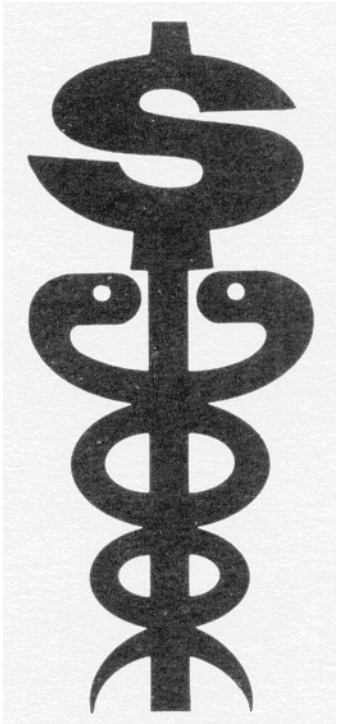
Public Policy Issues: 1

REGULATION AND COMPETITION:

CAN THEY BE USED TOGETHER TO CONTAIN HEALTH CARE COSTS?



YES

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NO

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Report Number 278

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This paper was financed by a grant from Touche Ross & Co.

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This paper is submitted in the interest of fostering informed public debate on a significant current issue. The opinions expressed are those of the authors and do not necessarily represent the views of either the Citizens Research Council of Michigan or Touche Ross & Co.

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PREFACE

One of the most difficult policy issues to be faced by government in recent years is that of adopting an appropriate response to the demands for containment of rising health care costs. It is generally agreed that Americans consume excessive amounts of medical care and that a successful policy of health care cost containment will involve some reduction in the level of services provided. The dilemma faced by policymakers is that, in doing so, a risk is created that needed care will be denied (or not sought) and that the quality of the system will be placed in jeopardy. With so much at stake, it is little wonder that policy development in health care cost containment has not occurred more rapidly.

Over the course of the last twenty years, two principal approaches to the problem have developed: Regulation and Competition. In short, the regulatory approach derives from the position that the market for health care is so imperfect and non-competitive that efficient and equitable allocation of resources can come about only through government intervention in that market. The market reform approach, on the other hand, is based on the position that, while a perfect market may not be obtainable, much can be done to reduce inefficiencies by eliminating some of the non-competitive aspects of the current market, many of which are the result of government action or at least acquiescence in private anti-competitive actions.

Government has not embraced either approach completely. Much of what is done in the name of healthcare cost containment is a mixture of regulation and competition. Certificate-of-need programs and hospital rate setting exist side-by-side with incentives for health maintenance organizations and preferred provider organizations. Whether this practice of adding regulatory controls at the same time pro-competitive initiatives are being adopted will be effective or counterproductive is the subject of this Citizens Research Council *Public Policy Issues.* To debate the question, Citizens Research Council is fortunate in having two distinguished experts in the field of health care costs, Clark Havighurst and Bruce Vladeck.

The problem of balancing concerns for equity and for efficiency is raised graphically by these two essays. Can we allow market forces to bring greater efficiency to the health care system without at the same time threatening the ability of those least able to pay to secure needed services? On the other hand, can we continue to support a system of care in which subsidies, hidden and direct, and regulation prevent economic discipline from removing inefficient producers of care from the market and lead to an ever-increasing burden on the economy?

It is hoped that these papers will stimulate interest in this issue and contribute to a more thoughtful public consideration of the complex problem of health care cost containment. Citizens Research Council welcomes your comments. We thank Touche Ross and Co. for the grant which made possible the publication of this public policy issue paper.

THE AUTHORS

Clark C. Havighurst has been Professor of Law at Duke University Durham, North Carolina, since 1968. He teaches courses in antitrust law, economic regulation, and legal issues in health care. His scholarly writings include articles on most phases of regulation in the health services industry, the role of competition in the financing and delivery of health care, and antitrust issues arising in the health care field. A member of the Institute of Medicine of the National Academy of Sciences, he is also an adjunct scholar of the American Enterprise Institute and has served as a consultant and advisor on health policy to the Federal Trade Commission and the Reagan Administration. He is known as a leading advocate of policies that would rely less on government regulation and moreon consumerchoice to guide the health care industry's development. His *book,* ***Deregulating the Health Care Industry****,* was published in March 1982.

Professor Havighurst received his bachelor's degree, magna cum laude, from Princeton University and his law degree from Northwestern University where he was elected to the Order of the Coif. He was visiting professor of law at the University of Michigan in the fall semester of 1983.

Bruce C. Viadeck was elected President of the United Hospital Fund of New York, effective July 1, 1983. Immediately prior to joining the United Hospital Fund, Dr. Viadeck was assistant Vice President of The Robert Wood Johnson Foundation. From 1979 through early 1982, he was Assistant Commissioner for Health Planning and Resources Development of the New Jersey State Department of Health where he oversaw the implementation of New Jersey's all payers DRG-based hospital prospective payment system, as well as directing activities in nursing home rate setting and HMO regulation.

Dr. Viadeck is the author of ***Unloving* Care: The *Nursing Home Tragedy***, and of numerous articles and book chapters on health policy, health care finance, and health politics. He is a member of the New York State Council of Health Care Financing and The Committee on Nursing Home Regulation of The Institute of Medicine, National Academy of Sciences.

Dr. Vladeck received his bachelor's degree, magna cum laude, in Government from Harvard College, and his M.A. and Ph. D. in Political Science from The University of Michigan. He taught for four and a half years at Columbia University, and served on the adjunct faculty of Rutgers, Princeton, and the College of Medicine and Dentistry of New Jersey.

APPROACHES TO HEALTH CARE COST CONTAINMENT: AN INTRODUCTION

by Citizens Research Council of Michigan

Responses to the problem of escalating health care costs tend to be oriented either toward governmental regulation or toward competition, although certain health care purchasing arrangements aimed at cost containment tend not to fit either category very well. **Regulatory approaches** normally are directed at controlling providers of health care by either (1) restricting the entry of new resources into the market, or (2) circumscribing the terms on which providers and private parties may deal in such areas as reimbursement. **Promotion of competition**, on the other hand, is directed toward creating incentives for consumers and providers and anticipates that competition among financing plans and among providers will contain costs, or at least ensure that resources are being used in accordance with consumer wishes.

Somewhere between these two approaches are certain **purchasing methodologies** that maybe closer to regulation or to market reform, largely depending on the type of authority employed to operate the program. If the arrangements are enforced by governmental agencies on third-party payers and providers, these approaches are essentially regulatory. If, however, they are used by health care purchasers as a part of a prudent purchaser approach they are more along the lines of market reform.

REGULATORY APPROACHES

Cost containment is relatively new as a regulatory goal. The rise of health care costs since the mid-1960's has resulted in the creation of new forms of cost-containment regulation and in the addition of new cost-containment objectives to regulatory programs originally established for other reasons, such as quality assurance.

RESTRICTION OF ENTRY OF NEW RESOURCES INTO THE MARKET

Because of the belief that if hospitals and other health care facilities are created they will be used, regardless of need, health facilities planning has sought to assure that only needed facilities are brought into being and that existing facilities deemed to constitute "excess capacity" are eliminated.

Health Facilities Planning. Most health facilities planning activities are now governed by the provisions of the National Health Planning and Resources Development Act of 1974 (Public Law 93-641), as amended, This act established common procedures, structures, and basic requirements for health planning in the United States tied to federal expenditures for that function. Agencies created under the act are responsible for approving health plans and making certificate-of-need determinations.

Certificate-of-need. The most prominent method of restricting capital investment in health care is certificate-of-need, which requires that before a major capital expenditure ($150,000 or more in Michigan) is made by a health care facility, the state must certify that the expenditure is needed.

Analyses of certificate-of-need programs nationwide have failed to show conclusively that they have had a significant impact on hospital expenditures. This has led to proposals to strengthen certificate-of-need review. Two initiatives of particular significance to Michigan include:

- **Bed Reduction.** Although certificate-of-need in Michigan was originally limited to restraining the growth in the number of hospital beds, the 1978 Public Health Code (Public Act 368 of 1978) provided for developing a plan for eliminating excess beds and restricting the issuance of CONs by the Department of Public Health to those projects in conformance with the bed reduction plan. Implementation of bed reduction has been slow and controversial, particularly in Southeast Michigan, where most of the excess capacity is located.
- **Capital expenditure limitation.** Proposals have been developed that would provide for the establishment of a statewide annual limitation on the total value of certificates-of-need issued. Generally, the proposals would permit establishment of regional limits on hospital capital expenditure, the total of which may not exceed a statewide limit established by a central body. Certificates-of-need then could not be issued that would exceed the limit statewide or in each region. A major assumption of a capital expenditure limitation is that, in addition to the savings resulting from direct control of construction and equipment acquisition, savings will also occur through avoiding the labor and other costs involved in operating the new facilities and equipment.

RATE SETTING

A second regulatory approach is the establishment of a governmental agency that imposes limits on the reimbursement that hospitals may receive for their services. In order to prevent the shifting of costs from one payer to another, the agency may regulate the reimbursement received from any source, resulting in an "all-payers" rate-setting agency.

The rate-setting agencies with the most authority exist in New York, New Jersey, Maryland, Massachusetts, and Washington. Various methods of rate-setting exist, but the most prominent are budget review in which the budgets of individual hospitals are reviewed and rates established according to guidelines, and formula based methods in which various formulas are employed to determine rates based on such things as patient characteristics, costs of similar hospitals, historical trends, and so on.

MARKET-ORIENTED APPROACHES

The market for medical care has been protected from most of the incentives to achieve efficiency that characterize the markets for most other goods and services. Competition, when it exists, is rarely based on price and consumers of health care usually find that, because of third-party payment, they are unaware of the cost of services provided.

The market reform approach assumes that if consumers and providers are given sufficient latitude, if sufficient incentives are provided, if consumers have more information, and if the prices of health care services more closely reflect their costs, innovative means of cost containment will occur as private payers seek ways of protecting themselves from rising costs and as providers attempt to accommodate themselves to new methods of purchasing care.

REDUCTION OF THE ROLE OF THIRD-PARTY PAYMENT

Many strategies for increasing consumer cost-consciousness have centered on reducing the role of third-party payment in health care. Although outright limitation of benefits has received some attention, cost sharing and taxation of the employer cost of health care benefits have been most widely discussed.

Cost Sharing. Cost sharing options are nearly unlimited. Broadly speaking, however, they can be grouped into three classes:

- **Deductibles**, which require a patient to pay all costs up to a specified maximum.
- **Coinsurance**, which fixes the patient's liability at some percentage of the cost.
- **Copayments**, which are fixed charges per unit of service.

Although cost-sharing is limited in public programs, it is relatively common in private insurance and forms the basis for many of the new so-called "cafeteria" fringe benefit packages (see below).

Taxation of Employer-Paid Health Insurance. The purpose of this approach is to reduce the incentive to employees to demand nontaxed health care benefits instead of regular cash income. This would reduce the amount of health care Insurance purchased and, at the same time, increase tax receipts to the U.S. Treasury. "Cafeteria" Fringe Benefit Packages. A number of employers have begun to offer "cafeteria" fringe benefits to their employees. Essentially, these packages consist of providing a given total value of fringe benefits to each employee, but permitting the employee to reach that total by combining the available benefits in any of several ways. Frequently, more than one health care plan is offered and if a more costly plan is selected, a corresponding reduction in another benefit, such as vacation or insurance, will be necessary. Thus, the high cost of the plan is passed on to the employee in terms of foregone alternative benefits and an awareness of the cost is created.

RISK-CREATION IN HEALTH CARE FINANCING

One of the more active areas of health care cost containment in recent years has been the development of plans that introduce an element of risk into the financing of health care. There are two distinct but related approaches.

Health Maintenance Organizations (HMOs). The basic characteristics of HMOs are (1) contractual arrangements with a specific group of physicians to provide a comprehensive range of services, and optional contracts with other kinds of providers; (2) defined population of enrollees; and (3) capitated annual rate of payment (i.e., fixed amount per person). The basic incentive created is for the HMO to minimize hospitalization for its enrollees since the hospital is the most costly setting in which to provide health care. Preventive care, including free office visits, is normally emphasized in an HMO. While HMOs have been growing rapidly in Michigan, they are still far from occupying a quarter of the market as is the case in some western states.

Preferred Provider Organizations. Preferred Provider Organizations are alternatives to HMOs, the principal distinction being that Preferred Provider Organizations are fee-for-service arrangements rather than capitation plans. Preferred Provider Organizations consist of teams of independent physicians, hospitals, and other providers who contract with specific groups to deliver medical care at a discount. The incentives for Preferred Provider Organizations to contain costs are the same as those in any competitive buyer-seller relationship. Preferred Provider Organizations normally employ utilization review techniques to identify physicians with greater than average utilization patterns and may even remove such physicians.

Issues have been raised regarding the anti-trust status of Preferred Provider Organizations despite their rapid growth in many states other than Michigan. The Michigan legislature is considering legislation that would authorize Preferred Providers Organizations (or "Prudent Purchaser Agreements") in Michigan and clarify their status with respect to state law.

HEALTH CARE PURCHASE APPROACHES: PROSPECTIVE REIMBURSEMENT

Prospective reimbursement is a reaction to the prevalent means of health care provider payment, namely, cost-based retrospective reimbursement. Prospective reimbursement attempts to contain costs by giving providers (principally hospitals) pre-set limits on the costs that will be reimbursed.

Whether this approach is closer to regulation or closer to risk-creation depends largely upon the type of authority employed to operate the program. If the rates are set by individual third-party payers or by coalitions of business and labor, for example, the approach tends to take on a "prudent purchaser" aspect. On the other hand, a rate-setting commission in which all third parties reimburse according to a schedule established by a governmental agency is more regulatory in approach.

Blue Cross-Blue Shield of Michigan uses a prospective reimbursement system based on a hospital's total inpatient operating expenses subject to a screen (ceiling on cost increases) determined each quarter. Capital costs (including depreciation and interest expense) are "passed through," that is, they are not subjected to the screen.

The Michigan Medicaid program establishes annual ceilings on the allowable rate of increase in costs and also sets limits on payments for certain cost elements.

On October 1, 1983, the other major third-party payer in Michigan, the federal Medicare program, adopted a fixed hospital payment system that reimburses hospitals on the basis of 467 Diagnostic Related Groups (DRGS) each with a fixed price. If a hospital exceeds the price for a given case, it will be forced to finance the excess cost in another way; if its cost is lower than the fixed price, it will be permitted to keep the difference. Capital costs will be passed through initially but are scheduled to be subsumed within the DRG rates by the time the system is fully implemented in 1986.

CONCLUSION

The interplay of the various methods of health care cost containment can create unexpected results and in some instances have the potential for being self-defeating. The proliferation of cost containment strategies raises the question of whether pro-competition strategies and regulatory approaches are compatible. It is hoped that the papers in this publication will help to raise the level of public debate and understanding of an issue critical to the future, not only of Michigan, but of the entire nation.

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REGULATION, COMPETITION, AND HEALTH CARE COST CONTAINMENT

by
Bruce C. Vladeck
President
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Throughout our history, American political rhetoric has generally been hostile to the notion of regulation. We like to think of ourselves as a nation of independent souls, facing the challenge of the frontier using only our wits and our ingenuity. The enterprising individual entrepreneur remains a powerful economic role model, even as the economy is increasingly dominated by multibillion dollar, multinational corporations. Nor, as a rule, do Americans tend to think very highly of government in general. The inherent, intrinsic advantages of private over public action have been an important tenet of American political mythology since at least the time of Jefferson.

Another year or two of experience with the deregulation of the telephone industry may encourage many Americans to rethink their attitudes about regulation, and feelings about the impact of the deregulation of financial institutions depend to a considerable degree on whether one is a borrower or a lender. For the purposes of the present discussion, however, the relevant point is that generalized public distaste for the very idea of regulation has substantially colored the discussion of efforts to get control over the spiral of health care costs in a way that may have ignored some of the particular characteristics of the healthcare industry. It may also have done us a significant disservice in terms of our ability to thoughtfully evaluate alternative courses of action.

To begin at the simplest level, there is a growing body of evidence that the mandatory regulation of hospital rates by government agencies is the only mechanism currently available to public policymakers with a demonstrated and incontrovertible record of success in reducing the rate of increase in health care costs without making it more difficult for people to obtain services. Debate over the expansion of rate regulation initiatives tends, in the particular rhetorical and philosophical context surrounding discussions of regulation, to be between those who, on the one hand, deny the efficacy of such rate setting programs because theoretically they should not work, and those who, whatever their qualms, keep pointing to the facts.

To reiterate, as straightforwardly as possible: Well-conceived "second-generation" state hospital rate regulation programs have demonstrated an ability to reduce the rate of increase in hospital costs to a level 2 to 5 percent per year below increases in states without such regulatory programs, even when one controls for all the other variables one can think of. Further, there is no demonstrable evidence that such programs make it more difficult for any significant group in the population to get care when they need it. Nor is there any serious evidence that the quality of care is adversely affected, again all other things being equal.

REGULATION AND INSURANCE

The problem with hospital rate setting as a regulatory intervention, apart from the issue of ideological acceptability, is that it only represents a partial approach to the problem of health care costs, as even its most ardent proponents would agree. Reductions in the rate of increase in hospital costs still leave those increases, in most circumstances, greater than inflation in the economy as a whole. It is further widely believed that the population consumes too many expensive health care services of all kinds, a problem that the regulation of prices does not systematically address in any way. Costs for physician, laboratory, and other out-of-hospital services, while not growing quite as dramatically as those for in-hospital care, also continue to increase at unacceptable levels, And the basic demographics of an aging population doom us to still further cost increases unless still further interventions are undertaken. This demographic imperative is of particular importance to current policy debates because of the way it is so integrally tied to the future financial status of the nation's largest health insurance program, Part A of Medicare.

So the search continues for more synoptic or comprehensive solutions. The most popular of these involves the introduction of greater "competition" into the health sector by the development of what are alleged to be more "competitive" incentives on consumers and providers alike, through the restructuring of health insurance.

The argument for increasing competition in the health sector as a means of controlling costs is derived, it should be emphasized, almost entirely from theoretical rather than empirical arguments. Just as a prevailing political culture is characterized by an inherent hostility to anything that might be called regulation, so too that culture glorifies anything that can be characterized as resembling a market, even while real markets tend not to behave as the theoretical ones in economic textbooks do.

Nonetheless, advocates of greater competition in the health care sector as a means of addressing the cost problem propose increases in co-insurance and deductibles to render consumers more sensitive to price at the point of service; limitations on the exemption from income taxation of part or all of the value of health insurance benefits provided as fringe benefits to employees; and requirements to insure that employees will be given a choice between competing health benefit plans, with economic incentives for them to pick the most economical.

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MIXING REGULATION AND COMPETITION: A DOUBTFUL PRESCRIPTION

by Clark C. Havighurst
Professor of Law
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Advocates of cost-containment regulation in the health care sector used to argue that hospitals and doctors were immune from price competition. Regulation was needed, they said, because market forces are incapable of transmitting cost concerns originating on the demand side of the market to providers on the supply side. Events are now showing, however, that this argument was greatly overstated – witness, for example, the growth of alternative health care plans, the Medicare program's decision to pay prospectively determined prices, the increasing use by health plans of selective contracting with providers, and the emergence of price competition among traditional providers through preferred provider organizations (PPOs). Nevertheless, because most advocates of regulation change their arguments rather than their minds when the fallacies of their positions are revealed, regulation is being promoted today on different grounds. Some of its advocates now claim that we do not have to make an either-or choice between regulation and competition but instead can have it both ways. In this comment, I dispute the claim that cost-containment regulation and competition can be combined to provide greater benefits to the public than could be derived by allowing the competitive scenario to unfold.

A common argument for including regulation among the tools employed in the cost-containment effort is that government, as a major purchaser of health care, has a large stake in the problem. But this assertion proves nothing at all about government's role in controlling private costs, which is the issue in this discussion. When government drives hard bargains in paying for services provided through its own programs, it is not engaged in regulation in any sense that is relevant for present purposes – however much its actions may feel like regulation to providers. Indeed, the pro-competition strategy for containing health care costs specifically contemplates that government will act as a prudent purchaser in administering its own programs but will allow private health care costs to remain a private responsibility.

METHODS OF COMBINING REGULATION AND COMPETITION

Although there are many reasons to doubt the efficacy and desirability of government regulation of hospital charges or revenues, the only issue considered here is the compatibility of such regulation with competition. Theoretically, it would be possible for regulators to impose a ceiling on a hospital's charges without destroying opportunities for an aggressive private payer to negotiate for lower prices. Thus, regulation setting either charges or revenue limits would not necessarily remove all incentives for payers to seek, and hospitals to grant, competitive price concessions. The Maryland Health Services Cost Review Commission has sought to implement its charge-setting program in just this way, so that it would not stifle opportunities for private cost containment and provider price competition.

Certificate-of-need (CON) regulation of capital expenditures is both theoretically and practically unsound as a way of accomplishing cost containment, but it also could be designed, at least in theory, so as not to prevent reliable market forces from developing. Indeed, in my 1982 book, ***Deregulating the Health Care Industry***, I attempted to lay out a detailed strategy for health planners and regulators to follow so that, in accordance with Congress's mandate in the Health Planning and Resources Development Amendments of 1979, this highly anti-competitive form of regulation would be administered in a way that did not wholly frustrate the emergence of effective competition. Though firmly believing that CON regulation is a misguided policy, I exerted a great deal of effort to help the planner-regulators constructively combine regulation and market forces.

Although the Maryland hospital charge-setting program allows any payer to negotiate a lower price with any regulated hospital, the more typical way of combining regulation and competition is to divide the market into regulated and unregulated sectors. Providers are allocated to one sector or the other according to whether they are subject to effective market discipline. This regulatory strategy was embodied in the 1979 health planning amendments, which contemplated that CON regulators, before proceeding to make a regulatory assessment of need, would evaluate the market's efficacy in allocating resources of the type in question, the same legislation also exempted a broad class of health maintenance organizations (HMOs) from CON laws, reflecting a congressional determination that all HMOs are reliably subject to market forces. A similar approach to combining regulation and competition appears in the federal law which conditions Medicare waivers – that is, the program's willingness to pay state-set hospital rates – on the state's allowing HMOs and so-called "competitive medical plans" to negotiate for hospital discounts. The recent Kennedy-Gephardt bill, which would establish federal or state regulation of hospital charges or revenues, includes a similar provision.

JUDGING COMPETITION'S PROSPECTS UNDER REGULATION: THE ADVOCATES AND THE ARGUMENTS

The obvious reason for dividing providers and payers into regulated and unregulated sectors is the belief that, while some actors or sectors are capable of operating

successfully under the market's discipline, the traditional system, because it features third-party payment and unlimited choice of provider, needs regulation in order to perform acceptably. As plausible as this logic may seem, it is basically incompatible with a policy of relying on market forces to reform the health care industry. Indeed, instead of letting competition trigger a vigorous search for more efficient health care arrangements, regulation is being invoked to cure the worst deficiencies of the traditional system, and thus to prevent that system's otherwise imminent breakdown under the weight of its own defects. Precisely why government should intervene to shore up a failed system is far from clear. Moreover, a review of the sources of the regulatory impulse and the arguments being advanced for regulation confirms the impression that its purposes, and thus its likely consequences, are distinctly anti-competitive. Indeed, some of today's most common arguments for regulation boil down to concern that market forces, rather than working poorly – as the older arguments had it – will work altogether too well.

Cost Shifting. Hospital rate or revenue regulation is vigorously advocated by many as a way of curbing the alleged practice of "cost shifting." This term refers to the alleged policy of some public and private health plans of paying hospitals less than the full cost of caring for their beneficiaries, thus forcing the hospitals in turn to shift their unrecovered costs to other payers. In particular, it is claimed that the Medicare program is currently underpaying hospitals. This charge is difficult to substantiate, however, without agreement both on cost accounting principles and on the obligation of government to pay full costs at the highest-cost institutions; certainly the fact that some costly hospitals find it unprofitable to care for Medicare beneficiaries does not prove that government is being irresponsible. Even if government programs should pay hospitals treating their beneficiaries so little that they could not survive or could not replace their obsolete capital facilities, such a policy of underpayment should be challenged as a default on the commitments represented by those programs, The conclusion that regulation is needed would not follow at all merely from a demonstration that cost shifting was occurring.

Complaints about cost shifting should not be taken seriously. Instead, cost shifting by hospitals should be seen as a desirable development, because it reveals how some payers – those complaining, who are mostly commercial health insurers – lack any capacity to discipline providers' spending habits. By always being available to pick up any cost that a hospital could not recover elsewhere, such payers of last resort have long represented an important leak in the public's defenses against runaway health care costs. Now that government and some private payers are switching to prudent purchasing and other defensive strategies, those payers who are unable or unwilling to resist the cost shift are increasingly recognizable as the sole remaining breaches in the dike that the market is gradually building to retard the flow of dollars to the hospital sector. For government to intervene with regulation just as market forces are poised to drive those inefficient insurance plans from the field would be to lose a golden opportunity.

Not only should complaints about cost shifting be seen as simply a crass effort by producers of an obsolete product to obtain government's protection against competition, but these interests' vigorous support of regulation should cast doubt on any claim that competition will not suffer substantially under the regulatory scheme proposed.

Competition's Threat to Industry Good Works. Another argument for introducing "all-payer' hospital rate setting cannot be dismissed so easily, because it is based on a concern for the welfare, not of inefficient insurers, but of patients who lack the resources to pay for needed care. During the long period when the health care industry was able to avoid price competition, many hospitals developed a capacity to cross-subsidize education and research and the care of patients who lacked both private and public means to purchase services. As in other industries that have undergone deregulation in recent years, the strengthening of competitive forces is eroding the monopoly revenues that previously made this cross-subsidization possible. Thus, one can reasonably cite as an argument for "re-regulating" the health care industry the hardships that unprotected patients can reasonably be expected to suffer if competition is allowed to devastate the institutions upon which they depend for care.

However, the societal choice is not so easy. For one thing, regulation is unlikely to do more than slow down the erosion of the resources available to institutions serving the poor. Higher charges at such institutions, even if paid by all payers, will induce some payers to steer their patients, by means of various incentives, to cheaper hospitals. Moreover, if HMOs and other competitive health plans are exempted from all-payer rates and allowed to negotiate lower charges with the burdened hospitals (a provision likely in most proposals to mix regulation and competition), the cream will be skimmed in another way. In general, all-payer rate setting seems to be only a stopgap, delaying the fiscal crisis at some hospitals but not providing a permanent source of financing for essential services.

It is also not clear that the needs of the working poor and non-Medicaid indigents could not be met by other means. Although new federal help seems unlikely to be forthcoming soon, a strong case has been made for capping the current tax subsidy for private health insurance and using the revenues thus obtained to fill the gaps that competition is creating. Even without relief in this form, however, funds for meeting local crises could often be found in county or municipal budgets, and direct federal or state help might be available for ailing institutions. Some states (e.g., Massachusetts, Maryland, and Florida) are currently exploring techniques of assessing all hospitals to create a pool of funds to aid those institutions that bear a disproportionate share of the indigent care burden.

The adequacy of public support for education, research, and health services for the poor is an issue that should probably be addressed directly in this instance.

Papering it over by a stopgap regulatory measure aimed at checking competition's development would simply perpetuate inefficiency and lessen the system's ability to grow and adapt in response to consumers' wishes. Admittedly, the proper balance between equity concerns and efficiency depends upon a value judgment, but the availability in this case of ways to satisfy the former without sacrificing the latter suggests that the decision to re-regulate the health care industry would be, if not a mistake, at least more costly than many regulation advocates would have us believe. Once again, because this rationale for regulation expressly contemplates the suppression of competition, it cannot be maintained that regulation is compatible with the emergence of market forces.

Are There More Reassuring Rationales for Regulation? The old claim that the market could never work in health care has lately been modified into an assertion that it cannot work soon. On this basis, regulation is being invoked by some as a transitional vehicle with which to hold the line against cost increases while the private sector develops the tools and skills needed to control costs sensitively and effectively. Aside from the fact that it loses force daily as the pace of private sector change accelerates, this argument for regulation as a temporizing measure can carry little weight if regulation would significantly inhibit the development of the very market forces for which it is meant as a temporary substitute. Thus, a final judgment on this rationale for regulation depends upon the answer to the ultimate question examined in this comment. Later analysis will show the way in which even good-faith efforts to regulate with an eye to fostering competition would interfere with its emergence.

Another possible argument for regulation rests on the perceived absence of vigorous demand for cost containment in the private sector. This argument used to carry more weight than it does today, now that employers are perceived to be intensely concerned about costs, but it is still possible to question their willingness to tolerate real cutbacks in the level or perceived quality of services. Moreover, one may be struck by the lack of measureably better cost experience in markets where competition (particularly as evidenced by a multiplicity of HMOs) seems well established. One answer to this observation is that competition may not yet have reached its full flower in any market and is only just now beginning to show – mostly through anecdotal reports of developing price sensitivity – what it can do. After all, the process of re-educating consumers to weigh cost considerations and tolerate different styles of care is only just beginning.

A more telling observation is that the incentive of employers and employees to economize continues to be diluted by the existing tax subsidy for employer purchased private health insurance. Because "capping" this tax subsidy has sometimes been presented as a cornerstone of the so-called competition strategy, a case for cost-containment regulation could perhaps be based on Congress's recent refusal to adopt such a limit. Nevertheless, Congress's refusal to eliminate the distorting effects of its tax subsidies does not automatically justify regulation. Tax subsidies are common in the overall economy – e.g., housing – and do not in themselves invalidate reliance on market forces to allocate resources. If government is unwilling to change private incentives, it is not unreasonable to expect it to accept the consequences of that decision rather than attempting to offset the distortions thus created with new interventions. In any event, Congress may yet yield to good sense and the need for new tax revenues by enacting a subsidy cap. Those concerned about weak economizing incentives in the private sector should vigorously support such action.

Unfortunately, most regulation advocates oppose any limitation of the tax subsidy, thus revealing that they embrace regulation not to correct for the lack of economizing incentives but for other reasons. Prominent among the advocates of regulation are insurers, employers, and labor unions who benefit handsomely from the tax subsidy, and it is probable that they perceive cost-containment regulation as a good way of reducing the pressure on Congress to legislate its limitation. Thus, it appears once again that those pleading for non-market controls have something to lose from the pursuit of economically efficient policies and that regulation is therefore likely to interfere with the emergence of effective market constraints on health care costs.

JUDGING COMPETITION'S PROSPECTS UNDER REGULATION: THE REAL WORLD

Even if regulation and market forces could be made compatible in theory, political and marketplace realities suggest that competition would suffer under any regulatory regime. Indeed, the claim that market developments would not be impeded by well designed regulation assumes a frictionless market in health care. Ironically, the existence of such a market is something that regulation advocates vigorously deny.

Lessons from Past Attempts to Combine Strategies. The few efforts that have been made to regulate for cost containment with harm to competition have not been noticeably successful in fostering the latter. In Maryland, where the hospital rate setters expressly left room for competitive negotiation of discounts below their ceilings, no development in this pro-competitive direction occurred until very recently, when the PPO movement began to have some effect; HMO's are apparently still unable to negotiate any discounts with Maryland hospitals. A possible explanation for competition's slow development in Maryland is that hospitals, obeying the theory of oligopolistic interdependence, have tacitly (or expressly) agreed to reject demands for competitive discounts and to accept regulated rates as the cartel price. Another possibility is that each payer has had less incentive to negotiate lower rates because regulation has already lowered rates for all payers and thus reduced the potential payoff from using its buying power. A payer might therefore find that, compared to the benefits, doing business in a new way would be too costly, too risky, or too easily emulated, if successful, by competitors free-riding on the pioneer's initiative. Whatever the explanation, competition has not

flourished even where a respected regulatory program – though one highly atypical in its commitment to competition – left some room for it to do so.

Congress's effort in the 1979 health planning amendments to compel CON regulators to engage in competition-sensitive regulation has also been a disappointment. Health planners and CON regulators made little or no change in their basic approach as a result of that legislation and continued, like most regulators, to construe their mandate in the way most compatible with their belief that market forces are unreliable. Lack of interest in my book among health planners and regulators may of course have had other explanations besides ideological resistance to its pro-competitive message, but I regard it as at least some evidence that it can take much more than an Act of Congress to change the behavior of regulators and to induce them to participate in deregulating the industry over which they preside.

Political Realities. Some additional reasons for doubting that competition would flourish under a regulatory regime have to do with the probable effect of a regulatory enactment on political agendas and perceptions. Even if regulation was proposed as only one of a series of measures that together would allow the market to show what it can do, political factors could easily lead a state legislature to conclude that, having enacted a regulatory program, it need do no more. Political resistance to pro-competitive measures is likely to be strong in any event, and legislators, having fought the battle for a regulatory bill that appears to "do something" about the cost problem, may find it easier to go on to other business. It would be unfortunate if a state should be diverted from pursuing such pro-competitive reforms as the following:

- lowering barriers to HMO and PPO development;
- repealing or liberalizing restrictive regulation,
- encouraging state antitrust enforcement against recalcitrant providers;
- taxing excessive insurance coverage (to raise cost-consciousness);
- controlling Medicaid costs by prudent purchasing and by limiting choice;
- reforming state employee health plans to encourage cost-conscious choice;
- providing funds to ensure that, despite the advent of competition, citizens who cannot pay their own way have continued access to a satisfactory standard of care.

Even if a judicious attempt was made to limit government's regulatory role, any recognition at all of direct governmental responsibility for the level of private health care costs would almost certainly politicize the issue and invite continuing efforts to tighten regulation. Many in the private sector would find lobbying for tighter controls easier than redesigning insurance coverage, negotiating new arrangements with providers' and educating customers, employees, and union members to new realities. In addition, the regulators themselves, who are nearly always the last to be convinced that competition is workable or desirable, could be expected to become leading advocates for an expansion of their own powers. The threat of stricter regulation, even if it never materializes, has effects on private behavior, as noted below.

The effects of Uncertainty on the Private Sector. Whenever a legislature seriously considers adopting regulation, an element of uncertainty is introduced in the private market, with inhibiting effects on pro-competitive developments. This uncertainty would not end with the proposal's enactment into law but would continue indefinitely as long as new proposals to tighten the regulatory program continued to be advanced. Private parties concerned about health care costs would find it necessary to devote resources to guessing what the legislature or the regulators might do next and to lobbying for various outcomes. As the industry's best minds were applied to tracking and influencing governmental policies, private cost-containment efforts would be neglected. In sum, any assumption of government responsibility for the level of private health care costs alters the climate for private cost containment by creating uncertainty, by altering the calculus of benefits and costs, and by offering those whose behavior must be changed an alternative approach to the problem that does not require hard bargaining or hard choices.

Lessons from Experience under Federal Policy. The history of federal health policy reveals both the danger in embracing mild forms of regulation and the desirability of definitively rejecting regulation in favor of competition. Although federal regulation was never particularly stringent in the 1970s, it was enough to divert Congress from pro-competitive initiatives. Moreover, its very weakness was always seen as an excuse for pursuing stricter regulation, and this threat of more direct controls persisted throughout the period. Only when Congress definitively rejected President Carter's hospital cost-containment bill in 1979 did a series of "pro-competition" bills begin to appear, and only then did the threat of ever stricter federal regulation finally recede, allowing the process of private sector innovation to begin in earnest.

What we should learn from the federal government's flirtations with regulation is that, as long as government professes a responsibility for solving the cost problem, the private sector will stand mesmerized, waiting for government to tell it what to do. It is possible that the only significant pro-competitive development of the 1970s, the HMO movement, would have been suppressed entirely if the federal government had not happened to signal that it was unlikely to do anything to harm HMOs in the regulatory or national health insurance programs it was constantly designing. Although federal policy was somewhat receptive to HMOs, it was also highly regulatory and, as a consequence, raised HMOs costs, distorted their nature, and slowed their development. During the same period, other equally promising pro-competitive developments (e.g., PPOs and similar arrangements) did not appear at all, emerg-

ing only after the private sector was convinced by the defeat of the Carter bill and by the arrival of the Reagan administration that government was not going to solve the cost problem after all.

Even though defeat of the Carter bill and the Reagan administration's policy of benign neglect toward private health care costs undoubtedly allowed some costs to rise more than they might have done under regulation, these developments triggered an important burst of innovation in the private sector. These innovations were inspired in large measure by the specter of uncontrolled costs and seem certainly to have justified the laissez-faire policy, Increasingly, the pursuit of prudent purchasing strategies by -both government and private payers and the accelerating emergence of HMOs, PPOS, and other mechanisms facilitating price competition among providers are being recognized as having ushered in a revolution in the health care industry. Although the process of revolutionary change is far from complete, its potential benefits in finally subverting the traditional monopolistic health care system and its anti-competitive methods of insuring and paying for medical care are now clear enough to dictate that the market's rapid evolution should not be interfered with by reintroducing threats of regulation.

Conclusion

More than a decade of following government's fits and starts has convinced me that private-sector innovation will not occur to an optimal degree without a clear signal that government (both state and federal) firmly believes that private cost problems should be solved privately. Because there are many reasons for believing that the private sector has, in the long run, a comparative advantage in solving these extraordinarily difficult problems sensitively and efficiently, a governmental policy of noninterference and pursuit of market-strengthening reform is ultimately, in my view, the most responsible one – at least if it is coupled with an appropriate concern for its potential side effects on the poor and underinsured. By the same token, governmental indecisiveness and intermeddling seem to me to inhibit the very changes that are most needed. It is, in short, a mistake to believe that a middle line between regulation and competition can be walked without harm to the development of reliable market forces and thus, I would submit, to the public interest.

REGULATION, COMPETITION, AND COST CONTAINMENT by Bruce C. Vladeck

(Continued from Page 6)

Increased competition in this form has indeed been taking place throughout the country, less as a direct result of conscious attacks on the health care cost problem (although the rhetorical support for such measures certainly hasn't hurt) than as part of the general reduction in the real value of employee compensation for working class and low-income people as a consequence of the severe recession of the last several years, In this regard, it might also be noted that rates of health care utilization have fallen dramatically in the last several years, especially in areas hardest hit by the recession, as the pro-competition theorists would suggest, although rates of increase in health care costs relative to general inflation have not fallen concomitantly, contrary to their predictions.

What is really at issue here, though, is the basic mechanisms for financing health care for the American people. Indeed, most citizens, or at least most heavy users of health care, already have health insurance packages that look a lot more like those the competition advocates would support than is generally believed. Medicare recipients, for example, who use roughly 40 percent of hospital services and just about one-quarter of all physician services, already face co-insurance and deductibles that limit the value of their insurance benefits to less that half, on average, of their total expenses.

Through the mechanism of health insurance, especially in the private sector, the younger and healthier members of this society have, in a basic economic sense, long subsidized the older and less healthy. To the extent that greater price sensitivity on the part of consumers, and especially the opportunity for individual employees to choose among benefit plans of various degrees of comprehensiveness and cost, is extended, those subsidies will be driven out of the system, transferring an increasing and eventually unaffordable burden to those who most need insurance. Ultimately, the way real markets tend to work, that responsibility gets passed on directly to government agencies as providers or insurers of last resort. A relatively effective and inexpensive system of hidden subsidies is thus translated into a need for increased taxes, or into the denial of service for those who need them.

No one has yet solved the problem of adverse selection when consumers have choices among insurance plans. People being relatively rational, those who don't expect to need health care will choose the less expensive benefits, while those who do need care will choose more extensive coverage. Over time, that dynamic creates an increasing spread in the cost of insurance between the healthy and the sick, gradually driving the sick out of the market.

The one thing that private entrepreneurs and private firms tend to do particularly well, and increasingly so with growing sophistication in data processing and mass communications, is segment their markets. The way to make money in the health insurance business is to insure only healthy people, just as the way to make money in the operation of hospitals is to treat only those who aren't very sick. Given that the full-time employed population in larger companies is substantially healthier than the unemployed, part-time employed, or employ-

ees of small businesses, larger employers certainly can reduce their costs by following the recommendations of the "competitive" school. In doing so, however, they will not have reduced the costs of health care, only transferred them to those less able to bear them.

COMPETITION AND PURCHASING

The dynamics of a highly competitive market for group health insurance created, until recently, a set of incentives on insurers which effectively discouraged them from enforcing any kind of pricing discipline on the providers of health care services. Because the purchasers of group insurance tended to be more sensitive to the service aspects of insurance than cost, and because they were reluctant to confront, either directly or through their agents, locally influential physicians and health care institutions, large groups long tolerated the prevailing practices of cost-based reimbursement for institutions and prevailing charges for physicians. With the suppliers of care thus essentially provided with a blank check, it is not surprising that costs have risen as rapidly as they have.

Economic realities are increasingly encouraging the purchasers of health care to drive harder bargains. In the rhetorical debate between "regulation" and competition", it is perhaps ironic to note that, in doing so, private purchasers are largely following in the footsteps laid down by public agencies. Indeed, most of the most effective models we have for the "prudent purchasing" of health services were originally tested in the much-maligned, and highly regulated, state Medicaid programs, while the Federal Government's adoption of its highly regulatory system of prospective payment of Medicare appears to have legitimated parallel efforts by private insurers in many parts of the country. Be that as it may, whether one calls it competition or regulation, there is no question f hat more effective approaches to controlling health care costs will require tougher bargaining between some agency representing the interest of consumers and some organizations representing the providers of service.

Putting antitrust considerations aside (something, of course, it is not always possible for private organizations to do) the question then becomes how closely regulated the process of negotiations between buyers and sellers ought to be, Again, there is a strong theoretical argument for relying relatively more on markets than on regulation in this instance, if one is concerned only with minimal price as the outcome of the negotiating process. But in talking about health services there are other considerations that need to be addressed as well.

Just as in the case of changes in insurance mechanisms, so too a restructuring of the basic bargaining relationship between buyers and sellers is likely to benefit the most affluent and less needy buyers, at the expense not so much of the sellers as the less affluent and more needy buyers. One presumes that, if General Motors gets substantially tougher in its negotiations, either directly or through Blue Cross, with hospitals, it will indeed be able to obtain highly preferential prices. But what's good for General Motors may not be good for the teenager working 20 hours a week at McDonald's for the minimum wage, or for the 55-year old widowed department store clerk. Even the Economics I textbooks will tell you that the one thing that markets don't do very well is insure equity. To this issue, the advocates of greater competition in health services have responded with a significant amount of rhetoric, but nothing in the way of realistic, concrete solutions.

CONCLUSIONS

Pressures to contain health care costs continue to mount. While an ideological hostility to regulatory interventions prevails, there is increasing talk of the need to more consciously accept movement towards a "two-class" or "multi-class" system of health care, in which the services available to the poor and working class are less desirable and perhaps lower in quality than those available to the more affluent. It is clear that Medicare and Medicaid, which between them comprise roughly half the market for hospital services, a third of the market for physician services, and two-thirds of the market for nursing homes, are going to be increasingly aggressive purchasers, whether one describes their behavior as regulatory or competitive. A private sector strategy seeking to integrate public and private purchasing mechanisms – a regulatory approach -can control costs within a single class of care. An approach based on every man for himself will, on the other hand, cause some people to drop out of the system altogether, while others receive less than minimally adequate services. The choice is a political – and moral – one,

COMMENTS
by
Clark C. Havighurst

In his essay, Mr. Vladeck has wisely resisted the temptation to lure policymakers back onto the regulatory track by holding out the hope that regulation can be introduced without inhibiting the desirable system changes that competition is currently inspiring, Indeed, he is reasonably candid in his recognition that the hospital rate-setting programs being tried or contemplated in many states are only a partial answer to the cost problem. The reader hoping to find a painless middle ground should not overlook Vladeck's expectation that regulatory controls will also be needed to deal with out-of-hospital services and with the perceived problem that "the population consumes too many expensive health care services of all kinds. "The immense technical and political difficulties of regulating our way through these difficult thickets are of course not alluded to.

Although Mr. Vladeck's claims for hospital rate setting can be debated in several respects, I have never argued, as he implies all competition advocates must, that regulation could never "work" in the narrow sense of slowing the rate of cost increases in the short run. The real questions, however, are whether regulation is generally reliable in all circumstances, whether it succeeds by directing limited resources to their best uses or in some other way, and whether it is the best permanent solution available. Although it is true that competition's pay-off has been hard to detect in gross statistics, recent data on hospital costs show a significant slowdown in the rate of escalation in relation to general inflation. Most assessments attribute this development in part to the growth of prudent purchasing and competition, and Mr. Vladeck himself acknowledges that the recession and "rhetorical support for such measures" have triggered an effective market response. It seems that some empirical evidence of the market's efficacy in containing costs is now beginning to appear.

Mr. Vladeck criticizes the health care marketplace for not resembling, say, the textbook market for widgets. This is an uninteresting issue, however, unless one can evaluate both the seriousness of the particular shortcomings and all the ways in which they might be compensated for, either by private adaptations or by government interventions to improve the market's functioning. Because Mr. Vladeck simply enumerates the market's imperfections without acknowledging that government, too, is an imperfect instrument, I see no need to pursue the matter at length. I would observe, however, that segmentation in insurance markets is objectionable only if, like Vladeck, one is ideologically committed to viewing private insurance as a social institution for redistributing wealth rather than as a voluntary mechanism by which persons can pool risks with others similarly situated. Although Mr. Vladeck is correct in observing that adverse selection –consumers taking advantage of their superior knowledge of their future needs to outguess insurers – is a real problem in insurance markets, neither he nor anyone else has shown that it cannot be managed and held within tolerable limits in health care insurance as in other fields. Finally, as I have argued in my own essay, the practice of cost shifting is a good rather than a bad thing, because it can hasten the demise of the blank check financing plans that are the immediate cause of runaway health care costs.

Mr. Vladeck and I agree that the adverse impact of competition on the availability of health care to the poor and underinsured could easily be intolerable. But, where I argue for replacing hidden subsidies with explicit ones and for ensuring that no one is denied an adequate minimum standard of care, he advocates a system that centralizes decision-making, socializes costs, and provides a single standard of care for all. Mr. Vladeck's regulatory agenda, aimed as it is at stopping some of us from consuming "too many expensive health services" and at enforcing "a single class of care," is essentially an egalitarian program. Tastes for egalitarianism vary, of course, but even if equality were a desirable goal for health policy, it is unlikely that it could be achieved in fact, in this heterogeneous society. Certainly, it could not be achieved by the halfway, half-hearted regulatory measurers currently being entertained. Because Mr. Vladeck must realize that his ideal cannot be realized in practice, it must be that he yearns not so much for a concrete result as for some symbolic action that affirms his egalitarian ethic. Unfortunately, such symbolic action in the name of equity has a high price tag, including a substantial hidden cost in regulation-sheltered inefficiency. I doubt that the benefit is worth the cost or the necessary infringements on personal freedoms.

Given the radical egalitarian impulse underlying Mr. Vladeck's position, one must wonder at his implication that only market advocates are inspired by ideology. My own sense is that we need to concentrate both on strengthening market mechanisms so that they can better translate consumer preferences and cost concerns into provider behavior and on directly remedying the side effects of such a policy on the care available to those who cannot pay. These are practical problems that could yield in time to the combined efforts of persons across a wide ideological spectrum.

COMMENTS
by
Bruce C. Vladeck

In commenting on the paper by Clark Havighurst, a Professor of Low, it was impossible not to be reminded of the old adage of trial lawyers: When the facts are against you, argue the law, when the low is against you, argue the facts; when both the facts and the law are against you, pound on the table. Having neither facts nor laws to support his argument, Professor Havighurst pounds on the table.

Indeed the entire logic of Professor Havinghurst's argument is grounded in the unsupported assertion that market forces will produce a more efficient healthcare system. He concedes the absence of empirical evidence to support that view, and further concedes that at least one regulatory system (Maryland's) does have an effect on controlling costs. (All available data seem to demonstrate that Maryland's system, while effective, is less so than the even more "anti-competitive" systems of New Jersey and, especially, New York.) But unless one accepts a priori Professor Havighurst's belief in market forces, his arguments are largely without substance.

Among those likely to benefit, or think they benefit, from regulatory initiatives, according to Professor Havighurst, are hospitals, physicians, employers, unions, poor and uninsured people, and government agencies. One might ask: Who loses? Presumably, one must infer, some anonymous, abstract "consumers." More concretely, one suspects, the losers are employers who pay premiums for the young and healthy members of large employed groups in non-unionized industries, entrepreneurs engaged in the promotion of "competitive plans," and professors of law disappointed by their book sales. Everyone, that is, except the old, the poor, children, the sick, the unemployed, and members of labor unions. As an unrepentant regulator, I can only say: Mea culpa, mea maxima culpa.

Most astonishingly, Professor Havighurst goes on to argue that the promotion of "pro-competitive" market forces is unfairly impeded by people who even talk about regulation. Doing so gives the non-believers hope that they can take the easy way out. This is table pounding of the highest order. In New York, we actually employ another technical term to describe this kind of argument: Chutzpah.

Indeed, it is perhaps unfair to characterize Professor Havighurst's arguments in terms of the legal process, for they partake much more of another mode of rhetoric, that of the Fundamentalist preacher. But just as mandating the teaching of "Creationism" does not make evolution go away, so sound public policy cannot be made by ignoring the facts, and then forbidding anyone to talk about them.