, employers could purchase supplemental benefits for their workers besides those in the standard government plan. But as indi-

5 H.R. 5936, Section 105 (i).

How "Managed Competition" Would Work



Source: Conservative Democratic Forum.

cated above, employers still would have to pay a 34 percent tax penalty on the cost of those benefits. In some versions of managed competition, employees would not receive a tax exclusion for any payments made for such benefits above the standard level.

4) Most Americans would obtain care through managed care networks.

Managed competition is designed to steer or force all consumers into "managed care" systems, like Health Maintenance Organizations (HMOs).[6] Managed care means that a family obtains its care through an organized network of hospitals and physicians, rather than by picking their own doctor or facility. Thus their care is "managed" by the network. In HMOs, families pay a monthly fee to the HMO, and normally receive care without any additional payments for treatments or physician visits.

For all employers and all individuals, managed competition would cap the tax deduction for health insurance at the lowest premium offered by any insurer in the HIPC for their geographic area. Inevitably, only HMOs or similar managed care programs would be able to charge this lowest premium, as they have direct control over who gives what care to their patients, and can even deny a patient's request for a treatment or service when the HMO believes it is not necessary. Since traditional insurance allows consumers to choose their own doctors and services for medically treatable conditions, these plans almost always would cost more.

Under managed competition, therefore, employers and employees would receive a tax deduction only for the lowest cost HMOs and similar managed care programs. For other, traditional insurance programs, with broader choice of doctors and services, only part of the premium would be deductible.

5) Accountable Health Plans would have to accept all families at the same price.

Under managed competition, insurers must accept everyone who applies for coverage during certain open enrollment periods each year. Generally, plans would not be allowed to exclude coverage for pre-existing conditions—although H.R. 5936 would allow insurers to exclude pre-existing conditions for the first six months of coverage. The pricing of plans would be based on "community rating." This means that insurers would be required to charge the same community rates or premiums for all applicants within certain age and family categories.[7] This means sicker individuals would be undercharged, in the sense that their premium costs would be consistently below the cost of the medical care they received. Meanwhile, healthier and low-risk individuals would be overcharged, in that insurers would have to charge them higher premiums than the predicted cost of their health care. Experience rating, which allows insurers to raise rates for those who have been sicker and have filed more claims, would be prohibited. Insurers also would not be allowed to drop coverage for anyone based on their claims or health experience. Insurers refer to this provision as "guaranteed renewability."

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6 See, Congressional Budget Office, *op. cit.*, pp. 7-8, 25-26, 34-35, 39-41. See also Enthoven, *op. cit.*; H.R. 5936, Section 105.

7 See Haislmaier, *op. cit.*, and Edmund F. Haislmaier, "A Policy Maker's Guide to the Health Care Crisis, Part IV: The Right to Health Insurance Reform," Heritage Foundation *Talking Points*, November 5, 1992.

A complex formula, to be determined by the new National Health Board, would be used by each HIPC to take some of the premiums for its plans that have signed up lower risk consumers and redistribute them to plans on its menu that have signed up higher risk consumers. Each HIPC thus would have enormous financial responsibilities. It should be noted that all of these enrollment, pricing, and regulatory restrictions, even if they were desirable, could be adopted without including the rest of the managed competition framework.

Insurers and health care providers also would be required under managed competition to participate in a new, nationally standardized system of reporting concerning their costs, quality performance, medical outcomes, consumer satisfaction, and financial standing. This information would have to be collected by each insurer and health care provider and reported to the regional HIPCs and the National Health Board. All this reporting and information collection is meant to help the government decide which services and treatments should be covered by the standard, government-required health plan, and to aid consumers in choosing among insurers and provider networks.

Additional Bureaucracies. The managed competition infrastructure would include other new government bureaucracies besides the National Health Board and the HIPCs in each state. Under H.R. 5936, for instance, a new national Health Benefits and Data Standards Board would be created to provide expert advice to the National Health Board on what benefits, treatments, and services should be covered by the national, standard, government-specified health plan. It would also provide advice on establishment and operation of the new, national, performance reporting system. In addition, a national Health Plan Standards Board would be created to advise the National Health Board on the regulation of HIPCs, insurers, and provider networks, as well as on the formulas for the redistribution of premiums from the lower risk insurers to higher risk insurers. Professor Enthoven would incorporate similar boards in his managed competition proposal.

Professor Enthoven and other managed competition advocates also would adopt a legal mandate requiring everyone to purchase the government-specified standard health plan, through some combination of payments from employers and employees and public taxes, thereby providing universal coverage.[8] H.R. 5936 would not include such a mandate. In addition, under these proposals, a new government program would provide subsidies to the poor to purchase such insurance. These new subsidies likely would require substantial tax increases. Under H.R. 5936, a new federal program, replacing Medicaid, would pay the premiums for the standard government-specified health plan for all poor Americans. This would be financed by capping the tax exemption for employer-provided health coverage, eliminating the current cap on wages subject to the Medicare (HI) payroll tax, and leaving the states full responsibility for financing current Medicaid subsidies for long-term care.[9]

The theory behind managed competition is to limit competition to the price of the standard health plan, and the capabilities of the different managed care systems in providing services covered by the plan. Competition over other factors, such as variations in cover-

8 Enthoven, *op. cit.*, pp. 41-42; CBO, *op. cit.*, pp. 11-12, 21-23.

9 H.R. 5936, Sections 211, 221, and 231.

age, is to be eliminated or minimized. This is thought to focus competitive attention on cost. Consumers would be steered into managed care systems so that these systems could use their power and control over services to reduce costs. The current tax exemption for health insurance would be limited to the lowest priced managed care plan in each area to further focus consumer concern over the cost of each plan. The purpose of the HIPCs is to control this competitive structure. All of this is thought by managed competition advocates to be the most effective means for reducing health care costs.

Managed competition advocates are to commended for recognizing that only a market system, rather than government price controls and budget limits, can ultimately be effective in reducing costs while maintaining quality care for consumers. But managed competition itself is so heavily regulated and controlled that it ultimately fails to create anything like a true market and open competition in health care services and insurance. As a result, as discussed in detail below, managed competition would not reduce costs, and would create many new intractable problems in health care, seriously harming health care consumers.

SIX WAYS CONSUMER CHOICE IS RESTRICTED UNDER MANAGED COMPETITION

Proponents of managed competition argue that the purpose is to introduce market forces into the health care system, including wider consumer choice. But when examined closely, managed competition sharply restricts consumer choice, and effectively deprives most consumers of direct control over their health care resources and services, particularly when compared with open market reform alternatives, such as the Heritage Consumer Choice Health Plan discussed below.

Restriction #1: All Americans would be required by tax policy and a legal mandate to buy the same health insurance policy, which would be specified by the federal government.

Given open enrollment and community rating, where everyone is charged the same premium regardless of risk, managed competition would legally require every family to purchase the single, government-specified benefit plan for the system even to function. Otherwise, it would be irrational to buy insurance coverage until one became sick, since insurers would be forced to accept a person who then applied and charge the same standard premium. Insurers would then be unable to spread risks and survive financially.

Restriction #2: With a standardized health plan, a federal government board, rather than individual consumers, chooses what illnesses, services, treatments, and types of providers would be covered.

This government board, rather than individual consumers, would decide what services are considered cost-effective and to be covered, and which are not. The board would also choose the uniform deductibles, co-payment fees, and stop-loss limits for everyone.

The national board set up under managed competition would be a kind of "Supreme Court of Health," in that it would be independent of Congress and yet would have enormous powers over the health care provided to every American. In theory, nothing would stop Americans from buying additional care above that specified by the board. But the

purchase of supplementary coverage would not, in most instances, be feasible under managed competition. Few employers, for instance, would purchase more than the standard board-specified plan without a full tax deduction for the firm or the exclusion of the health benefits from the workers' incomes. The employer or the worker in either case would be better off with the payment of the equivalent amount in wages instead. If open enrollment and community rating applied to such supplementary benefits as well, as under H.R. 5936, it would be irrational to buy such coverage until an individual became sick. But if this were permitted, the health market would be unable to function. Moreover, many managed competition advocates argue that such supplementary coverage should be legally banned in any event, to ensure the maximum incentives and competition to reduce costs under the standard government plan.[10]

The issue is not only what provisions that individual consumers might want would not be covered under the government plan. An additional issue is that treatments might be covered that families do not want to pay for but would be forced to buy. Given current political pressures, the standard government-specified plan probably would include open-ended coverage for abortion on demand, generous mental health counseling, drug and alcohol treatment, and treatment for AIDs and for other diseases that may result from drug or alcohol abuse or sexual promiscuity. The addition of such benefits would likely make the standard government-specified plan quite costly. Moreover, many consumers may not want such benefits for themselves, and may have a conscientious objection to being forced to subsidize such services for others.

Restriction #3: Most, if not virtually all, workers would be forced to buy their health insurance from the insurers chosen by their HIPC, rather than from an insurer of their choice on the open market.

Employees of larger companies that might be exempt from the HIPCs would, like today, still have only the plan or choice of plans picked by their employers, rather than an open market choice. If these employees changed jobs, they would normally lose their current health insurance plan, as under the current health care system, and have to participate in the health care arrangements established by their new employer. All other families would have to choose from among the HIPC plans.

Restriction #4: The entire system is designed to force consumers into HMOs and other similar managed care systems, effectively preempting their choice of alternative systems.

A full tax exemption would be available only for lower-priced managed-care systems, with only a partial exemption for alternatives. The state HIPCs also could limit the availability of alternative systems, if they include any such alternatives at all. Thus a HIPC might require all plans to be managed care networks. Moreover, with the highly favored managed care systems signing up doctors and facilities for their networks, little scope may remain for alternative, open choice, insurance or health care delivery systems in any event.[11]

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10 CBO, *op. cit.*, pp. 9-10, 12, 20-21. See also pp. 15, 21-23, 28-29.

Restriction #5: Under managed competition, a family's choice of doctor would be greatly curtailed.[12]

Consumers would be able to choose only among doctors affiliated with their managed care network. And even here they may be subject to restrictions imposed by their managed care plan concerning which among the network-affiliated doctors they may consult. Americans would have to get used to limits of this kind. As Senator John Chafee, a strong proponent of managed competition, explains;

> Managed care, by its very definition, limits choice of health care providers ...[S]ome regulation is going to have to come into the lives of our constituents who are currently enjoying fee for service type of medical care where they can go to any doctor they want to, any hospital they want to. That, to a great extent, will no longer be possible.[13]

Restriction #6: A family's choice of services and treatments also would be greatly curtailed.

Under the dominant managed care model, doctors would lose the freedom to provide services and treatments that they and their patients thought desirable. Instead, insurers and government boards would have the power to restrict services and treatments in order to save costs.

The managed care insurers, having received a fixed fee from an enrollee for the entire year, ultimately would choose what services and treatment its doctors would provide in return. Doctors effectively would be on the staffs of the managed care plans and would be subject to their policies and ultimate control. The government would get into the act as well. The National Health Board and its related federal agencies would study health treatments and services, using data from its health care reporting system. The Board then would seek to control what doctors provided to their patients through federal practice guidelines, restricted coverage in the national health plan, and other means. These decisions would be based on the judgment of these federal bureaucracies, rather than the judgment of doctors and the preferences of patients. For instance, surgery might be more cost-effective in a certain instance. But for work-related or quality-of-life reasons, a patient may strongly want an alternative form of treatment.

For many of these same reasons, the Congressional Budget Office, in a major study of managed competition issued in May 1993, concludes that under such a system:

> Consumers would probably have less choice, more limited access to many providers, fewer services, and slower access to new technologies.... Consumers would have less choice about the range of services covered by insurers as well as about the providers from whom they could receive care.[14]

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11 Indeed, Mr. Cooper has stated that, under managed competition, "my guess is that fee-for-services medicine will be discouraged and mostly die out." "Managed Competition: Wave of the Future?" *AAPS News*, February 1993, p. 1.

12 Enthoven, the leading theorist of managed competition, in fact disparages "free choice of doctor by the patient" because it leaves insurers with no bargaining power with the doctor. Enthoven, *op. cit.*, p. 25.

13 *Congressional Record*, March 11, 1993, p. S-2710.

14 CBO, *op. cit.*

The bottom line: Despite being portrayed as vigorous consumer choice, managed competition is not really a system based on consumer choice and control. Rather, employers, managed care planners, and government-appointed boards in reality would wield the power and control.

ENSURING LESS COMPETITION

Managed competition would also greatly restrict competition between insurers. This is ironic, because proponents of the concept claim such competition to be one of its central features. Yet insurers within each HIPC would be legally protected from competition by insurers outside the HIPC. Since new plans would need the permission of the HIPC before they could be offered to consumers, the HIPC for each geographic area would constitute an artificial barrier to market entry by new competitors. In practice, the well-established large insurers likely would dominate each HIPC, just as heavily regulated industries often "capture" their regulators and use regulation to frustrate new competitors. Thus existing health insurers would seek to use the HIPC to close off entry by new insurers or to thwart innovative, alternative health care delivery systems.[15]

In addition, under the managed competition model, there would only be one HIPC for each geographic area. As a result, there would be no competition between HIPCs and their affiliated insurers, and a cozy relationship would develop. Thus consumers in each area would face what amounted to a cartel of insurers, each selling exactly the same insurance policy.

Further, managed competition would eliminate or sharply reduce one of the main features of competition between insurers—alternative and innovative patterns of coverage. Insurers would each be required to offer the same, standard policy, with supplemental variations sharply curtailed or eliminated. This would further reduce the opportunity for many competitors to find a market niche and offer new services to the consumer.

Crowding Out Small Insurers. Over time, the number of insurers competing within each HIPC would in all probability be limited to a few large insurers. The largest insurers, who would be big enough to organize a managed care network staff of doctors and health facilities, would dominate the system. In signing up the available doctors and facilities, these insurers would leave little room for other insurers to compete, whether by developing their own managed care systems, or using any other insurance model. Small and moderate size insurers would be less able to develop full managed care systems of their own, and would tend to disappear. Ultimately, the thousands of health insurers now competing across the country would likely be reduced to a handful of large, powerful insurers in each geographic area. Consumers would have no choice but to accept the cartels.

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15 Indeed, as Robert Moffit of the Heritage Foundation noted, the HIPCs, as state-run institutions, would be highly politicized. "In Maryland, you would now have the William Donald Schafer H[I]PCs; in New Jersey, the Jim Florio H[I]PCs; in Virginia, the Douglas Wilder H[I]PCs; in New York, the Mario Cuomo H[I]PCs, Republican-appointed H[I]PCs and Democratic-appointed H[I]PCs." Robert E. Moffit, "Overdosing on Management: Reforming the Health Care System Through Managed Competition," *Heritage Lecture* No. 441, February 23, 1993, p. 3.

A decline in options for consumers, and a contraction in the number of suppliers, is projected by the Congressional Budget Office (CBO). In its recent study on managed competition, the CBO said:

> Specifically, to be effective in reducing the growth rate of spending on health care, a managed competition system would need to result in a relatively small number of insurance organizations that had substantially non-overlapping networks of affiliated providers....If a managed competition policy containing these elements were adopted and price competition among insurers increased, the number of insurers would probably be significantly reduced. Most primary care providers, and some specialists, would be affiliated exclusively with one insurer.[16]

This concentration of insurers would be most acute in rural areas with little capacity to support competing managed care networks. A recent study published in *The New England Journal of Medicine* found that 29 percent of Americans live in areas that could not support as many as three separately functioning managed care networks, even assuming they shared hospital facilities and many specialist services. Only 42 percent of Americans, according to the study, live in areas that could support three fully independent managed care networks.[17]

As a result, managed competition would not be what Americans envision in the term "competition"—a market where the consumer is king. It would mean instead a market dominated by a cartel of a few giant, dominant insurance companies, again backed by government regulation. As Representative Pete Stark, the California Democrat, says of managed competition, "We're not going to have a Canadian System, we're going to have a HIPC system, and King HIPC will make the decisions."[18]

REDUCED ACCESS AND QUALITY OF CARE

Managed competition also would inevitably produce reduced access to medical care and reduced quality of care for most consumers.

The method of reducing costs under managed competition is to give insurance companies the effective power, through HMO and other managed care models, to deny services to consumers in order to save funds. Consumers pay the managed care insurer an up-front fee for medical care during the year, and after that the managed care insurer determines what services and treatments its doctors will provide the patient, based ultimately on the insurer's judgment rather than the judgment of the patient and his or her chosen doctor. Doctors would be affiliated with particular managed care insurers and would be subject to their policies and control in order to receive their incomes. If they did not agree to this, they would be frozen out of the health care cartel. So doctors would in prac-

16 CBO, *op. cit.*, p. xii.

17 Richard Kronick, David C. Goodman, John Manberg, and Edward Wagner, "The Marketplan in Health Care Reform: The Demographic Limitations of Managed Competition, *The New England Journal of Medicare*, Vol. 328, No. 6 (January 14, 1993), pp. 148-192; see also CBO, *op. cit.*, pp. 40-41.

18 Hilary Stout, "Proposal for Health Care Cooperatives Draws Criticism as Some See Growing Regulatory Role," *The Wall Street Journal*, May 10, 1993, p. A12.

tice be employees on the payroll of the insurers rather than independent professionals responding to patients.

Insurance companies consequently would be further inserted into the relationship between doctor and patient with the dominant power to determine what services the doctor may provide. Doctors would lose their traditional freedom and control over their own practices to give consumers the care they think best in their own professional judgment. Doctors instead would be responding to the interests and preferences of insurance companies, rather than patients, because it would be insurers, rather than patients, who would dominate and control the flow of funds and payments to doctors and hospitals. Consumers would no longer have the power, as under the current system, to determine which doctors receive payment and for which services. Rather, the managed care insurer would make those decisions.

Managed care systems work well today, and are a preferred option for millions of Americans. But this is all dependent on one critical factor—if managed care systems go too far today in denying care to consumers, the consumers can easily leave the system and opt for alternative coverage. Managed competition, however, is not based on such open consumer choice and market competition. As discussed above, managed competition is designed to force consumers into managed care systems under the control of insurance companies and the government. Moreover, through its restrictions on competition among insurers, managed competition would ultimately leave a cartel of a few, large, powerful insurers in control of each geographic area.

Under this system, managed care insurers would have far greater power to deny consumers the care they may prefer. With just a few dominant managed care insurers essentially all denying care under the same general practices, consumers would not have anywhere else to turn. Indeed, with such greatly restricted competition and alternatives, insurers would be more able to cut corners, at the expense of quality, in order to save costs. They could also slow the adoption of new technology and innovative treatments. The few large insurers controlling each area could even collude to adopt these practices and inflate their profits.

Less for the Sick. The managed competition framework, moreover, would include additional incentives for the managed care insurers to deny care to consumers most in need. Since the insurer must charge the same premium to all consumers regardless of their health, under the system known as community rating, the insurer has no financial incentive to give the best treatment to the most sick, since the insurer would not receive additional compensation for doing so. To the contrary, the plan would bear the added costs of maintaining top quality facilities for the most sick and treating them, but would receive no compensation for such costs.

Consequently, the managed care insurers would tend to limit their facilities and capabilities for treating the sickest patients. Their facilities for treating cancer or heart disease or AIDS, would in all probability become increasingly inadequate and out of date over time. They will lack sufficient cancer specialists or heart surgeons on their staffs, which they will insist they just cannot find. They will move slowly in acquiring new technologies and facilities for treating these diseases over time. Indeed, they would even be eager to let the public know of these inadequacies, so the most sick would choose and impose their costs on other insurers.

Managed care networks generally work well in today's markets. But managed competition's combination of steering consumers into managed care systems, limiting competition to a cartel of a few, large dominant systems in each area, and imposing on these systems the incentives of community rating, is a prescription for a health care disaster for the sick and the elderly who most need the best and most sophisticated health care.

Less "Alternative" Care. Managed competition would result in reduced access and quality in other ways as well. Patients of one managed care network would, of course, not have access to the providers and facilities of other managed care networks, which they may prefer at different times. Consumers who live in one geographic area and work in another may find themselves limited to a network of providers in one area or another. For example, a worker who lives in Maryland but works nearby in the District of Columbia may find that he can only have a managed care network with providers in the District.

Moreover, patients would lose access to practitioners of "alternative," non-establishment medicine. Under a government-regulated system, insurance companies are unlikely to bear the cost of retaining practitioners of, say, holistic medicine on their managed care staffs. Specifically, they are unlikely to cover practices or therapies that do not have the imprimatur of establishment medicine. Yet, medical conditions are sometimes cured and lives saved only by turning to alternative "renegades," whose methods may one day become part of the standard practice of establishment medicine.

Less Innovation. Innovation would be slowed under managed competition, because new technologies and treatments would be subject to long delays. The reason: the political, bureaucratic process to get coverage in the single, standard, national health plan. The result would be similar to the effects of the lengthy and time-consuming drug approval process of the Food and Drug Administration.[19] Moreover, the bureaucrats overseeing this process would face strong political pressure from insurance companies and employers to keep costs down, but little pressure from a general public unaware of possible new medical technologies and innovations. Averse to accepting risk or change, like any bureaucrats they would tend to slow or reject such new developments.

The centralized managed care providers would raise an additional barrier to such innovations. Reluctant to absorb the costs of a new technology, and not pressured by stiff competition or by clients—who would normally be unaware of cutting-edge medical possibilities—the plans would have little incentive to incorporate the latest medical technology unless it cut costs. The uncertainty of ever gaining approval for new procedures, new treatments, or new technologies through this slow and bureaucratic gauntlet would discourage many innovators from even trying to develop breakthroughs in the first place.

Loss of Benefits. Employees of large companies with generous health plans also would lose the rich benefit packages they currently enjoy. Given the tax penalties for offering more than the standard plan, employers would likely limit their health insurance contributions to the maximum tax-exempt amount, which would be equal to the lowest-

19 Paul Rubin, "Regulatory Relief or Power Grab: Should Congress Expand FDA Enforcement Authority," Heritage Foundation *Backgrounder* No. 900, June 11, 1992; Sam Kazman, "The Food and Drug Administration's Real Problem: Drug Unavailability, Heritage Foundation *Backgrounder Update*, No. 112, October 4, 1989.

cost managed care plan in their respective HIPCs. This would mean a sharp reduction in the benefits in many current corporate plans. Even if the employers were to give back the savings to the employees in increased pay, the employees could not purchase replacement coverage without first bearing the burden of paying full federal, state, and local income and Social Security taxes on that income, sharply increasing the cost of obtaining the same benefits they enjoyed previously.

In fact, these large employers would have strong incentives to dump their employees or retirees into the HIPC for their area, rather than providing insurance themselves. They would save administrative costs as a result, and if they are not going to pay more than the maximum tax-exempt amount for the lowest-cost HIPC plan anyway, they would have no reason not to do so. Large employers with an older or sicker work force could gain substantially by paying the community rating premiums of the HIPC plans, rather than organizing their own insurance plans, requiring higher insurance rates to cover their greater risks. The currently generous benefit plans for employees of these corporations would consequently be replaced by the much less generous and heavily controlled managed care plans offered by the HIPC. This means other businesses with healthier employees would bear higher costs by having to share through the community rating premiums the higher costs of the older and sicker work forces, and retirees, in many large corporations.

WHY MANAGED COMPETITION WOULD NOT CONTROL COSTS

Managed competition is advanced first and foremost as a system that will control and reduce rapidly rising health costs. But the system fails to address the basic cause of rapidly rising health costs. Indeed, it includes many elements that ultimately would increase rather than reduce costs.

The root cause of rapidly rising medical costs has been universally identified as the tax-supported, employer-based third party payment system. Because some third party—insurers, or the government through Medicare and Medicaid—pays most health bills, both consumers and medical providers lack incentives to keep costs down. So they do not shop for the lowest cost care or seek to avoid unnecessary care, and demand services even where costs greatly exceed the benefits. Because consumers are not concerned about direct costs, moreover, providers and innovators do not compete to keep costs down.[20]

Managed competition would do nothing to address this third party payment problem. Rather, it would perpetuate and extend it. In fact, it would expand third party coverage to everyone through a universal mandate. One authoritative study estimates that expanding third party coverage to the uninsured would alone add $30.6 billion per year to national health costs because of increased utilization under the incentives of third party coverage.[21] At the same time, managed competition would limit or preclude health plans with

20 For a general discussion of this problems, see Butler, *Talking Points I, op. cit.*

21 John F. Sheils, Lawrence S. Lewin, and Randall A. Haught, "Potential Public Expenditures under Managed Competition," *Health Affairs*, Vol. 12, Supplement 1993, p. 233.

high deductibles that reduce third party coverage and expand direct consumer incentives. It would also preclude medical savings accounts, an innovation that would encourage higher deductibles by allowing families to establish tax-exempt accounts to cover direct purchases of medical care. Instead, managed competition would impose a single, standard health plan on everyone that, because of the political process, most likely would include only a modest deductible. Indeed, many people likely would have even lower deductibles in the standard plan under managed competition than they do under their insurance plans today, again adding to the third party payment problem.

Direct Consumer Incentives Needed. Managed competition seeks to rely on competition among insurers and their managed care networks to reduce costs. But that is only one part of the overall system of incentives that would control costs in an open market. Just as important would be direct incentives for consumers to control costs when they seek care, translating as well into direct-on-the-spot incentives for providers to control costs as well. Studies show that expanded cost sharing through high deductibles and copayments is nearly twice as effective in controlling costs as managed care systems alone.[22] Without such direct incentives, any system to control costs would always be fighting a losing battle against the current incentives underlying the demand of millions of consumers and their doctors, who would still be largely insulated from the economic consequences of their daily decentralized health care decisions.

Managed competition would directly increase costs in numerous ways as well. The leading proposals would establish three new federal bureaucracies: the National Health Board, the Health Benefits and Data Standards Board, and the Health Plan Standards Board. The proposals would also require a new HIPC bureaucracy in each state. This added bureaucracy would necessarily drive up costs. Managed competition also would require a new detailed reporting and data collection system by all health providers nationwide. This system would involve substantial new paperwork and costs as well.

But the biggest factor driving up costs under managed competition would be its reliance on a single, standard plan of health coverage for every family. Chosen through the political process, it would ultimately end up covering numerous expensive benefits supported by politically favored interests. Even now, as the Clinton Administration contemplates a standard benefits package, there is pressure to include open-ended mental health counseling, drug and alcohol treatment, open-ended treatment for AIDS, prescription drugs, dental benefits, and even long-term nursing home care. Mandating inclusion of such benefits necessarily would drive up national health costs, just as state insurance mandates have driven up local insurance costs.[23]

Besides the general benefits, numerous specialty practitioners, such as chiropractors or acupuncturists or osteopaths, would lobby heavily to have their treatments covered under the standard national plan as well. Such groups already are campaigning to be included

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22 Mark V. Pauly, "Killing with Kindness: Why Some Forms of Managed Competition Might Needlessly Stifle Competitive Managed Care," paper delivered at American Enterprise Institute conference on Health Care Expenditure Controls: Political and Economic Issues, April 21-22, 1993, p. 9.

23 John C. Goodman and Gerald L. Musgrave, "Freedom of Choice in Health Insurance," National Center for Policy Analysis, *Policy Report* #134, November 1988.

in the Clinton benefit package. They will rightly see such coverage as essential to the prosperity and possibly even survival of their practices. Most, therefore, would fight hard for such coverage. Many would doubtless succeed.

Adding on a Christmas tree of benefits would make the standard plan under managed competition very costly. And extending full third party coverage to all of these benefits would likely spur a rapid acceleration of national health care expenses. Employers who think that managed competition would reduce their costs are sorely mistaken. What they would discover is a loss of control over what they must pay for. And they would be stuck with costs driven by a political process far more sensitive to interest groups than to employer concerns over health care costs.

Some proponents of managed competition claim that these pressures to raise costs could be constrained by price controls and a fixed national budget for all health care. But this is an admission that managed competition would not be successful in holding down costs. Indeed, if price controls and global budget limits are the factors to control costs under a managed competition framework that would otherwise increase costs, then what is the point of adopting managed competition? Significantly, Enthoven, Elwood, and other originators of managed competition reject price controls and global budget limits as inconsistent with managed competition. Indeed, Enthoven compares global budgets to "bombing from 335,000 feet, where you don't see the faces of the people you kill.[24] And well they should, for managed competition is based on the idea of creating a price competition among managed care plans, and a price competition is not possible if the government is setting prices.[25]

In addition, if price controls or global budget limits are added to managed competition, then that would result in further reductions in access to and quality of care, as these mechanisms would arbitrarily starve the health system of funds to reduce costs.[26]

A TROJAN HORSE FOR BIGGER GOVERNMENT

Managed competition would add to the nation's health care problems, rather than solving them. It would also prove to be the vehicle for a huge expansion of government.

Managed competition would mean a major tax increase by capping the tax exemption for health insurance in each geographic area at the premium level for the lowest cost plan in that area's HIPC. It would also involve a major increase in welfare spending because the government would pay large, means-tested subsidies to everyone at lower incomes to pay for premiums of the standard, government-specified health plan. Under H.R. 5936, for instance, the government would pay full premiums for everyone in poverty, and continue some subsidies at income levels up to 200 percent of the poverty level. The poverty

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24 Enthoven made the comment during a recent conference on health care reform, as reported in *Health News Daily*, January 11, 1993, p. 2.

25 Stuart M. Butler, "The Contradictions in the Clinton Health Plan," Heritage Foundation *Backgrounder* No. 924, January 12, 1993.

26 Edmund F. Haislmaier, "Why Global Budgets and Price Controls Will Not Curb Health Costs," Heritage Foundation *Backgrounder* No. 929, March 8, 1993.

level for a family of four in 1992 was close to $14,000, meaning subsidies would continue for four-person families up to almost $28,000 in income. At the same time, the proposals include no broader reforms to ensure this increased welfare spending would not add to the counterproductive effects of the current system in encouraging non-work, family breakup, and long-term dependency. Paying full health care premiums for everyone below the poverty line would substantially increase the reward for not working, and phasing out these added subsidies would add to the effective marginal tax on work effort. Any increase in health care subsidies for low-income recipients should be adopted in the context of broader welfare reforms to ensure that these added subsidies do not add to the counterproductive effects of America's welfare system as well.

But that is only the beginning. Managed competition would also be used to fund many other big government social programs. Lawmakers could do this simply by adding long-sought benefits to the standard, government-specified health plan that almost everyone would effectively have to buy. The premiums for that health plan paid by almost everyone would then effectively serve as a tax to finance these big benefit programs.

Consider the promotion of elective abortion. Adding unlimited abortion on demand to the standard health plan would finance, at a shake, free unlimited abortions not only for the poor, but also for everyone else, effectively using the standard health plan premiums as a new tax for funding by general taxpayers. Consider also expanded drug rehabilitation programs. Adding drug and alcohol treatment to the standard health plan would provide such benefits for everyone without limit, again financed by the premium "tax" that everyone must pay for the standard health plan. Open-ended, unlimited treatment for AIDS and other sexually-related diseases is another example of services that could be financed through this premium tax as well, again by adding such treatment to the standard health plan. The same would be true for long-term care. Overall, through this process, congressional liberals could obtain massive new social spending increases in new off-budget spending and taxes, effectively hiding the financial impact of this spending on America's taxpayers.

A Back-Door Canadian System. Finally, with a highly regulated managed competition framework in place, it would be much easier to impose a full-blown Canadian-style national health system on America. Such a system would result from just a few simple changes in the managed competition structure:

1) The premiums paid to state-run HIPCs would be replaced by a uniform federal tax, such as a payroll tax.

2) The HIPCs would then distribute these funds to the established managed care networks through a formula based on their expected utilization, and advise residents in each state to choose among these networks for their care, similar to the process in the Canadian provinces.

3) The government would then impose an expenditure limit on these networks, equivalent to the funds they received from the HIPCs—again, just like the Canadian medical budget caps.

The resulting system would be indistinguishable from the Canadian national health care system, and would have all of the same negative effects, such as waiting lines, delays in treatment, and the tragic loss of the current expansive access to high quality, sophisticated medical technology enjoyed by the average American.[27]

JOB LOSSES UNDER MANAGED COMPETITION

If managed competition includes a mandate that employers purchase a health package for their employees, that would destroy jobs by raising the cost of employment.[28] H.R. 5936 includes no such mandate, and thus would not lead to a universal health system. One recent study estimates that the employer mandate advocated by Enthoven and the Jackson Hole Group would cause the loss of about 1 million jobs in small businesses of less than 500 employees.[29] The study also estimates that about 16.3 million workers, or almost 25 percent of all small business employment, would face the risk of prolonged layoffs, lost benefits, and plant closings.

THE ALTERNATIVE—REAL CONSUMER CHOICE

Instead of government-regulated managed competition, what is needed is open competition, with consumers making the central decisions over what their benefits will be. That would be provided under the Heritage Foundation Consumer Choice Plan.[30] Legislation based on the Heritage proposal was introduced last year by Senator Orrin Hatch, the Utah Republican.

Under the Heritage plan, unlike managed competition, there would be no requirement for every American to have the same coverage through a comprehensive standard health insurance policy, only the minimal regulation that families must obtain catastrophic coverage—to protect society from "free riders" who could afford coverage but would

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27 Edmund R. Haislmaier, "Problems in Paradise: Canadians Complain About Their Health Care System, Heritage Foundation *Backgrounder*, No. 883, February 19, 1993; Edmund F. Haislmaier, "Northern Discomfort: The Ills of the Canadian Health Care System," *Policy Review*, Vol. 58, October 1, 1991; Edmund F. Haislmaier, "Perception v. Reality: Taking a Second Look at Canadian Health Care,"Heritage Foundation *Backgrounder* No. 807, January 31, 1991; John Goodman, "Beware of National Health Insurance," *Heritage Lecture* No. 276, August 1, 1990; Michael Walker, "Why Canada's Health System is no Cure for America's Ills, " Heritage Foundation *International Briefing* No. 19, March 13, 1989.

28 Edmund F. Haislmaier, "The Mitchell Health America Act: A Bait and Switch for America's Workers," *Issue Bulletin* No. 170, January 17, 1992; Stuart M. Butler, "Why 'Play or Pay' National Health Care is Doomed to Fail," *Heritage Lecture* No. 329, August 14, 1991.

29 CONSAD Research Corporation, "The Employment Impact of Proposed Health Care Reform on Small Businesses," May 6, 1993.

30 In addition to the Heritage studies cited earlier, see Stuart M. Butler and Edmund F. Haislmaier, eds., *A National Health System for America* (Washington, D.C.: The Heritage Foundation, 1989); Stuart M. Butler, "Assuring Affordable Health Care for All Americans," *Heritage Lecture* No. 218, October 1, 1989; Stuart M. Butler, "Using Tax Credits to Create An Affordable Health System," Heritage Foundation *Backgrounder* No. 777, July 26, 1990; Robert E. Moffit, "Consumer Choice in Health: Learning from the Federal Employee Health Benefits Program," Heritage Foundation *Backgrounder* No. 855, September 23, 1991; Stuart M. Butler, "Why Conservatives Need A National Health Plan," *Heritage Lecture* No. 442, March 23, 1993.

choose to rely on taxpayers to pick up the tab if they or their dependents had a serious illness. Beyond these minimal requirements, consumers would be free to purchase whatever additional provisions or coverage they preferred. To help them pay for coverage, families would receive tax credits and any money now being spent on coverage by their employer.[31]

Families would receive tax credits for three kinds of health care purchases:

1) **health insurance;**

2) **payments they made directly to a doctor, hospital, pharmacist, or other provider;**

3) **contributions to a medical savings account, which would be a special account set aside for future out-of-pocket medical expenses.**

The Heritage Plan would not require consumers to purchase their insurance through a HIPC, but would allow them to buy their coverage from any insurer in the open market that they preferred. Consumers and businesses could voluntarily form and join HIPCs to purchase insurance if they preferred to do so, and legal restrictions against such collective purchasing would be removed. Families also could buy a plan through some other organization, such as a union, church, or farm bureau, and obtain the tax credits.

Unlike managed competition, the Heritage plan does not establish any requirement or institutional bias forcing consumers into managed care systems. These systems would compete on the open market on the same terms as everyone else. Such a free market would allow for the development and marketing of alternative health care delivery options, enabling entrepreneurs to take advantage of new technologies and new systems of health care delivery to patients without time-consuming bureaucratic delays.

The Heritage plan consequently would place consumers at the center of power and control. Consumers would make the decisions, and have ultimate control over the funds and where they go. The entire health care system, therefore, would be forced to respond to them, rather than to employers, insurers, or the government, as under most other proposals. Consumers also would have maximum freedom of choice regarding all aspects of their health care, including services, treatments, providers, coverage, and insurers.

Unlike managed competition, the Heritage plan would also maximize, rather than restrict, competition among insurers and all health care providers. The Heritage Plan would also maximize, rather than restrict, access to and quality of care, allowing consumers to purchase the services and quality they prefer. It would create a competition among insurers to keep costs down, as they vied for consumer favor. But it would also maximize market incentives for consumers to control costs by avoiding unnecessary or overly expensive care. This in turn would result in stiff competition among providers and innovators to meet this newly-heightened consumer concern by reducing costs. At the same time, the Heritage plan avoids the added costs of unnecessary additional bureaucracy and regulations imposed by managed competition. The Heritage Plan would consequently reduce rapidly rising health costs in accordance with consumer preferences.

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31 Low-income families not paying taxes would receive "refundable" credits, equivalent to vouchers.

CONCLUSION

Health care policy makers only have two choices in designing reforms to reduce health care costs while achieving universal coverage. Either they can establish true markets in health care, with market incentives and competition to reduce costs. Or they can adopt some regulatory scheme where the government attempts to reduce costs by arbitrarily rationing and denying care through one system or another. Managed competition does not involve some sort of third way that enables policy makers to avoid this choice.

Managed competition would involve so much heavy-handed, unnecessary government regulation and control that it would ultimately fail to create true open market competition and effective market incentives to control costs. As a result, it would ultimately fail to reduce health care costs. Indeed, because it would extend and perpetuate the third party payment problem underlying the health care cost explosion, add new political pressures to the system to expand benefits favored by politically powerful special interests, and enshrine costly regulatory requirements and new bureaucracies, it would likely increase rather then reduce costs.

Along the way, managed competition would greatly restrict consumer choice and control. It would also greatly restrict competition among insurers, ultimately leaving consumers to face a cartel of a few larger, dominant managed care systems in each area. In the end, such a system would produce sharply reduced access to and quality of care for the average American. It also would produce higher taxes, more special interest spending, more government regulation and control, more government bureaucracy, and a short-term way station to a full-blown Canadian system after managed competition inevitably fails, resulting in the ultimate tragedy for American patients.

The Heritage Consumer Choice Health Plan shows how to establish true open market competition and incentives. It would consequently solve America's health care problems, slashing runaway costs increases, while achieving universal coverage. It would accomplish this precisely through expanding consumer choice and control, and market competition, maximizing along the way the access to and quality of care that Americans desire. Managed competition, by contrast, would be a seriously harmful, heavily restrictive failure.