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MANAGED CARE—THE FIRST CHAPTER COMES TO A CLOSE

Sallyanne Payton*

The articles in this Symposium present a fair snapshot of the state of mainstream academic thinking about managed care as of the fall of 1999. Mainstream academic theorizing about health care and health insurance has been generally favorable to managed care: the conventional wisdom of health policy is that integrating the insurance and provider functions holds the best promise of correcting the inefficiencies and market imperfections of fee-for-service medicine financed through third-party indemnity payment, and of stimulating the provision of medically effective care at a price and quality for which consumers would be willing to pay out of their own funds. This conviction has grown at a time of general valorization of "markets," meaning price competition among for-profit commercial enterprises, as the vehicle for stimulating innovation and achieving efficiencies. In this view, managed care, in the form of fully-integrated medical care organizations, is an elegant comprehensive solution to the enormous and enormously complex problems of the health care sector, bringing to medical care delivery the discipline of private commercial business.

This view has dominated discussion among health policy experts. Within the framework of this general approach, the task of health policy as it pertains to law and regulation is to design a legal regime to support the efficiency-enhancing functions of managed care while bringing the industry within the reach of the fundamental legal standards and values that are pervasive in American law. The challenge is to integrate managed care into the fabric of the law without destroying it as a result of adopting normative premises that are inconsistent with managed care itself. As Peter Jacobson and Scott Pomfret point out in their Article in this Symposium, the courts (and legislatures) have historically faced this challenge with respect to other emerging industries that represent radical transformations in the nature of basic production

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processes.¹ Jacob Hacker and Theodore Marmor remind us that the term “managed care” is itself a largely undefined term with a strongly positive normative implication that “is a confused assemblage of sloganeering, aspirational rhetoric, and business-school jargon”² that ought to be replaced in health policy discussions by “more precise and neutral conceptual tools with which to evaluate changes in modern medicine’s reimbursement methods, managerial techniques, and organizational forms.”³ Fortunately for this Symposium, our authors’ discussions do in fact get right down to the operational level, legal analysis being notoriously impervious to slogans in its focus on actual transactions and legal relations. It should come as no surprise that the principal challenges to “managed care” are coming from courts and lawyers, who are penetrating the rhetoric to argue about the application of principles of contract and tort in the new medical economy.

In the case of managed care, some of the most hotly contested issues have to do with just this fundamental level of legal principle, captured in the ideas that individuals ought to be required to perform in accordance with the promises that they make and ought to be accountable to those whom they injure. Because managed care rearranges the economic relationships between and among patients, physicians and payers, mainly with the intention and effect of encouraging physicians to incorporate into their medical decisions financial considerations of the type that concern payers, managed care forces a reconsideration of much of the law of medical practice and the professional standards and ethics of the medical profession itself. Haavi Morreim attacks the main issue: to what extent should a managed care organization that seeks to influence clinical decision making be regarded as practicing medicine itself and therefore be held to the standards applicable to clinical professionals?⁴ Professor Morreim suggests, at the end of her comprehensive analysis of the issues, that managed care organizations should contract to provide disclosed processes of and standards for medical decision making, as by adopting clinical guidelines, but should leave the actual clinical decisions to those

1. See generally, Peter D. Jacobson & Scott D. Pomfret, *Establishing New Legal Doctrine in Managed Care: A Model of Judicial Response to Industrial Change*, 32 U. MICH. J.L. REFORM 813 (1999).

2. Jacob S. Hacker & Theodore R. Marmor, *How Not to Think About “Managed Care,”* 32 U. MICH. J.L. REFORM 661, 662–63 (1999).

3. *Id.* at 663.

4. See E. Haavi Morreim, *Playing Doctor: Corporate Medical Practice and Medical Malpractice*, 32 U. MICH. J.L. REFORM 939 (1999).

with primary responsibility for making them.⁵ Eugene Grochowski contributes a reflection on the ethical responsibilities of physicians in a managed care environment.⁶ Marc Rodwin deploys Albert O. Hirschmann's famous distinction between and among "exit," "voice," and "loyalty" to illuminate some of the difficulties facing consumers and patients in managed care plans.⁷

Enthusiasm for erecting expanded systems of health coverage partly or wholly on the foundation of integrated organizations that both assume insurance risk and arrange for the provision of medical services has forced a closer look at the problems of designing systems of insurance regulation adequate to the task of assuring coverage for higher-risk patients in the face of private insurers' incentives to engage in risk selection. In this Symposium are three contributions that address these regulatory problems. Mark Hall, in his empirical study of the effect in seven states of state insurance reform laws designed to stabilize and expand coverage in the small-group market, reaches the conclusion that the results of those reforms do not repay the optimism of advocates who had hoped that various regulatory measures might counteract insurers' tendencies to engage in risk selection and other forms of regulatory evasion.⁸ Timothy Jost, in his study of health care financing and insurance regulation in Chile, reaches similar conclusions.⁹ Eleanor Kinney, using Indiana's experience, observes that states, faced with the dynamic of competitive federalism and taxpayer resistance to higher taxes, have difficulty generating out of their own resources the revenues required to provide to the uninsured either coverage or adequate care.¹⁰ She advocates rethinking federal-state relations in both funding and regulation, with special emphasis on the problems caused to the states by the existence of employer self-funding under ERISA. These three studies are discouraging even when read individually; taken together they suggest the need to reconsider the strategy of using commercial insurance markets under state regulation as the principal mechanism for providing coverage

5. See *id.*

6. See Eugene C. Grochowski, *Ethical Issues in Managed Care: Can the Traditional Physician-Patient Relationship Be Preserved in the Era of Managed Care or Should It Be Replaced by a Group Ethic?*, 32 U. MICH. J.L. REFORM 619 (1999).

7. See Marc A. Rodwin, *Exit and Voice in American Health Care*, 32 U. MICH. J.L. REFORM 1041 (1999).

8. See Mark A. Hall, *The Competitive Impact of Small Group Health Insurance Reform Laws*, 32 U. MICH. J.L. REFORM 685 (1999).

9. See Timothy S. Jost, *Managed Care Regulation: Can We Learn from Others? The Chilean Experience*, 32 U. MICH. J.L. REFORM 863 (1999).

10. See Eleanor D. Kinney, *Clearing the Way for an Effective Federal-State Partnership in Health Reform*, 32 U. MICH. J.L. REFORM 899 (1999).

or achieving adequate risk pooling. David Hyman contributes a cautionary note about imposing government regulation and conventional tort liability on managed care plans, pointing out that regulation and liability are not themselves cost-free and bring with them their own set of failures.¹¹

Finally, Peter Hammer, writing both alone and with William Sage, argues that economic changes in the health care industry are challenging antitrust courts to think more carefully about the role of non-price competition in economic analysis of hospital mergers, and indeed the role of non-price competition generally in consumer welfare, a problem that has generally been submerged in the assumption that price competition encompasses, and therefore accounts for, non-price competition.¹²

All of these authors have set for themselves the goal of reforming managed care, creating legal structures to contain some of its more destructive tendencies without confronting the nature of managed care itself. Physicians and patients are more skeptical, however, and are expressing their doubts through the political system. The defeat of the Clinton Administration's national health insurance initiative of 1993-94 is attributable in part to the public's wariness about the implications of obtaining their care through HMO-type health plans, which would have been the principal vehicles for medical service delivery under the Clinton Plan.

The essential background of this Symposium, as of the reform effort to which it contributes, is that the defeat of the Clinton Plan did not defeat the idea of managed care but rather marked the beginning of a decisive and dramatic turn to managed care on the part of the private sector. In just a few years after the failure of the national health insurance initiative, private employers have virtually discontinued traditional unfettered indemnity fee-for-service type coverage. Physicians and patients now frequently find themselves contending with management by health care organizations with many different styles of economic and functional integration. This change has taken place mainly in the universe of private employee benefit plans, which serve well over 100 million workers and their families; these programs and the management entities that serve them are the principal targets of the current drive to "reform" managed care. Managed care has entered the main-

11. See David A. Hyman, *Accountable Managed Care: Should We Be Careful What We Wish For?*, 32 U. MICH. J.L. REFORM 785 (1999).

12. See Peter J. Hammer & William M. Sage, *Competing on Quality of Care: The Need to Develop a Competition Policy for Health Care Markets*, 32 U. MICH. J.L. REFORM 1069 (1999); Peter J. Hammer, *Questioning Traditional Antitrust Presumptions: Price and Non-price Competition in Hospital Markets*, 32 U. MICH. J.L. REFORM 727 (1999).

stream medical marketplace in a form that is more vigorous, entrepreneurial, innovative, and disorderly than would have been allowed under the terms of the pervasively-regulated, interest-group-bargained managed competition regime projected by the Clinton Plan.

Things have not gone well. Events in the managed care industry are already suggesting that entrepreneurial managed care needs to be not only reformed but rethought. Commercial insurance companies and other managed care entities that have invested heavily in creating the capacity to meet the demand for managed care have had less success than they expected. In the HMO industry there have been many business failures, withdrawals from markets, and price increases that reveal the difficulty of actually controlling medical costs. Farther down the chain of commercial risk-bearing entities, capitated physicians' practices and physician practice management firms have found themselves in financial difficulty. In the public programs that have relied on managed care organizations, exit of suppliers is frequent and prices are rising. Even as private for-profit enterprises are doing less well than they expected, the nonprofit institutions that have historically been the stable providers of coverage and care are finding it difficult to operate in the commercialized marketplace and are themselves coming under threat of absorption by for-profit firms, are assuming for-profit form, or are being forced to behave like their entrepreneurial competitors. Meanwhile, the backlash against managed care has taken the form of serious bipartisan reform efforts in both state legislatures and the Congress.

Against what norm should these events be considered troubling? Patient and physician resistance to managed care was anticipated, because physicians and patients had been taught by indemnity insurance to engage in over-consumption that managed care attempts to correct. Some backlash was to be expected, and so the fact of backlash does not suggest a mistake in basic policy, although it does suggest a need to make some adjustments in the legal and regulatory regimes. Under-pricing is common where firms jockey for market share: casualties are to be expected. What is more surprising is that adequate management of medical services is proving so difficult to achieve. The difficulties are not confined to particular firms, management styles, markets, regions, or sizes of firms. Failure is pandemic. Markets are volatile. The industry-wide failure of managed care actually to manage either the delivery of care or the cost of care calls into question the entire set of ideas about medical markets that have in the last few decades guided public

policy and private investment. This is very serious indeed, not to be cured simply by providing more revenue to managed care firms anxious to raise their prices. The condition of the new medical market casts doubt on the wisdom and even the workability of all the policy initiatives that contemplate that medical services should be supplied mainly through firms that integrate insurance and medical service delivery functions.

There have been many such ideas, most notably the national health insurance plan proposed by President Clinton in the first year of his administration. In the past several years a number of states have turned more decisively to managed care for their Medicaid populations and the Congress has enacted the Medicare+Choice program, which its advocates expected to displace fee-for-service Medicare. Managed care promised to bring mainstream business practices to health care, to capture for the health services sector the "market"-favoring techniques applied successfully to the problems of other areas historically dominated by governments, state or quasi-state enterprises, government regulation, and tax financing. For public programs, such as Medicare, Medicaid, or a new national health insurance system, managed care held out the possibility of enlisting private enterprise in the business of managing directly the purchase or delivery of services, moving government back a step to the role of financier. Because managed care was associated with efficiency values, it also created for the first time in health services delivery a legitimate role for for-profit enterprise, as an instrument for correcting the inefficiencies created by nonprofits and governments. The innovators, therefore, in the rush to managed care that occurred after the failure of the Clinton Plan, have mainly been the organizers of new economic relationships: the HMOs, the insurance companies, the network organizers and administrators, the physician practice management firms, and sometimes the third-party payers themselves.

This first generation of managed care plans based on these ideas is in the process of failing, and the question is what to think now and do next. One obvious explanation for the failure is that the work of integration and reconfiguration did not reach sufficiently down from the contracting level, where there has been much innovation in devising new techniques of integrating services financially in order to make the contracting process more efficient, to the functional level where the task is clinical integration and actual improvement of practice. Nor did the concept of closely-integrated exclusive managed care organizations resonate with the public. Most managed care is supplied through private employee

benefit plans, and consequently has had to meet the test of employee and employer acceptance in a marketplace driven by health benefits purchasing on the part of employer-based group health plans. Consumers' dislike of closed-panel plans has led their employers to encourage alternatives based on looser styles of integration, such as Preferred Provider Organizations and Point of Service plans. These looser networks, however, have had difficulty managing medical services sufficiently well to be economically viable.

There is an irony in this failure. "Managed care" as promoted by health policy experts was intended to bring market discipline to health coverage and health care delivery within a transition to a national health insurance system. However, in the market for furnishing services to private employer-based health plans, which is the only health care market that functions largely independently of government regulation, the closed-panel style of managed care preferred by the experts has proven problematic and the looser styles preferred by the patients have proven unprofitable. Taking the judgment of the actual market to be suggestive, if not conclusive, this experience points to the need to ask fundamental questions, in order to take a closer look at basic principle.

FUNDAMENTALS

The null state—the state of nature, so to speak—in health services, to which policy is applied, would be a market in which government neither attempts to regulate relationships nor subsidizes demand or supply, and limits itself to enforcing, through the judicial system, agreements between contracting parties in accordance with their legitimate expectations as determined through the use of common law principles. In such a market, any person may hold out himself or herself to be a healer and may try to persuade patients of the efficacy of the service and of his or her own competence and trustworthiness. Patients will pay out of their own pockets, which means that (a) individuals will decide for themselves what they want and how much they are willing to pay for it; and (b) more expensive services can be afforded only by the more affluent, the more subsidized, or those receiving them through charity; otherwise they must be financed from the surplus extracted from paying patients through price discrimination, i.e., the traditional "sliding scale." Patients will not have good information on which to judge the quality of the service, or even the need for it,

except perhaps as they start in distress and end with some positive change. The practitioner's actual art will be opaque; reputations made by individual healers may take on the character of folklore.

Capital is difficult to accumulate in this kind of market, and it is difficult for individuals in private practice to find the time and the financial ease that might allow them to engage in study and innovation, in teaching, writing, and building an organized profession with a canonical literature and a defined art. Physicians have tended to find economic shelter in such markets by making themselves useful to the holders of wealth and power, arranging to be supported by the state, the aristocracy, the church, the university, and other institutions that can provide consistent sustenance and a patient base. Another technique is to seek special privileges and monopolies for their private practice. The government's conferring of monopoly power is an endorsement of the profession's claim to competence and importance to the public interest. Where the profession actually has a legal monopoly it can both invoke the power of the state to prosecute those who attempt to practice *without* a license and decide who shall be allowed to practice *with* a license. Those admitted to practice with a license therefore come to the public with the imprimatur of the profession itself and acquire immediately a portion of the reputation of the profession as a whole. The combination of licensed monopoly and good reputation can yield a very comfortable living; the learned professions have aspired to make it possible for their members to live like gentlemen.

Monopoly or no, the challenge for any industry that is basically a handicraft is large-scale capital accumulation. In the interest of making certain that individual practice is economically viable, the ethics of the medical profession have prevented physicians from creating large organizations with hierarchies of physicians and other caregivers, even though the creation of such organizations has been financially as well as technically practicable since the rise of third-party payment. Individual practitioners may become wealthy, but it has not been possible within the rules of the profession to build large organizations in which professional and other labor is rationalized and surplus is captured by a single owner of the organization. The medical profession consequently has long-standing alliances with religious, community, educational, and governmental institutions that can generate capital from sources other than patient fees. The expensive equipment and facilities required for in-patient practice have been supplied through hospitals that have traditionally been religious or charitable institutions.

Medical education took a leap forward in terms of sophistication and cost when the medical elites joined with private foundations and universities to move medical education out of mail-order and storefront entrepreneurship and into the universities. Foundations, governments, universities, and private corporations have funded most medical research. The medical profession's collaboration with these religious, charitable, and governmental institutions has helped physicians in private practice to claim association with commitment to public service and learning, which contributes to a public perception of their own trustworthiness.

This combination of institutions created the base on which the market for hospital care was built, making it realistic for the hospitals to create hospitalization insurance in order to stabilize their cash flows during the Depression years of the 1930s, and then making such coverage attractive for employers to supply as a fringe benefit of employment during World War II when cash wages and prices were frozen by the government. After the war, advances in medical efficacy centering on improved surgical techniques and drugs made modern, scientific medical care a highly desired item of consumption, and health coverage a desirable fringe benefit of employment for workers at large. Employer-based health coverage funneled billions of dollars into the medical services sector and made possible modern medicine as we know it. Government health programs have mainly imitated the private programs, in the name of assuring that their benefit structures should make it possible for their beneficiaries to have equal access to services. Private employer-based health benefit programs have thus driven innovation in coverage as well as in medicine itself.

Harnessed to the economic engine of indemnity coverage with provider payment on a fee-for-service basis without provider price competition, the constant search for technical improvement on the part of these sophisticated, linked institutions produced both great strides and runaway costs. The resulting markets appear, from the vantage point of conventional economic expectations, to be distorted and inefficient. It should not be thought, however, that if the distortions were withdrawn the markets would right themselves and the nation would experience, by the working of some invisible hand, technologically advanced and efficiently organized medical care. Large-scale scientific research and education must always be funded by entities other than practicing professionals, and access to medical services must continue to be extended by some non-market means to those who are not well-off. Therefore the appropriate allocation of function between market and non-market

mechanisms is necessarily a matter of public policy in any nation that wants scientific medicine and universal access. In other industrialized countries, governments have solved the problem by making health care part of government policy and finance rather than part of the ordinary market, even when the providers are private professionals and institutions. In this country, the private and public sectors together have created a set of institutions that provide private and public health financing, service delivery, regulation, research, and education. Without this network of institutions the medical art itself would be much poorer and the market for medical practice thinner and less well-organized.

The central institution in this web of support has been the private employee welfare and health benefit plan, because the purchasing strategies of the large employer-based plans have complemented the aspirations of the medical elites. Employers and employee associations have tended to take a long view of their interests, which include providing to the populations they serve medical services that are constantly improving, a stance encouraged by the fact that employer-paid health benefits are not included in employee income for federal tax purposes. The consequent generosity of private sector plans, which by enabling constant intensification of care has pushed up standards of practice, has precipitated indirectly a crisis in public finance because governments obligated themselves to pay for equivalent service for their beneficiaries enrolled in Medicare and Medicaid. These programs have claimed increasing shares of public resources and have threatened governments' ability to finance other essential public services. By the 1980s the escalating cost of health care was a principal economic issue facing the country, affecting American industry's ability to compete in the world economy and American governments' ability to govern.

Managed care and managed competition were supposed to have been the solution to these problems. The root cause of the inflationary pressure seemed to be in the private sector, where employers seemed to be supplying too much health coverage and employees consuming too much health care. Employers frequently supplied health benefits without informing employees of their cost or giving them incentives to be frugal in their resource consumption. Many employees were unaware that the money being spent on their health benefits was part of their compensation and therefore might, if health care costs were lower, be paid to them as cash wages. Mainstream economic analysis set out to solve this problem. Fatefully, the diagnosis of the situation having been grounded in a

failure of rational purchasing at the level of the individual, the solution proposed was itself situated in the individualistic tradition of microeconomics: the idea was that the market for employer-provided health coverage might be made more efficient—i.e., the total amount of health coverage supplied and the price paid for it could be made to approximate the amount that would be demanded by employees if they were spending their own money—if the employees were informed of the price of coverage and given incentives to select lower-cost, less full-featured benefit packages. This reasoning led to an argument for creating individualistic markets *within* employer-based employee benefit plans by offering choices in coverage options and prices. The net result would be a hybrid scheme in which a group might use its purchasing power to obtain size-related favorable prices, while the actual level of its demand would be the aggregate of the individual decisions of its members made in a properly-structured internal market.

The second culprit in the health care inflationary dynamic being indemnity fee-for-service provider compensation, which had exacerbated the moral hazard effects that attend any system of third-party payment, the other principal reform proposed was to integrate insurer and provider functions in order to place a check on utilization and to create incentives to ever-greater operating efficiencies by embarking upon functional and economic integration of the providers themselves. Managed care and managed competition were thus linked: the most efficient arrangement would be one in which the supply of medical service would be made efficient by managed care and demand in the market would be made rational by managed competition. This link was the premise and principle of the Clinton Plan.

Health policy is complicated. Correcting the unfortunate consequences of the practice of indemnification became a problem to be solved simultaneously with the failure of the employer-based system to create adequate access to coverage for the private workforce. By the 1980s this failure was leading to a troubling rate of increase in the numbers of uninsured workers, most of them self-employed individuals or employees of smaller businesses. The shortcomings of the employer-based system led to hopes on the part of advocates of national health insurance that a government-sponsored system might finally be created. The effort to reform the system of payment focused on inefficiencies and inequities in the private sector and began with an indictment of the employer-based system generally. The Clinton Plan expressed this dissatisfaction with the performance of the private sector by proposing to replace

the employer-based system with a complex government-supervised system based on government-managed competition among regulated managed care plans.

Ironically, then, the essentially private but non-market system of employer-based coverage was attacked by the government in the name of efficiency, which was to be achieved through a combination of government regulation and private markets in which commercial businesses, namely for-profit managed care organizations, would dominate. Thus the relatively *unregulated* market, which had evolved a complex of non-market and quasi-market institutions in order to create a market for high-quality medical services, was assaulted in the name of a scheme that was simultaneously more governmental and more commercial, powered by a conviction that health care markets could be improved by enlisting the profit motive in some of its crudest forms. "Comprehensive health care reform" actually meant dismantling the private employer-based plans, bringing the employees into a government-managed system, instituting price controls on medical service providers, creating regional risk pools that would allow higher-risk customers access to coverage, rationalizing the rate of technological advance by requiring that new technologies be demonstrably more effective than old ones, and reducing costs by reducing the amount of care the cost of which might exceed the medical benefit to the patient. Anticipating that accomplishing all of this by direct regulation would require politically unacceptable levels of power and unachievable levels of skill on the part of government, President Clinton proposed to enlist private businesses as the organizers of medical services: all coverage in the Clinton Plan was to have been supplied through regulated insurer-provider organizations, most of them anticipated to be for-profit entities.

In the aftermath of the defeat of the Clinton Plan the legislative effort to create a comprehensive system has slowed to a pace of opportunistic incrementalism, but enthusiasm for fundamental reform of the medical marketplace still tends to dominate health policy on both the political left and the political right. Neither the friends of government nor the friends of free enterprise approve of employer-based coverage in its present form, and tend to use it as a foil for their own more theoretically coherent policy preferences. The fully-integrated HMO remains the idealized solution as a vehicle for coverage and service delivery, and both liberals and conservatives continue to advocate the creation of purchasing groups that will manage a competition among health plans for the patronage of their members. The result is that the combination of

the preference of government planners for a government-managed health care system and the preference of free-market advocates for one that looks more like a real market deprives the actual institutions of the health care sector of normative status as serviceable ways of doing business that might be in need of improvement rather than abolition. Existing institutions are described mainly to be denounced. Policy experts have been concerned so urgently with the failings of employer-based health coverage, compared with the potential advantages of an efficient market or a government-managed system, that they have not focused on the *advantages* of the employer-based health coverage system compared with the *failings* of commercial markets and government systems. The same is true of their attitudes toward the nonprofit institutions that have dominated the health care sector: because the nonprofits engineered the web of voluntary and governmental restraints on innovation and competition in medical services, they tend to be identified with intrinsically anti-market rather than market-promoting forces. Less appreciated are the *advantages* of nonprofits in the health care market, reaching to the likelihood that they have created the market for health services that could not have emerged from commercial for-profit enterprise.

The failure of the current generation of managed care should alert us to the need to reconsider this hostility toward existing institutions.¹³ Granted, policy likes ideas and tends to criticize arrangements that have more the flavor of pragmatic adaptations than of deliberate strategies; but adaptations may point to problems in the structures to which adaptation is made, and apparently ad hoc adaptations may be seen as an emergence of rational and coherent action, and therefore more theoretically defensible, as the context is better understood. Both the demand and the supply sides of the existing medical marketplace are full of institutions that are hybrids or anomalies, if viewed in the light of conventional general theory, but that work quite well in practice. An employer-based health plan, for example, is difficult to characterize in theoretical terms. The plan neither sells benefits to employees nor purchases on their behalf as agent. Plan administrators are fiduciaries while the plan sponsor is free to pursue its own self-interest in designing

13. Professor Kinney expresses a view held by many who hope to accomplish risk-pooling through state or federal government action: the self-funded employee benefit plans, governed by ERISA, do not participate in state taxation designed to fund the uninsured; nor are they subject to state insurance mandates that require coverage, and therefore risk-pooling, for certain categories of health expenditures. See Kinney, *supra* note 10, at 924. Mental health benefits, for example, are frequently not covered or are only partially covered by employers unless forced by regulation to provide such coverage. See *id.* at 934.

benefits. The employee's correlative interest is something like a property right and something like a contract right, is partly protected by the common law and partly by a confused and oddly limited set of remedies under ERISA. Similarly difficult to characterize are the nonprofit corporations of the voluntary sector, which, standing between the state and the market, have been the organizing institutions of the health care sector. These are puzzling to political theorists because they perform public functions without being part of governance through political representation in the state; and they are mainly ignored in conventional economic literature, not being quite part of the apparatus of capitalism.

These voluntary institutions have shown, perhaps precisely because of their hybrid qualities, great flexibility and resourcefulness in taking on the tasks of governing and managing the medical services sector and creating its economy. Charitable organizations can, consistent with their tax-exempt status, engage in market transactions, and thus can organize and deliver medical services. Because any surplus they make must be used for charitable purposes, i.e., may not be distributed to shareholders, a nonprofit's principal way of acquiring capital from outside sources is to solicit gifts and incur debt rather than to raise risk capital in the equity markets. Nonprofit corporations are therefore not responsive to the interests of equity capital in determining their business strategies, and do not conform to conventional economic models because their principal institutional purpose is the pursuit of the objectives to which their charters dedicate them, not the pursuit of profit for the purpose of paying returns to shareholders. They are *in* but not *of* the market. Conversely, employers are deeply *of* the market. Employer-based health benefit plans are part of intracorporate governance structures, which are private relationships; but because these plans organize the demand side of the health care market and make health coverage practicable they perform what would otherwise be a function of government.

The consequence of the theoretical muddle created by the institutions supplying and purchasing health benefits is that employer-based health coverage tends to be treated as an accident of history, the product of the nation's failure to construct an adequate state-managed system such as those found in peer nations. In actuality, however, both government management of health care and the kind of hybrid arrangements invented in the United States are responses to the failures of private commercial markets, and the employer-based system of group coverage coupled with the voluntary system of delivering medical services

through nonprofit institutions has succeeded, differently but perhaps not less well than government might have, in overcoming or counteracting many of the intrinsic imperfections of commercial markets for health care and health coverage. Ironically, much of the objection to these hybrids is that they have succeeded too well, transforming individualized markets whose underlying tendency is under-consumption, because of consumer distrust of providers and lack of effective demand in the absence of a financing mechanism, into organized markets whose tendency is over-consumption.

The markets need to be turned toward greater efficiency, but carefully. Commercialized health care delivery and individualized insurance markets are now valorized as antidotes to employer-based group coverage and nonprofit health care delivery; but it must be remembered that commercial health care and individualized markets for insurance were originally the problems to which the nonprofit hospital system of delivery and the employer-based system of coverage were the solutions. Policy that would reverse direction at this stage should be approached with care because commercialized health care and individualized health insurance seem likely to produce markets that will fail. It is particularly important to resist the temptation to think that government management would be tolerable were it to be coupled to private delivery systems, as where government programs might provide premium support to enable beneficiaries to purchase services from private HMOs. A government-managed program that relies on commercial HMOs as its delivery vehicle combines the failures of government with the failures of commercialism. A government program that might attempt to engage in large-scale direct administration, such as one that would scale up Medicare fee-for-service to cover the population under sixty-five or use the Federal Employees Health Benefit Program as a platform for a national health insurance system operated through managed competition, would require administrative capacities in government that would be somewhat beyond what the public seems willing to support, in addition to both politicizing the health care delivery process and bringing health care issues into the center of political life. It is too easy to "reform" arrangements that work imperfectly into new arrangements that are even less satisfactory.

This does not mean that retreat from government management and private commercialism must lead back to fee-for-service indemnity arrangements in economically unintegrated markets. That approach has been abandoned decisively by both public and

private payers determined not to tolerate the expense that such arrangements entail. From the payers' point of view, whose distress stimulated interest in managed care, the new cost-containment strategies must at least be regarded as a temporary success. The crisis is no longer a crisis of cost as experienced by payers. Acute distress has now been distributed. There are problems of the uninsured and of those providers that render uncompensated care to them; the failures of so many organizations that have stepped up to assume business and insurance risk; the volatility of markets for health coverage; and the increasing unhappiness and dissatisfaction of consumers and patients because of their experience that access is so problematic within the plans. The question now is not whether to manage care but how to manage it more effectively and more in the interest of patients.

The trend toward entrusting patients to organizations that accept business and insurance risk and are accountable for value as well as other aspects of service delivery seems unlikely to abate: private employer-based plans will continue to create a market for health plan management, and it seems likely that government programs will increase their effort to transform their directly-administered fee-for-service programs into programs with private risk-bearing delivery systems, creating a continuing need for reliable public-private partnerships. The critical task for public policy, therefore, particularly in light of what has happened in the current HMO experiment, is to make certain that the private sector has the ability to organize itself in a way that makes it serviceable to the widest range of private customers, a fit custodian of the public interest in its own right, and a competent and trustworthy partner for government. This objective implies a larger role for employer-based health plans and nonprofit organizations, and a smaller one for commercial insurance and insurer-provider integrated organizations than previously assumed in health policy analysis.

INSTITUTIONS, INCENTIVES, ETHICS

The argument of this Introduction is that because it is rational for consumers and patients to wish to receive their medical services through organizations that are committed and accountable to them, the legal infrastructure for the health services sector ought to be designed in such a way that the types of organizations that

have built the health services sector will be able to serve as the foundation for the new medical economy.

The importance of enabling these institutions to continue to function transcends the question whether the financing of health care ought to be mainly a governmental function: even a national health insurance system will need competent, reliable, trustworthy private sector partners to handle major aspects of service delivery and to mediate conflict. Nonprofit institutions and employer-based health benefit plans can do this work without presenting fundamental issues of legitimacy because they are already part of the governance structure, representing the capacity for private voluntary action that makes it possible in the United States for people to undertake collective action to solve collective problems without building the state. Advocates of managed care have hoped that governance functions might be submerged and obscured by being transformed into market relationships in a commercialized health sector; but that effort has not gone as well as expected and we are now confronted with the need to face up to the governance issues and to nurture organizations that can contain them. The employer-based health benefit plans and the nonprofit medical care organizations have all along been performing governance as well as service delivery functions; it would be perverse to destroy this capability just when it is needed most urgently.

To say this is not to suggest that commercial entrepreneurial enterprises are somehow intrinsically deficient. To observe that their managers' duties, fiduciary in nature, lie in a direction different from the duties of health care professionals with clinical responsibility for patients is to state a fact, not to make an accusation. Corporate commitment to maximizing value for shareholders is not a moral failing but simply an aspect of the structure of for-profit enterprises that provides assurance to those who invest in them. Without this assurance and investment the level of economic activity would be a good deal lower and the society less prosperous. The dominance of these types of businesses in the managed care industry threatens, however, to bring into the health care world not only the energy and initiative of private organizations but also the value structure of the commercial world. There is no reason to believe that commercial organizations calibrate their devotion to shareholder interest inversely to the degree of vulnerability of the clientele they serve, while the duty to put self and self-interest aside in order to serve patients and clients is the essence of professional responsibility. The present travail of the health care sector is that commercialized managed care has suddenly come to dominance

within a structure of health care markets and regulation that were built in a time when fee-for-service coverage, nonprofit organization, and full-bore professionalism were the norms. The lack of fit between the old legal regime and the new entities and practices governed by it has given rise to a demand for aggressive managed care regulation.

The rhetoric being deployed in the drive to regulate managed care is, however, plagued by at least as much confusion about what kinds of entities populate the health care sector as is the discourse of health policy. Managed care has elicited a stylized assertion that “managed care reform” is necessary because “HMOs” are making “profits” on “denying care to patients,” thus implicitly conflating managed care with HMOs and HMOs with for-profit enterprise. This rhetoric is an impediment to clear thinking. It is true that publicly-traded commercial companies that combine insurer and provider functions are more prominent in the health care industry than is arguably in the public interest; but managed care itself is here to stay and the organizations that provide it can be customer-led or nonprofit and need not take insurance risk. Moreover, even at present a good deal of “managed care” is being provided by employers as direct procurement from providers or through third-party administrators that are their agents. It stretches the term to think of the officers of, for example, the Ford Motor Company, as a “managed care organization,” or, even more implausibly, as an “HMO,” but all the organizations arranging for medical care for patients tend to be swept up in the same rubric that feeds into the political shorthand. Different types of organizations tend to behave differently, even when they are all managing care.

Confusion about what the entities are that arguably need to be regulated stems in part from the experience of the past few years in which the public discovered that the nonprofit organizations on which they have relied for care or coverage have been or are in the process of being displaced or commanded by presumptively less-trustworthy commercial insurers or HMOs, at the same time that they are being asked to negotiate the transition to managed care. Theory has long taught that any insurance organization that accepts a risk-based premium payment in advance of the obligation to pay claims and then charges off claims expenses against premium income will have an interest in avoiding or at least delaying paying even legitimate claims. Following the same principle, capitated payment to a provider creates incentives, perhaps undetectable by patients, to under-treat. There is thus reason to

worry about all premium- or capitation-financed arrangements, and special reason to worry where the incentives to opportunistic behavior created by insurance-type risk arrangements are not counteracted by professional or institutional commitment to the provision of high-quality medical service. Thus from the point of view of the patient or consumer the for-profit integrated insurer/provider enterprise is the most dangerous form of integrated medical services organization because it marries the risk of opportunism intrinsic to insurance coverage with the information imbalance characteristic of medical practice and suffuses the entire arrangement with profit motive. Consumers and patients are reporting experiences with the practice of managed care that confirm the theory of it, namely that the behaviors of integrated insurer-provider organizations may threaten the medical interests of the patients.

As a practical matter, however, it seems likely that in the new medical economy care will be provided through organizations that will link coverage and provider functions: the challenge is to find techniques of realizing the potential of such arrangements for medical and economic efficiency while mitigating their negative effects. Given the inherent dangerousness of premium- or capitation-financed arrangements for health care delivery, and indeed of all arrangements that allow providers to profit on the difference between revenues and costs where costs may be controlled by declining to render or by postponing medically useful service to patients, it is especially important that financing and service delivery be handled by organizations whose incentives are aligned very basically with those of the patients. This can be accomplished to some degree through entrusting the supply functions to professionals and nonprofit organizations, as is the tradition, but those craft-minded suppliers have already demonstrated their propensity to believe that higher quality from their point of view is always the higher good from the patient's point of view, which is not the case. Even the most professionally trustworthy service provider still operates within the essentially adversarial relationship between seller and buyer, wherein a seller prospers by inducing the buyer to buy what is most advantageous for the seller to sell, regardless of buyer's own best interests. The provider's duty to respect the patient's best interest as the patient believes it to be has been imposed by the law in the doctrine of informed consent; even so the provider is required only to inform the patient of the patient's medical options at the time when the treatment for which consent is sought is to be administered.

Integrated medical service arrangements, by contrast, aim to have the patient consider and express his or her general, including economic, interests at an earlier point in time, a point at which the patient is not yet a patient but only a consumer of an insurance package. As idealized by health policy experts, insurer/provider integration enables the consumer at the time of buying a health plan to decide on a price that he or she is willing to pay for all the medical services covered by the plan under all the circumstances in which they might be necessary, and to decide on the style of care, including restraints on utilization, to which the persons covered under the contract of coverage will be bound.¹⁴ A person who buys a managed care plan therefore agrees to a rationing scheme to be applied to his or her future self, as well as the present and future selves of others covered by the contract. This act of rationing tends to be more drastic than ordinary advance purchases, because patients typically cannot afford major health care expenses at time of service, which is why they buy coverage in the first place. When coverage for medically useful care is not available because of a contract limitation, that care is generally foregone and is most likely to be foregone where the care is very expensive. A person buying a managed care contract thus takes an elaborate set of risks.

First is the risk that the buyer will not be able to tell at the time of entering into the contract what is actually promised by way of medical service. Because contracts for health coverage are agreements for the provision of custom medical services, the customer buys a combination of treatment capability and clinical judgment process, culminating perhaps in an intervention. Although the contract will say in general that, for example, "inpatient and outpatient services" are "covered," almost as though inpatient and outpatient care were commodities, the coverage is actually for inpatient and outpatient services that are medically indicated in the particular circumstances in which the patient seeks medical assistance. The care that a patient receives under the contract results from the deployment of capability pursuant to the exercise of clinical medical judgment. Traditional, familiar indemnity-style coverage contracts, by not specifying any other procedure, allowed the patient to select the provider, and promised to pay for whatever treatment recommendations resulted from the provider's own medical decisionmaking process, not influenced by the insurer. Insurance organizations engaging in managed care now frequently

14. Professors Morreim and Hall both take this view; Professor Morreim suggests some techniques for making the restraints more articulate and enforceable. See Hall, *supra* note 8; Morreim, *supra* note 4.

restrict choice of provider and treatment, often without alerting buyers to the restrictions or providing information as to how these restrictions are imposed. Managed care organizations also frequently provide financial incentives to providers to restrict the amount of care given, also without informing the buyers about the restrictions. The buyer is therefore placed in a position in which elements of the contractual bargain that are material to the definition of the insurer's obligation, and which the insurer intends to use to limit an otherwise open-ended duty to furnish or pay for medical services, are kept secret by the insurer. Persons buying managed care contracts are therefore vulnerable to nasty surprises when they require medical care. The theoretical argument that managed care can introduce a tendency toward efficiency into medical markets because it allows consumers to make quality/price tradeoffs collapses if the consumers cannot tell what they are buying. All models of efficient markets assume perfect information on the part of buyers and sellers: so far from curing this problem managed care aggravates it by increasing the uncertainty as to the content of the insurer's promise. The uncertainty deprives the consumer and patient of value in unpredictable ways: the unpredictability is itself a cost. Specification of clinical guidelines and constraints is a useful partial corrective, but is best coupled with trustworthiness on the part of clinicians.

Second is the risk that the company may behave opportunistically with respect to performing under the contract on matters that involve plan administration, such as paying claims legitimately presented or approving or exploring the benefits of a particular course of treatment. Especially in gatekeeper models, limiting referrals for specialty assessment is the governor on utilization, making it unusual for a claim to be created or presented for a service that the company is unwilling to supply. Coupled with the essential indeterminacy of the company's promise, discussed above, opportunism is a major risk in managed care contract administration. A variant on this problem is that insurers seeking to please and attract low-risk customers may be relatively generous with inexpensive services while being reluctant to provide care to patients who become seriously ill. Patients who respond to plan marketing of attractive benefits may discover to their sorrow that when they become ill their insurer can think only of how to discard them.

Third is the risk that the plan might seek to influence providers to exercise their medical judgment in the interests of the plan rather than of the patients, or that the providers might allow their

medical advice to be influenced by their own economic interest in maintaining their relationship with the company, or that, where the patient is required to use providers of the plan's own choosing, the plan will choose only less-qualified or more-docile providers. These are among the much-discussed inherent risks of any sort of third-party payment arrangement that is not unlimited indemnity insurance; however, the hazards in commercial insurer-provider organizations are very considerable and contribute to the uncertainty that the customer faces in making a contract, since the customer cannot be certain that the medical advice promised in the contract will be medical advice informed by ordinary professional standards and rendered with an exclusive consideration of her own interests. If the consumer cannot find out the ways in which the company seeks to influence the providers she cannot decide what technique to use to discount the medical advice for the possibility of insurer influence, thereby contributing to uncertainty and therefore to her cost.

Fourth is the risk that the consumer will buy the wrong insurance product because the consumer is mistaken in some crucial respect as to what medical situations are likely to arise and what care will need to be provided. This is a very large problem in contracting for insurance, since it is well-known that individuals substantially mis-estimate risks and miscalculate the likely consequences of assuming risk. It is exacerbated when the consumer cannot tell what is actually likely to be provided under the contract of coverage.

Fifth is the risk that, in the event of a difference between the care covered and the care needed the patient will be unable financially to make up the shortfall. The irony of health insurance is that people require it most at its most expensive, but health insurers have an incentive to attempt to save money for the company on precisely those services.

These are enormous risks, and they are risks against which it is rational for consumers to seek legal and regulatory protection. Common law and regulation have traditionally imposed heightened legal duties on medical professionals and insurers. Insurance regulation has been mobilized to make certain that health insurance packages are not designed in ways that take advantage of laypersons' propensity to make mistakes in characterizing and estimating medical risk, or their inability to bargain for the coverage they might desire, insurance contracts being contracts of adhesion; and the common law imposes on insurers a legal duty to perform contract administration in good faith and encourages clarity in

drafting by construing insurance contracts against the drafter. The law governing medical care requires providers to give care that is within the professional standard of care regardless of the business relationship between provider and patient.

These are, however, rules for the old fee-for-service economy of medical care in which professionalism was a dominant value. They and others that might be invented to redress injuries retrospectively do not furnish sufficient protection when the entity subject to them is part of an integration of insurer and provider: the capitated payment technique aggravates unmanageably all of the problems of information and agency that inhere in insurance and professional services contracts and produces irresistible incentives for opportunistic behavior. From the patient's point of view, the ability to sue or to call a regulatory agency is no substitute for adequate performance willingly rendered. The implication is clear: where underlying arrangements allow predation the customer's best protection lies in the character and trustworthiness of the persons with whom he or she is dealing and their own structural imperative to be responsive to the interests of their customers. Economic theory thus teaches that persons who must receive medical care through organizations may rationally prefer to deal with entities whose structure and personnel convey an implicit assurance of trustworthiness because of intrinsic commitment. In health care in particular it may be wholly rational as an economic matter, taking into account the stakes, to prefer, e.g., an organization managed by a faith-based institution or a community-supported one or one associated with an academic medical center to one that is driven by the imperatives of the commercial marketplace and the equity markets. Patients may prefer indemnity-style health coverage to managed care mainly because they are not paying the full cost; but they may rationally prefer nonprofit to for-profit health care firms for reasons grounded solidly in considerations of value, and perhaps of values as well.

It will come as no surprise, then, that managed care, which in order to succeed in the marketplace needs to carry badges of trustworthiness, is not at all the child of commercial entrepreneurship but rather was pioneered, like other forms of health coverage, by nonprofits, professionals, and employers. The first generation of managed care was created by employer-, provider- or community-based organizations such as Kaiser Permanente, the Roos-Loss Clinic, and the Group Health Cooperative of Puget Sound. These organizations were created out of enthusiasm for conscious collaboration among patients and providers: providers

were to assume responsibility for the health of the patients rather than pursuing opportunities in the economy of fee-for-service practice, and patients were collectively to take responsibility for the financial security of the providers by employing them on salary or contract. Part of the strategy of these organizations was to maintain the health of the patients through preventive and primary care in order to obviate avoidable medical expenditures. The classic "group health plan," as these arrangements were called, was therefore an ethical compact between and among providers and patients to try to achieve something approaching medical and economic efficiency and self-governance through the voluntary form of organization. Organizational constraints on the consumption of services by the individual members could be regarded as collective allocation of collective resources through governance rather than market processes. Medical efficiency was to be achieved through functional and clinical integration; all of these forms of integration, including economic integration, would allow for close communication among practitioners and therefore better patient care. The original flavor of the organizations is captured in the fact that patients were said to "join" HMOs, to "belong to" them, rather than being "covered by" them, in a language that suggests governance rather than business relationships. Some of these group health plans were organized as customer-led cooperatives.

These earliest group health plans might usefully be regarded as "idea-driven," because the inspiration for their creation came from physicians, patients, and employers who were searching for ways to improve the medical care available to patients and communities in which they had a stake. The organizations themselves tended to be local and somewhat small relative to the total marketplace, which was dominated by the indemnity fee-for-service Blue Cross and commercial insurance plans. Because the delivery of service in the group health plans was strongly differentiated from fee-for-service practice and its cost to the patients not significantly lower, the plans appealed to persons who preferred the style of practice.

The idea-driven managed care organizations were detested by organized medicine. In part because the physicians were seen as being insufficiently interested in the economic rewards of private fee-for-service practice, rewards that were thought to stimulate a pursuit of excellence, physicians affiliated with them were persecuted by their mainstream colleagues. The group health plans thus began an ideological conflict within the medical profession in which the plans were on the political left, associated with unions

and the cooperative movement, while organized medicine, associated with private entrepreneurial practice, was on the political right. It is these first-generation managed care organizations, greatly valorized by public health experts, that have furnished the basis for the enthusiasm for HMOs in orthodox public health circles.

How this enthusiasm for community-based HMOs morphed into an enthusiasm for for-profit HMOs is a story about the nonprofit hospitals' search for ways to compete on price as cost-reimbursement declined as a technique of provider payment. The story needs telling here because it points to the juncture at which policy seems to have gone wrong: legal constraints on nonprofit hospitals' ability to raise outside risk capital or to make large profits on commercial activity prevented the nonprofits from growing provider-led organizations to meet the emerging demand for managed care. In the critical period of the early 1990s it was the commercial insurers, armed with vast reserves and access to financial markets, that developed the managed care industry. The collapse of the industry thus created and public uneasiness with the dominance of commercial enterprise in managed care suggest that it is appropriate to re-think some of these limitations on the ability of nonprofit institutions to raise risk capital. Insofar as the failure of managed care can be thought of as a consequence of a mismatch between the tasks to be done and the types of organizations that fortuitously had the wherewithal to undertake them, the failure of managed care might be thought of as a consequence of correctable failings of the underlying law of nonprofit organizations. The prospects for managed care may appear somewhat less discouraging in this light.

Hospital Strategies in the 1980s

All throughout the postwar period of the growth of modern medicine the nonprofit hospitals were aligned mainly with organized medicine and against the group health plans. The HMO form of organization did not move into the medical mainstream until the 1980s when respectable nonprofit hospitals created HMOs as cost-containment devices in order to compete in a marketplace becoming more price-sensitive, in which government payments were falling and the tide of hospital regulation rising and the need to acquire privately-insured patients more urgent. This development in practice had followed and was facilitated by a

development in theory. In the 1970s, economists had concluded that the rate of price inflation in the medical services sector could be brought down only if the underlying organizational structure were rationalized. They therefore promoted economic integration as the vehicle for achieving efficiency and enabling vigorous price competition. At the same time, the antitrust onslaught began against anti-competitive economic arrangements that were enforced as part of collective professional self-governance. After the American Medical Association's competition-d discouraging professional ethics were abandoned as a result of Federal Trade Commission enforcement action, physicians could no longer legally resist by collective action the movement toward rationalization and integration. They consequently found themselves involved in the hospitals' attempts to create new organizations intended to align physicians' interests more closely with those of hospitals.

Nonprofit organizations are not treated differently from for-profit ones for purposes of antitrust analysis, so as antitrust scrutiny intensified nonprofit hospitals found their market behaviors being evaluated under the same standards applied to other industries. Hospital planning through private agreements became illegal and state certificate-of-need regulation a less-certain shield against anti-trust liability,¹⁵ and individual hospitals were turned loose to compete on price. Faced with the need to survive in the new marketplace, during the 1980s numerous nonprofit hospitals reorganized to create complex corporate structures in which a family of related organizations centered on a hospital might include, for example, a physician-hospital organization and a licensed HMO deployed in the marketplace to allow the taking of insurance risk. Unless they themselves owned hospitals, as did some of the older idea-driven integrated organizations, these provider-sponsored HMOs were typically for-profit corporations owned by the hospital or its holding company. A holding company for a nonprofit hospital might own a for-profit medical equipment company or a home health agency or other profit-making ventures as well. The for-profit satellite organizations fed the nonprofit mother institution, which remained a charity. Much of the urgency in these arrangements was stimulated by the adoption for Medicare cost reimbursement of the Diagnosis Related Grouping payment methodology, the effect of which was to increase substantially the business risk involved in being a provider and to make it advanta-

15. Professor Hammer sets out this history. See Hammer, *supra* note 12, at 732-38.

geous to move into separate entities a hospital's potentially profitable activities.

The line between nonprofit and for-profit blurred. Nonprofit hospitals, through their affiliated HMOs, were competing head to head with regulated insurers and HMOs. Physicians on hospital medical staffs organized and joined profit-making entities that contracted for them with health plans, distributed economic incentives for controlling utilization, and assumed and passed through to them business risk. Regardless of whether all of this activity had any significant effect on medical cost inflation, it had a tremendous influence on thinking about medical care organization. For the first time, health care providers were taking business risk; some were even taking insurance risk. This was forward integration of providers into the insurance function, not unlike the idea-driven group health plans; but these moves were being made to enable hospitals to compete in the market of corporate health benefits purchasing, not to serve self-governing communities of patients. Far from being idealistic, these arrangements were predicated on the conviction that mutual financial risk provides incentives for prudence in resource consumption and stimulates innovation for the sake of achieving efficiencies. Conventional economic thinking had arrived in the nonprofit health care industry.

If creating an integrated organization in order to compete in the market was the objective, however, it was not clear that nonprofit hospitals were best suited to be the integrators: what a nonprofit hospital could do by creating a thinly-capitalized for-profit subsidiary, an insurance company could do more easily by creating a richly-capitalized one. Moreover, because non-provider-based companies are neither tied to investments in bricks and mortar nor encumbered by legally mandated ongoing relationships with medical staffs they are more free than are hospital-based HMOs to select their participating providers with an eye on market demand and the presumed dictates of efficiency. A hospital might as a practical matter have to include all of its specialist physicians in its HMO, while a non-hospital-based HMO can be selective and therefore obtain a cost advantage. More importantly, a commercial for-profit company has access to capital that is provided to it explicitly for the purpose of allowing it to take business and insurance risk, while nonprofits must use capital acquired by debt financing, charitable contributions, or operating reserves.

Hospital-based HMOs struggled throughout the 1980s to compete with commercial insurers in the emerging managed care marketplace. By the time the Clintons proposed their massive,

HMO-based restructuring of the health care sector, it was already apparent that commercial for-profit HMOs would be major forces in the proposed government-supervised markets should the Clinton Plan be adopted. Indeed the germ of the design for the Clinton Plan had been proposed by the Jackson Hole Group, an informal convocation of health policy experts and insurance company executives. During the pendency of the Clinton Plan several major insurers, as well as other for-profit enterprises, invested large sums in creating the networks that, after the Clinton Plan failed, would be the foundations of their HMOs and other managed care products. Nonprofits joined in this effort to scale up, but the lack of access to risk capital has been a crippling constraint on their ability to compete in the construction of large networks covering markets throughout a region or across the country. For all of these reasons, the major firms in the new managed care industry have not been provider-based or provider-sponsored. The largest are for-profit commercial insurance carriers and HMOs.

New Uses for Old Solutions: The Customer-Sponsored Organization

And so we arrive at our current situation, with commercial, for-profit, even publicly-traded organizations suddenly having emerged to dominate the health care industry. The fact that capital can flow so suddenly toward apparent opportunity is a strength of the economy and a credit to the legal infrastructure that supports commercial business; but where commercialism itself is problematic care should be taken not to allow the superior capital resources of entrepreneurial enterprise to result in the elimination of institutions that are more reliable servants of the common interest. Entrepreneurial capitalism did not build the health care sector and arguably cannot sustain it. There is a large difference between practicing or arranging for good medicine because good medicine is good "customer service," and practicing or arranging for good medicine because one is required to do so because of professional norms, fiduciary duties, and institutional identity. Protection for the patient and guarantees of service to the common good have historically lain in the medical profession's assumption of positive duty and in the commitment of voluntary medical care organizations to patient care and community service, not in anything so fragile as commercial organizations' self-interest in achieving high levels of "consumer satisfaction," whatever that may mean in a market so shaped by imbalances of information and imperfections

of agency. In medical markets, consequently, because of customer demand for quality and trustworthiness, professional and institutional virtue count as economic value that it ought to be the objective of public policy to build.

This train of reasoning leads to the conclusion that the turn toward publicly-held for-profit corporations that combine insurer and provider functions is a mistake from all points of view. Their largely adversarial relationships with providers make it difficult for them to command the allegiance of health care knowledge professionals that might make possible the continuous stream of innovation and improvement that they require in order to achieve genuine long-term gains in efficiency and productivity. If they do business with Medicare and Medicaid they are vulnerable to changes in public policy and financing that force them to flee, which many of them have done. If they do business with private employers they face customers whose organizing principles and fundamental interests in risk pooling and coverage are not consistent with their own and that will not tolerate their making large profits on assuming and managing risk. The upshot of all of these structural difficulties is that commercial managed care seems to be unable to bring to the health care industry the efficiency and productivity gains that were to have been its principal contribution; and the tension between the business imperatives of the managed care organizations and the needs of their institutional customers has made them behave in ways that have generated uncertainty, unreliability and turbulence. It bears emphasizing that the cost of much of this failure has been borne by those who risked their own capital in pursuit of the expectations raised by the theories propounded by health policy experts. The failure in practice of this generation of managed care has to be understood as a failure also of theory.

The issue is how to satisfy that demand for quality and trustworthiness without resurrecting fee-for-service medicine. The move away from fee-for-service practice nonetheless seems irreversible, and health care delivery through organizations inevitable, irresistible. If commercial managed care organizations are not the answer, where might we turn? The argument of this Introduction is that, barring some unlikely upsurge of legislative enthusiasm for government management, the American health care sector cannot be operated except through nonprofit and employer-based organizations of the type that historically have been responsible for it. The question with which we began this section was "what types of entities are best suited to be part of

public-private partnerships to provide essential medical services?" The answer is that for structural reasons some of the most attractive entities are employer-based health benefit plans and nonprofit medical care organizations, that is, that we ought to want what we have, with some improvements.

Before pursuing this idea further, let us reflect briefly on the implications of the history just presented and the arguments just made. The critical starting point for understanding medical markets is that fee-for-service practice as we know it, while certainly familiar, and venerable enough to be considered traditional, is not the natural state of the economy of medical practice in a modern industrial economy based on large organizations. As noted earlier, some medical practitioners can be expected to try to escape artisanal fee-for-service practice by seeking the patronage of clients that can provide the capital to move the practitioners from a need to generate revenue through ad hoc patient contacts paid for on a fee-for-service basis to stable relationships that provide continuity of financial support and a patient base. Large organizations will tend to employ physicians to serve their clientele, which may be workers or customers; and where there is a possibility of expanding demand they will furnish the capital to construct multi-practitioner medical care organizations that can develop the market for medical service. These organizations can provide the capital to move the practitioners from a need to generate revenue through ad hoc patient contacts paid for on a fee-for-service basis to stable relationships that provide continuity of financial support and a patient base. Such a multi-practitioner organization may be internal to another organization and may serve its clientele (as, for example, the medical unit of a military or industrial or educational organization) or may seek a wider clientele, as does a university medical center. The connections of the multi-practitioner organization with the source of its capital may be tight or loose: the organization may be an internal unit; or it may be independent and under the governance of others, who may be the physicians, the patients, investor-owners, or other entities. There are many options.

All other things being equal, because of the risks to patients of obtaining medical service through organizations rather than directly from individual providers whose primary duty is to the patients, it is rational for them to prefer organizations in which their interests are represented in the governance structure itself, or organizations led by providers whose interests are aligned structurally with their own, insofar as that can be achieved. Indeed, this

preference was expressed in the creation of the older, idea-driven group health plans, just as the present revolt against commercial managed care reflects some patient distrust of profit-making firms in the role of integrated medical service organization. How the health care industry as a whole would have been configured if the nonprofit idea-driven integrated organizations had not been discouraged systematically by organized medicine is difficult to tell. The popularity of these nonprofits with patients suggests that there might have been room in the market for more of their type, assuming that capital could have been found to enable their formation.

Because idea-driven nonprofit managed care organization did not have an adequate test in the mainstream markets, however, we do not know what particular styles of medical care delivery might have been developed under the guidance of provider- or consumer-sponsored boards in an industry less shaped by the culture of fee-for-service practice. Theory teaches, at the very least, that (a) customers are likely to suffer less from opportunistic behaviors on the part of management where the customers own the enterprise itself and are the governing body to which management must report (assuming that management does not succeed in corrupting this relationship); (b) customer-led organizations can design their own products and services to respond to the preferences of the customer-members as expressed directly and complexly through their voice in the organizations as well as silently and inferentially by their behaviors as consumers; and (c) customer-led organizations can rectify many information deficits on the part of patients by supplying the resources necessary to educate their clientele, including some deficits that lead to provider-patient information asymmetries. A customer-led organization is also in a position to provide internal dispute resolution processes that may be responsible and responsive complements to civil liabilities. I do not mean to suggest that every customer-led organization will display these virtues immediately upon its creation, simply that the powers and incentives just mentioned inhere in the form itself.

There are very few customer-led organizations in the business of delivering medical services, but there are thousands of such organizations presently performing the work of organizing risk pools and negotiating for coverage or directly for services. These are the employer-based employee health benefit plans: the plan sponsors are *ipso facto* customers because they buy medical services for distribution to the participants in and beneficiaries of their plans; from the point of view of the employees, the plan sponsors can be considered (imperfect) agents of the employees for purposes of

arranging for coverage or care. In principle, every employer-based plan could be converted into a free-standing organization with power to manage the assets devoted to the purchase of health benefits. Such an organization could include representation of plan participants and beneficiaries in the governing body, could be multi-employer for the purpose of achieving efficient size for risk pooling, could hire its own administrators, and, if of appropriate size and if backed by guaranty, stop-loss, and reinsurance arrangements, could be self-funded just as the employer-sponsored plans are now. Examples of such customer-led multi-employer organizations are TIAA-CREF, presently operating in the pension area, and the numerous Taft-Hartley plans, which are governed jointly by labor and management. I do not suggest that either of these models could be used unmodified for employee health plans, only that the idea of the customer-led employee pension or welfare benefit plan is not novel. The line between an employer-based health benefit plan and an employees' mutual insurer is in principle quite thin, and the one can be made into something approximating the other with only modest changes in structure and funding. There is, in short, already a record of successful operation of organizations of a type that can overcome the more glaring imperfections of integrated insurer-provider organizations. Customer-led organizations would create governance problems, and adverse selection would have to be combated; but only the most determined pessimist would believe that nothing can be designed that would be preferable to commercial HMOs as the backbone of the American health care system. With these thoughts in mind, let us take a longer look at the employer-based health benefit system.

HEALTH COVERAGE WITHOUT HEALTH INSURANCE:
THE STRUCTURE OF THE EMPLOYER-BASED SYSTEM
OF EMPLOYEE HEALTH BENEFITS

Nothing in the health care sector operates quite the way it works in the ordinary commercial marketplace, least of all the system of risk pooling. Despite the virtually universal perception that what patients have or ought to have is "private health insurance," and the popular misapprehension that the unit of coverage is the individual, the fact is that private insurance companies did not develop the market for health coverage and have never been able to create stable arrangements for individual coverage. Health insurance as we know it is a group product and is the fruit of the collaboration

between nonprofit hospitals and large employers. It began as *hospitalization* insurance invented by a university hospital and sold to a teachers' organization. In the 1940s and 1950s the market for coverage was developed nationwide by the nonprofit hospitals and their captive nonprofit insurer, the Blue Cross plans. Commercial insurers came late and marginally to health care markets, as cream-skimmers, offering low rates to actuarially attractive customers, frequently using health insurance as a loss-leader for the more lucrative business of selling life and disability insurance. To look to commercial insurance as having established norms by which successful markets in health insurance function is to adopt a mistaken view of this history: coverage has in fact been supplied by or through large private employers that are in no sense insurance carriers.

The role of employers in health coverage is the subject of much confusion. They are, to repeat, not in the business of insurance. For them, providing coverage is not an opportunity to profit but rather a cost associated with maintaining a workforce, expressed under present practices as an aspect of employee compensation. If employers' powers are not constrained by regulation, provider collusion, or collective bargaining agreements, employers have the same power that, for example, military or sports organizations have to decide whether, in what quantity and quality, and by what techniques, to supply medical services to their employees. They can hire medical personnel and build hospitals and clinics, as Kaiser Engineers did in creating the medical care organization that became Kaiser Permanente. Employers may administer their medical program with their own personnel or may decide as a matter of convenience, as in any other "make or buy" decision, to employ outside contractors to run medical programs for them. This is the null state, the condition that would exist in the absence of defensive collective action by providers or regulation by government. Physicians have consequently feared employer-based coverage, as they have feared government health programs, because large organizations that have a responsibility to provide medical services to substantial populations have the capital to build integrated medical care organizations or to create a market for them: the AMA's prohibitions on "contract practice" and "corporate practice" were aimed at physicians who might find it attractive to work for employers or for integrated medical organizations. For decades professional ethics that were enforced by drastic penalties against offending physicians inhibited any but fee-for-service practice. Physicians have supported indemnity

insurance very strongly. Consequently, most employers until relatively recently have outsourced their provision of health benefits through the purchase of insurance from regulated carriers, including Blue Cross plans.

This technique of providing employee health benefits coverage *through* the purchase of insurance or the Blue Cross “service benefit” plans has created the impression that the basic nature of what was being provided *was itself* “insurance,” the unit of coverage the individual, the group simply a vehicle for obtaining a kind of volume discount, and the employer a source of administrative support. Large employers have been able to create the market for group health coverage, however, precisely because they perform the essential insurance function of creating the groups within which risk is pooled but themselves do not behave like insurers. Let us take up these points in reverse order. What distinguishes an employer from an insurer is the complex nature of the employment relationship of which health coverage is part, as compared to the simple nature of the insurance relationship of which health coverage, if sold as a separate product, is the whole. Insurers must engage in risk selection in order to avoid having to pay claims that exceed the amount of revenue attributable to the insured persons who incur the claims; given the opportunity insurers will attempt to break off relationships with customers whose claims seem likely to exceed the income they generate. An employer, by contrast, evaluates employees in the context of the totality of their contribution to the employer’s enterprise judged against their compensation, of which their health benefit cost is a component. This style of evaluation produces personnel decisions based on principles different from those used in insurance underwriting, with the consequence that employers may tend to keep in their employment groups persons who might not be regarded as good customers by insurers offering coverage in an individual market. The larger the employer, the greater the opportunity to submerge the health care costs of high-risk employees in the general flow of revenues and expenses. Many high-risk persons have health coverage only because they belong to large employer-based groups that provide or obtain coverage for everyone in the group.

This matters. Although risk selection and adverse selection operate in employer-based groups they must be mediated through the personnel process and, therefore, proceed at paces that are much slower than insurance underwriting cycles, making employee groups relatively stable from an underwriting point of view. The key to this stability is that in order to engage in risk selection the

employer must make a large, complicated decision to hire or fire an individual instead of a small, uncomplicated decision to offer coverage or not; in order to engage in adverse selection (meaning, in this non-insurance context, to have an undisclosed intention to incur medical costs in excess of imputed contributions to the common fund available for employee health benefits) a person must succeed in being hired. The complexity of the personnel decision makes entry into and exit from an employer-based group relatively difficult, leading to stability in its composition. This stability, when coupled with large size and the ability of the plan sponsor to reduce administrative costs by making a single contract covering all the subscribers within the group, makes the pre-formed large employment group an attractive customer for a health insurer. Another way to say this is that the large groups transfer to their insurance arrangements their own stability. For other customers, health insurance markets are inherently unstable.

There are really three segments to the health insurance market: those groups large and stable enough to take advantage of the law of large numbers and stop-loss or reinsurance in estimating likely medical costs, self-funding their health benefit programs and those groups that are inherently risky as an actuarial matter, regardless of the health status of their members at any particular time, because they are too small to buy stop-loss or reinsurance to protect against excess risk; and individuals. Most large- and medium-sized employers self-fund their employee health benefit programs, leaving mainly smaller groups and individuals in the markets served by regulated insurance carriers. The insurance market that serves small groups and individuals consequently has the dynamic of a death spiral, resulting from the fact that a small group is likely at some point to incur medical costs substantially in excess of the premium revenue that it generates. Given the gap between premium income and risk, insurers search out and expel from their books of business the highest-risk individuals and groups, and raise rates to adjust to remaining high risk and cost. If all insurers engage in aggressive medical underwriting, very high risk groups and individuals become uninsurable. Meanwhile, there is active competition for very low risk persons and groups, who have the benefit of low rates as long as they have low claims experience. The remaining participants in the market have high average risk and pay high average prices. In response to high cost, employers large enough to self-fund their programs pull out of the insurance market. The insurers must engage in frequent underwriting of the customers who are left in the market because all of these smaller groups are likely

to have claims that exceed the premiums that can be collected from them and even customers with favorable historical claims experience are risky because extremes tend to regress to the mean.

All groups therefore experience rate instability and have to pay for the considerable administrative cost of the insurer. The cost of insurance is consequently quite high, and the lowest-risk customers are likely to flee the market because the insurance offered may not seem to be a good value at the price demanded. The cycle repeats: lower-risk customers flee, the highest are pushed out, the average risk and cost rises, and the market shrinks at a higher price. The higher the cost of the insurance the more the insurer needs to fear "adverse selection," which is the likelihood that those most interested in purchasing coverage are those most likely to feel themselves in need of medical care, since insurance may seem a good value only to those who think themselves likely to use medical services. All measures that tend to increase risks and costs for insurers, even those undertaken in the name of "reform," therefore tend to lead to premium increases that drive lower-risk and lower-income customers out of the market. The individual and small-group market tends therefore to be characterized by high prices, rate instability, and uncertain availability of coverage. This dynamic is compatible with aggressive competition for (temporarily) attractive groups, so it is not uncommon for a small group to enjoy a relatively low rate until, upon a group member becoming seriously ill, finding itself suddenly uninsurable. Sometimes the insurers withdraw from the market, thereby reducing the availability of coverage. The entire dynamic pushes low-income workers in small businesses into Medicaid, if they qualify, or forces them to seek charity care. The cost of this care is then passed back, incompletely, to the paying customers of, or is taken as a loss by, the entities that provide the uncompensated care. All of this contributes to the insolvency threat faced by institutions that serve poor people, the unattractiveness of poorer areas for professional practices, and the general rise in health care prices that must be paid by large employer-based plans. Because employees of small businesses that cannot get access to coverage in the commercial insurance market are, on average, more likely to be women and more likely to be members of otherwise disadvantaged minorities than are employees of larger employers, the problem of access to health coverage runs along general lines of social inequality and segregation.

The problems of the small group insurance market, the inability of insurance firms to avoid adverse selection and to create stable large books of business across which to spread risk, affect everyone.

The problems are endemic and intractable. They were masked as long as large employers bought health benefits from regulated insurance companies and Blue Cross plans, because the large employers contributed large, stable groups around which insurers could build their books of business and therefore absorb riskier smaller customers. When the large, and then medium-sized, employers withdrew into self-funding after authorized to do so by the Employee Retirement Income Security Act of 1974, however, the inherent dynamic of the remaining insurance market asserted itself and the death spiral became manifest.

The question is what to do. The experience of the past half-century teaches that the only organizations that have ever been able to provide stable coverage for American workers have actually been the large employers; any solution likely to work must be designed to mimic their virtues. Those virtues include not only their ability to amass large, stable groups but also their ability to align their own coverage practices with the interests of the patients most in need of medical care. This is not to suggest that employers' interests are perfectly aligned with those of their very sickest patients, only that employers' interests are complex. Because they cover many high-risk individuals the interests of the employer-based plans complement, very generally, the interests of medical professionals in improving the state of the art in treating function- and life-threatening diseases affecting their workforces, such as cardiovascular disease, cancer, and diabetes. This fact has historically made them reliable partners in the development of American medicine.

The great failing of the employer-based plans has been that, historically, they have been relatively insensitive to price, creating expectations and habits on the part of the medical profession and the public that have made the plans' recent pursuit of cost control through managed care jarring. The fault of profligacy having been largely corrected in recent years, the employer-based plans remain the entities in the system best suited to balance considerations of cost and quality in order to achieve value for the customers. The argument of this Introduction is that in light of the hazards of trying to transform the health care system into one financed and regulated by government but operated by commercial businesses, we should look for a way to allow employer-based, customer-led organizations to create a system of universal, portable coverage to meet the needs of the emerging economy. This seems wholly achievable as a matter of technique, but doing it will require a good deal of private collective action and public-private

partnership, and a commitment on the part of private organizations to take on as collective self-regulation some of the functions that might, in a wholly public system, be assumed by government.

The private sector has done something like this before, in creating the Blue Cross, for many years the dominant institution in health care finance around which employer-based coverage formed itself. The Blue Cross is another of the hybrid, quasi-market institutions of the health care sector developed to enable nonprofit organizations to develop extensive markets without having access to risk capital. Blue Cross organizations may perhaps best be thought of as customer-led joint selling cooperatives ("service benefit" plans), owned by their participating nonprofit hospitals and designed as financing mechanisms to increase and stabilize hospitals' cash flow and to enable patients to ensure for themselves access to hospital services at their time of medical need.

These motivations and practices contrast with those of commercial insurers, which must create value for shareholders, tend to have an interest in restraining rather than encouraging the utilization of medical services in order to depress their loss ratios, and have no intrinsic institutional interest in encouraging the provision of medical care or the development of the medical arts. Although commercial insurers have had to accommodate their behaviors to health insurance markets historically shaped and dominated by the Blue Cross plans, their intrinsic interests are irreducibly in conflict with the interests of the patients most in need of medical services and are therefore in conflict with core medical values.

The contrast between the commercial insurers and Blue Cross plans should not, however, be overstated. What made the Blue Cross plans work as risk-spreaders was not that they were nonprofits, nor that they were owned by their participating hospitals, but rather the way in which they structured the markets. The achievement of the Blue Cross plans was to diminish the operation of ordinary insurance incentives by developing large group customers as risk-spreading entities in their own right, to spread risk among such entities by the system of community rating, and to provide guarantees of service to subscribers through hospitals' promising service performance rather than through raising or accumulating large amounts of risk capital. In combination with large employer-based coverage, the Blue Cross plans were, in a word, ingenious in their ability to create a market for health insurance while sidestepping ordinary insurance market imperfections.

Such ingenuity is required again. This time the task is to create not just service but value for customers, to do so within markets characterized by vigorous price competition, and to provide an institutional framework for private medical services delivery that makes it practicable for governments to partner with reliable, committed private organizations in the delivery of essential medical services. As with the original Blue Cross architecture, however, it is necessary to design around the failures of insurance markets and the intrinsic unsuitability of commercial insurance as the principal vehicle for health coverage. Before making some suggestions for how to create coverage arrangements that would be more protective of customer interests, I would like to close this section with some observations on the theory and practice of managed care as we have come to know it for the past few years.

Health policy experts disapprove of the impulse to risk selection on the part of insurers, and understand that insurance premium-type techniques of financing medical services produce incentives to under-treat, but otherwise find attractive insurers' interest in controlling claims experience and competing on price. The allure of the integrated insurer-provider organization was its potential to internalize the conflict between financial and service values in the interest of constraining expenditures: in theory, if insurer and provider functions can be integrated economically then the insurance and provider interests in the resulting organization should counteract each other and result in the organization's providing medical services that represent the optimal relationship between economic cost and medical benefit, which echoes the relationship between the interest of a participant as a consumer interested in economic value and as a patient interested in quality medical care. Ideally, the insurer-provider conflict within an integrated organization should therefore be like the productive tension in other industries between engineering and marketing, or between manufacturing and finance.

The flaw in this vision lies in the confusion between understanding economic theory and predicting business practice, manifested in the tendency of HMO enthusiasts to assert or assume that any insurer-provider organization necessarily as a consequence of its intrinsic structure will achieve an appropriate balance between medical values, i.e., providers' craft interests, and cost, i.e., insurers' financial interests, under conditions of price competition. In reality, however, perfect balance is not an intrinsic attribute of the integrated firm, emerging automatically upon integration. Rather, accommodation between insurer and provider values is achieved, if

at all, through internal bargaining local to the firm and has to be arrived at by mutual adjustment among real people with different interests, personalities, skills and cultures. An insurer-provider firm dominated by providers can be expected to start with provider values and compromise toward insurer values, and vice versa. How far the compromise must go will depend on how difficult it is to express and act upon any particular set of values within the firm itself, and of course on the characteristics of the market that the firm faces. The firm may get the balance wrong; it may not be able to manage effectively; it may make mistakes; it may fail. It may also exploit information asymmetries between it and its customers or patients and may not be able to resist temptations to act opportunistically. What has caused the backlash against managed care is not disagreement with abstract economic theory but outrage over concrete business practices.

It is too soon to draw hard conclusions about the success or failure of managed care in general, or managed care plans in particular, from the current backlash and economic turmoil, but at the very least it has proven unrealistic to regard HMOs as the comprehensive solution to the problems of the health care sector, inappropriate to talk of the insurer-provider firm as the ideal balancer of medical with cost considerations, and wrong to assume that competent management springs up in automatic response to financial incentives. The pervasive failure of managed care suggests problems at its core, not simply particular failures on the part of particular managers. The romance with managed care ought now end. Strategies that are proposed in order to make the demand side of the marketplace work in a way that will inspire acceptance of commercial managed care, such as transforming employer-paid insurance into an individual defined-contribution model and eliminating tax preferences for employer contributions, would tend to subject all health coverage to the failures of the individual insurance market and would subject virtually all working Americans to a very significant tax increase. This seems a large step to take in order to support a form of health care organization as flawed as is the commercial insurer-provider firm. There must be a better way.

MOVING FORWARD: REVIVALS AND INNOVATIONS

The direction of the argument of this Introduction is that the private sector ought to be empowered to create medical financing

and delivery vehicles that will be more closely aligned with the interests of the customers than are the commercial managed care organizations that presently dominate the field. This argument stems from the observation that customers may rationally prefer to obtain their services through customer-led or provider-led organizations and that because of their intrinsic commitment to the provision of health services these organizations are appropriate partners for governments that have statutory or constitutional obligations to provide such benefits. If possible, therefore, organizations of this type ought to be added to the mix of firms operating in the health services industry. In this section I suggest some directions for further thinking along these lines.

Business and customer cooperatives are hardly novel. I suspect that imaginative lawyers and their clients would be able to devise any number of governance structures to contain the private interests of the parties to cooperative arrangements of the type suggested here. The more challenging problems surround the interface between private and public interest. Managed care was to have been, or at least to have facilitated, the solution not just to private but to systemic problems. Customer-led organizations look promising, despite the effort required to create and use them, because they seem to have potential to help solve the systemic problems: risk pooling, value for customers, medical efficiency, economic efficiency and the relationship between markets and governance in the health care sector.

Of these problems, the one that leaps out as most characteristic of health coverage is that of risk pooling and its associated practices of risk selection and adverse selection. A full proposal for how to approach this issue is beyond the scope of this Introduction, but the solution is sufficiently within view that some design principles can be offered. We know from the experience of employer self-funding that risk pooling can be handled at the reinsurance level rather than at the primary insurance level: the risk of fairly small groups can be aggregated and distributed by a set of reinsurers. This is good news for the customer-led organization strategy because it means that groups small enough to engage in active participatory decisionmaking nonetheless are large enough to buy insurance or to self-fund, given sufficient financial protection supplied by reinsurance, guaranty funds, and the like. It is not at all difficult to imagine creating a family of private organizations that would be able to regulate the risk-pooling relationships through private collective action.

The next problem is pricing. I have argued that the reason why the employer-based plans have been so successful in providing coverage for higher-risk individuals is that their funding comes not in the form of premiums paid by employees but rather as a share of the revenues generated by the business. Non-premium financing does not eliminate completely the incentive to engage in member selection on the basis of health risk, but it provides other bases for evaluating desirability. Taft-Hartley plans furnish examples of various non-premium pricing structures. Any non-premium technique of financing will require explicit decisions on the part of the members of the organization, which is both the burden and the advantage of customer-led entities. It is worth keeping in mind that because efficient pricing leads to the death spiral, efficiency is not the goal.

Finally there is the question of stability. In the current system, because employees have few choices with respect to risk pools any employer's plan will consist of almost all the employees to which the plan is offered. Employers sponsoring single-employer plans therefore need fear adverse selection only through the creation and destruction of employment relationships. A multiple-employer or customer-led plan may not enjoy these advantages: because individuals eligible for its coverage may have other choices available as a result of the employment relationship, as perhaps a choice between the plan offered by an employer and one offered by the trade association, any particular plan needs to fear being selected against in ways that confound its actuarial projections based on population-level information about the pool of eligible persons. At the extreme, if employees had many options—as if, for example, they could choose to be covered by their fraternal organization or church in preference to their employer—all risk-pooling groups would be relatively unable because of fluid boundaries and would have to fear adverse selection. This problem can be solved by making entry into an insurance group relatively challenging (as by imposing affinity requirements) and making exit challenging enough to deter casual adverse selection but not so difficult as to deprive an individual of medically responsible choice of plan and provider. The latter can be accomplished by, for example, offering coverage in multi-year contracts with penalties for early cancellation.

Finally, there is the problem of access to risk capital. Nonprofit status is not inherently inconsistent with the acquisition of funds from persons who are willing to risk the loss of them in business operations; nor is it inconsistent with searching out new markets.

Customer-led cooperative organizations generally raise capital from their members and have some ability to serve customers who are not their members. In the case of health services, it is easy to imagine that business firms might launch and finance a customer-led health plan, purchasing, or management entity. It is not farfetched to imagine large purchasers of health benefits forming ventures with attractive providers that allow the customers to contribute capital to the provider's operations.

Much becomes possible if we turn our minds to the solution of the problems posed by the current state of managed care. The forces of commercial entrepreneurship have been allowed to claim, by default, a territory that is not properly theirs. In many respects the turn to for-profit managed care has been a great success; but present difficulties suggest that it is time to moderate our enthusiasm for the invisible hand and to engage in conscious design.

Let me leave this subject with a last thought. In the American system, tax-financed governance is a scarce resource and public tolerance for regulation is limited. Moreover, legislation and regulation are not themselves perfect or perfectible instruments for achieving the greater good: interest-group politics tend to direct legislative efforts into channels cut by private interest, and the actual performance of regulatory programs will reflect the capacity and competence of the government agencies to which implementation responsibility has been assigned. The current large trend in American political life seems to be to reduce the capacity and competence of government by reducing its revenues and personnel. Under these circumstances it seems incautious to design major new regulatory tasks for government unless the tasks are urgent and the objectives cannot be achieved by other means. It is also unrealistic to think that because the tasks are important the resources will be committed. The combination of large tasks and under-nourished capacities may well leave the situation worse off. Reliance on commercial managed care organizations selling what amounts to individual insurance requires an immense regulatory apparatus that it is unrealistic to expect the Congress and the state legislatures to create or government organizations, under present conditions, to manage.

It is preferable, therefore, to assign health care management responsibilities to institutions that can work independently, with modest intervention or support from public entities and minimal public funding and that can manage their local issues through private ordering and private law. The nonprofit organizations and

employer-based health benefit plans have historically been able to do this. My argument is that in the interest of not squandering a large social resource that is already in place and is accustomed to acting independently of, but in cooperation with, government, we should help these institutions adapt successfully to the new economy of health care. Untrammelled commercialism in the private sector leads, as we now see, to a demand for extensive regulation by the public sector, and pushes all issues up to a level at which patient interests cease to be the principal drivers of the action, as large amounts of money from insurer and provider interests flood into the political area and governments express their own interests as purchasers and regulators. The resulting contests of large powers tend to make political conversation about health policy lose detail and nuance, flatten into slogan and accusation. Large structural issues such as the redesign of Medicare must be resolved as problems of governance structure and public finance, but many of the issues of coverage design and administration that would be resolved by the current burst of managed care reform legislation are matters that could be handled better through responsible private governance and contract, as in the health services sector. The present challenge is how to create responsible private governance for health care in the new economy.

In this as in all other matters, the price of liberty is self-restraint and social responsibility. The health care system is breaking down all around us. It will be fixed, whether well or poorly. Current policy that has pushed radically toward a fix based on commercialism has evidently failed; to overlay the commercialism with government regulation does not seem more promising, because government regulation comes with its own known tendencies toward regulatory capture and policy failure. The better course seems to be to fix the system by building responsible customer-centered private organizations using the capabilities that already exist in the employer-based plans and nonprofit institutions. Taking this path will require, however, that the private sector design institutions that are stable in the face of short-term financial exigencies of individual businesses and that explicitly engage in quasi-governmental functions. I do not mean to underestimate the challenge of building stable access to medical services through private institutions and public-private partnerships; I only mean to suggest that this is the only course of action that can succeed in stabilizing the present situation and moving toward universal coverage and access to quality care. It also bears noting that customer-centered private organizations hold out the

best promise of solving the problems of patient privacy that are looming in the age of digitized information.

This argument has not addressed any of the specific managed care reform legislative measures proposed or enacted. It does, however, suggest a principle for evaluating them, which is that in the current drive for managed care reform we ought to be careful not to impose regulation or liability that seems likely to drive away from the function of providing health benefits any substantial number of private employers. In the end, the health care sector must be brought within the ordinary principles of tort and contract law and must be responsible and accountable to public authority as well as private interests. However, in the current legislative climate when so much is proposed and so little understood, it might be well to stay the harshest hand unless one is certain that one is not demolishing the possibility of a more attractive future.

