Recent efforts to rationalize health care are now facing a political backlash.

The Competitive Revolution

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In the last 25 years, U.S. health care and health policy have evolved in surprising and fascinating ways. The main surprise was the competitive revolution in health care markets, stimulated by subtle, unrelated policy changes and the rapid growth of managed care. The grand health care reform plans, such as the health planning initiatives of the 1960s and the Clinton administration's attempt at national health insurance, turned out to be surprising failures.

The grand reform plans were motivated partly by a belief that people consume so much medical care that a significant fraction has no real benefit. From that perspective, substantial reductions in health care could enhance efficiency, even if done in a fairly crude way. But there is increasing evidence that recent technological progress, especially for pharmaceuticals, has cost-effectively increased life expectancy. Even though the United States spends a lot on health care, spending more may not be nearly so inefficient as was once thought.

The last five years have not only been characterized by a large increase in expenditures on pharmaceuticals but also growing state regulation of health insurance, particularly managed care. That is part of a general backlash, supported by organized medicine, many politicians, and the news media, against the competitive revolution. Future developments may include expanded federal regulation (the "Patient's Bill of Rights") and physician collusion.

IN THE BEGINNING

U.S. health care has always been heavily regulated, especially since the rise of organized medicine in the early twentieth century. By the 1930s, organized medicine had effective control of physician supply. Further, it was able to restrain competition and discourage innovative, pro-competitive health plans.

Early in the twentieth century, regulation of health care was not so important because health care was not terribly effective. Indeed, some medical historians believe that medical care was, on balance, harmful to health until about 1910. In any case, care was inexpensive and insurance was rare.

Tax subsidies and technology That changed with World War II, which brought high income taxes and wage controls. Employers added health insurance to evade the wage controls. Adding further impetus, in 1943 the IRS held that employer-provided health insurance premiums were nontaxable. The enormous tax subsidy of health insurance caused it to soar in popularity. The tax subsidy continues today as a major cause of high health care costs and inefficiency.

Over the same time period, medical care has become more productive, with the introduction of penicillin in 1939, followed by the streptomycin family of antibiotics. Technical progress has continued and accelerated in recent years.

As a result of the tax subsidy, insurance, and technical progress, spending on health care grew rapidly until the early 1990s. However, from 1993 through 1999, health care spending remained almost constant — at about 13 percent of GDP. Rapid growth of managed care, leading to what I call the competitive revolution, is widely credited with that pause.

Hospital planning The first major initiative of the postwar period was the 1966 introduction of public health insurance — Medicare and Medicaid. Naturally, the programs increased health care spending. At about the same time, the tradition of local hospital planning and regulation reached its zenith. A few

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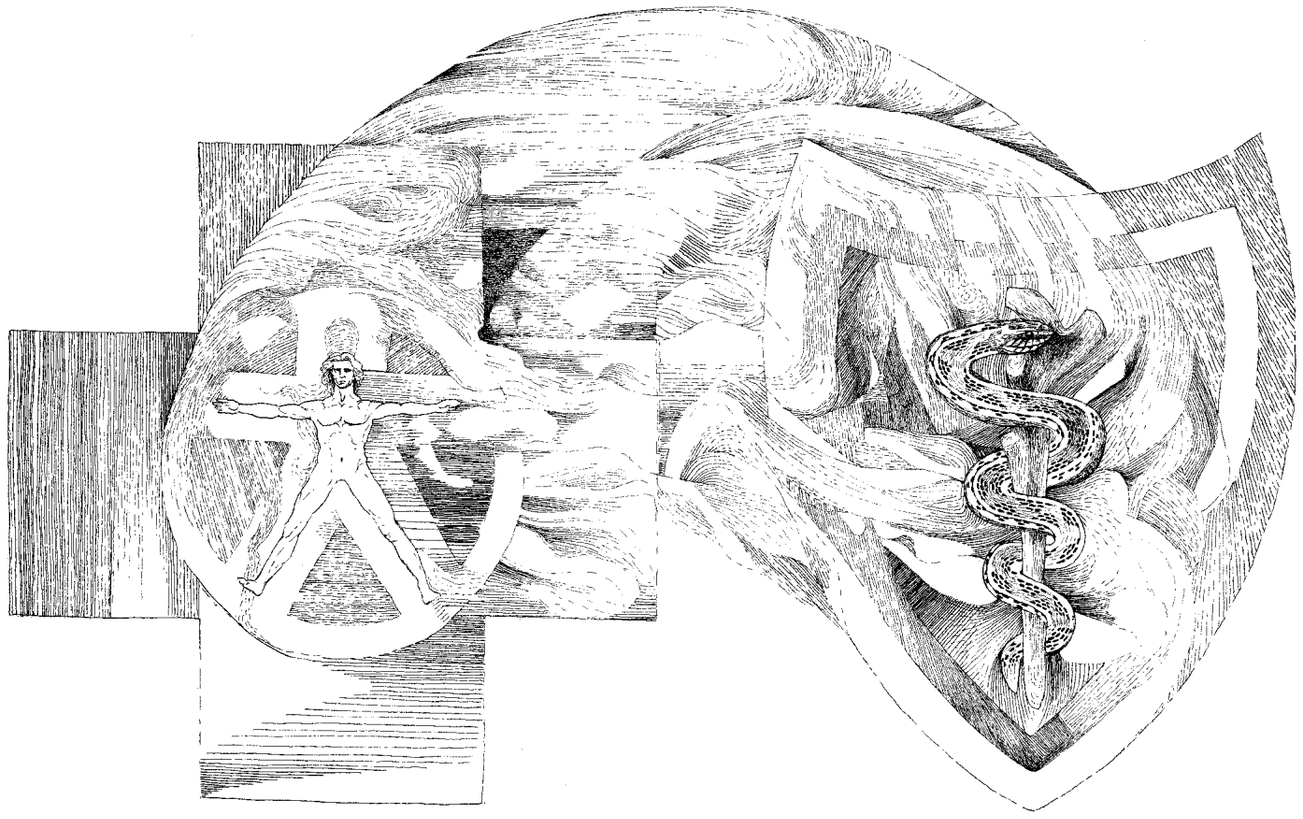

MORGAN BALLARD

years later, hospital planning and cooperation (or collusion) became national policy under the 1974 National Health Planning and Resources Development Act (NHPRDA).

There is a long history of collusion and cooperation among hospitals, partly nurtured by local hospital planning agencies. For example, in the 1980s, planners in Delaware bragged that a low hospital bed-to-population ratio "has been achieved through the voluntary cooperation and joint planning efforts among Delaware hospitals." Collusion among hospitals typically focuses on easily observable elements of non-price competition, such as the number of beds or the services offered, rather than on prices. For example, in 1975 the three Modesto, Calif., hospitals agreed to allocate several services among themselves.

Entry limitation for hospital care has a long history. In many locales, the existing hospitals have long cooperated through formal or informal local hospital planning committees. Physicians, the hospitals themselves, and major donors dominated the committees, so when the committees disapproved, it was difficult for nonprofit hospitals to enter or expand. Also, the planning groups generally opposed entry by profit-seeking hospitals and, originally, entry by HMOs. Under NHPRDA, entry restrictions at various levels of government became formalized under Certificate-of-Need (CON) laws.

CON The relationship of the planning movement to physicians is intriguing. Economic research suggests that physicians benefit from restrictions on the supply of complementary hospital services. In separate studies, economists Mark Pauly and Frank Sloan found that physician prices are higher where hospital beds and nursing resources are limited. William Custer found that, where hospitals are more competitive, physician prices are lower. Surprisingly, the American Medical Association has long opposed CON regulation. (Of course, hospital associations supported CON regulation.)

Whatever the politics, by 1974 several states had instituted CON laws. In that year, Congress mandated the laws for the rest of the states. Most research shows that the regulation had little or no effect on hospital costs.

While ineffective in controlling costs, CON regulation was sometimes effective in inhibiting competition from HMOs by stopping them from building hospitals. For example, doctors and existing hospitals in the San Fernando Valley area of Los Angeles used CON to delay Kaiser's second hospital.

Partly because of the research by Sloan and others, CON regulation has lost its appeal. Under more permissive federal legislation, many states have quietly dropped or weakened their CON regulations. Only 36 states still have CON laws of any sort. However, recently, there has been renewed political pressure to strengthen or enact state CON laws.

THE COMPETITIVE REVOLUTION

The big news of the last 25 years is the competitive revolution in health care and insurance. Very much a work in progress, it has led to improved utilization control and more competitive prices. The revolution was largely accidental, and was the spontaneous result of many organizational innovations in health insurance under the general name of "managed care." The innovations were made possible by many small-scale policy deci-

sions, undertaken by different policymakers for various reasons.

Until the early 1980s, insurers largely ignored their adverse impact on medical costs and provider competition. Since then, health insurance competition has focused on cost control, leading to the dominance of innovative forms of managed care and selective contracting. The result has been a revolutionary increase in health provider competition and improvement in cost control.

The Blues In the recent past, two types of firms — commercial insurers and Blue Cross/Blue Shield — sold most U.S. private health insurance. The Blue Cross plans were organized by hospitals to provide hospital insurance, and the Blue Shield plans were organized by physicians to provide physician services insurance. The boards of directors of the Blues had heavy representation of hospital and physician interests.

The Blues had considerable market power, based on two sources. First, they had favorable regulation and taxation. Second, they often obtained large discounts from doctors and hospitals. The Blues used their market power to promote very complete insurance that featured little consumer co-payment.

Blue-plan market power created health care policy problems because of the very complete insurance. Insurance causes consumers to buy more health care, including some care that is worth far less to them than it costs. That phenomenon, called the moral hazard problem, is exacerbated with more complete coverage.

Two major distortions push consumers in the direction of excessively complete insurance. The first is the previously discussed tax subsidy of employer-provided health insurance. It is a large subsidy that varies from about 28 to 50 percent depending on an individual's marginal tax rate. The second distortion is the market power of the Blues, which promotes more complete insurance. Aside from moral hazard, overly complete insurance reduces the incentives for consumers to search for and choose low-priced providers, which reduces competition among them. In recent years, the Blues have lost much of their market power, market shares, and their ability to promote overly complete insurance. In many cases, they have joined the competitive revolution themselves.

New forms of insurance In the mid-1970s, traditional insurance covered about 93 percent of people who were privately insured. Most of the remaining seven percent were covered by health maintenance organizations. By 1994, HMOs and preferred provider organizations (PPOs) served almost 40 percent of the market; that number grew to almost 90 percent by the year 2000.

Another change is that many employers are now self-insured and, thus, traditional health insurers must compete with the third-party administrators (TPAs) that operate the health payments programs of self-insured companies. More importantly, self-insured firms avoid costly state regulation.

Savings from managed-care practices are large. Based on a large-scale review of the economic research on the impact of managed care practices, James Langengfeld, Michaelyn Corbett, and I have estimated that the cost of eliminating managed care practices would be about $329 billion from 2002-2005, which averages out to about $3,600 per household and eight percent of private health insurance costs. About 6.4 million people would lose medical insurance coverage because of the price increases that would be required. Complete elimination of the practices might be thought of as the worst-case result from the current legal attacks on managed care or more vigorous and hostile state and federal regulation.

HMOs and PPOs Health maintenance organizations effectively combine the insurer with affiliated doctors and hospitals to reduce moral hazard. An HMO's incentive to supply fewer services offsets its subscriber's incentive to demand more services because of moral hazard. Competition among HMOs reduces the short-run incentive for them to provide too few services.

HMOs also increase provider competition. Because they can steer patients, even HMOs with small market shares negotiate large provider discounts. For example, startup HMOs with a near-zero share usually get hospital discounts of at least 20 percent, and sometimes can achieve savings in the 40-to-50-percent range.

Pressure from HMOs has led to competitive responses from insurers and TPAs, including the development of preferred provider organizations. PPOs are contracts among insurers (or

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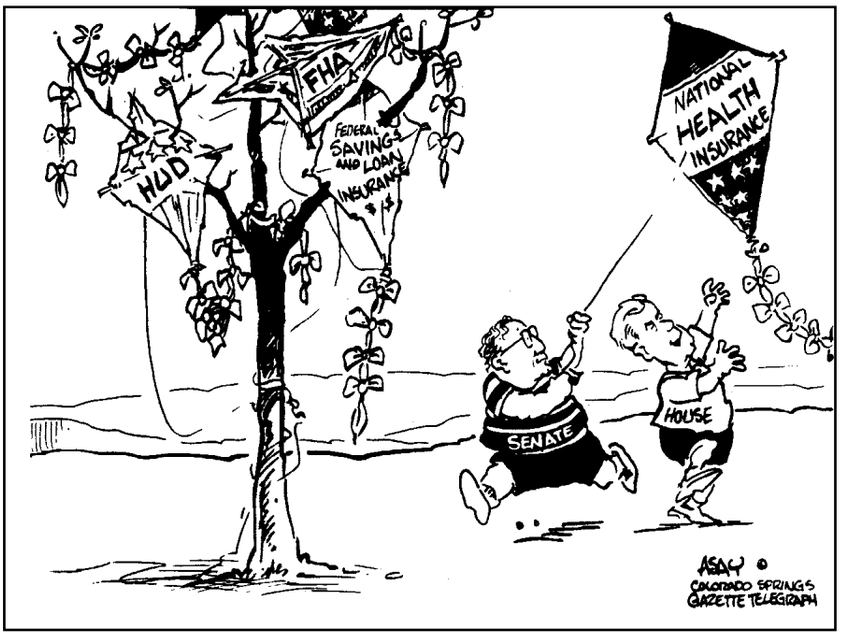

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TPAs), providers, and consumers wherein providers agree to serve PPO consumers at a lower price and agree to cooperate with utilization review. In return, contracting providers get larger volume because the PPO steers consumers to the providers, usually by financial incentives. PPOs are more liberal than HMOs because non-plan providers are covered (though with more cost-sharing). PPOs have become very popular, covering about 45 percent of the market by 2000.

The coverage of non-plan providers is a significant attraction of the PPOs. Observing that, some HMOs are experimenting with limited partial coverage of non-plan providers. Such organizations are called Point of Service (POS) HMOs.

Why more competition and price control? Especially since the late 1980s, corporate management has taken more interest in controlling the health care costs for employees and their dependants. Perhaps the central reason is the growth in health benefit costs, which increased from 1.6 percent of wages and salaries in 1965 to 5.3 percent in 1985.

The 1981 and 1986 federal tax cuts that reduced individual income tax rates also contributed to increased interest in cost containment. Under the lower rates, the value of the insurance tax subsidy declined.

Antitrust enforcement The growth of innovative, pro-competitive health plans was delayed for years by the threat of boycott by physician groups. However, antitrust enforcement has reduced those barriers. Prior to 1963, medical societies could use hospital accreditation standards to keep out HMOs. The staff of accredited hospitals was limited to medical society members; by ejecting HMO physicians, local medical societies were able to slow HMO growth. The 1963 *Griesman v. Newcomb Hospital* court decision eliminated medical society membership as a prerequisite to hospital access. I believe the decision was important to the boom in managed care and to the improvement of physician and hospital competition.

Local medical societies, though with less effect, continue to hinder managed care. For example, in Stanislaus County, Calif., the county medical society formed its own PPO and signed most of the local physicians to exclusive contracts, thus keeping out other PPOs and HMOs. When threatened with an antitrust suit by the U.S. Department of Justice, the medical society disbanded its PPO. Such anti-competitive activities continue throughout the nation, as one can see by looking at the websites of either the Federal Trade Commission or the antitrust division of the Department of Justice.

Antitrust exemption A bigger concern today is the effort of organized medicine to seek exemption from the antitrust laws so that physicians can legally collude against health care plans. Under current law, independent physicians, like any other seller of a service, cannot collude, nor can health care plans collude in the purchase of health care. Both physician and health plan mergers can be challenged for anticompetitive effects.

Federal legislation to allow collusion was introduced in 1999. On the state level, a 1999 Texas law exempts physicians from antitrust law in certain circumstances. Similar antitrust exemption bills were introduced in 18 states and the District of Columbia in 2000.

There are two expected results of allowing physician collusion against health plans. First, prices would be higher than competitive levels, with both redistributive and efficiency effects. A Charles River Associates study, conducted by Monica Noether, estimates that physician antitrust exemptions would increase average private insurance premiums by four to 18 percent. The Congressional Budget Office estimates a much smaller increase of two percent, but James Langenfeld and I argue that the CBO estimates are seriously understated. A second, and more serious, result is the likely weakening of utilization controls, which would increase aggregate health care costs without a corresponding increase in benefits.

THE MANAGED-CARE BACKLASH

In the mid-1990s, and continuing on to today, there has been political backlash against managed care. The backlash was strongest against the relatively tight traditional HMO type, fueled by negative media coverage and political commentary. In my view, providers and the media largely drove the backlash. Supporting my view, surveys commonly show consumers to be hostile to managed care in general, while simultaneously happy with their own managed care plan.

The backlash has produced several political results, foremost of which is the increased pressure for expanded federal regulation of managed care. In 1996, Congress passed the Health Insurance Portability and Accountability Act, the Mental Health Parity Act, and the Newborns and Mothers Protection Act, all of which overrode managed care provisions that constrained utilization of services. Currently, there is pressure for further detailed regulation of managed care under the guise of "Patients' Bill of Rights."

The backlash also produced a series of physician and consumer class-action lawsuits against essential managed care practices. Some versions of the "Patients' Bill of Rights" would expand health plan liability, which would enable further lawsuits.

Mandates There has been an explosion of state regulation of insurance, primarily of managed care. The regulations, generally in the form of state mandates, have a long history and some of them pre-date the current backlash. Mandates were rare in 1970, but now most states have a least one and the total across the nation is over 1,000.

The mandates vary in their focus. Some require that certain services be covered by insurance (e.g. optometrists), some require specific benefits (e.g. alcohol abuse treatment), and some require that coverage be offered to certain classes of consumers (e.g. conversion from group to non-group). Many of the mandates are directed at utilization control, e.g. hospital length-of-stay. A less common mandate is directed at provider recruitment and management. "Any-willing-provider" regulations frustrate the plans' attempt to concentrate volume. "Freedom-of-choice" regulations require that plans cover non-plan providers, thus frustrating the plans' attempts to steer consumers to their providers. Retail pharmacists have been especially successful in obtaining freedom-of-choice mandates.

Recent research has focused on the mandates' effect on insurance decisions and costs. Basic economics suggests that mandating a feature that was not already chosen would reduce the attractiveness of insurance. The new feature would be of some value to consumers, but not enough value to overcome the higher premiums that result from its inclusion. That discourages employers from offering coverage and discourages consumers from buying insurance.

Researchers Frank Sloan and Christopher J. Conover have shown that state mandates are a major cause of consumers being uninsured. Quantitatively, they calculate that a complete elimination of mandates would cause the uninsured, non-elderly population to fall from 18 percent to 14 percent. Thus, mandates account for over 20 percent of the existing uninsured.

ERISA However, state mandates do less harm than one might expect, for two reasons. First, many mandates are limited to group coverage, so they do not apply to those with individual coverage. More importantly, much of the population is protected from state mandates by the federal Employee Retirement Income Security Act (ERISA) law, which preempts state law for covered employee benefits. The 1974 law protects some, but not all, employer-provided plans from the mandates.

ERISA was designed to simplify and homogenize regulation, largely by preempting state regulation and imposing a simple national structure. It shields employers that self-insure from state mandates and other costly state regulation, and thus provides a quasi-constitutional limit to the ability of special interest groups — traditionally more successful at the state level — to load up health plans with benefits that are not worth their costs to consumers. University of Tennessee professor Haavi Morriem has argued that ERISA was purposely designed to ease regulatory burdens on employee benefit plans, and thus to encourage them.

Without ERISA, state mandates would be far more harmful. Further, the freedom to experiment with managed care and selective contracting created by ERISA was important to the growth of managed care and competition generally. Congress probably did not foresee its beneficial effect on health care, and that effect still does not get much attention.

The part of ERISA that does get attention is its preemption of state tort law, which makes it difficult to sue an ERISA-qualified managed care plan for malpractice. Many congressional proposals would either end or weaken that protection. I view the issue as less important than ERISA's protection from state mandates, though if malpractice imposes standards on the amount and type of care (not just avoiding mistakes), it has similar effects as mandates. But all of ERISA is at some risk in today's political and media climate.

Clinton Care The 1993 Clinton health care plan was written from a curious mixture of planning and managed care perspectives. It combined detailed regulation with what was called "managed competition." Clinton Care would have required employers to purchase health insurance from private health plans, and it included price controls at two levels hidden by euphemisms ("global budgets" for health insurance premiums and a ban on "balance billing" for providers). The plan was expensive and, thus, would have been a tax on employment. In addition, it was unusually authoritarian in structure and was developed in near secrecy.

The plan's drafters clearly intended for HMOs to provide most of the insurance, so that health care use would be managed and costs would be controlled. Different HMO plans were to compete, but in a highly controlled manner — hence the label "managed competition."

Political fallout By the time the plan got to Congress, it was so unpopular that it was not even brought up for a committee vote, despite the fact that Clinton's own party controlled Capitol Hill. The unpopularity of the Clinton Plan is widely viewed as a major contribution to the Republican capture of both houses of Congress in the 1994 election.

The campaign against Clinton Care stressed consumer choice of insurance plan and provider. Both themes resonated well. The campaign for consumer choice is implicitly hostile to the stricter forms of managed care — the HMO — with a traditionally small panel of providers. Probably inadvertently, the campaign against the Clinton plan also fueled the backlash against managed care.

POLICY PROBLEMS

While public discussion of health care policy focuses on health care costs and the adoption of government mandates, policy analysts often discuss two other issues: Does heavy utilization of medical care bring sufficient benefit, and how should the nation address the uninsured? Let us consider both of those issues.

Flat-of-the-curve medicine? The goal of utilization control was based implicitly on the belief that many middle-class people consume medical care that has marginal health benefits well below marginal costs. Medical care analysts often refer to that belief as flat-of-the-curve medicine after the (flat) shape of the curve that depicts the relationship between additional health spending and health benefits.

But that attitude is changing. There is less policy concern with costs and high utilization. There is renewed support for medical research. The change in attitude is partly a result of a long economic boom and resulting tight labor market, which reduced pressure on employers to control costs. But I believe that there are more long-term forces at work.

Recent research has shown that health care, particularly pharmaceutical care, is surprisingly productive, even in rich countries with high health care use. That is particularly evident in the treatment of cardiac disease. Apparently, the slope of the benefits curve is not so flat anymore.

Consumers without insurance A long-term policy problem in the United States is the large fraction of the population — about 18 percent of those under 65 — with no health insurance. That proportion has been fairly stable in recent years. But it was far larger in the early 1960s, before the creation of Medicare and Medicaid. The uninsured today are mostly in

working families and are mostly under 65. Also, they are disproportionately young.

Access to care Many people are surprised to learn that the uninsured consume almost as much health care as those with insurance. In a 1986 survey with no regression controls, the uninsured consumed 73 percent as many doctor visits and 81 percent as many hospitalizations. A 1992-94 survey of people age 51 to 61 showed, further, that consumption was actually higher for the uninsured. Once control variables were introduced in a regression framework, the uninsured consumed 71 percent as many doctor visits and 100 percent as many hospital days. A pair of recent (June and September 2001) NBER papers by Harvey Rosen and William Perry found that the relative lack of health insurance among the self-employed (69 percent of the self-employed are insured, versus 82 percent of other workers) had little effect on health care use and, surprisingly, no effect on their health status as measured in a variety of ways.

Those who lack health insurance do, in fact, receive health care. Those without insurance sometimes get free outpatient care in hospital emergency rooms or free clinics; other times, they pay out-of-pocket. For larger expenditures, typically involving hospitalization, they fall back on public and private charity, often by presenting themselves at hospitals in emergency or urgent conditions.

In a crude way, the charity care most often goes to poorer people. But that system has a number of negative features, including:

- Incentives for the poor to wait until late in the course of an illness to seek medical help, when earlier treatment would have been less expensive and more likely to avoid bad outcomes.
- Limited competition among medical service providers, because hospitals and patients do not have to compete for poor patients. As a result, the quality of care received is uneven.
- A haphazard and hidden system for paying for uncompensated care, which violates the principle that, in a democracy, policy should be transparent.
- The prevalence of charity care, which provides a political rationale for restrictions on competition in health care: to preserve monopoly rents that can be used to cross-subsidize the uninsured.

Over the years, there have been many proposals to deal with the uninsured. Clinton Care included mandatory coverage. Many alternatives included tax credits, vouchers, or other subsidies. In the early 1990s, Mark Pauly, Patricia Danzon, Paul Feldstein, and John Hoff designed a particularly clever plan for mandatory health insurance at the individual consumer level that did not burden employment. It provided income-related subsidies for the poor and operated through the income tax system.

Mandatory insurance is a hard sell in the United States, because of Americans' libertarian attitude. But in this case, I believe that a health insurance mandate on individuals is preferable to the mishmash of charity and cross-subsidized care that rewards irresponsible behavior.

Recently, the Bush administration proposed a tax credit plan to encourage the purchase of health insurance. Such plans can cause some crowding out of private insurance by causing consumers to drop their private insurance (or not buy it in the first place) to qualify for tax credits. To avoid that, the Bush proposal closely ties tax credit availability to income. Eliminating or reforming state mandates on health insurance would probably go further than a tax credit system, but today's climate of hostility to managed care makes eliminating state mandates politically difficult.

CONCLUSION

The last 25 years of American health policy have been fascinating. Large-scale, centrally directed national health insurance schemes and supply-side regulation have both failed. But a host of seemingly minor and unrelated policies, from antitrust decisions to the enactment of ERISA, set the stage for the competitive revolution in health care. A host of small-scale policy decisions had huge consequences, while attempts to plan the entire system led to naught.

The immediate challenge is to protect the competitive revolution in health plans and health care. The biggest current threats come from state mandates, broad legal attacks, and the possibility of physicians attaining a special antitrust exemption. That suggests continued federal preemption of state mandates, as under current ERISA. The general argument against mandates applies equally well to federal ones, so the small number of federal mandates should be removed. Also, any new federal legislation should reduce competition as little as possible.

In the longer run, the tax subsidy to excessive health insurance should be either eliminated or capped. Also, antitrust activity needs to be maintained, perhaps with new attention to the use of state regulation to achieve anticompetitive outcomes.

Another long-run issue is the uninsured. Mark Pauly and his colleagues have convinced me that the best solution is mandatory insurance, as illiberal as that seems. In their plan, the required insurance is defined very broadly to allow a wide variety of policies, including managed care and policies with high co-payments and deductibles. Further, they argue convincingly that the mandate should be aimed at the individual, not the employer, to lessen the mandate's negative effect on employment. In the context of a voluntary system, tax credits like the ones proposed by the Bush administration can help, as can eliminating or reducing the state mandates on insurance. R

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