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I. INTRODUCTION

Medical care is expensive, and it rapidly is becoming even more so. This truism is much discussed as we enter the ninth decade of the twentieth century. People voice concern about the size of hospital and doctor bills, the price of group health insurance, the rapid rise of government health care spending, and even the share of the gross national product devoted to health spending.[1] The main problem—at least with most medical care—is that both patients and medical care providers are insufficiently cost conscious at the time that medical spending decisions are made.[2] The principal roots of this problem are the provider-dominated nature of medical care decisionmaking, the third-party payment system that has evolved to protect patients from medical costs, and the resulting biases of the delivery system.[3]

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1. The literature is voluminous. *See, e.g.*, Iglehart, *You Can't Have It Both Ways*, 9 NAT'L J. 1086 (1977).

2. This Article focuses upon cost containment and efficiency, and thus discusses what may be termed "overinsurance." *See* Pauly, *Overinsurance: The Conceptual Issues*, in NATIONAL HEALTH INSURANCE: WHAT NOW, WHAT LATER, WHAT NEVER? 201 (M. Pauly ed. 1980). A significant problem of underinsurance also exists, however, with as much as 13% of the population of the United States totally unprotected. HEALTH INSURANCE INSTITUTE, SOURCE BOOK OF HEALTH INSURANCE DATA, 1979-1980, at 11 [hereinafter cited as SOURCE BOOK]. Some procompetitive proposals address the latter issue, and others do not.

3. This Article is thus principally concerned with what might be termed "mainstream" medical care—that is, care for the working population and Medicare and Medicaid beneficiaries, consisting mainly of curative services from physicians and general hospitals. The separate and severe cost and other problems of long-term care, catastrophic illness, and public provision of care of last resort deserve separate attention. To a great extent, they are problems of caring for the very needy—the aged and chronically ill, the mentally retarded, victims of end-stage renal disease, and so on—whose integration into conventional insurance

For a variety of reasons, many people are looking to federal action to deal with the cost problems. How best to address these issues is the subject of this Symposium and this Article. The possibilities usually are posed as a choice between increased government regulation to control medical costs or increased competition. This dichotomy, however, is overly simplistic. In many ways we already have a very competitive health care financing and delivery system, but the present competition is not productive. Moreover, regulation in the sense of government efforts to control costs will always exist—at least as long as government continues to be a principal third-party payer and deliverer of services of last resort. Other regulation is also needed to promote the correct sort of competition.

Instead of relying solely on this overdrawn dichotomy for policy guidance, we should be asking just what is wrong with our present health care system, what corrective incentives are needed, and whether they should be imposed on a system-wide or a decentralized basis. The focus should be on the kinds and mix of competition and regulation that are most desirable.

This Article discusses these issues in considering the "competitive" approach to reforming medical care financing and delivery. Although the approach is an extremely promising one, strongly held individual and social values underlie the current system, and powerful private interests have a stake in the status quo. Reforms, therefore, may never be fully implemented or realize their theoretical potential in practice. In any case they will take some time to work; no approach can be an immediate panacea. If government is to embark upon a "procompetitive" course, it needs to proceed carefully. Especially during the transition to a more competitive system, we need to be particularly careful to create constructive incentives, whether through regulatory or competitive means, and not to get the worst of both worlds by inappropriately mixing them. This Article considers the sources of current cost problems, discusses regulatory and procompetitive responses, notes the lessons of today's unproductive competition for future procompetitive efforts, and makes some policy suggestions.

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plans would be even more difficult than it is for Medicare and most Medicaid beneficiaries.

II. Weak Cost-Control Incentives: Inherent in Doctor-Patient Relations, or Due to the Intervention of Third Parties?

The current marketplace for medical services is far from the competitive ideal in which the prices and quantities of services are set by supply and demand, with knowledgeable and price-conscious consumers confronting competitive suppliers.[4] Virtually all real-world markets, of course, differ from the idealized economic model. In the case of medical care services, however, cost-enhancing, noncompetitive structures, incentives, and behavior seem to be particularly extreme.

Many noncompetitive features of current arrangements appear to be inherent in the fundamental nature of the medical care enterprise.[5] Thus, medical care may be intrinsically different from other spheres of economic activity. Such a view is often expressed as being self-evident—that of course the medical care marketplace cannot function correctly, and therefore government regulation is necessary to control costs and achieve other goals.[6] This view holds that competition is inherently impossible for a variety of reasons, the most important of which is that providers—primarily physicians, but also hospitals and others—dominate resource-allocation decisions in medicine.[7] Providing medical care is a very technical enterprise in which providers are expert and consumers are often largely ignorant. Both the desirability of treatment and the quality of care provided are difficult for laymen to evaluate, and the information cost to consumers to learn about health and medicine is quite high. Thus, consumers do not know very well what they want, and consumer sovereignty—a fundamental axiom of free-market economics—is seriously weakened.

As a consequence, patients delegate much decisionmaking to their doctors, who often play the role of consumer as well as provider. Indeed, only doctors can admit patients to a hospital, order lab tests, and arrange for the consumption of other types of care. This situation leads to the common observation that physicians to some extent can "create demand" for their own and other medical

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4. *See, e.g.*, M. Friedman, Capitalism and Freedom (1962); V. Fuchs, Who Shall Live? (1974).

5. *See generally* Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 Am. Econ. Rev. 941 (1963).

6. *See, e.g.*, E. Kennedy, In Critical Condition: The Crisis in America's Health Care (1972).

7. *See generally id.*

services.[8] Patients fully control only their initial decision to seek medical attention.[9] The doctor, more than the patient, then, determines when care is desirable, as well as what care should be given and how much is appropriate. It is also the doctor who defines a unit of service and, to a great extent, judges whether it has been successful. A large part of what a doctor provides is thus not the medical service itself (which may indeed be given by a hospital or other provider) but expertise in its consumption and evaluation. Consumers generally have trouble judging when a particular service is needed, but they have even greater difficulty judging its quality—and hence its worth—before it is given.

Moreover, patients in pain or in danger of life and limb are seldom very price conscious or able to bargain over the terms of their care. There is a general presumption in favor of high quality, almost regardless of cost. When a miscalculation can have serious and potentially irreversible consequences, consumers are not apt to make close quality-versus-cost calculations. Although "shopping around" for alternative providers is hardest when important care is needed quickly, it is never easy. The product is not well-defined, and it can be difficult to anticipate future needs and services, particularly when many are ordered by the physician and not the patient. The cost and quality of the total package of goods and services may not even be assessible in advance, since much will depend on diagnostic and therapeutic developments after the initial visit to the doctor. Comparing medical care prices is also difficult because the quality of care may vary considerably in ways that consumers find hard to assess. Even professionals have great difficulty in assessing the quality of care under different treatments. In medical literature, great battles are fought over what constitutes quality and how it is to be measured; there are even indications that much medical care is poorly evaluated by physicians themselves and is of unproven effectiveness.[10]

Patients can of course become more sophisticated consumers, but only at considerable cost in search time, self-education, and

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8. *See* Holahan, *Physician Reimbursement*, in NATIONAL HEALTH INSURANCE: CONFLICTING GOALS AND POLICY CHOICES 73 & n.4 (J. Feder, J. Holahan & T. Marmor eds. 1980).

9. L. ROSSITER, NATIONAL HEALTH CARE EXPENDITURES STUDY: WHO INITIATES VISITS TO A PHYSICIAN? 1 (Nat'l Center for Health Serv. Research, Sept. 1980, HHS Pub. No. (PHS) 80-3278).

10. *See, e.g.*, A. COCHRANE, EFFECTIVENESS AND EFFICIENCY: RANDOM REFLECTIONS ON HEALTH SERVICES (1972); Brook & Appel, *Quality-of-Care Assessment: Choosing a Method for Peer Review*, 288 NEW ENG. J. MED. 1323 (1973).

the like. Because of the need to entrust important decisions to physicians, an ethic of doctor-patient trust is an important part of the commercial relationship. A long-standing relationship and knowledge of a patient's history and circumstances may also improve the quality of care. Because this factor makes shopping around even more costly and difficult, many patients are understandably quite reluctant to change doctors.[11]

Clearly, the extent to which competitiveness in health care departs from the theoretical ideal varies according to circumstances—from great departures such as with emergency hospital care, to minor ones like purchasing an identified drug. In many cases, however, it is difficult to see anything approaching ideal competition regardless of the circumstances.

On the other hand, the medical care market may be different only in degree and not in kind from other marketplaces that allocate resources without the need for significant governmental intervention. Some commentators maintain that we have merely created a medical services marketplace in which inappropriate structures and incentives lead to cost-increasing behavior.[12] Under this view, the chief villain is insufficiently constrained third-party payment for care. While doctors and patients decide what care to consume, payment for that care is typically made by a "third party" to the transaction. The third-party payer may be a private insurance plan or a government program, and the patient may or may not be liable for a portion of the payment. Third-party payment, by divorcing consumption decisions from payment responsibility, greatly decreases cost consciousness at the time of need.[13] Indeed, reducing or eliminating precisely this anxiety over payment is one of this system's chief virtues, if not its major reason for being. The payment system has wide-spread effects because it features broad, almost comprehensive coverage of many or most medical services. Employment group plans—by far the dominant mode of purchase—often include even dental care, psychiatric social work, and other such services traditionally not considered part

11. This factor is often cited as a reason that Health Maintenance Organizations (HMOs) of the prepaid group practice type find it difficult to attract older subscribers who may have free choice of provider under Medicare or a fee-for-service style HMO.

12. *See, e.g.*, Feldstein, *The Welfare Loss from Excess Health Insurance*, 81 J. POL. ECON. 251 (1973); McClure, *The Medical Care System under National Health Insurance: Four Models*, 1 J. HEALTH POL., POL'Y & L. 22 (1976); Pauly, *The Economics of Moral Hazard*, 58 AM. ECON. REV. 531 (1968).

13. *See* Feldstein, *supra* note 12; McClure, *supra* note 12; Pauly, *supra* note 12.

of medical service.

Other aspects of our financing system, in addition to the basic fact of third-party payment, also contribute to cost-increasing behavior. One feature is the method of paying providers. Doctors, hospitals, and others are typically paid on a fee-for-service basis, which gives providers more revenue only when they provide more services; hence, it penalizes economizers.[14] Third-party payment also typically pays almost the entire cost of each covered service, with little cost-sharing by the patient, particularly for inpatient hospital care. Insurance often provides almost "first-dollar" coverage, meaning that deductibles (initial costs of care that must be borne by patients) are relatively small or nonexistent for many services. Traditionally most coverage was not only first-dollar, it was also "shallow," in that it left uncovered major expenses beyond certain levels. Recently, however, "deeper," "major medical," and even "catastrophic" coverage has become the norm,[15] greatly expanding protection for the insured—and also reducing cost restraints in the system—although gaps remain for many insureds.

Moreover, most insurance pays for institutional care on a cost-related "reimbursement" basis. Most Blue Cross plans, Medicare, and Medicaid—the last with some exceptions—purport to pay the full "reasonable costs" of hospitals.[16] Regardless of whether actual costs are met fully, payment is closely related to costs actually incurred. The critical incentive is that an institution is typically paid more for raising its costs and less if it holds down its costs. Blue Cross plans usually pay on a "service" basis directly to the hospital; the patient sees a bill only much later, if at all. Most "commercial" insurers—that is, for-profit or mutual, conventional insurance plans—pay reasonable hospital "charges." These charges are whatever the hospital actually bills, within reason, which tends to be higher than "cost."[17]

In the case of physician payment, Blue Shield plans, Medicare,

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14. *E.g.*, Holahan, *supra* note 8, at 78.

15. *See* HEALTH INSURANCE ASSOCIATION OF AMERICA, GROUP HEALTH INSURANCE (1976) [hereinafter cited as GROUP HEALTH INSURANCE]; SOURCE BOOK, *supra* note 2; Havighurst, Blumstein & Bovbjerg, *Strategies in Underwriting the Costs of Catastrophic Disease*, 40 LAW & CONTEMP. PROB., Autumn 1976, at 122, 124-27.

16. *See, e.g.*, Feder & Spitz, *The Politics of Hospital Payment*, in NATIONAL HEALTH INSURANCE: CONFLICTING GOALS AND POLICY CHOICES, *supra* note 8, at 301, 303-11.

17. *See generally id.* Some plans, particularly the relatively small number of commercial ones sold on a nongroup basis, pay only "indemnity" amounts—that is, fixed sums per day. These sums may be well below actual costs or charges, leaving the balance to be paid by the patient.

and often Medicaid pay some variant of the "usual, customary, and reasonable" (UCR) fees.[18] "UCR" means that physicians are paid based upon how much they *usually* have charged for a given service during a previous accounting period unless that usual charge exceeds what is *customarily* charged by most other doctors in their specialty; and even this amount may be raised if a special *reason* exists for doing so. This system allows doctors to be paid what they normally bill and raises the customary ceiling as fast as doctors raise their bills. Other health care professionals, if they are not paid by a hospital that is then "reimbursed," may be paid on a UCR basis or for their actual fees up to some fixed limit set by the insurance policy. Commercial insurers, on the other hand, usually do not pay UCR per se, but pay actual fees limited to some maximum "reasonable" amount—often a customary charge limit computed for a geographic area.[19]

Whatever the system, provider payment is generally thought of and paid as "reimbursement,"[20] meaning that providers determine what level of medical spending is appropriate, undertake that level, and are repaid for their spending. Thus, the medical care providers whose services are covered are less the takers of a price impersonally set in a free market than they are the setters of the price. Each doctor or hospital (except those charging over some ceiling) receives an insurance payment unique to that provider. Moreover, an insurance plan almost always gives its enrollees "free choice of provider." Medicare and Medicaid by law allow patients to receive care from any licensed provider who is also accredited for the program, which means almost all of them.[21] Private insurers similarly, for competitive reasons, cover all or almost all providers. Thus, insureds may go as patients to whichever provider they (or their doctor) choose and still receive comprehensive coverage and payment. This system largely frees providers from the necessity of competing for patients on a price basis.

The effect of all of these features is that an insured patient typically faces a very small or even nonexistent cost at the time of service. In 1979, 63.5% of physician payments and fully 91.9% of hospital payments were made by third parties. Only 36.5% and 8.1%, respectively, of these payments were out-of-pocket payments

18. *See* Holahan, *supra* note 8, at 81-83.

19. *See, e.g.*, GROUP HEALTH INSURANCE, *supra* note 15, at 26-31.

20. *See, e.g.*, Feder & Spitz, *supra* note 16; Holahan, *supra* note 8.

21. Freedom of choice by the patient is guaranteed by statute. *See* 42 U.S.C. § 1395b (1976) (Medicare); § 1396a(23) (1976 & Supp. III 1979) (Medicaid).

by patients themselves.[22] Under these circumstances, it is virtually impossible to rely on either consumers or providers to insist that every dollar spent by a third party produce a dollar's worth of care. Patients are motivated to seek every treatment of any potential value, and of course providers are motivated to help them as much as possible, with an additional effect being to increase providers' own revenues.[23]

The final notable characteristic of insured fee-for-service care is that insurers and government programs have been very slow to impose their own cost-containment limits as a substitute for the largely absent market discipline.[24] Competition among insurers has tended to focus upon providing more comprehensive coverage, better access to providers, good claims service, and the like. Cost control has primarily meant holding down administrative costs, including such things as claims payment mistakes, rather than controlling medical services rendered.

The result of all of these factors is that our current medical care financing and delivery system is not very cost-conscious or price-competitive. The bottom line is that considerable professional autonomy exists in resource allocation. Medical spending consequently is much higher than it theoretically might be. To some extent, this result may be inherent in the system, given the nature of medicine and deep-seated individual preferences. To some extent, it is clearly due to the financing and delivery system that presently exists. Both the "intrinsic market failure" and "insurance market failure" views seem to be correct. Medicine is considered special, and this belief is reflected not only in our first-party relations with medical providers, but also in the third-party financing relationships that we have created. Unconstrained third-party payment is not only a cause of higher spending; it is also the result of important social and cultural forces. Whether medical care "could" be more competitive and less expensive under a system of one hundred percent first-party payment is a moot point because personal and social choices have acted systematically to make third-party systems dominant. An uninsured world is both undesirable and unlikely. Thus, the real question is how to make

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22. Gibson, *National Health Expenditures, 1979*, 2 HEALTH CARE FINANCING REV. 1, 25, 27 (Table 5) (Health Care Financing Admin. Summer 1980).

23. *See, e.g.*, Havighurst & Blumstein, *Coping with Quality/Cost Trade-Offs in Medical Care: The Role of PSROs*, 70 NW. U.L. REV. 6 (1975).

24. Havighurst, *Controlling Health Care Costs: Strengthening the Private Sector's Hand*, 1 J. HEALTH POL., POL'Y & L. 471 (1977).

the third-party system behave more cost-consciously and deliver medical care more efficiently.

III. Regulation Versus Competition in Cost Control

A. Regulatory Efforts

1. Program-Specific and System-Wide Controls

The main cost-controlling response to the rapid rise in medical spending has come from government. In a sense, this fact is not surprising since government medical spending has been rising even more rapidly than medical spending overall.[25] Cost-control concerns, however, extend beyond the money spent on government programs, in part no doubt because to guarantee access for public beneficiaries government programs must pay competitive prices to providers.

To date, most public cost-control initiatives have been regulatory in nature. Generally, "regulation" means that public rather than private choices dominate cost control, but it is useful to distinguish among types of regulation. The principal regulatory efforts seek to control spending under government programs, primarily Medicare and Medicaid. Such efforts have attempted to limit the number of services paid for, through utilization control and "Professional Standards Review Organization" (PSRO) review of inpatient care to judge its necessity and appropriateness.[26] Price controls for government beneficiaries have also been tried; "routine" Medicare hospital costs—room and board—are subject to a ceiling for which increases are limited.[27] Some of the state-admin-

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25. *See* Gibson, *supra* note 22, at 16 (Table 1). The governmental share of health expenditures rose from 26% in 1965 to 43% in 1979, with the federal share rising from 13% to 29%. *Id.* Such increases in spending, even starting from a relatively low base, have raised considerable pressures to economize. Another reason that government appears more concerned about spending increases than the private sector is the redistributive nature of government spending. Medicare, Medicaid, public hospitals, and other government programs pay for care for parts of society with taxes largely drawn from other parts. In contrast, insured private spending involves people buying their own insurance, even though considerable pooling and risk-spreading occurs. Ironically, it is also notable that in the public sector, medical spending must compete dollar-for-dollar with other needs, whereas private medical spending (along with other fringe benefits) is tax subsidized compared with other possible expenditures.

26. *See generally* Havighurst & Bovbjerg, *Professional Standards Review Organizations and Health Maintenance Organizations: Are They Compatible?*, 1975 Utah L. Rev. 381, 382; Havighurst & Blumstein, *supra* note 23; Stuart, *Utilization Controls*, in National Health Insurance: Conflicting Goals and Policy Choices, *supra* note 8, at 423.

27. Routine cost limits, which restrict the growth of room-and-board costs but not those of ancillary services, are known as § 223 limits, after that section of the Social Security

istered Medicaid programs also control hospital rates rather than paying "reasonable costs."[28] Also, the rise in Medicare payments to physicians has been limited by an extrinsic index; consequently, increases in physician billings do not automatically become higher allowable Medicare fees.[29] Controls under Medicaid have been even more drastic. Many states have imposed long-lasting freezes or even cuts in physician payments, for example, since they are not required to "update" their physician payments on a regular basis.[30] The federal government has also attempted to control the cost of care under Medicare and Medicaid by requiring "section 1122" approval of increases in the number of hospital beds and other capital investments.[31]

All of these controls attempt to curb only public program expenditures. Some are indeed successful in that they hold down growth in particular categories of government expenditures, such as Medicaid physician services.[32] There is consensus, however, that their success has been limited.[33] Physicians, for example, can simply refuse to accept Medicaid patients or Medicare's allowable fee as payment in full since there is ample demand from other insured payers willing to pay higher fees.[34] Hospitals have also been able to

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Amendments of 1972, Pub. L. No. 92-603, § 223, 86 Stat. 1393 (amending 42 U.S.C. § 1395x(v)(1)). *See* [1980] 2 MEDICARE & MEDICAID GUIDE (CCH) ¶ 7541.

28. A state's Medicaid plan may provide for an alternative method of payment for inpatient hospital services. *See* [1979] 3 MEDICARE & MEDICAID GUIDE (CCH) ¶ 14,725.67. As many as eleven states have done so.

29. Section 224 of the Social Security Amendments of 1972 allows Medicare physician payment ceilings to be limited by an economic index, beginning in 1973. Pub. L. No. 92-603, § 224, 86 Stat. 1395 (amending 42 U.S.C. § 1395u(b)(3)). *See* [1980] 1 MEDICARE & MEDICAID GUIDE (CCH) ¶ 3225.

30. B. SPITZ, STATE GUIDE TO MEDICAID COST CONTAINMENT (1980) (Center for Policy Research, National Governors Association).

31. Section 1122 takes its name from that section of Social Security Act, 42 U.S.C. § 1320a-1 (1976 & Supp. III 1979) (added by Pub. L. No. 92-603, § 221, 86 Stat. 1386 (1972)). It disallows Medicare and Medicaid reimbursement for that portion of hospital expenses attributable to capital investments not approved by local planning agencies.

32. In almost every state examined in a forthcoming Urban Institute study, physician payments grew more slowly as a category of expenditure than other state Medicaid expenditures. Bovbjerg, *Health Services Spending*, in EFFECTS OF STATE AND LOCAL EXPENDITURE LIMITATIONS ON HUMAN SERVICES FINANCING (G. Peterson ed., forthcoming).

33. Perhaps the most convincing evidence is the continuing concern over mounting costs. *See, e.g.*, Demkovich, *For States Squeezed by Medicaid Costs, The Worst Crunch Is Still to Come*, 13 NAT'L J. 44 (1981).

34. According to the Select Committee on Aging of the U.S. House of Representatives, "Today, doctors accept assignment for only 1 out of every 2 elderly patients; 2 out of 3 elderly patients were accepted for assignment in 1966." HOUSE SELECT COMM. ON AGING, 96TH CONG., 2D SESS., MEDICARE AFTER 15 YEARS: HAS IT BECOME A BROKEN PROMISE TO THE ELDERLY? 12 (Comm. Print 1980).

shift costs to uncontrolled areas by raising ancillary charges faster than room and board.[35] Moreover, even if some governmental costs are limited, much spending may be shifted to the private sector, as when hospitals raise rates to "charge-paying" patients to make up for deficits on Medicaid patients.

Some system-wide government regulations have also been implemented, applying across-the-board to all providers. For example, price controls on all medical services were an important feature of the short-lived Economic Stabilization Program of 1971-74.[36] Currently, two types of controls are prominent. The federal section 1122 limits on hospital investment—applicable only under Medicare and Medicaid—have been replicated on a system-wide basis under state certificate-of-need laws, which were virtually mandated by the Federal Health Planning Act of 1974.[37] In addition, many states have enacted price or budget controls for hospitals going far beyond earlier controls that applied only to Medicaid.[38] Other regulatory proposals have been made; former President Carter's proposed hospital cost-containment controls were a high priority but were twice defeated.[39]

2. Internal-Incentive Programs

In addition to distinguishing regulation as program-specific or system-wide, it is useful to differentiate between extrinsic controls imposed on providers and attempts to change their internal incentives through government regulation. Planning restrictions, for example, are extrinsic controls. They attempt to superimpose external requirements upon health care institutions' own plans based

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35. One hospital examined in a recent Urban Institute study provides a dramatic example. It had routine charges that rose from $17.3 to $17.6 million during 1974-79, while ancillary charges rose from $6.1 to $20.0 million. L. PARINGER & R. BOVBJERG, HEALTH RELATED PROGRAMS IN AN ERA OF FISCAL LIMITATIONS: THE MICHIGAN CASE STUDY (forthcoming).

36. *See, e.g.*, Ginsburg, *Inflation and the Economic Stabilization Program*, in HEALTH: A VICTIM OR CAUSE OF INFLATION? 31 (M. Zubkoff ed. 1976).

37. *See* 42 U.S.C. §§ 300k-300t (1976 & Supp. III 1979). *See generally Symposium: Certificate-of-Need Laws in Health Planning*, 1978 UTAH L. REV. 1; *see also* note 31 *supra* and accompanying text.

38. *See, e.g.*, Bauer, *Hospital Rate Setting—This Way to Salvation?*, in HOSPITAL COST CONTAINMENT 324 (M. Zubkoff, I. Raskin & R. Hanft eds. 1978).

39. The bill would have created federal hospital rate setting for institutions in states that did not have their own mandatory rate-setting programs. It would have limited the growth of revenues available for hospital spending. *See* Dunn & Lefkowitz, *The Hospital Cost Containment Act of 1977: An Analysis of the Administration's Proposal*, in HOSPITAL COST CONTAINMENT, *supra* note 38, at 166 (discussing the 1977 version; it and the next session's counterpart were both defeated).

upon their own incentives. Reimbursement reforms, in contrast, attempt to alter incentives. Notable among the latter are hospital rate-setting programs that establish prospective prices rather than paying full cost retrospectively.[40] Prospective systems rely upon the incentives of advanced limited payment to induce hospitals to economize. Unlike the situation under retrospective cost-based payment, increasing costs does not immediately increase third-party payments. There are many varieties of prospective systems. Most rate-setting programs project an institution's past costs to determine allowable future rates and thus address only the rate of change in spending. Other programs go further, penalizing relatively high-cost facilities by setting rates for care not by the actual costs of a given institution but according to something like the average costs of all similar facilities. They may also reward efficiency by allowing below-average-cost hospitals to keep their savings. Over time these incentives may create downward pressure on the average as well.[41] Such incentive-oriented approaches make theoretical sense[42] and may be one reason why mature rate-setting programs show evidence of controlling costs, while health-planning controls—like section 1122 and certificate-of-need approval—do not.[43]

B. Promoting Competition

In the 1970s, an alternative economizing strategy came to the fore: greater reliance on newly increased and restructured competitive forces and private economizing choices. A procompetitive strategy is very appealing because, among other reasons, it would operate system-wide and would alter consumer and provider incentives. Correctly functioning competition holds promise of controlling overall costs by achieving medical efficiencies rather than

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40. *See* Bauer, *supra* note 38; Hamilton, Walter & Cromwell, *First Annual Report of the National Hospital Rate-Setting Study: A Comparative Review of Nine Prospective Rate-Setting Programs*, in HEALTH CARE: FINANCING GRANTS & CONTRACTS REPORT (1980) (Department of Health and Human Services, Health Care Financing Administration).

41. *See, e.g.*, NATIONAL CONFERENCE OF STATE LEGISLATURES, *Hospital Case Mix Reimbursement: The New Jersey Diagnostic Related Groups Experiment*, in STATE HEALTH NOTES (Sept. 1980) (Intergovernmental Health Policy Project).

42. *See, e.g.*, Schultze, *The Public Use of Private Interest*, HARPERS, May 1977, at 43 (superiority of "incentives" approach to social intervention over "command-and-control" method).

43. Steinwald & Sloan, Regulatory Approaches to Hospital Cost Containment: A Synthesis of the Empirical Evidence (Sept. 1980) (paper presented at American Enterprise Institute Conference on Health Care: Professional Ethics, Government Regulation, or Markets?, Washington, D.C.).

merely by reducing what government pays for care. The first major effort of this sort was the "Health Maintenance Organization" (HMO) strategy adopted by the Nixon Administration in 1971.[44] That strategy was to promote HMOs, alternative medical service organizations that contract to deliver comprehensive care on a prepaid basis and are thus well motivated to economize, unlike insured fee-for-service providers.[45] By subsidizing HMOs and preempting restrictive state laws, federal policy encouraged HMOs to provide not only good, economical care for their subscribers but also healthy competition for the dominant fee-for-service system. Many competitive variants have surfaced since that time, culminating in a number of recent federal legislative proposals.[46]

To date, many different ideas have been put forth in the public debate over restructuring health care financing to create more competition. As just mentioned, some proposals have been introduced formally as legislation while others have been set forth in the literature with greater or lesser degrees of specificity concerning how they would work in practice. The following discussion is therefore necessarily somewhat general in its terms.

Greater private economizing does not mean a reversion to total first-party financing, but rather changes in the way third-party coverage is acquired. "Procompetitive" strategies have two parts. The first is to make insurance premium payers more cost-conscious by increasing the reward for choosing relatively less expensive plans, so that insurers will be more price-competitive. This goal is to be accomplished by government action: limiting the tax subsidy for medical care purchases and restructuring insurance purchase choices. The second element of the strategy is for insurers to translate these economizing insurance incentives into greater efficiency in the medical services market. Little agreement exists, however, about how this translation would occur. The assumption

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44. *See, e.g.*, President's Message to Congress on National Health Strategy, 7 WEEKLY COMPILATION OF PRESIDENTIAL DOCUMENTS 244 (Feb. 18, 1971) (supporting federal promotion of HMOs). The result was the Health Maintenance Organization Act of 1973, 42 U.S.C. §§ 300e to 300e-15 (1976) (setting minimum standards for HMOs and providing technical and financial assistance to them).

45. HMOs are discussed at notes 64-68 *infra* and accompanying text.

46. In the 96th Congress, for example, three leading bills were the Health Incentives Reform Act of 1979, S. 1968, 96th Cong., 1st Sess. (1979); the National Health Care Reform Act of 1980, H.R. 7527, 96th Cong., 2d Sess. (1980); and the Health Costs Restraint Tax Act of 1979, H.R. 5740, 96th Cong., 1st Sess. (1979). *See* Havighurst, *Competition in Health Services: Overview, Issues and Answers*, 34 VAND. L. REV. 1117 (1981); Marmor, Boyer & Greenberg, *Medical Care and Procompetitive Reform*, 34 VAND. L. REV. 1003 (1981).

is that the insurance and delivery markets would develop many different ways of holding down prices and delivering care more efficiently. Whatever paths are chosen, it is clear that, to succeed, competition must ultimately restructure health care delivery as well as health care financing.

Many proposals concerning the existing tax subsidy would limit it rather than eliminate it; this approach would preserve a government subsidy for the purchase of some reasonable amount of insurance coverage without subsidizing very generous packages. For example, Senator Durenberger's bill, introduced in 1979, set the contribution limit for family coverage at $125 per month per family.[47] This limit is somewhat high, however, and would not affect most current group insurance plans.[48] How restrictive such a limit would be thus depends on a number of factors, not the least of which is the absolute limit itself. A second factor is whether the incentive only penalizes "over"-spending or also rewards "under"-spending—that is, whether companies and employees are allowed to accept tax-free cash in lieu of the full health insurance subsidy. Finally, there is the question of how quickly the subsidy limit will be allowed to grow. Clearly an absolute dollar cap would have an increasingly hard bite over time, while a limit tied to some rising index would be less severe, depending upon the index.

The next step in promoting competition is for this increased cost-consciousness of less-subsidized employees to be translated into the choice of a lower cost plan.[49] In addition to changing marginal incentives by capping the tax subsidy, procompetitive proposals generally mandate that each employee be able to choose among multiple plans of different price and benefit structures. Many employees do not now have this opportunity. Choice would be ensured by mandating that to qualify for the tax subsidy, firms must offer multiple plans and make equal contributions to all of them for any given person. Then, if an employee elects a lower-cost plan, he benefits fully from the savings. The idea is to allow em-

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47. Health Incentives Reform Act of 1979, S. 1968, 96th Cong., 1st Sess. (1979).

48. The 1979 average for major employer plans was only $67 per month (not including dental coverage). Thus, $120 per month "is a very adequate level of benefits; it corresponds to the upper range of the large union plans with the glaring exception of auto," where monthly family benefits may exceed $200 in some locations. *Proposals to Restructure the Financing of Private Health Insurance: Hearings on H.R. 5740 Before the House Comm. on Ways and Means*, 96th Cong., 2d Sess. 150 (Feb. 25, 1980) (statement of Willis B. Goldbeck).

49. Of course, whoever pays for coverage now benefits from economizing, but not on a dollar-for-dollar basis because of the open-ended tax subsidy.

ployees to keep every dollar saved by their economizing choices. The increased cost-consciousness of premium payers thus presumably would lead to relatively lower-priced plans. Plans would then lower their expenditures on medical care to match income. Procompetitive proposals, however, are generally less specific about the mechanisms for achieving savings than they are about creating more insurer competition.[50]

There are two basic ways that efficiencies might be achieved. One method is to restructure consumer incentives; the other is to utilize provider incentives or controls. Consumer incentives would operate principally by increased cost sharing on covered services, but also to a certain extent through the benefit package itself. An illustration of the latter is that insurance purchasers might choose (within the limits allowed by federal minimum standards) not to cover certain services with insurance at all. These services might include such predictable items as dental care, normal childbirth, or certain types of outpatient psychotherapy. This method is a variant of cost sharing in that it creates a category of 100% cost sharing—the excluded services. Medical services efficiency is thereafter presumably achieved both by harder bargaining by patients and by competition among physicians for patients on the basis of price and patterns of care. Cost sharing alone, however, is unlikely to achieve sufficient changes. For one thing, cost sharing is indeed only "sharing," so that consumers do not bear the full cost of care in any range except perhaps initial deductibles. For another, achieving the laudable goal of "catastrophic" protection dictates a ceiling on out-of-pocket expenditures—above which there is no cost sharing and all of providers' spending is covered. Moreover, cost sharing, to achieve its impact, relies on consumer choice at a time when consumer cost-consciousness and independence are most limited—when care is needed and the urgency of treatment and the anxiety over access to quality care may well greatly outweigh other considerations.

Provider behavior, on the other hand, may be more directly affected in two basic ways by cost-conscious insurance plans. The first way is to continue broad coverage for services from all providers but to subject them to external controls. Controls might be placed directly on services (very much akin to government-spon-

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50. *See, e.g.*, Egdahl & Walsh, *Private Cost Containment: The Art of the Possible?*, 300 NEW ENG. J. MED. 1330 (1979); Havighurst & Hackbarth, *Private Cost Containment*, 300 NEW ENG. J. MED. 1298 (1979).

sored controls for public programs like PSRO or utilization review) or on prices paid (somewhat akin to government rate setting, except that private companies do not enjoy government's coercive power). The second way is to alter provider incentives directly by creating competing groups of providers, from one of which an insurance plan's members would get all of their care. The idea is to create true interprovider competition over prices and styles of care. This change presupposes an end to the consumer's free choice of provider and to the provider's free choice of patient and (insured) treatment method. Thus, both consumers and providers may resist such changes.

In practice, and certainly in the short run, one would expect a mixed system of some sort—featuring some plans covering many providers and imposing external controls, and some covering few providers whose incentives are changed. To help draw lessons for any competitive system in the future, it is instructive to reexamine how competition has functioned under the current system.

IV. Lessons from Current Competition for Future Competition

By no means should one suppose that competitive and economizing forces have disappeared from today's medical care services and insurance markets. The impulse to better one's situation relative to others by acting in one's self-interest is a strong one, and it motivates all actors in our medical economy. The focus and nature of competition in medical care services and insurance is skewed, however, because of the field's special characteristics. How and why the current markets function as they do are important as guides to future policy.

A. *Unproductive Competition*

Desirable competition in the medical services financing and delivery markets is that which results in appropriate economizing based upon cost, quality, and accessibility of services. The goal is efficiency in medical services, not some arbitrary level of spending or a perception that some groups are competing on some basis with other groups. Unfortunately, much current competition is unproductive when measured by this yardstick.

1. Nonprice Competition in Medical Services

Price competition among providers for patients is greatly re-

duced under a system of unconstrained third-party payment. Providers instead compete for insured patients by offering greater access, higher quality care (to the extent that consumers can perceive it), or increased amenities.[51] Competition over these factors usually produces cost-increasing behavior. Indeed, under the current system, consumer-patients may often quite rationally prefer higher-priced physicians, hospitals, and other providers to lower-priced ones. When quality is difficult to assess, price may be taken as a proxy for quality.[52] Consumers may also simply enjoy the conspicuous consumption cachet of patronizing a high-priced rather than a low-priced provider.

The end result is that consumers buy a lot of "flat-of-the-curve" medicine.[53] As more goods and services of any type are purchased, the marginal utility provided by the last unit of each at some point begins to fall, while the cost of producing it tends to rise. It appears that many medical services may be so far along the downward slope of the marginal utility curve that they are not worth what third parties have to pay for them. Exactly how much insured consumers "overspend" is unknown. The assumption that there is a large amount fuels the demand for some change, by regulation or more price-oriented competition, to improve resource allocation.[54]

A good example of flat-of-the-curve medicine is the care de-

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51. It is easy to find extreme examples of amenities, such as "free" color television in hospital rooms. It is of course more difficult to determine whether having a private or semi-private room rather than a bed in a ward contributes to good health (quality) or not (amenity).

52. Rosoff, *Antitrust Laws and the Health Care Industry: New Warriors into an Old Battle*, 23 ST. LOUIS L.J. 446, 476 (1979).

53. The expression is borrowed from Alain Enthoven. *See generally* Enthoven, *Consumer-Choice Health Plan*, 298 NEW ENG. J. MED. 650 (1978). For a longer discussion of the same concept, see Havigburst & Blumstein, *supra* note 23, at 15-20 ("quality/cost no man's land").

54. Obviously, normative statements about "overspending" are not empirically verifiable, and one person's unnecessary amenity may be another's valued service. Large estimates without sound basis often appear. The Massachusetts Medicaid program, for example, is currently attempting to win political support for a radical reshaping of the program that, it is said, would save over 20% of the spending under the current approach. Interview with R. Moran, program director, January 1981. *See also* Boston Globe, Jan. 8, 1981, at 15, col. 2 ("22% Cut Proposed in Medicaid Funds"), Feb. 5, 1981, at 27, col. 1 ("Details Lacking on Mass. Plan to Cut Medicaid"). For an interesting intra-article debate on expected public program savings, see Havighurst & Blumstein, *supra* note 23, at 20 n.45, 60-61 n.207.

This Article argues that much of the current system's bias toward higher spending is desired by premium payers and even taxpayers, and no estimate of savings will be made here. It is worth noting again that the greatest pressure for savings comes from government.

rided by doctors as "defensive medicine."[55] This term refers to diagnostic or therapeutic services aimed at protecting the doctor from a lawsuit, and not at improving the patient's prognosis. Most of these services may be medically unnecessary or at least of low medical value. No one knows how much defensive medicine is practiced, but everyone seems to agree that it occurs and is a problem. Defensive medicine is often cited to argue that lawyers and malpractice law intrude too far into the practice of medicine.[56] Another explanation for the practice of defensive medicine, however, lies in consumer ignorance and the existence of third-party payments, which permit professional priorities to dominate economic considerations. Informed patients or insurers would not pay for such care.

A second type of nonprice competition occurs when hospitals, drug companies, medical laboratories, and other providers compete more for the patronage of doctors—who are relatively indifferent to cost—than for that of patients, who may have economic concerns. The physician, not the patient, is their real customer.[57] Leaving aside kickbacks and side-payments of dubious morality and questionable legality, such competition for doctors is not significantly based on price because the physician does not pay and is poorly motivated—given third-party payment—to be cost-conscious on behalf of patients. Hospitals must fill their beds to stay solvent, and because doctors are the only people who can help them do so, hospitals are well motivated to offer inducements to physicians.[58] Such inducements take the form of offering the highest practicable quality, so that doctors can practice medicine in their preferred professional style. This competition prompts hospitals to acquire the latest technology almost regardless of cost or proven effectiveness. Institutions also generally strive to offer full services, including tertiary, high-technology, and specialist-oriented care, regardless of whether another hospital can provide it better or cheaper. The inefficiencies, wasteful duplication, and

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55. *See, e.g.*, Bovbjerg, *The Medical Malpractice Standard of Care: HMOs and Customary Practice*, 1975 DUKE L.J. 1375, 1397 & nn.71-76.

56. *See id.* at 1397 nn.73-74.

57. *See* V. FUCHS, *supra* note 4, at 56-78 ("The Physician: The Captain of the Team"); text accompanying notes 8-10 *supra*.

58. A glance at publications aimed at hospitals confirms this observation. Consider the following back-cover advertisement: "EMPTY BEDS . . . Hospitals with new medical office buildings have experienced sharp census increases and higher outpatient revenues . . . . We fill empty hospital beds because we find doctors to fill medical office buildings." TRUSTEE, Oct. 1980, at 82.

sometimes low quality that result from this tendency are often lamented and form one of the theoretical hases for supporting health planning as a way to rationalize institutional services.[59]

Whether it is doctors competing for patients or other providers competing for doctors, the lesson is hasically the same. Given the nature of medical care and of the present financing system, what might be called "atomistic" competition among many providers facing ill-informed and cost-indifferent consumers is very likely to be cost-increasing rather than cost-reducing.

2. Unproductive Competition Among Insurance Plans

The group insurance industry is very competitive, featuring comparatively large and knowledgeable buyers (employers and occasionally unions), a large number of sellers (the "Blues" and commercial insurers), and a vast number of available permutations upon the basic third-party payment model.[60] Competition in this industry, however, has not focused on the central cost—that of providing medical care services. Although employers are sensitive to costs and frequently may change plans or insurers to get lower premiums, insurers' cost-cutting historically has been limited to administrative costs. Consequently, automated clainns processing, checking for billing errors, and the like receive a lot of attention, while attempts to influence medical resource allocation, which anger both providers and insured patients, has received very little attention. High priority goes to achieving broad coverage, full access to providers, prompt claims payment, and the like, and insurers sell their plans based on these factors rather than on medical efficiency. Although this method has changed somewhat recently, it remains basically the case.[61]

When asked why they sell so little medical cost containment, insurers often insist that no market exists for medical cost containment. It does seem that employers and group insurance beneficiaries alike care far more about access to care, good coverage, prompt payment, and the like, than they do about controlling pre-

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59. *See, e.g.*, Grosse, *The Need for Health Planning*, in REGULATING HEALTH FACILITIES CONSTRUCTION 27 (C. Havighurst ed. 1974).

60. *See* GROUP HEALTH INSURANCE, *supra* note 15. Medicare and Medicaid are of course not competitive, and their structures are set by government.

61. Blue Cross-Blue Shield plans recently have begun advertising that they save money on medical spending, unlike their commercial plan competitors, which control only administrative costs. *E.g.*, Wall St. J., Dec. 2, 1980, at 17; *id.*, Dec. 10, 1980, at 15; FORTUNE, Nov. 17, 1980, at 32.

mium costs.[62] Stiff resistance to cost containment also comes from provider interests. When insurer price ceilings are implemented, providers typically remain free to collect the balance of their billed fees from patients; this strategy then reduces to one of increased patient cost sharing.

Similarly, creative ways have been found to enable employer groups to administer their medical benefits more cheaply. Administrative services contracts allow large employment groups to self-insure for most of their coverage. Insurers then insure for the riskiest portion of coverage—very high, unexpected bills—and administer the plan for a fee or percentage of the benefits paid. In this way, groups save part of the risk premium that they would otherwise pay and also avoid state taxes on insurance premiums.[63]

One notable exception to the general dynamics of third-party payment is a fundamentally different sort of health plan—the health maintenance organization (HMO). Although it comes in many institutional variations, the key features of an HMO are that it arranges for the delivery of a full range of medical services for a fixed price paid in advance and has agreements with the providers of services to control the delivery of those services through a variety of means.[64] The classic HMO is the prepaid group practice, which controls costs by providing medical services through a "closed panel"—or limited number—of physicians and other providers who typically are paid on a salaried basis. Other models with similar payment incentives but different mechanisms for delivering care also exist.[65]

Unlike most third-party payers, HMOs attempt directly to influence their services' cost, quality, and access, and achieve significant reductions in expensive hospitalization.[66] Such plans first

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62. H. Sapolsky, *et al.*, Corporate Attitudes Toward Health Care Costs (Dec. 1980) (unpublished report to Department of Health and Human Services, National Center for Health Services Research).

63. *Does Industry Actively Pursue Cost Containment?* and *Self-Funding*, EMPLOYMENT BENEFIT PLAN REV., Jan. 1980, at 18 & 19. It is estimated that in 1978, some 18% of commercial insurance company group coverage took the form of such self-funding, up from less than 5% before 1975. SOURCE BOOK, *supra* note 2, at 8. In 1978 commercial insurers had a slightly larger share of the market than did the Blues. *Id.* at 25.

64. *See* INSTITUTE OF MEDICINE, HEALTH MAINTENANCE ORGANIZATIONS: TOWARD A FAIR MARKET TEST (1974).

65. The most prominent is a fee-for-service model with an "open panel"—or large number—of participating doctors who are paid fees for services and subjected te a variety of extrinsic cost and utilization controls. *See, e.g.*, Egdahl, Friedland, Mahler & Walsh, *Fee-for-Service Health Maintenance Organizations*, 241 J.A.M.A. 588 (1979).

66. The most comprehensive review of the literature estimates that HMOs save their

played a significant role in California just after World War II and today have achieved a substantial market share in that state. Yet HMOs have not swept the country, and, even today fewer than five per cent of the population is covered by an HMO.[67] Among the many reasons for this small figure is that cost containment is less important to people than are other goals. Even where they have a significant market share, HMOs seem to compete as much or more in access and quality as price. They strongly emphasize the comprehensiveness of their coverage, the good quality of their care, after-hours service, and so on. Moreover, rather than seeking great increases in enrollment through major price cuts, HMOs typically use their basic cost advantage to provide more extensive services, usually on a first-dollar basis, and thereby attract consumers. Most HMOs seem to offer broader services than comparable third-party coverage plans but only at modest, if any, premium savings.[68]

3. Risk Allocation Versus Medical Resources Allocation

Insurers concentrate considerable competitive zeal upon medical risk allocation rather than risk or cost reduction. Having a competitive edge in identifying and insuring lower-risk populations rather than higher ones seems to be a surer and more attractive way for insurers to make money than attempting to control the medical care costs of the groups that are covered.

Group insurance on a third-party basis began on a large scale with the formation of Blue Cross and Blue Shield plans. These plans initially used a "community rating" methodology—that is, they charged all subscribers the same premium calculated in the

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enrollees about 10-40% in the total cost of health care, counting both premium and out-of-pocket payments—almost all achieved by lesser hospitalization rates. Luft, *How Do Health-Maintenance Organizations Achieve Their "Savings"?*, 298 NEW ENG. J. MED. 1336 (1978).

67. Demkovich, *Cutting Health Care Costs—Why Not Let the Market Decide?*, 11 NAT'L J. 1796, 1797 (1979) (8.3 million in 1979); 13 NAT'L J. at 2140 (1980) (9.1 million as of July 1980).

68. "HMOs are most often in the position of trying to sell more benefits at a higher price when competing with standard insurance plans," according to one analysis generally favorable to HMOs. J. CHRISTIANSON, DO HMOS STIMULATE BENEFICIAL COMPETITION? 17 (Inter Study 1978) (commenting on experience in Minnesota, along with Hawaii the focus of the analysis). Christianson notes the role of government requirements in making HMOs offer such broad benefits. *Id.* Yet very comprehensive coverage and high quality care are fundamental to the HMO ideology. *See, e.g.*, Phelan, Erickson & Fleming, *Group Practice Prepayment: An Approach to Delivering Organized Health Services*, 35 LAW & CONTEMP. PROB. 796, 800-02 (1970). In addition, they are probably very important to the acceptance of HMOs by the general public even to the limited extent that they have been accepted in most markets. It is significant that "cut-rate" competitors have not flourished.

aggregate as adequate to meet anticipated medical expenses and other costs. Commercial insurers then found it fairly easy to identify which groups had lower than average expected medical costs, based upon underwriting predictions. The insurers moved to offer those groups "experience rated" premiums specific to their actual or expected experience that were lower than the community rate. This strategy was more effective than attempting to offer lower rates by controlling medical costs. Subtracting the lower risks from the pool covered by community rating naturally raised the community rate further for those higher risks remaining in the pool. The new, yet higher community rate increased the number of risks who could benefit by experience rating in a continuing cycle. As a result, the entire industry has moved much closer to across-the-board experience rating.[69]

This "cream skimming" of preferred risks also can exist within one employment group when more than one plan is offered to the group members at one time—a comparatively rare phenomenon until recently. If an insurer can attract persons with lower medical risks to its plan, it can offer lower premiums without affecting the efficiency of medical care. The apparent health care savings due to multiple choice and competition among insurance plans may in fact be due only to a realignment of insureds' risks rather than to any efficiency gains. Some suspect that much or all of HMOs' cost advantage may be due to risk selection rather than to improved cost-control efforts.[70] A high-cost-sharing plan, designed to make cost-conscious patients demand greater medical efficiency because they pay with their own money, may actually achieve many of its economies through cream skimming.

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69. R. EILERS, REGULATION OF BLUE CROSS AND BLUE SHIELD PLANS 89-90, 214-20 (1963); S. LAW, BLUE CROSS: WHAT WENT WRONG? 11-12, 29-30 (1976).

70. *See* Luft, Feder, Holahan & Lennox, *Health Maintenance Organizations*, in NATIONAL HEALTH INSURANCE: CONFLICTING GOALS AND POLICY CHOICES, *supra* note 8, at 129, 142-46. *See also* H. Sapolsky, *et al.*, *supra* note 62, at 20-21; *Big Business Questions if HMOs Reduce Cost of Employee Health Benefits*, PSRO LETTER, March 1, 1980, at 5. When insureds have multiple options and open enrollment periods, high-risk people have an incentive to choose a good value like an HMO, which may promise comprehensive care with almost no cost sharing for little or no greater premium than a conventional insurance plan. Despite open enrollment, however, it is possible that location of HMO facilities may enable them to deter high-risk persons disproportionately. Another possibility is that some of HMOs' savings come from attracting people who do not like high-technology or high-surgery-rate care and thus select themselves to be less expensive recipients of care on the basis of HMOs' reputations for discouraging surgery and hospitalization. To the extent that such explanations are true, competition by HMOs does not improve overall medical resource allocation in the sense of providing more care for the same price or the same care for less. It merely rearranges the financial burden.

High-cost-sharing meant to promote efficiency also sends signals to relatively low-risk, high-income people that they will save money by joining. Any savings actually achieved by cost-sharing thus may well be partly attributable to reallocations of risk, not to increased efficiency. Individual enrollees may be able to predict their likely risk—*i.e.*, their need for medical insurance—far better than any insurance underwriter. Indeed, especially if a plan's coverage is broad, consumers can control the timing of many covered medical services, such as some types of elective surgery, normal childbirth, and others. This type of "moral hazard" allows some people the possibility of enrolling in a low-premium, high-cost-sharing plan in one year and thus contributes to cream skimming. These individuals may then switch to a high-premium plan only in a year when they expect high medical bills. Such "adverse selection" is a chronic problem for insurers that allow individual options.

Rewarding lower-risk enrollees with lower premiums and penalizing higher-risk ones with higher insurance costs may or may not be appropriate, depending upon one's philosophy.[71] In any case, it is less obviously attractive than saving everyone money by improving medical efficiency.

B. *Difficulties in Shifting to Productive Competition*

Truly productive competition focusing on medical efficiency cannot be expected to arrive quickly, even with the adoption of competitive government policies. The first major reason is that cream skimming, as just discussed, may prove to be more rewarding, at least in the short run, than driving hard bargains with

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71. The basic question is whether high-risk individuals should pay higher insurance premiums out of their own pockets, or whether they should be subsidized, either through private risk pooling (as in the group insurance market) or through government subsidy of some kind. Alain Enthoven's Consumer-Choice Health Plan is one of the few competitive proposals to address this issue squarely. *See* A. ENTHOVEN, HEALTH PLAN: THE ONLY PRACTICAL SOLUTION TO THE SOARING COST OF MEDICAL CARE (1980).

Whether higher-risk persons should pay higher premiums is a matter of philosophy, but one's attitude may be influenced by one's rough sense of the extent to which risk factors are within the control of insureds. Higher premiums might promote healthy changes in behavior—if insurers are able to isolate them, economically establish differential premiums, and avoid moral hazard. Unfortunately, only sketchy evidence exists about such matters of health and risk. To the extent that lower premiums reward greater economy in the use of medical resources rather than lower inherent risk, there is probably greater agreement on their appropriateness. Unfortunately, it is difficult to distinguish whether low utilization is due to low risk or high efficiency.

providers and otherwise directly attacking medical inefficiency.[72] The second major reason is that current patterns of financing and delivery may be more deeply entrenched than is often acknowledged by competition advocates. To change consumer and provider behavior may require stronger action and more time than is often predicted. The starting point for analysis is to note again how the existing competitive insurance market differs from the policy goal of competition to improve medical efficiency. The real questions are why more insurer and employee group cost-reducing initiatives have not already evolved, why it should be necessary to create them through federal legislation, and whether the proposed legislative changes are sufficient to achieve the goal being sought. These inquiries are necessarily speculative, since no systematic study has been done of the current insurance system and tax incentives. Nonetheless, many instructive inferences can be drawn.

1. The Tax Subsidy

Many of the features of current third-party payment plans are very strongly entrenched and presumably will change only very slowly. The insistence upon broad coverage, including nearly first-dollar coverage, with low cost-sharing, free choice of provider, cost-based reimbursement, and few cost controls has been very strong. That people have not been quick to take cost-saving initiatives cannot be blamed entirely upon the tax subsidy.[73] The subsidy today means that the typical person or group choosing a plan is spending, for example, seventy-cent dollars. In other words, any reduction in benefits saves only seventy cents for each one dollar of benefit foregone. Despite this initial observation, it must be realized that a dollar's reduction does nonetheless save seventy cents. Thus, the incentive to save money is there; it is just weakened. Yet

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72. *See id.* at 78-82. The Enthoven plan would establish different risk categories for tax subsidization purposes. To the extent that this plan is practicable, its success would ameliorate the cream skimming problem. Making it work requires considerable increases in administrative complexity and in government "regulation" of insurance practices.

73. *See* notes 47 & 49 *supra* and accompanying text. The tax subsidy is the double exclusion of health insurance premiums from taxation. Employer contributions are both deductible as business expenses in computing the employer's taxes and not included as income to the heneficiaries on whose behalf the contributions are made. *See generally* Vogel, *The Tax Treatment of Health Insurance Premiums as a Cause of Overinsurance*, in NATIONAL HEALTH INSURANCE: WHAT NOW, WHAT LATER, WHAT NEVER?, *supra* note 2, at 220. Its existence is often cited to explain why private insureds buy first-dollar coverage. *See, e.g.*, Pauly, *National Health Insurance: Government Regulation or Consumer Choice?*, AM. C. SURGEONS BULL., May 1980, at 14, 17.

cost-saving initiatives are not very popular, and the big growth area in health insurance is expanding coverage (such as the very rapid growth of dental plans) and not containing costs. In particular, the trend has been to reduce cost-sharing, especially at higher levels of spending. Presumably, people feel that cost-sharing saves less money in insured spending than the tax subsidy provides.

Similarly, the subsidy causes people to want to buy more coverage. In deciding how to spend tax-subsidized dollars in designing a health package, however, it does not seem logical that the decision to start with shallow rather than catastrophic coverage, for example, is influenced by whether the purchaser is spending seventy-cent or one-hundred-cent dollars. Additional evidence of the strength of nontax factors is that over half of Medicare eligibles spend after-tax dollars to buy supplementary coverage that usually fills in Medicare's deductibles and coinsurance.[74] People seem to prefer shallow coverage for reasons other than the tax subsidy—reasons that proposals to increase competition may need to identify and change. A similar case can be made with respect to other cost-enhancing preferences such as free choice of provider.

2. Consumer Preference for High-Cost Care

It is possible to argue that provider preferences, the accidents of historical development, or other factors have contributed to the present situation.[75] One should take very seriously, however, the simple hypothesis that current plans do not focus on medical cost control because no one really wants them to. As patients, as (subsidized) premium-payers, but also even as taxpayers, consumers desire freedom from cost controls in order to avoid facing hard allocative decisions. For example, consumers might save money and receive more efficient care if they belonged to a plan that required certain well-designed cost sharing and that avoided the cream skimming/adverse selection problem. Yet because the savings might well be achieved only at considerable psychic cost—having to confront very hard choices about foregoing care—consumers prefer to pay more, both as individuals and through social choices.

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74. *See, e.g.*, HOUSE SELECT COMM. ON AGING, 95TH CONG., 2D SESS., ABUSES IN THE SALE OF HEALTH INSURANCE TO THE ELDERLY IN SUPPLEMENTATION OF MEDICARE: A NATIONAL SCANDAL (Comm. Print 1978). It must be conceded that the shallow nature of Medicare Supplement insurance is partly due to regulatory requirements; but these requirements are considerably influenced by insurance industry interests and perceived consumer preferences.

75. *See, e.g.*, Goldberg & Greenberg, *The Effect of Physician-Controlled Health Insurance:* U.S. v. Oregon State Medical Society, 2 J. HEALTH POL., POL'Y & L. 48 (1977).

Examining the HMO experience also raises some doubts about how quickly a cost-conscious third-party payment regime can be created. Again, one is left with the impression that people want high-quality, expensive coverage more than many commentators may realize. HMOs enjoy a considerable cost advantage over insured fee-for-service practice because of significantly reduced hospitalization. Yet they compete in great measure by providing more comprehensive coverage (and lower cost sharing) rather than a lower premium.[76] Significantly, there seem to be no "neo-HMOs" offering lower hospitalization and more limited other services, at a great savings in premiums. Of course, premium savings provide relatively lower benefits than savings on cost sharing because of the tax subsidy.

3. Resistance to Multiple Plan Options

In addition to capping the tax subsidy, another competitive change is to require employers to offer multiple plan options to employees. Each individual with after-tax dollars at stake can then seek to choose the level of economizing that he wants in a plan. One must wonder, however, why, if it makes economic sense to require such options at all, the current health insurance market has not adopted this approach. As a concomitant, it is often proposed that employers who do offer multiple plans should make the same contribution to each, so that employees choosing a cheaper plan will receive the full benefit of their economizing. Again, it is not clear why employment groups do not do so now. One possibility is that they paternalistically prefer that employees undertake higher medical spending and thus give a higher payment to those choosing more expensive plans. This explanation is not appealing. Another is that large unions, whose health plans have a considerable pace-setting influence, prefer to take compensation in benefits rather than additional take-home pay. One important reason that multiple-choice options may not be popular as cost-cutting mechanisms is that it is difficult to tell whether they actually do cut costs. When a plan saves money and can offer lower premiums by seeking out and insuring generally lower-risk enrollees, it simply rearranges the total spending of the entire group because the remaining higher-risk enrollees must pay more. A group may quite rationally prefer to have no option at all than to have one that encourages such cream skimming.

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76. *See* note 68 *supra* and accompanying text.

When a plan saves money by excluding certain services or by imposing high-cost-sharing on some or all services, enrollees will segregate themselves by their perception of their risk. The result is "cream skimming" for plans that draw low risks and "adverse selection" against plans attracting high risks. It is possible for plans to protect to some degree against adverse selection—for example, by imposing waiting times on certain benefits and thoroughly investigating claims. Insurers who sell in the individual market, where the problem is much worse because of the greater incentives to self-select, do use such methods, but they are expensive. Because of this and other reasons, individual insurance plans generally offer much less coverage at greater cost than group insurance.

A similar phenomenon involves the premium-rating changes that an insurer (or several insurers) must make if a group moves from single coverage for a large group to a set of competing coverages each for a smaller number of people. Altbough the aggregate risk of illness or accident does not change, the risk as perceived by each of the smaller insurers is larger than its pro rata share of the total. This effect is independent of changes in coverage that may induce greater demand for medical care. The law of large numbers makes the predictability of claims greater for a large group than for smaller subgroups; insurers refer to tbe "credibility" of a group's experience being greater.[77] Because of this fact and the likelihood of adverse selection, insurers must get a higher "risk premium" to insure a smaller group. This factor is especially important to a small employment group today and would remain important under a more competitive system unless legal changes ended the employment basis of insurance purchase or altered allowable pooling and rating practices.

4. The Incremental Nature of Change

Another reason to believe that current insurance arrangements will be slow to change is the incremental nature of the proposed change in tax incentives. The tax subsidy would not be terminated under existing proposals, but merely capped and made to grow more slowly. This change in incentives, in the short run at least, would have the greatest impact at the margin; that is, the cap could be expected to halt the trend of bringing ever more services under the health insurance umbrella to be bought with pre-tax dol-

77. *E.g.*, D. MACINTYRE, VOLUNTARY HEALTH INSURANCE AND RATE MAKING 30-33, 78-81 (1962).

lars. Such items as dental care, mental health and alcoholism coverage, and coverage for chiropractors, nurse practitioners, and the like have been added as discrete packages onto the more traditional acute care services. Plans already at the tax subsidy limit presumably would stop adding such services unless the addition itself would cause offsetting economies in the use of other services. Altering the basic structure and operation of the more traditional coverage, however, which at first would presumably still be affordable under the tax subsidy cap, would be likely to occur far more slowly.

5. Provider Resistance to Private Efforts

Finally, it is worth noting that providers are likely to resist private cost containment, just as they resist public restrictions. Many controls might apply to third-party payment plans that offered a relatively free choice of provider. Attempts to require prior authorization for care or to otherwise limit medical practice are likely to arouse the most opposition. Changes in coverage, leaving a greater share of a provider's bill to be paid on a first-party basis, will be less unpopular. In any case, it likely will take time for many restraints to become effective; insurers will find it difficult to implement restraints piecemeal when providers have the option of receiving more unquestioned payment from other sources.

A major premise of many competitive proposals is that providers will align themselves into competing systems of care, so that true inter-provider-group competition on price and styles of care could occur. This is an important reason for the appeal of the earlier HMO strategy and is a major component of, for example, Alain Enthoven's carefully thought-out scheme.[78] In the past, however, physicians and hospitals have not been eager to affiliate with competing systems. The open question, again, is how much difference would be made by the change in incremental consumer demand because of the capping of the tax subsidy. Indeed, perhaps the greatest incentive for a fundamental realignment of providers is not a result of any overtly competitive policy at all—namely, the apparent current oversupply of hospital beds and the impending "surplus" of physicians.[79]

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78. *See generally* A. ENTHOVEN, *supra* note 71.

79. *See generally* INSTITUTE OF MEDICINE, CONTROLLING THE SUPPLY OF HOSPITAL BEDS (1976); OFFICE OF TECHNOLOGY ASSESSMENT, FORECASTS OF PHYSICIAN SUPPLY AND REQUIREMENTS (1980).

For all of these reasons, it seems likely that the transition from the current low cost-consciousness to an efficient, fully competitive regime could take considerable time.[80] Indeed, it may never happen as envisaged if consumer and political preferences continue to militate against efficient medical resource allocation.

V. Policy Implications

A. *Insights for the Competitive Approach*

There is general agreement that medical care should be provided more efficiently. Achieving this goal requires careful attention to how provider and consumer controls or incentives are structured—whether through regulation or competition. This Article argues that two key considerations must be kept in mind when discussing competitive strategies. First, it must be understood clearly that the goal is true systems competition based on medical efficiency. One should not mistake this objective for those laissez-faire policies or unproductive competition that actually raise costs or simply rearrange them through cream skimming and adverse selection. Second, the magnitude of the task should not be underestimated, particularly with respect to public beneficiaries. Real competition will come slowly, with considerable resistance from established interests—both provider and consumer—and traditional patterns of operation in the health care sector. Many aspects of our current financing and delivery system are apt to continue unchanged, most notably the basic pattern of third-party payment itself. These general insights lead to a number of more specific observations about future changes. Although it is difficult to predict just how various procompetitive plans actually would alter medical services delivery in practice, it is useful to examine each of the alternatives and to consider its possible influence.

1. Government Regulation

Considerable "regulation," or at least government action, is required to create systems competition. This realization is hardly surprising, given the extent of past government action and the extent to which this nation has chosen—through both public and private mechanisms—to move away from reliance on an atomistic

80. One realistic assessment is that "it would take a decade or more before half of the population was cared for by some kind of alternative financing and delivery system." A. Enthoven, *supra* note 71, at xxiv.

"free market" of completely autonomous individual buyers and sellers. Innumerable subtle and not-so-subtle incentives have been created in the effort to achieve the entirely appropriate social goals of risk spreading and caring for the needy. Changing the current climate to reintroduce more effective cost-controlling incentives will require more government action, whether it be pro-competitive regulation or more traditional government regulation.

On the level of consumer purchases of insurance plans, for example, restructuring the tax incentives, standardizing minimum benefits packages, and requiring multiple choice of plan and open enrollment periods all call for social choices through government. Guarding against cream skimming and adverse selection is another problem that may well call for government action, especially if integration of the currently uninsured into the group insurance plan market is attempted. On the supply side, encouraging the development of competing groups of providers and preventing existing providers from unfairly resisting attempts to impose cost discipline are important objectives of government action. It has been suggested that vigorous antitrust action should help prevent providers from acting in concert to resist cost control.[81] While this effort may not be classic economic regulation, providers would certainly perceive it as a new governmental intrusion. Moreover, antitrust by its nature fails to provide positive incentives to providers—for example, to reorganize into competing groups.

While the need for government action may seem obvious, it is also often overlooked. In particular, it appears that considerable current support for the general notion of "competition" is based less on a procompetition ideology than on antigovernment sentiment. Some people want government simply to stop interfering—whether by imposing governmental controls or by encouraging private controls—with the third-party payment system that has proved so lucrative for providers.[82]

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81. *See* Havighurst, *Controlling Health Care Costs: Strengthening the Private Sector's Hand, supra* note 24; Havighurst, *Professional Restraints on Innovation in Health Care Financing,* 1978 DUKE L.J. 303; Havighurst & Hackbarth, *supra* note 50. *See also* Havighurst, *Competition in Health Services: Overview, Issues and Answers, supra* note 46; Leibenluft & Pollard, *Antitrust Scrutiny of the Health Professions: Developing a Framework for Assessing Private Restraints,* 34 VAND. L. REV. 927 (1981).

82. For example, current federal policy encourages the purchase of "generic" drugs rather than more expensive brand-name equivalents. This policy is effectuated for government program beneficiaries by limiting the program payment to the cost of the generic equivalent and by issuing a booklet explaining equivalence to beneficiaries. While there are technical difficulties in determining equivalence, this policy is essentially straightforward

Under one "procompetitive" bill, for example, Medicare itself and a new federal plan covering catastrophic expenses otherwise uncovered by third parties would have to pay "reasonable costs" to hospitals and "usual, customary, and reasonable" fees to physicians.[83] Perpetuating these mechanisms, particularly for the very large share of hospital care that would be involved, is hardly likely to realign medical services delivery or to save money.

2. Government Program Costs

To the extent that separate government programs continue for people unable to buy private insurance, the need to control program costs will continue. On this problem, public and private plans can undoubtedly learn from one another. A good deal of the cost problem under unconstrained third-party payment results from an uncertainty about how best to alter the delivery system in order to save money. It is notable, however, that already some government regulatory initiatives have been modeled on private plan cost control measures. The PSRO program, for example, which was greatly opposed by organized medicine, actually had its basis in initiatives taken by medical societies.[84] Conversely, private plans may be able to benefit from adapting some notions currently most salient in the public sector. Different hospital payment methods from the almost universal per-service, cost-related reimbursement method may well be useful to private as well as public plans. Thus, by adopting each other's best ideas, the public and private sectors could work together to hold down program costs.

In addition, it is important to remember that rules addressing what care is considered necessary, what length of stay in a hospital is allowable for a given type of case, how providers are paid, and the like are standard provisions that are essential to the operation of any health plan, even if for public plans they are set by govern-

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and pro-consumer-choice. Yet it is far from universally accepted among those who purport to favor deregulation and procompetitive proposals. *See, e.g.*, Demkovich, *Reagan's Cure for Health Care Ills—Keep the Government's Hands Off*, 12 NAT'L J. 2124, 2127 (1980). Everyone favors cost containment—except when his favorite ox is being gored.

83. The Medical Expense Protection Act, H.R. 6405, 96th Cong., 2d Sess. § 2111 (1980).

84. For the derivation of the PSRO program from the American Medical Association (AMA) national health insurance proposal, see SENATE COMM. ON FINANCE, 93D CONG., 2D SESS., BACKGROUND MATERIAL RELATING TO PSROS (Comm. Print 1974). PSRO review is based on the style of review used by fee-for-service HMOs discussed in Egdahl, Friedland, Mahler & Walsh, *supra* note 65. For the AMA's current view of the program, see *Delegates Vote to Seek Elimination of PSRO*, AM. MED. NEWS, Dec. 19, 1980, at 1, col. 2.

ment "regulations." This sort of cost control clearly should be maintained until a fully competitive regime is established and government beneficiaries can be integrated into a system of competing health plans.

3. Systems Competition

The proper goal of the competitive strategy is "systems" competition among competing plans, not "atomistic" competition among individual providers facing individual insured consumers. Past experience has shown that, given the opportunity, individual providers compete only too vigorously—and in cost-increasing ways. Consumer incentives, including those of large group insurers acting on behalf of consumers, must be realigned to place far more emphasis on cost control before an effort is launched to make providers more competitive through antitrust or other means. Most competitive proposals recognize this prerequisite and would indeed begin by restructuring the insurance market. As argued above, however, these changes in the market for medical services will come slowly, and thus there is reason to be cautious.

Private cost consciousness must truly be ready to supplant public controls before the controls are abandoned entirely. Consequently, a number of public controls—like state hospital rate setting which operates as real competition should by constructively altering hospitals' treatment incentives—should be retained in the interim.[85] Moreover, even less meritorious types of regulation should be reviewed carefully before they are summarily jettisoned. For example, since there is little evidence that the current approach to health planning has actually reduced institutional investment or saved third parties money, it is a prime candidate for repeal or drastic alteration under competitive approaches. Such steps would be unwise, however, until hospitals and other institutions clearly understand that their future prosperity depends on their satisfying more cost-conscious third parties rather than on receiving cost-based reimbursement. Ending even such a questionable restraint as the current planning system could send the wrong signal to providers if it is done before other changes have clearly altered provider incentives and expectations.

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85. New Jersey's experiment with "DRG" rate setting is one such incentives-based approach. *See* NATIONAL CONFERENCE OF STATE LEGISLATURES, *supra* note 41.

4. Flexible Government Policies

Antitrust and other procompetitive policies need to be flexible. What approach will most appropriately reaffirm the need for cost-consciousness in medical decisionmaking will vary according to how systems competition operates in practice. If the marketplace is reorganized into small groups of providers, each competing with the others to give enrollees comprehensive health care, and cream skimming/adverse selection does not prove an insurmountable problem, consumers' informed choices of plan will translate directly into an appropriate incentive for the plans' providers to conserve resources. This is essentially the strategy adopted by HMO proponents. On the other hand, if many or most consumers continue to participate in plans that are run more like today's insurance plans, with free choice of provider, stiff controls extrinsic to each provider's internal economic incentives will be necessary. Under these circumstances, providers' resistance to change can be expected to be more severe and more successful, because they will be able to play one plan off against another. Consequently, prevention of such behavior increases in importance, and antitrust enforcement should play a greater role. Indeed, if one believes that the market for medical care services must be realigned into competing systems of providers in order for economizing pressure in the insurance market to be translated into efficiencies in the delivery of services, one should consider incentives more positive than antitrust enforcement to encourage such realignments.

Those seeking to improve future competition among providers through antitrust must obviously set policy and attempt to influence judicial doctrine according to how the marketplace is functioning at the time. In practice, this flexibility may mean following a "Rule of Reason" approach in order to carefully analyze the effects of given trade restraints.[86] In particular, it is important to keep in mind that the goal is systems competition, not atomistic competition. Antitrust policy and doctrine should recognize that many restraints on individual freedom that may be inappropriate under atomistic competition are entirely appropriate for competition among competing health care systems.

Some plan requirements may at first blush seem anticompetitive. Limits on fees may appear to be price fixing and, when enforced by refusals to deal with noncomplying providers, may result

86. *Cf.* Leibenluft & Pollard, *supra* note 81.

in antitrust suits. The facts as described by the United States Supreme Court in *Group Life & Health Insurance Co. v. Royal Drug Co.*,[87] for example, show entirely appropriate behavior for a competitive insurer. The "Blues" plan in *Royal Drug* limited the amount that it would pay to participating druggists and then essentially penalized subscribers using nonparticipating druggists. The druggists charged price fixing and a boycott but lost in the lower courts on the ground that suit was barred by the McCarran-Ferguson Act.[88] The Supreme Court, reversing on the McCarran ground, expressly noted that it was not deciding the merits of the case.[89] Nonetheless, the case may have a chilling effect on other insurer controls. In this context, it is encouraging that in a footnote the Court cited a government brief arguing that although the "Blues'" practice might be subject to antitrust scrutiny, on the merits it was perfectly legal.[90]

In most contexts, price fixing by a third party to a commercial transaction is considered unwise or illegal price maintenance. The now discredited "Fair Trade Laws" are a good example. Under these laws, prices set by a manufacturer artificially inflated retail prices.[91] In health care, however, third-party payment and provider dominance present a different problem. Under proper systems competition the insurer can be viewed as a vital party to the retail transaction, needed to supply otherwise-absent price consciousness. Insurers ideally should act and be seen as acting almost as the agents of premium-payers and future patients in preserving the plans' funds for the highest-valued uses.[92]

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87. 440 U.S. 205 (1979). *See generally* Note, *Insurance Provider Agreements Subject to Antitrust Scrutiny*, 17 HOUS. L. REV. 643 (1981).

88. 440 U.S. at 207-08.

89. *Id.* at 210.

90. *Id.* at 210 n.5. The Blue Shield plan in Massachusetts has been sued in several interrelated actions for limiting the fees of its participating physicians, not allowing them to balance bill their patients for more, and not paying nonparticipants at all. Thus far, the plan has been upheld, essentially on the state action ground that the insurance laws and the insurance commissioner have required or overseen the various aspects of the cost controls. *See* Kartell v. Blue Shield, Inc., 592 F.2d 1191 (1st Cir. 1979) (federal antitrust suit); Nelson v. Blue Shield, Inc., 79 Mass. Adv. Sh. 953, 387 N.E.2d 589 (1979) (Mass. state action).

91. *See* 2 E. KINTNER, FEDERAL ANTITRUST LAW §§ 10.15-.16 (1980).

92. As a matter of antitrust doctrine, this result probably could be achieved hy applying the Rule of Reason, rather than a per se analysis, or by use of the doctrine of ancillary restraints. For a different perspective on the proper antitrust role in health care, see Leibenluft & Pollard, *supra* note 81.

5. Realistic Expectations

Since the transition to true systems competition is likely to be long and difficult, one should not expect too much too soon. Old habits—and interests—die hard, and overly high expectations could cripple a reasonable incentives-based strategy if it did not produce results quickly enough. In attempting to move to a competitive ideal, reasonable "half-way houses" should not be rejected simply because they are not ideal. Letting long-range perfection be the enemy of immediate good is a short-sighted policy. For example, one result of existing health plan competition has been the appearance of fee-for-service, physician-run HMOs, often called Individual Practice Associations because they provide for physician services through associations of doctors known as "IPAs."[93] While on theoretical grounds it is proper to be concerned about any large group of sellers controlling the prices and terms of purchase of their services, what is objectionable here is that local physicians might use such a plan to lock all or almost all local physicians into the IPA alternative. Such a tactic could easily block still better developments that would be more adverse to physician interests. Yet because IPAs considerably improve physician incentives over the current system of fee-for-service under unconstrained third-party payment and appear able to reduce spending below current levels, it seems desirable to allow their existence, at least pending better long-range developments.[94]

6. Lingering Features

Relatively unconstrained third-party payment with free choice of provider and service benefits may long maintain a significant market share. This approach is extremely popular with providers and consumers alike. To the extent that such plans persist, the problems of the present system will likewise endure, although perhaps in a less pervasive form.[95] It may thus be appropriate to seek

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93. IPAs are so called because of the use of this term in the federal HMO Act to describe groups of fee-for-service physicians through which fee-for-service HMOs would provide medical services. *See* Egdahl, Friedland, Mahler & Walsh, *supra* note 65.

94. A major issue is whether the antitrust laws do or should bar professionally run HMOs like IPAs. *See generally* Havighurst, *supra* note 24. The FTC is presently considering whether and under what circumstances physician control of medical prepayment plans, including Blue Shield and IPAs, may be anticompetitive. 45 Fed. Reg. 17,019 (1980). If the IPA-style plan is considered a significant stumbling block on the road to a more competitive system of provider groups, the tax subsidy laws could be changed to incorporate a requirement that eligible insurance or other medical services plans not be of the undesired type.

95. The problems would persist in the sense that inappropriate consumer-patient and

system-wide controls of some types—particularly on payment rates and appropriateness of care—either by private plans acting in concert or by government action, particularly if government beneficiaries are still covered by relatively unconstrained third-party payment.[96] For example, commercial health insurers today have been reluctant to initiate ceilings on physician fees or hospital charges because each fears that affected providers or even all providers would then refuse to deal with its insureds. Insurers believe that such controls are only feasible if most or all insurers agree to impose them at once, but they reject such joint action because of likely antitrust liability. Interestingly, in Connecticut, home of many major commercial health insurers, which dominate the market there, the insurance industry has been the major supporter of the state-run hospital rate-setting program.[97]

Under a more competitive regime than presently exists, with consumers lacking an open-ended tax subsidy to help pay high provider prices, cost-containment initiatives would have a better chance for success. Nonetheless, it is still worth considering whether to allow concerted action by consumers through their health plans to counter entrenched resistance. If, in the development of a more competitive system, a number of third-party, free-choice-of-provider plans share a market with smaller closed panels of providers, it does not seem inappropriate for the free-choice-of-provider groups to be able to take a joint approach to restructuring payment in their subsector of the health services market. Such joint setting of fees and rates would be somewhat troublesome, but

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provider incentives would continue. Pressure for reform might therefore also continue. To the extent that the resulting costs were "privatized," that is, kept within the particular groups of individuals with relatively unconstrained third-party payment, government might be able to ignore it. To the extent, however, that the problem was one of risk allocation and that a result was increased pressure on government provision of care of last resort and on government programs, it might be less possible to ignore it.

96. Some may contend that, beyond initial procompetitive changes, government should not intervene further. One philosophy of political economy would hold that if truly competitive alternative systems do not develop once tax incentives and other inhibiting factors are altered, then people must not want them. Thus, in this view, there would be no further role for government to play; and, indeed, at least government's tax losses would be limited. It seems appropriate, however, to recognize that people could rationally prefer to make choices through social mechanisms when relatively unfettered individual choices do not achieve policy goals for which there is a political consensus. Moreover, tax subsidies and other market intervention (such as licensing to promote quality) would remain. Thus, government could properly consider different interventions into medical services financing and delivery, even while in some sense preferring a fully competitive system.

97. Interview with Bernard Forand, Executive Director of the Connecticut Commission on Hospitals and Health Care, in Hartford, Connecticut (Apr. 9, 1980).

it is far less troublesome than a system of fee setting directly by provider groups that tends to raise rates. The worst thing that could happen with such a shared rate-setting approach would be a decrease in the supply of medical services below what consumers want because prices might be too low to prompt providers to render enough services. In such an eventuality, consumers would surely bid up the price to restore services. An easier case would be joint agreement on the type of payment to be made; one example might be to move to a per-case payment instead of cost-reimbursement for services.

B. Making a Transition to Competition

The picture that this Article envisions is not a rosy one of inefficient regulation quickly and painlessly being supplanted by smoothly operating market forces. Rather, it seems likely that regulatory and competitive forces will coexist at least during some rather lengthy transitional period even if a fully procompetitive strategy is enthusiastically embraced by all levels of government. Indeed, it may well be that the transition will last forever. There is reason to believe, as already discussed, that many cost-enhancing features of the current financing and delivery system are strongly desired and will not be altered by procompetitive changes so as to create strong alternative forms of delivery.

The competitive ideal, like the regulatory ideal, thus in practice may be either unattainable or at least long delayed. Consequently, a final caution is that in coping with a mixed system, whether during a transitional period or in the longer run, unproductive combinations should be prevented. Commentators favoring competition have long focused on how regulatory approaches may cripple market-oriented strategy.[98] Equally, some conceptions of competitive strategies may hamper legitimate government objectives. Coordination of strategies is therefore important. One potential conflict exists between current health planning's efforts to limit institutional expansion and antitrust policies in favor of facilities' freedom to expand in pursuit of competitive advantage.[99] Another conflict is the tension between allowing free competition

98. *See, e.g.*, INSTITUTE OF MEDICINE, *supra* note 64. *See also* Egdahl, Friedland, Mahler & Walsh, *supra* note 65; Rosoff, *supra* note 52, at 479-80.

99. *See* National Gerimedical Hosp. v. Blue Cross, 628 F.2d 1050 (8th Cir. 1980), *cert. granted*, 101 S. Ct. 938 (1981); Business Review Letter, U.S. Dep't of Justice, Antitrust Division, May 6, 1980 (case of Central Virginia Health Systems Agency); *id.*, Aug. 27, 1980 (case of Westlake Health Campus).

among insurers and avoiding unproductive cream skimming, particularly in the difficult merging of public beneficiaries into private plans. Following a competitive policy in this sphere with the left hand while trying to pursue an avowedly nonmarket strategy with the right hand may prevent both policies from succeeding. Economists are familiar with this truism as "the problem of second best": when not all conditions for reaching the optimum competitive equilibrium are met, attempting to reach just one of them will not necessarily bring the system closer to the optimum.[100] Common sense indicates that an uneasy marriage of incompatible strategies can easily lead to the worst of both worlds instead of the best.

VI. CONCLUSION

Moving to a truly price-competitive health care financing and delivery system that also achieves other important goals will be neither easy nor quick. Significant governmental and other concerted action will probably be necessary to promote competition that actually focuses on more effective and efficient delivery of medical services rather than on unproductive cream skimming and nonprice competition. Ending the current tax subsidy for the purchase of insurance will certainly not be enough, nor is it realistic to seek a complete return to first-party incentives to promote cost control and efficiency. What we need is a judicious mix of government and private action; "regulation" and "competition" must learn to coexist without hampering each other. The most important goal is to reintroduce cost-containing incentives into provider behavior, whether through regulatory or competitive means, and the present may be a particularly auspicious time for such an undertaking. Pressures for cost control within the public sector at all levels are extremely high. Moreover, by all accounts, a more-than-adequate supply of both physicians and hospitals exists. Provider resistance may thus be less than might otherwise be the case.

100. *See, e.g.*, J. HENDERSON & R. QUANDT, MICROECONOMIC THEORY: A MATHEMATICAL APPROACH 286 (1971).