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Competitive Reform in Health Care: The Vulnerable Revolution

Thomas L. Greaney†

The revolution in health care in the 1980s has generated the belief in some quarters that the nation's long-simmering competition-versus-regulation debate has been resolved in favor of competition. Those predicting rapidly growing alternative delivery systems and diminishing professional sovereignty seem to assume that competition will inevitably generate sufficient momentum to overcome any residual regulatory or professional obstacles.

But allocating health care resources by market principles is far from unanimously accepted today. Moreover, an impressive array of legal, political, and social obstacles still impede competition. While private markets for other goods and services have adapted and grown in spite of public and private impediments, it is questionable whether health markets can do the same. Indeed, if policymakers allow competitive reform to proceed without addressing the severe disruptions it may cause, a powerful reregulation backlash might emerge.

In arguing that reports of the triumph of competitive reform are premature, this Article should not be held to slight the considerable benefits to consumer welfare that health care competition offers. Indeed, the results in those states where competition has spread most quickly lend powerful support to the argument that provider rivalry can produce quality health care more cheaply than can traditional noncompetitive arrangements.¹ However, policymakers may overlook these successes as competition forces them to make many difficult choices.

This Article argues that policymakers should pay far greater attention than they do at present to the regulatory apparatus that must evolve to cope with transitional problems arising from the transformation of health care financing and delivery systems. Moreover, the absence of a uniform national policy addressing competitive reform may inhibit both its pace and its effectiveness. Enthusiasm for market-based reform may produce the mistaken notion that competitive markets obviate the need for govern-

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1. Babbitt & Rose, *Building a Better Mousetrap: Health Reform and the Arizona Program*, 3 YALE J. ON REG. 243, 262 (1986); Johns, Anderson & Derzon, *Selective Contracting in California: Experience in the Second Year*, 22 INQUIRY 335 (1985); see also sources cited *infra* note 65.

ment supervision. Recently, free-market advocates have broadly invoked the purported self-correcting properties of the market to resist government regulation. Where policing is necessary, they find self-regulation preferable to government involvement. However, this Article argues that judicial and governmental intervention has been necessary to maintain and promote competitive health care markets and, moreover, that competition would be short-lived in a totally deregulated environment. Ironically, competitive health care may require some additional government involvement.

This Article examines the regulatory and legal context of the competitive reform movement in health care. Part I surveys the role of the courts in spurring competitive change and considers the political implications of this background. Part II analyzes a number of public and private impediments to expanding the role of markets in health care. Part III considers some likely consequences of continued competitive change and assesses the claims of the groups most affected by deregulation. Part IV suggests some regulatory measures necessary to minimize frictions, advance social goals, and hasten political acceptance of competition in health care. The Conclusion summarizes the policy options.

I. The Emergence of Competition in Health Care

Until relatively recently, the health care industry was essentially exempt from competitive pressures, shielded as it was from the antitrust laws and from significant pro-competitive legislation. Since the 1970s, however, a combination of judicial action and changes in publicly funded reimbursement programs has stripped the industry of most of its antitrust immunity and subjected it to procompetitive reform, including laws encouraging HMOs and other alternative care providers. The details of the move toward competition will be discussed in this Part, while the transitional problems arising from the transformation of American health care and delivery systems will be discussed in the Parts following.

A. *The Role of Litigation in Imposing Competition*

The regulatory reform movement that has profoundly changed the nation's airline, railroad, trucking, telecommunications, and financial services industries is one of the most significant developments in recent American economic history. This movement reflects a broad consensus that regulatory agencies have failed to accomplish various public objectives because they have been captured by the institutions they were designed to regulate.² Deregulation of these industries was intensely debated nation-

2. For some influential discussions of this phenomenon from varying ideological bases, see

ally and change was accomplished largely through federal legislation and administrative action.³

Competitive growth in health care markets has proceeded quite differently. Because the most significant impediments to competition were imposed by private regulation,⁴ much of the deregulation of the health care industry has been accomplished through litigation under the federal antitrust laws, mainly Section 1 of the Sherman Act⁵ and Section 5 of the Federal Trade Commission Act.⁶

Many of the changes came in a series of opinions issued in the late 1970s and early 1980s, in which courts held that health care providers and insurers did not enjoy various legal defenses that for many years had been thought to immunize their conduct from antitrust challenge. Courts disabused physicians of the notion that their activities were protected because they practiced a learned profession,⁷ eased standing and jurisdictional requirements for bringing lawsuits,⁸ narrowed the scope of the statutory immunity of insurers,⁹ and limited defenses predicated on prior approval and review by state agencies¹⁰ or on the existence of federal

Peltzman, *Toward a More General Theory of Regulation*, 19 J.L. & ECON. 211 (1976); Posner, *Theories of Economic Regulation*, 5 BELL J. ECON. & MGMT. SCI. 335 (1974); Stigler, *The Theory of Economic Regulation*, 2 BELL J. ECON. & MGMT. SCI. 3 (1971).

3. Federal legislation has been instrumental in deregulating the following industries: Air transportation, Airline Deregulation Act of 1978, Pub. L. No. 95-504, 92 Stat. 1705 (codified in scattered sections of 49 U.S.C.); banking, Depository Institutions Deregulation and Monetary Control Act of 1980, Pub. L. No. 96-221, 94 Stat. 132 (codified in scattered sections of 12, 15, 22, 42 U.S.C.) and Garn-St. Germain Depository Institutions Act of 1982, Pub. L. No. 97-320, §§ 311, 709, 96 Stat. 1469, 1470, 1540 (codified in scattered sections of 12 U.S.C.); telecommunications, Record Carrier Competition Act of 1981, Pub. L. No. 97-130, 95 Stat. 1687 (codified as amended in 45 U.S.C. § 1017; 47 U.S.C. §§ 222, 609 (1982)) and Cable Communications Policy Act of 1981, Pub. L. No. 98-549, 98 Stat. 2779 (codified in scattered sections of 47 U.S.C.); securities, Securities Act Amendments of 1975, Pub. L. No. 94-29, §§ 2-24, 27(b), 89 Stat. 97, 97-163 (codified at 15 U.S.C. §§ 78-83 (1982)); transportation, Railroad Revitalization and Regulatory Reform Act of 1976, Pub. L. No. 94-210, 90 Stat. 31 (codified as amended in scattered sections of 15, 31, 45, 49 U.S.C.), Motor Carrier Act of 1980, Pub. L. No. 96-296, 94 Stat. 793 (codified in scattered sections of 18, 49 U.S.C.), Staggers Rail Act of 1980, Pub. L. No. 96-448, 94 Stat. 1895 (codified in scattered sections of 11, 45, 49 U.S.C.), and Household Goods Transportation Act of 1980, Pub. L. No. 96-454, 94 Stat. 2011 (codified in scattered sections of 26, 28, 39, 49 U.S.C.). See generally Weiss, *The Regulatory Reform Movement*, in CASE STUDIES IN REGULATION: REVOLUTION AND REFORM 10 (L. Weiss & M. Klass eds. 1981) (early deregulation). On potential efficiency gains from deregulation and justifications for governmental intervention in markets, see S. BREYER, *REGULATION AND ITS REFORM* (1982).

4. Private regulation here refers to the assumption of control over price, output, quality, or other competitive variables by private entities such as medical societies, committees, and private accrediting and licensing groups or by informal or ad hoc understandings among providers.

5. 15 U.S.C. § 1 (1982).

6. 15 U.S.C. § 45 (1982).

7. See *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975) (learned professions defense curtailed for attorneys); see also *Ballard v. Blue Shield of S.W. Va., Inc.*, 543 F.2d 1075 (4th Cir. 1976), cert. denied, 430 U.S. 922 (1977) (interpreting *Goldfarb* to exclude protection for medical care providers).

8. *Hospital Bldg. Co. v. Trustees of Rex Hosp.*, 425 U.S. 738 (1976).

9. *Group Life & Health Ins. Co. v. Royal Drug*, 440 U.S. 205 (1979).

10. *North Carolina ex rel. Edmisten v. P.I.A. Asheville, Inc.*, 740 F.2d 274 (4th Cir. 1984), cert.

health planning laws.¹¹ Perhaps most significant for health care providers, the Supreme Court held in 1978 that professional practices in restraint of trade could not be excused even when they were undertaken to preserve quality or protect public safety.¹² These opinions eliminated the special treatment afforded business arrangements in the health care industry.

The examination of a wide variety of health practices through the lens of antitrust law produced a number of significant changes in health care institutions and professional relationships. Most importantly, antitrust litigation helped remove a complex set of firewalls that had for many years shielded health care providers from market discipline. By protecting professional discretion, eliminating interference by third parties, and establishing the industry's control over such important economic variables as the division of labor, reimbursement methods, and entry, these restraints had supported each other and had thus made competition among providers almost unthinkable. The network of restraints and the absence of effective law enforcement in health care "allowed anticompetitive traditions and attitudes to permeate public policy toward the industry."¹³

The elimination of private restraints affecting health care finance serves as an illustration of how the profession's firewalls were gradually dismantled. Initially, antitrust cases¹⁴ helped promote the emergence of independent buyers by lessening professional control over Blue Cross and Blue Shield plans and by challenging medical society boycotts of health maintenance organizations (HMOs).¹⁵ In addition, successful legal challenges to

denied, 471 U.S. 1003 (1985). *But see* Patrick v. Burget, 800 F.2d 1498 (9th Cir. 1986), *cert. granted*, 108 S. Ct. 65 (1987) (state action doctrine exempts peer review activity from antitrust liability).

11. For discussions of the progression of cases applying antitrust principles to the health care industry, see T. Greaney, *Applying Antitrust Law to the Health Care Industry: History, Rationale and Emerging Issues* (Nov. 7, 1987) (unpublished manuscript) (on file with author); Havighurst, *The Contributions of Antitrust Law to a Procompetitive Health Policy*, in *MARKET REFORMS IN HEALTH CARE* 295 (J. Meyer ed. 1983).

12. *National Soc'y of Professional Eng'rs v. United States*, 435 U.S. 679 (1978). *But see* *Wilk v. American Medical Ass'n*, 719 F.2d 207, 226-28 (7th Cir. 1983) (AMA refusal to associate with chiropractors for medical reasons justifiable on professional grounds if means narrowly tailored), *on remand* 671 F. Supp. 1465 (held unjustifiable on factual grounds).

13. Havighurst, *supra* note 11, at 300.

14. *See, e.g.*, *American Medical Ass'n v. United States*, 317 U.S. 519 (1943); *Feminist Women's Health Center, Inc. v. Mohammad*, 415 F. Supp. 1258 (N.D. Fla. 1976); *Group Health Coop. v. King County Medical Soc'y*, 39 Wash. 2d 586, 237 P.2d 737 (1951).

15. HMOs are medical prepaid plans providing subscribers with specified health services in return for advance fixed periodic payments. There are at least three basic forms of HMOs: staff model HMOs in which the HMO employs physicians on a salaried basis, the group model form in which the HMO contracts with a physician-sponsored entity to provide services, and the independent practice association (IPA) form in which the HMO contracts with independent practitioners. Extensive economic literature concerning HMOs shows that they reduce health care costs by introducing risk-sharing incentives for hospitals and physicians. P. FELDSTEIN, *HEALTH CARE ECONOMICS* 326-57 (1983); Spies, Friedland & Fox, *Alternative Health Care Delivery Systems: HMOs and PPOs*, in *HEALTH CARE COST MANAGEMENT: PRIVATE SECTOR INITIATIVES* 43 (P. Fox, W.

the American Medical Association's ethical prohibitions against all forms of contract medicine or underbidding by physicians helped today's competitive medical plans proliferate.¹⁶ More recently, courts have refused to allow physician groups or hospital associations to bargain collectively with third-party payers¹⁷ or to pressure them to refrain from imposing cost-saving measures.¹⁸ Thus, for example, in 1986 the Supreme Court struck down a collective agreement by Indiana dentists to refuse to provide X-rays to third-party payers who needed them to evaluate the appropriateness of the dental care.¹⁹ The Court unanimously agreed that there was no legal basis for allowing professional groups to interfere with the normal rules governing buyer-seller relationships.

B. Legislative Initiatives

Litigation has thus done much to impel competition in the health care industry. In essence, the courts have presumed that market principles will govern private economic arrangements unless the legislature enacts laws that provide otherwise.²⁰ This litigation has focused the attention of federal and state lawmakers on competition as an important policy option in health care, thus prompting legislative and administrative actions that reinforced the movement toward greater competition.²¹

Goldbeck & J. Spies eds. 1984). See *infra* notes 28, 32 & 144.

16. American Medical Ass'n, 94 F.T.C. 980 (1979), *modified and enforced sub nom.* American Medical Ass'n v. FTC, 638 F.2d 443 (2d Cir. 1980), *aff'd*, 455 U.S. 676 (1982). Until this successful antitrust challenge by the FTC in the 1970s, the AMA's professional ethical norms had effectively foreclosed price competition among physicians. These rules prohibited physicians from accepting "inadequate compensation" (defined as less than "the usual fees paid for the same kind of service and class of people in the community"), soliciting patients directly or indirectly, "underbidding" other physicians "in order to secure a contract", or otherwise agreeing to provide services for specified prices or on a salary basis (referred to as "contract practice"). American Medical Ass'n, 94 F.T.C. at 1011-12; see generally P. STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 304-06, 323-27, 397-98 (1982) (origins of ethical prohibitions); Greaney & Sindelar, *Physician-Sponsored Joint Ventures: An Antitrust Analysis of Preferred Provider Organizations*, 18 RUTGERS L.J. 513, 531-37 (1987) (antitrust analysis of medical association standards); Weller, "Free Choice" as a Restraint of Trade in American Health Care Delivery and Insurance, 69 IOWA L. REV. 1351, 1355-75 (1984) (same).

Earlier, the AMA had insisted that private insurance companies provide remuneration on a fee-for-service basis at rates set by local medical societies, and had condemned HMOs as a form of "unethical practice." American Medical Ass'n v. United States, 130 F.2d 233, 238-40 n.23 (D.C. Cir. 1942), *aff'd*, 317 U.S. 519 (1943); see also Comment, *The American Medical Association: Power, Purpose and Politics*, 63 YALE L.J. 938, 984 (1954).

17. Third-party payers include employers, insurers, and Blue Cross/Blue Shield programs.

18. United States v. North Dakota Hosp. Ass'n, 640 F. Supp. 1028 (D.N.D. 1986); Michigan State Medical Soc'y, 101 F.T.C. 264 (1983); United States v. Montana Nursing Home Ass'n, 1982-2 Trade Cas. (CCH) ¶ 64,852 (D. Mont. 1982) (consent decree); United States v. South Carolina Health Care Ass'n, 1980-2 Trade Cas. (CCH) ¶ 63,316 (D.S.C. 1980) (consent decree).

19. FTC v. Indiana Fed'n of Dentists, 106 S. Ct. 2009 (1986).

20. See cases cited *supra* notes 7-10.

21. See Havighurst, *supra* note 11, at 300-02.

States have been particularly responsive to the claims of alternative care providers, such as nurse-midwives, psychologists, and chiropractors, enacting laws which assure these groups access to facilities and mandate insurance reimbursement or prohibit discrimination in third-party payment for their services.²² However, few states have adopted competitive contracting for their Medicaid and indigent care programs, although a number have elected to participate in demonstration programs.²³ Federal legislative initiatives have included encouragement of HMOs through the HMO Act of 1973²⁴; more recent policies facilitating participation in Medicare by HMOs and other forms of risk contracting;²⁵ and policies affecting health insurance for military and federal employees.²⁶

Ultimately, however, the incremental nature of change—described as “medicine’s creeping revolution”²⁷—may undermine its staying power. The lack of a national debate on the wisdom of applying competitive policies to health markets gives few policymakers a stake in competition’s success. Fewer still have carefully considered the impact of this change or concerned themselves with designing measures to cushion competition’s disruptive effects without vitiating its salutary effects.

II. Continuing Obstacles to the Emergence of a Competitive Market

Antitrust enforcement and recent legislation have not eliminated all private and public barriers to competition. Although state and federal regulation of health care markets has been relaxed greatly—most notably by removing or weakening such supply-side controls as certificate-of-need

22. See *infra* notes 29–54 and accompanying text. On the role of and capacity of states to assume greater responsibility for developing health care policy, see Thompson, *New Federalism and Health Care Policy: States and the Old Questions*, 11 J. HEALTH POL. POL’Y & L. 647 (1986).

23. In 1981, the Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, 95 Stat. 357 (codified in scattered sections of 42 U.S.C.) amended the Medicaid statute to permit states to establish their own qualification standards for HMOs contracting with Medicaid and allow waivers of certain Medicaid requirements, thus permitting selective contracting and other activities necessary to permit alternative delivery systems to service Medicaid beneficiaries enrolled in HMO or other prepaid health plans. Over three-fourths of these enrollees come from four states, Arizona, California, Illinois, and Michigan, that have aggressively pursued these programs. See Freund & Neuschler, *Overview of Medicaid Capitation and Case-Management Initiatives*, HEALTH CARE FINANCING REV. 21, 21–22 (Supp. 1986). Preliminary studies indicate that these programs are cost-effective, especially in states that mandate participation in capitated systems and that have successful quality assurance programs. *Id.* at 28–29.

24. Health Maintenance Organization Act of 1973, Pub. L. No. 93-222, 87 Stat. 914 (codified in scattered sections of 42 U.S.C.).

25. See generally Langwell & Hadley, *Capitation and the Medicare Program: History, Issues and Evidence*, HEALTH CARE FINANCING REV. 9 (Supp. 1986) (history and analysis of HMO risk contracting under Medicare). See also *infra* notes 67–70 and accompanying text.

26. See 5 U.S.C. §§ 8901–13 (1982 & Supp. III 1987) (recent amendments to federal employee health insurance laws require cost monitoring and encourage HMO membership).

27. Ellwood, *Competition: Medicine’s Creeping Revolution*, in FINANCING HEALTH CARE: COMPETITION VERSUS REGULATION 69 (D. Yaggy & W. Anlyan eds. 1982).

(CON) requirements²⁸—deregulatory reform is far from complete. Health care providers and insurers continue to be governed by myriad public regulations that may limit competitive forces. With a handful of states experimenting with removing most regulatory restrictions and a larger number adopting public utility-style rate and supply regulation, it is tempting to conclude that a useful national experiment is under way. However, as discussed below, a mixed and conflicting regulatory regime in health care will likely undermine confidence in competitive solutions, thus encouraging inadequate regulatory reform.

A. State Laws Inhibiting Selective Contracting

Third-party payers are increasingly using negotiation or competitive bidding to contract with physicians and hospitals and to set fees, payments, and, importantly, utilization standards which govern the provision of care to patients. Market failures such as moral hazard²⁹ and information asymmetries³⁰ make this process of competitive or selective contracting between providers and payers central to market-based reform in health care.³¹ Thus, most procompetitive strategies rely on competition among rival provider groups to bid down the amount of reimbursement and to determine which costs are properly reimbursable.³²

28. State certificate-of-need laws require that health care providers obtain prior approval from a state agency before making capital expenditures of specified amounts or instituting costly new services. Most analysts and empirical studies have sharply criticized this form of regulation because it creates artificial incentives to increase use of unregulated services, fails to constrain expansion by health facilities, and discourages the use of cost-effective alternative facilities. See, e.g., C. HAVIGHURST, *DEREGULATING THE HEALTH CARE INDUSTRY: PLANNING FOR COMPETITION* 195-222 (1982); P. JOSKOW, *CONTROLLING HOSPITAL COSTS: THE ROLE OF GOVERNMENT REGULATION* 76-99, 138-68 (1981); Bovbjerg, *Problems and Prospects for Health Planning: The Importance of Incentives, Standards, and Procedures in Certificate of Need*, 1978 UTAH L. REV. 83. Until recently, federal law conditioned availability of certain federal health care funds on a state's usage of certificate-of-need programs to curtail expenditures. See National Health Planning and Resources Development Act of 1974, Pub. L. No. 93-641, 88 Stat. 2225 (codified at 42 U.S.C. §300k (1982)). Legislation has recently been enacted to make state participation voluntary. Medicare & Medicaid Patient Protection Act of 1987, Pub. L. No. 100-93, 1987 U.S. CODE CONG. & ADMIN. NEWS (101 Stat.) 680.

29. "Moral hazard" occurs when insurance lessens incentives for the insured to protect against loss, thus increasing the likelihood of loss. In health care, moral hazard is seen as the overuse of such care due to its low marginal cost under traditional forms of health insurance and the patient's and physician's consumption of more resources. See Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941 (1963).

30. Information asymmetries result when, due to differing willingnesses to pay information costs, potential bargainers bring different amounts of information to the bargaining process. This results in relatively poor bargaining by the less-informed party and thus in economic inefficiency. See G. CALABRESI, *THE COSTS OF ACCIDENTS* 150-51 (1970).

31. For a discussion of the way in which selective contracting may mitigate market failures in health care, see Greaney & Sindelar, *supra* note 16, at 537-49.

32. See, e.g., A. ENTHOVEN, *HEALTH PLAN: THE ONLY PRACTICAL SOLUTION TO THE SOARING COST OF MEDICAL CARE* 70-78, 110-13, 119 (1980); *Proposals to Restructure the Financing of Private Health Insurance: Hearings on H.R. 5740 Before the Subcomm. on Health of the House Comm. on Ways and Means*, 96th Cong., 2d Sess. (1980).

However, state laws governing such areas as insurance, nonprofit insurers, freedom of choice of providers, and mandated benefits constrain the ability of provider panels to engage in selective contracting and to compete with each other. While virtually every state has some regulatory apparatus affecting contracting, their provisions and effects vary widely. In many states the effect is benign.³³ In some cases, however, state requirements discourage or block competitive bidding entirely.³⁴ Overall, these limits may suppress vigorous selective contracting by making the status of the law uncertain and by providing a convenient rationalization for provider intransigence.

The most significant limitation on selective contracting occurs in the nine states that regulate hospital rates.³⁵ In these states, regulatory mechanisms determine the rates that third-party payers pay for hospital services and the services of hospital-based physicians. Although a number of states with rate regulation permit hospitals to negotiate discounts with preferred provider organizations (PPOs),³⁶ most impose limitations on the type and size of any agreed-upon discount. Connecticut, for example, allows hospi-

33. For example, some states require that a plan's conditions and terms be established in advance and be used as a basis for "open" negotiations. *See, e.g.*, ILL. ANN. STAT. ch. 73, para. 982h (Smith-Hurd Supp. 1987); *see also* RAND CORPORATION, STATE LAWS AND REGULATIONS GOVERNING PREFERRED PROVIDER ORGANIZATIONS 24-25 (1986) [hereinafter RAND STUDY] (interviews with PPOs' sponsors indicating that, depending on latitude given to set terms and conditions in advance, such provisions may not interfere significantly with selective contracting).

34. *See infra* note 35.

35. The following states control hospital rates, typically by regulating both total hospital revenues and the rates that all payers are charged for care: Connecticut, CONN. GEN. STAT. ANN. §§ 19a-145 to 166 (West 1985); Maine, ME. REV. STAT. ANN. tit. 22, § 381 (1986); Maryland, MD. HEALTH-GEN. CODE ANN. §§ 19-201 to -220 (Supp. 1985); Massachusetts, MASS. GEN. LAWS ANN. ch. 6A, §§ 31-77 (West 1987); New Jersey, N.J. STAT. ANN. § 26:2H-4.1 (West 1987); New York, N.Y. PUB. HEALTH LAW § 2807 (McKinney 1985 & Supp. 1987); Washington, WASH. REV. CODE ANN. §§ 70.39.030 to .39.910 (1975 & Supp. 1987); West Virginia, W. VA. CODE §§ 16-5F-1 to -6 (1985); Wisconsin, WIS. STAT. ANN. §§ 54.01 to .31 (West 1987). Although state rate regulation has had some success in slowing the rate of increase in hospital costs, empirical studies fail to provide any evidence that rate-setting provides greater cost savings than competitive alternatives. *See* Eby & Cohodes, *What Do We Know About Rate-Setting?*, 10 J. HEALTH POL. POL'Y & L. 299 (1985) (comprehensive survey of studies of state rate regulation concluding that, although mandatory rate-setting has constrained per diem hospital costs, there is no direct evidence that total health costs have been constrained and that rate-setting states differ from other states in ways that are likely to make rate setting less effective in the latter). *Cf.* Mitchell, *Issues, Evidence and the Policymakers Dilemma*, HEALTH AFF., Summer 1982, at 89; Sloan, *Rate Regulation as a Strategy for Hospital Cost Control: Evidence from the Last Decade*, 61 MILBANK MEMORIAL FUND Q. 195 (1983); *see also* RAND STUDY, *supra* note 33, at 55.

36. Preferred provider organizations (PPOs) are arrangements in which services are provided to enrollees by an organization or panel of providers, usually at a discount. Unlike HMO members, enrollees are not required to use preferred providers, though they have economic incentives to do so. The providers also agree to abide by the PPO's controls on service use. *See* Spies, Friedland & Fox, *supra* note 15, at 45; Greaney & Sindelar, *supra* note 16, at 515-22. PPOs differ from HMOs because PPO providers assume no risk for aggregate patient costs, as do HMOs. In addition, PPOs save little, if at all, from practice integration or economies of scale. Greaney & Sindelar, *supra* note 16 at 538-49.

tals to extend discounts only for certain demonstrated efficiencies: prompt payment (up to two percent) and administrative cost savings (up to one and one-half percent).³⁷ Other states require that PPOs wishing to enter into negotiated discounts with providers must demonstrate to a rate-setting commission that the discounts are economically justified and will not cause cost-shifting to other payers.³⁸ Finally, most states regulating rates also continue to limit capital expenditures and facility expansion through CON controls.³⁹ This form of regulation interferes with competitive contracting by constraining hospitals, free-standing delivery centers, and group practices from developing ways to compete with established providers. Not surprisingly, PPO development has been slowest in states with rate regulation.⁴⁰

Other state laws restricting selective contracting are so-called freedom-of-choice or antidiscrimination statutes.⁴¹ These laws generally prohibit third-party payers from restricting their insureds' ability to obtain reimbursement regardless of which provider is chosen or from paying different amounts to different providers who provide the same service. Virtually every state has some law or administrative regulation that may impede bargaining or restrict an insurer's ability to channel patients to low-cost providers.⁴² According to a recent study, administrative and judicial interpretations of these laws may have blunted their impact in a number of jurisdictions.⁴³ Nevertheless, these laws may undermine the vigor of negotiation by lessening the reward to successful bidders.⁴⁴ Moreover, the in-

37. See CONN. GEN. STAT. ANN. §§ 19a-166(d) to -166(e) (West 1985).

38. RAND STUDY, *supra* note 33, at 55.

39. Congress has recently repealed all federal requirements regarding state CON programs (previous amendments had removed most federal compulsion). Act of Nov. 14, 1986, Pub. L. No. 99-660, 1986 U.S. CODE CONG. & ADMIN. NEWS (100 Stat.) 3743, 3799 (to be codified at 42 U.S.C. § 300(m)(6)) (repealing Title XV of the Public Health Service Act, effective Jan. 1, 1987, including 42 U.S.C. § 300 (m)(6), which provided for state CON programs). The repeal did not affect any funds obligated for purposes of Title XV before Jan. 1, 1987. State CON programs are voluntary and subject to the discretion of the states, but approximately 35 have CON programs. Widespread removal of these programs is unlikely in the near future. See Simpson, *Full Circle: The Return of Certificate of Need Regulation of Health Facilities to State Control*, 19 IND. L. REV. 1025, 1086-87, 1110-11 (1986).

40. RAND STUDY, *supra* note 33, at 56-57.

41. Freedom-of-choice statutes typically forbid insurance companies to require that insureds obtain services from particular hospitals or providers. One common variant of such statutes also requires that insurers be left free to choose nonphysician providers. Antidiscrimination statutes assume that providers do not discriminate (for example, in fees, premiums or rates) among insureds of the same class using health services. Virtually all states have antidiscrimination statutes and over half have some form of freedom-of-choice law that may limit selective contracting. RAND STUDY, *supra* note 33, at 22-25. See also Weller, *supra* note 16, at 1351-91.

42. RAND STUDY, *supra* note 33, at 28-33.

43. *Id.*

44. Interviews with insurers and third-party payers suggest that considerable uncertainty exists about the meaning and future application of laws of this kind. In addition, these laws have made some third parties wary about excluding providers and may have deterred some from engaging in selective contracting. *Id.*

consistent state and federal laws designed to protect allied health professionals may also impair efficient contracting. Nonphysician groups that have won guarantees of equal treatment are generally those that have been able to exert political pressure in state legislatures or Congress; where nonphysicians have been poorly organized, they have not achieved legislative protection.⁴⁵ More fundamentally, requiring equal or comparable reimbursement across provider groups fundamentally alters the allocation of risk and strategic elements of bargaining, thus undermining the price-lowering effects of selective contracting.

Recognizing the potential of these laws to curb development of alternative financing systems, twenty-two states have enacted PPO enabling laws.⁴⁶ In general, these statutes are designed to facilitate selective contracting and override freedom-of-choice and antidiscrimination laws. Ironically, many such laws have imposed their own regulatory restrictions on contracting.⁴⁷ To date, only three states, California, Iowa, and Nebraska, have enacted completely permissive statutes.⁴⁸ Most other states require equal or nondiscriminatory treatment of providers or delineate the terms of discount agreements. For example, many such enabling laws require that payers must provide reimbursement to any provider willing to meet specified requirements, while others limit the differential between what the payer may pay its preferred panel and what it must pay to all others.⁴⁹

By removing or constraining an insurer's ability to promise benefits to its select panel of providers benefits in exchange for fee discounts and utilization limitations, these laws tend to undermine the cost-saving potential of competitive negotiation. Although federally qualified HMOs and self-funded insurance plans are for the most part exempt from such statutes,⁵⁰ they may be subject to similarly restrictive state regulations. As

45. Havighurst, *The Changing Locus of Decision-Making in the Health-Care Sector*, 11 J. HEALTH POL. POL'Y & L. 697, 705-09 (1986).

46. RAND STUDY, *supra* note 33, at 28-29.

47. See, e.g., RAND STUDY, *supra* note 33, at 40-51.

48. CAL. INS. CODE §§ 10133-10133.6, 11512-11512.11 (West Supp. 1987); CAL. WELF. & INST. CODE §§ 14165-14165.10 (West Supp. 1987); IOWA CODE ANN. §§ 508.29, 515.485.a (West Supp. 1987); NEB. REV. STAT. §§ 44-4101 to -4113 (1984).

49. For example, in Maryland insurers may not reimburse non-panel providers at a rate below 20% of the rate they pay preferred providers. MD. ANN. CODE art. 48A, § 470X(b)(4) (1986).

50. The HMO Act exempts federally qualified HMOs from state freedom-of-choice and antidiscrimination laws. 42 U.S.C. § 300e-10(a) (1982). While the Act enumerates a number of insurance regulations that are preempted, the list may not be exhaustive. *Health Care Plan, Inc. v. Schweiker*, 553 F. Supp. 440 (D.N.J. 1982), *aff'd*, 707 F.2d 1391 (3d Cir. 1983). The Employee Retirement Income Security Act (ERISA), Pub. L. No. 93-406, 88 Stat. 829 (codified as amended at 29 U.S.C. §1001-1461 (1982)) relieves self-funded employer or union-underwritten plans from state regulation except those laws regulating insurance. Whether ERISA preempts state laws mandating reimbursement for certain providers is unclear. See Note, *ERISA Preemption of State Mandated Provider*

discussed below, state laws mandating benefits, requiring use of certain classes of providers, or regulating premium rates can affect their competitiveness.⁵¹ To the extent, however, that self-insured plans escape burdensome state regulations and taxes imposed on commercial insurers and health service corporations, they may enjoy an advantage. Some critics contend that these laws unfairly penalize employers too small to self-insure.⁵² These laws may also create artificial incentives for some employers to choose one organizational form (and degree of risk) over another.

Other laws may also affect competitive contracting. For example, state laws and regulations governing advertising, controlling entry and expansion through CONs and credentialing, and limiting the corporate practice of medicine have all restricted provider rivalry in the past.⁵³ While legal precedent and administrative inaction may have diminished the significance of these regulations, most could readily be revived by states. Indeed, recent Supreme Court decisions encouraging federalism and strengthening the state action defense to claims under federal antitrust laws suggest that those seeking to contain the growth of competition in health care could readily do so through state regulation.⁵⁴

B. *Private Restraints on Competition*

Another obstacle to competitive reform is the possibility that private restraints of trade may undermine the workings of emerging markets. As suggested above, the medical profession has enjoyed de facto immunity from the effects of competition for most of this century.⁵⁵ While legal doctrine and public attitudes have changed significantly, health care professionals still retain a powerful ethos fundamentally hostile toward competitive change. Thus, it is not surprising that a great many lawsuits brought under the antitrust laws involve the health care industry. This suggests that private collusive actions to curb competition are unlikely to disappear quickly. In an era of declining law enforcement budgets,⁵⁶ it is unclear

Laws, 1985 DUKE L.J. 1194; cf. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985) (state regulation mandating minimum health benefits for insureds not preempted by ERISA as it applies to insurance plans subject to Act).

51. See *infra* notes 147-60 and accompanying text.

52. See, e.g., RAND STUDY, *supra* note 33, at 69-70.

53. See sources cited *supra* note 11.

54. See, e.g., *Town of Hallie v. City of Eau Claire*, 471 U.S. 34 (1985).

55. See generally Havighurst, *Professional Restraints on Innovation in Health Care Financing*, 1978 DUKE L.J. 303.

56. The staff of the Antitrust Division of the United States Department of Justice decreased by nearly one-half during the 1980s. *Administration Unveils More Budget Data*, [Jan.-Jun.] Antitrust & Trade Reg. Rep. (BNA) No. 1300, at 157 (Jan. 29, 1987).

whether health care professionals will be able to reassert guild principles through private restraints of trade.⁵⁷

As noted above, a web of ethical norms, institutional arrangements, and formal and informal agreements has historically shielded providers from competition. Although cataloguing the rich variety of trade restraints devised by health professionals is outside the scope of this article, recent experience suggests that cartelizing schemes have not disappeared. In 1986, for example, the United States Department of Justice successfully prosecuted a case in which the hospitals of North Dakota had held meetings and had collectively agreed under the auspices of their trade association to refuse to extend discounts to the Indian Health Service.⁵⁸ The Justice Department has also challenged payment plans sponsored by local medical societies which were nothing more than thinly-veiled agreements among local physicians to block aggressive HMOs and PPOs.⁵⁹

Particularly vulnerable to future anticompetitive activities are the seams in the system where buyers seek independent competitive responses from health professionals. A prominent example is provider contracting. Payers and consumers can benefit from competitive bidding or negotiations only if providers do not collaborate. Successful collusion destroys economic efficiency. Another example occurs where the market calls for professional judgments that overlap with the economic self-interest of those supplying the professional judgments. Peer review⁶⁰ and credentialling⁶¹ decisions

57. Medical guild principles are generally those rules and norms that historically enabled medical associations to assume responsibility for determining "the amount of production, for prices, and for the competitive relations of their members." Weller, *supra* note 16, at 1355 n.23, (quoting AMERICAN MEDICAL ASS'N, AN INTRODUCTION TO MEDICAL ECONOMICS 19 (1935)). This approach to market organization obviously conflicts directly with the market model which regards professionals as separate economic entities competing with each other over price and other factors. *Id.* at 1355-59.

58. United States v. North Dakota Hosp. Ass'n, 640 F. Supp. 1028 (D.N.D. 1986).

59. See Arizona v. Maricopa County Medical Soc'y, 457 U.S. 332 (1982). The Department of Justice has pursued enforcement actions against efforts by local medical organizations to form PPOs in order to preempt competition. See Remarks of J. Paul McGrath before the 33rd Annual American Bar Association Antitrust Spring Meeting 4-7 (Mar. 22, 1985).

60. Peer review refers to reviewing such things as quality of care, the reasonableness of fees, compliance with ethical standards, and the medical necessity of treatment. These functions are provided for diverse authorities (governmental agencies, third-party payers, hospitals) and by a variety of entities (medical societies, hospital staff committees). Havighurst, *Professional Peer Review and the Antitrust Laws*, 36 CASE W. RES. L. REV. 1117 (1986). Havighurst focuses on community-wide physician peer-review bodies examining private-sector care for use by such independent decisionmakers as insurers. Such organizations might review professional fees, resource utilization, or quality of care. *Id.* at 1123-27. Historically, peer review activities have been intimately linked with professional efforts to maintain price levels and homogenize practice patterns. *Id.*; P. STARR, *supra* note 16, at 44-47, 57-58, 102-07. At the same time, payers and governmental agencies require professional assistance to overcome their information handicaps. It is difficult to resolve disputes involving private peer review actions because competitively impermissible motives and legitimate quality of care issues may often both be present in peer review actions. See, e.g., Patrick v. Burget, 800 F.2d 1498 (9th Cir. 1986), cert. granted, 108 S. Ct. 65 (1987).

61. Health care credentialling refers to a variety of public and private mechanisms for certifying professionals and institutions as suitable for providing health care services. State licensing statutes, for

are two examples. Finally, structural or organizational arrangements among providers in local markets can dictate the competitiveness of those markets. Hospital mergers, over-inclusive Individual Practice Associations (IPAs)⁶² or provider-controlled PPOs, and large physician group practices or joint ventures can in some cases reduce competitiveness among providers and hence dilute the effectiveness of competitive contracting. When the number of competing entities is reduced so that only a few sellers remain—an oligopolistic market—prices and other competitive variables tend not to be optimal.⁶³

The risks of private anticompetitive activity indicate that enthusiasm for market-driven reforms should not diminish vigorous enforcement of antitrust laws. Large profits tend to elicit opportunistic behavior, and, as discussed above, competition in the health care industry has been particularly vulnerable to subversion. Regrettably, as we have been reminded by the securities industry, professionals are not immune from these temptations. Self-regulation is not a reliable substitute for public law enforcement.

C. *The Government as Purchaser of Health Services: Lagging Behind the Private Sector*

Because government programs consume nearly forty percent of all health care expenditures,⁶⁴ they can dictate the pace of change in the

example, regulate entry and supervise quality standards for physicians, allied health practitioners and, to a limited extent, institutions such as hospitals and nursing homes. Private credentialing includes certification of professionals through various means such as professional specialty boards, institutional providers by entities such as the Joint Commission on Accreditation of Hospitals, and the scope of professional practice within institutions through peer control over staff privileges. For an excellent analysis of public and private quality assurance programs, see T. Jost, *The Necessary and Proper Role of Regulation to Assure the Quality of Health Care* (Nov. 7, 1987) (forthcoming in 10 Hous. L. Rev.). For analyses of competitive risks in credentialing, see Havighurst, *Doctors and Hospitals: An Antitrust Perspective on Traditional Relationships*, 1984 DUKE L.J. 1071, 1075-76 & n.13 (1984) (physician control over staff privileges); Havighurst & King, *Private Credentialing of Health Care Personnel: An Antitrust Perspective*, 9 AM. J.L. & MED. 131 (1982) (benefits of competitive credentialing entities); Jost, *The Joint Commission on Accreditation of Hospitals: Private Regulation of Health Care and Public Interest*, 24 B.C.L. REV. 835 (1983) (hospital accreditations); Kissam, *Government Policy Toward Medical Accreditation and Certification: The Antitrust Laws and Other Procompetitive Strategies*, 1983 WIS. L. REV. 1 (physician accreditation).

62. IPAs are medical plans that contract with solo practitioners and small practice groups. These are thus distinct from HMOs that deliver care from central sites. If too many physicians join an IPA, it effectively becomes a cartel. It will thus set prices to maximize profit, which may well be uncompetitively high. See Spies, Friedland & Fox, *supra* note 15, at 47.

63. See F. SCHERER, *INDUSTRIAL MARKET STRUCTURE AND ECONOMIC PERFORMANCE* 151-68 (2d ed. 1980); 4 P. AREEDA & D. TURNER, *ANTITRUST LAW: AN ANALYSIS OF ANTITRUST PRINCIPLES AND THEIR APPLICATION* 54-60 (1980); Weiss, *The Concentration Profits Relationship and Antitrust*, in *INDUSTRIAL CONCENTRATION: THE NEW LEARNING* 189 (H. Goldschmid, H. Mann & J. Weston eds. 1974). For an application of oligopoly theory to physician joint ventures, specifically over-inclusive provider-sponsored PPOs, see Greaney & Sindelar, *supra* note 16, at 576-78, 582-89.

64. Medicare payments, totalling \$70.5 billion in 1985, make up approximately 50% of the total governmental health care payments. Medicaid and state and local indigent care programs constitute

health care industry. Competition in health care markets would be markedly enhanced by competitive techniques such as bidding, vouchers, and selective contracting by state, local and federal governments. Such a policy shift would hasten physician acceptance of contract medicine, awaken employers to alternative arrangements, and enhance consumer awareness of the potential benefits of panel medicine in lieu of the arrangements they have previously accepted.

To date, however, governmental agencies have been slow to adopt market principles. Indeed, they have lagged behind the private sector in using contracting methods to effect cost savings. Most states continue to use cost reimbursement in their Medicaid programs, relying upon such regulatory tools as eligibility, benefit design, and fee controls to limit costs. Only a few states, most notably California and Arizona, have turned to large-scale selective contracting programs in their Medicaid programs.⁶⁵ At the other extreme, nine states have adopted some form of explicit rate regulation of hospitals.⁶⁶ These states generally permit a governmental agency to set rates based upon the historic costs of each hospital or of categories of hospitals. Significantly, under all-payer regulatory schemes, these governmentally-set rates apply to both public programs and private insurance. Rate-setting regulation's success in controlling to some degree inpatient costs encourages proposals to extend fee controls to other sectors of the industry.

The federal government has given only modest encouragement to competitive approaches to cost control in Medicare.⁶⁷ Instead of giving Medi-

the remainder. Prospective Payment Assessment Commission, *Medicare Prospective Payment and the American Health Care System; Report to Congress*, Medicare & Medicaid Guide (CCH) No. 517, at 12 (extra ed. March 23, 1987) [hereinafter *ProPAC Report*].

65. See *supra* note 1. A number of Medicaid programs have begun demonstration projects for contracting with alternative delivery systems authorized under the Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, § 2178, 95 Stat. 357, 873-74 (codified as amended at 42 U.S.C. §§ 300e, 1395-96 (1982 & Supp. 1986)). Preliminary evaluations of the costs and access to care in these demonstration projects have been favorable. Freund & Neuschler, *Overview of Medicaid Capitation and Case-Management Initiatives*, HEALTH CARE FINANCING REV. 21 (Supp. 1986).

66. See *supra* note 23. For an analysis of rate-setting methods used by several states with all-payer regulation, see Meyer, *Financing Uncompensated Care With All-Payer Rate Regulation*, in UNCOMPENSATED HOSPITAL CARE: RIGHTS AND RESPONSIBILITIES 167 (F. Sloan, J. Blumstein & J. Perrin eds. 1986). These programs may control health care costs ineffectively over time. See *infra* notes 111-14. However, recent studies show that rate-setting schemes have proved effective in the few years in which they have operated. See, e.g., Thorpe, *Does All-Payer Rate Setting Work? The Case of the New York Prospective Hospital Reimbursement Methodology*, 12 J. HEALTH POL. POL'Y & L. 391 (1987).

67. See *infra* note 142 (HMO Act largely ineffective). However, the Department of Health and Human Services (HHS) is contemplating modifying traditional Medicare Part B (physician services) coverage to provide financial incentives for consumers to use PPOs for medical care. *HHS Devising PPO Plan for Medicare Payment of Physician Services*, HEALTH LAW. NEWS REP., Nov. 1987, at 1, 1-2. As discussed above, the government has a critical role in setting standards and bargaining over the terms of PPO provider contracts.

care beneficiaries strong incentives to join HMOs or other competitive plans, for the first fifteen years of the program the federal government refused to reimburse HMOs on the same basis as other Medicare providers. Then, three years after Congress authorized the use of per capita payment, the government began to reimburse HMOs on a basis that made it attractive only for certain beneficiaries to join.⁶⁸ In addition, the Reagan Administration abruptly changed policies in 1983, embracing a prospective payment system (PPS) for Medicare.⁶⁹ While heralded by some proponents as a step toward competitive reform, PPS is regarded by others as giving strong support to system-wide rate regulation.⁷⁰

Whatever the direction in which it propels public policy, prospective payment suffers from the serious defects that make administered pricing plans poor substitutes for market-driven prices. One recognized difficulty with most forms of rate regulation is the regulator's tendency to resolve issues in favor of the regulated entity. In health care it is particularly difficult for them to resist the claims of health professionals, especially when these professionals appeal for resources that will be used in life-saving enterprises. A second problem with regulation is the considerable uncertainty inherent in the process of evaluating competing claims for scarce health care monies. As argued below,⁷¹ the link between health expenditures and effective cures is poorly understood even with respect to well-established procedures and technology. Ex ante evaluations of new technologies are even more problematic.⁷² Moreover, most regulators are

68. Before 1985, requirements for participation in HMO contracting with Medicare were highly restrictive and unattractive to potential contracting. Regulations that became effective February 1, 1985 allow for risk contracts on a capitation basis at 95% of the average per capita cost adjusted for age, sex, disability, and other factors and subject to other requirements that may reduce the plan's ability to retain surpluses. See OFFICE OF TECHNOLOGY ASSESSMENT, PAYMENT FOR PHYSICIAN SERVICES: STRATEGIES FOR MEDICARE 7-51 (1986).

69. In 1983, Congress adopted a prospective payment system to be phased in over a four year period beginning in 1984. Social Security Amendments of 1983, Pub. L. No. 98-21, § 601(c)(1), 97 Stat. 65 (codified as amended at 42 U.S.C. § 1395ww (Supp. III 1985)). Under the new system, the Medicare program pays hospitals fixed, prospectively-determined prices based on the patient's diagnosis. The fixed amounts are determined by which of 470 diagnosis-related groups (DRGs) the patient falls into, subject to certain cost adjustments for certain hospitals and "outliers" (cases involving unusually high costs). DRGs comprise a means by which patients are grouped into homogeneous categories with respect to specific diagnostic, therapeutic, and demographic criteria in order that the costs appropriate for substantially similar patients be relatively uniform. HHS is required to update payment rates annually by adjusting for inflation, technology, and other factors comprising the component cost elements of the system and recalibrating the DRG weights. *Id.* at §§ 1395(d)(2)(9)(D) & (d)(3)(A). Congress also established the Prospective Payment Assessment Commission (ProPAC) to make recommendations to the Secretary of HHS on updating payment rates and modifying DRGs as well as to assess the impact of PPS on the American health care system.

70. Morone & Dunham, *Slouching Toward National Health Insurance: The New Health Care Politics*, 2 YALE J. ON REG. 263 (1985).

71. See *infra* notes 99-102 and accompanying text.

72. For analyses of the problems of evaluating and regulating changes in medical technology, see OFFICE OF TECHNOLOGY ASSESSMENT, STRATEGIES FOR MEDICAL TECHNOLOGY ASSESSMENT

not well equipped to make such evaluations. Finally, the familiar observation that reducing health expenditures is not synonymous with reducing the total costs of illness has particular bearing on the efficacy of regulatory solutions. Cost-saving mechanisms like price and supply regulation that do not give providers incentives to reduce the *total* cost of illness are likely to be ineffective in constraining overall costs.⁷³ Nonetheless, because these approaches may produce quick and politically attractive savings in program budgets, they may have considerable appeal to policymakers.

Medicare's PPS system illustrates some of the problems inherent in regulatory solutions. Because of the enormous inefficiency and perverse rewards that drove the cost-based system that preceded it,⁷⁴ prospective payment has achieved some measure of savings. By assigning fixed payment rates to inpatient hospital services and procedures, Congress has deployed price controls that cause inpatient costs to increase less rapidly than others in the health care system, which are still largely tied to cost-based reimbursement principles.⁷⁵

There are reasons to be skeptical about the efficacy of shifting cost-control policy to the supply side, as prospective payment does. PPSs yield administered prices, not market prices.⁷⁶ Efficient providers cannot take away business from the inefficient and thus force cost containment upon them. Indeed, the PPS system does nothing to discourage admissions, and may even encourage them.⁷⁷ To control admissions, Medicare relies on peer review organizations (PROs).⁷⁸ These organizations employ adminis-

(1982); Mehlman, *Health Care Cost Containment and Medical Technology: A Critique of Waste Theory*, 36 CASE W. RES. L. REV. 778 (1986). Although in principle prospective payment seems to eliminate the need for coverage evaluation, peer review organizations, *see infra* note 78 and accompanying text, may deny payment on DRG claims that reflect technologies not approved by Medicare. HEALTH CARE FINANCING ADMIN., PEER REVIEW ORGANIZATION MANUAL 59 (1986). More fundamentally, the prospective payments system entails an administrative determination of which technologies will be classified in certain DRGs, thus recalibrating DRG payment rates to reflect new or changing technologies. *See* Chu, *Health Care Cost Containment and Technology Assessment*, 36 CASE W. RES. L. REV. 884, 904 (1986).

73. *See* A. ENTHOVEN, *supra* note 32, at 93-113; P. JOSKOW, *supra* note 28, at 71.

74. *See supra* note 32; Greaney & Sindelar, *supra* note 16, at 525-28.

75. For example, Medicare inpatient expenditures (those covered by PPS) showed a real growth rate of 1.3% in 1985, compared to the real growth rate of 6.5% in total Medicare expenditures. *ProPAC Report*, *supra* note 64, at 12. Interpreting the effects of PPS is complicated by data limitations, changing demographics and health patterns among the elderly, and substitution of various services not under PPS for inpatient care. *Id.* at 11.

76. *See* Enthoven & Noll, *Prospective Payment: Will It Solve Medicare's Financial Problems?*, 1 ISSUES IN SCI. & TECH. 101, 112 (1984).

77. *Id.*

78. Peer review organizations (PROs) are private organizations primarily controlled by physicians that contract with HHS, among other organizations, to monitor hospitals' inpatient services to Medicare beneficiaries by retrospectively reviewing to insure that services are medically necessary, reasonable, and cost-effective. PRO enforcement authority consists primarily of the power to deny payments to hospitals. Secondly, in some cases, PROs refer practitioners to HHS for additional sanctions under 42 U.S.C. §§ 1320c-1320c-12 (1982). *See* Kinney, *Making Hard Choices Under the*

trative controls which have high transaction and information costs and are unlikely to be as effective as incentive-based controls.⁷⁹ Governmentally set prices also determine which technologies are rewarded, forcing the regulator to choose between procedural and cognitive therapies and to make countless other decisions in setting relative rates. In addition, economic analysis suggests that under prospective payment an efficient supply of hospital services will be provided only in the unlikely case that physicians act as perfect agents for their patients.⁸⁰ If, as is far more likely, physicians are more responsive to incentives provided by the hospital, then hospital services will be undersupplied as physicians help hospitals meet DRG-inspired goals. There will also be strong incentives for hospitals to attract low-risk patients by increasing advertising, amenities, and promotions.

Finally, the administrative structure for PPS rate setting is subject to political intervention. As the forces described above drive up the costs of even the most efficient hospitals, HHS, or, more likely, Congress may ease price pressures by raising PPS reimbursement.⁸¹ As one authority concluded, rate setting under PPS in its first years demonstrates "Congress's ability to control the rate-setting process politically"⁸² with results that appear to have served the financial interests of the regulated entity.⁸³

Medicare Prospective Payment System: One Administrative Model for Allocating Medical Resources Under a Government Insurance Program, 19 IND. L. REV. 1151, 1179-80 (1986).

79. Kinney, *supra* note 78; see also Havighurst & Blumstein, *Coping with Quality/Cost Trade-offs in Medical Care: The Role of PROs*, 70 NW. U.L. REV. 6 (1975). Although PROs differ in many respects from physician service review organizations (PSROs), the problems inherent in implementing retrospective review, difficulties in making trade-offs between cost and quality, uncertainty about PRO policy objectives, and the difficulties in setting standards by contract make it unclear how effective this form of regulation will be. See generally B. FURROW, S. JOHNSON, T. JOST & R. SCHWARTZ, HEALTH LAW 419-29 (1987); Kinney, *supra* note 78, at 1190-93.

80. Ellis & McGuire, *Provider Behavior Under Prospective Reimbursement: Cost Sharing and Supply*, 5 J. HEALTH ECON. 129 (1986).

81. The initial experience of HHS and Congress in updating payment rates supports this analysis. Proposals by HHS to freeze hospital payment rates for fiscal year 1986 and allow only a 5% increase in 1987 met strong resistance from the American Hospital Association and other interest groups; as a result, Congress approved higher rate increases. See Kinney, *supra* note 78, at 1182-87. In addition, ProPAC has a large role in the process, principally by providing "Congress [with] the information that it needs to substitute its own judgments for those of the executive branch in this complex, highly technical area, through the political process." *Id.* at 1187.

82. *Id.* at 1196.

83. The Office of the Inspector General of HHS strongly criticized the high profit margins realized by hospitals under PPS, reporting that for fiscal year 1985 (Sept. 1, 1985 to Aug. 31, 1986) hospital profit rates from PPS averaged 15.3%, up from 14.8% in fiscal year 1984. *Will Profit Data Drive Medicare Policy?*, HOSPITALS, Apr. 5, 1987, at 28. In fiscal year 1984, the first year of PPS, 82% of 2,099 PPS providers studied earned profits averaging \$1.3 million per facility, resulting in a net profit margin of about 15% on Medicare revenues and a return on investment (equity) of 25%. Eighteen percent of the sampled hospitals incurred losses averaging \$155,000 per facility, so that average profits were eight times average losses. *Inspector General Memorandum on Financial Impact of PPS*, [1986 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 35,420 (May 30, 1986). Aggregate Medicare payments are expected to exceed aggregate costs by 11.5% in fiscal year 1987.

D. *The Tort System*

A final impediment to achieving cost savings through enhanced competition is the tort system. The threat of malpractice actions may impose social costs by fostering excessive care (defensive medicine) and discouraging cost-efficient decisionmaking by providers.⁸⁴ Although the extent to which the tort system actually causes physicians to practice defensive medicine is unclear,⁸⁵ fear of malpractice judgments coupled with faltering malpractice insurance markets may, at the margin, place limits on the economizing potential of market based reforms. For example, physicians worried about potential malpractice claims may simply be unwilling to undertake the large personal risks associated with joining the most cost-effective alternative delivery systems.

Moreover, the legal standard used to determine liability in malpractice actions tends to compel practice styles that may be costly and unnecessary in an attempt to insure the safety of patients. Conversely, that standard of care may discourage innovative practice arrangements associated with competitive payment systems. Under tort law, physicians are judged by whether their actions depart from the prevailing reasonable or customary practice.⁸⁶ The consequence of this standard may be to buttress doctors' resistance to economical practice styles or technologies. This risk is underscored by case law suggesting that a single standard of care applies in malpractice actions regardless of the cost containment objectives of a payment system's utilization control mechanism and that physicians may be personally liable for malpractice in such situations despite the pressures exerted on them by such mechanisms.⁸⁷ Therefore, unless the threat of malpractice claims is eased by tort reform or by other means, the cost-saving potential of alternative delivery systems may be limited.

Although a variety of proposals have been put forward to solve the malpractice dilemma, none seems likely to resolve the problems discussed here. The many proposals to reform the tort system have yet to prove their efficacy.⁸⁸ Moreover, even if successful, these reforms run the risk of

CONGRESSIONAL BUDGET OFFICE, REDUCING THE DEFICIT: SPENDING AND REVENUE OPTIONS: A REPORT TO THE SENATE & HOUSE COMMITTEES ON THE BUDGET—PART II 69 (1987).

84. See P. DANZON, *MEDICAL MALPRACTICE: THEORY, EVIDENCE AND PUBLIC POLICY* 146-50 (1985).

85. *Id.*; U.S. GEN. ACCOUNTING OFFICE, *MEDICAL MALPRACTICE: NO AGREEMENT ON THE PROBLEMS OR SOLUTIONS* 34-35 (1986) [hereinafter GAO REPORT]. Moreover, cost-based reimbursement itself is probably responsible for much defensive medicine because it permits doctors to disregard cost when ordering care. Hence, the extent to which tort reform would alleviate this problem is unclear.

86. RESTATEMENT (SECOND) OF TORTS §299A (1965).

87. See, e.g., *Wickline v. California*, 183 Cal. App. 3d 1175, 228 Cal. Rptr. 661 (1986).

88. Reform proposals include caps on liability, common law restrictions on contingency fees, modification of such doctrines as the collateral source rule, the use of arbitration panels, and others. See GAO REPORT, *supra* note 85, at 18-21, 83.

undermining the traditional quality assurance function that the tort system provides.⁸⁹ Given the inadequacy of existing regulatory regimes in monitoring and policing incompetent practitioners,⁹⁰ this may be a high price to pay. A second group of reform proponents argue that marketplace competition among health plans can alleviate the malpractice crisis by placing contractual limits on liability through such means as caps on awards, no-fault principles of claim resolution, and mandated alternative dispute resolution procedures.⁹¹ Most importantly, the potential for altering by contract the standard of care applicable to alternative delivery systems could provide some protection against excessive awards.⁹² However, because contract-based solutions to malpractice risks rely on judicial enforcement, their effectiveness remains uncertain.⁹³ Moreover, if, as some contend,⁹⁴ actual malpractice claims may vastly understate the actual quantity of medical negligence, these contractual remedies may prove far more costly than it now appears. In any event, the efficacy of malpractice law reform is likely to influence the efficacy of competitive approaches to reforming health care delivery as well.

III. Conducting the Social Triage

I have argued that a shift to competitive markets will significantly alter relationships and reshape health care institutions. For a number of groups, these changes will have significant economic consequences that will in turn generate political side effects. For competitive reform to suc-

89. See Sloan, *State Responses to the Malpractice Insurance "Crisis" of the 1970s: An Empirical Assessment*, 9 J. HEALTH POL. POL'Y & L. 629, 643 (1985) (finding "no indication that . . . state legislative actions had their intended effects on premiums"); cf. Danzon, *The Frequency and Severity of Medical Malpractice Claims: New Evidence*, 49 LAW & CONTEMP. PROBS. 57 (1986) (analyzing impact of such factors as urbanization, business cycles, and tort reforms on number of malpractice claims).

90. See *infra* notes 130-41 and accompanying text.

91. See, e.g., Havighurst, *Reforming Malpractice Law Through Consumer Choice*, HEALTH AFF., Winter 1984, at 63.

92. See Havighurst, *Private Reform of Tort-Law Dogma: Market Opportunities and Legal Obstacles*, 49 LAW & CONTEMP. PROBS. 143, 148-49 (1986) (arguing for flexible standards in malpractice actions to take into account private agreements between providers and patients which reflect patients' economic choices); see also Furrow, *Medical Malpractice and Cost Containment: Tightening the Screws*, 36 CASE W. RES. L. REV. 985 (1986) (noting that most doctors and commentators fear increased tort liability only during transition from high resource-use practice style under cost based reimbursement to lower resource-use styles under prospective payment or capitation system, but arguing that tort doctrine can be refined to deal with cost-effective medical decisions by focusing on institutional setting rather than on individual practitioner).

93. See Furrow, *supra* note 92. Other reform proposals rely on legislative initiatives to redirect most malpractice claims away from the tort system. Havighurst, "Medical Adversity Insurance"—*Has Its Time Come?*, 1978 DUKE L.J. 1233, 1252-56; O'Connell, *Neo-No Fault Remedies for Medical Injuries: Coordinated Statutory and Contractual Alternatives*, 49 LAW & CONTEMP. PROBS. 125 (1986).

94. Saks, *In Search of the "Lawsuit Crisis"*, 14 LAW MED. & HEALTH CARE 77 (1986).

ceed, the claims of these groups need to be understood and, in some cases, accommodated.

A. *Bitter Pills for Providers: Reduced Incomes and Changing Practice Styles*

Competitive reform of health care financing and delivery, if successful, will precipitate two unpleasant consequences for physicians: incomes will fall and practice styles will change. For hospitals, the forecast is equally severe: many acute care facilities may fail as services are delivered in less costly settings. If these disruptive effects are not addressed in advance, political repercussions from the affected interest groups could cut short pro-competitive policy initiatives. More important, of course, are the economic consequences of the twin precipitants of competition—lowered provider incomes and improved technical efficiency. The questions to be asked, then, are whether the economic losses to providers result in lower-quality health service or other side effects which would offset any cost savings that competition may produce and whether rationing is an inevitable byproduct of intensified competition.

To place competition's potential effects on providers in proper perspective, we must first recognize that health costs represent nothing more than the gross incomes of all providers of health care and their suppliers. Thus, improved performance in the health care industry necessarily implies lowering those incomes or reducing technical inefficiency in the system or both.⁹⁵ Competition therefore tends to reduce incomes in the health care industry directly. With that decrease come disruptions in current practice arrangements⁹⁶ and, the argument goes, deterioration in the quality of the health care workers.

However, there appears to be little economic support for this argument. Even though it is possible for lower professional and managerial incomes to deter talented individuals from entering those professions (and thereby lower the quality of care the system produces), the experiences of countries that have capped increases in professional incomes, such as Canada

95. R. Evans, *The Spurious Dilemma: Reconciling Medical Progress and Cost Control* (Mar. 1985) (unpublished manuscript) (on file with author).

96. Physicians have long been accustomed to practice arrangements that permitted almost unchecked professional discretion and autonomy in practicing medicine. See P. STARR, *supra* note 16, at 198-232. This freedom has permitted physicians to avoid many of the burdens of the corporate form, such as hierarchical controls, division of labor through team arrangements and other forms of coordination, and the need to generate their own sources of capital. *Id.* Disruption of these accustomed patterns of doing business and usurpation of long-standing "professional norms" may arguably make the practice of medicine less attractive. On the other side, as discussed below, displacement of these practices or norms may often permit more cost-effective ways of rendering care to develop. See *infra* note 98 and accompanying text.

and Great Britain, does not support this theory.⁹⁷ With the prospect of more efficient matching of professional tasks to professional skills, greater use of teaming in administering care, and the potential lessening of administrative and other nonpractice burdens, it is possible that the attractiveness (or the opportunity costs) of practicing medicine will not be diminished at all.⁹⁸ In short, there are strong reasons to doubt that current income levels fix human capital and output optimally.

More importantly, the potential for reducing technical inefficiency in the health care system carries with it the prospect that competition can generate significant savings without sacrificing quality or substantial provider income. Epidemiologic studies of regional variations in medical practice styles offer evidence that the nation's health needs could be met at lower costs without sacrificing quality or rationing care. One study has shown four- to ten-fold variations in hospital admission rates and resource usage over a large range of surgical and medical DRGs.⁹⁹ Strong regional differences in the intensity and cost of medical care without corresponding variances in health benefits support the argument that there is technical inefficiency that can be removed from the system. Similarly, a recent review of medical records from 1982 to 1984 found that twenty-three percent of hospital admissions were for treatment that could have been provided in a doctor's office or clinical setting, and that an additional seventeen percent of surgical admissions could have been performed on an out-patient basis.¹⁰⁰ The private sector has demonstrated that it can make effective use of this kind of research. Based on studies indicating that as much as twenty percent of laboratory and medical testing may be unnecessary, Blue Cross and Blue Shield recently announced guidelines to control reimbursement for such tests.¹⁰¹

97. Evans, *Finding the Levers, Finding the Courage: Lessons from Cost Containment in North America*, 11 J. HEALTH POL. POL'Y & L. 585 (1986); Klein, *Why Britain's Conservatives Support a Socialist Health Care System*, HEALTH AFF., Spring 1985, at 41.

98. Evans, *supra* note 97. For an analysis of studies showing economies of scale in physician practices and that physicians tend to work in groups smaller than the most efficient size, see P. FELDSTEIN, *supra* note 15, at 178-81, and Frech & Ginsburg, *Optimal Scale in Medical Practice: A Survivor Analysis*, 47 J. OF BUS. 23 (1974); see also Tarlov, *HMO Enrollment Growth and Physicians: The Third Compartment*, HEALTH AFF., Spring 1986, at 23 (consequences of increased unencumbered physician time include more time with patients, more continuing medical education and teaching, more time to care for poor).

99. Wennberg, *Dealing with Medical Practice Variations: A Proposal for Action*, HEALTH AFF., Summer 1984, at 38; Wennberg, McPherson & Caper, *Will Payment Based on Diagnostic-Related Groups Control Hospital Costs?*, 311 NEW ENG. J. OF MED. 295-99 (1984).

100. Siu, Sonnenberg, Manning, Goldberg, Bloomfield, Newhouse & Brook, *Inappropriate Use of Hospitals in a Randomized Trial of Health Insurance Plans*, 315 NEW ENG. J. OF MED. 1259 (1986).

101. New Guidelines on Giving Tests in Medical Care, N.Y. Times, Apr. 2, 1987, at A-12, col. 1; see also Linn, Yager, Leake, Gastaldo & Palkowski, *Differences in the Numbers and Costs of Tests Ordered By Internists, Family Physicians and Psychiatrists*, 21 INQUIRY 266 (1984) (wide variations in tests ordered for hypothetical patient, both between and among medical specialties).

Epidemiologic evidence thus tends to refute the contention made by some economic theorists¹⁰² that the market efficiently resolves uncertainty in medicine only by delegating complete discretion to physicians. Unchecked discretion seems only to compound uncertainty and encourage waste. If technical inefficiency can be reduced, savings can coexist with the continued quantity and quality of care. Thus, the income losses and disruption of existing practice arrangements that providers are likely to experience do not necessarily affect lower total health care or system-wide quality.

From this perspective it can be argued that the rationing debate is simply an effort to divert attention from the private economic interests that are at stake.¹⁰³ Even if rationing is a red herring, there is another serious consideration. Changing payment patterns may displace certain private cross-subsidies, thereby causing a redistribution of health resources away from those most in need of them.

B. *The Uninsured and the Poor*

The inattentiveness of competitive reform advocates to the effects of market-driven policies on the uninsured and the poor is surprising on two counts. First, the magnitude of the problem commands attention. The simple, compelling economic fact is that a great deal of indigent care will be squeezed out of the existing system as private and public hospitals adjust their policies to accommodate the price demands of payers in a competitive market. In all but a few states, alternative methods for financing and delivering this displaced indigent care are not even on the horizon. The second cause for surprise is pragmatic. Further medical neglect of the poor and an increased burden on other social services can only undermine public confidence in market-based policies and strengthen the call for governmental control of health care.

Hospitals in the United States have engineered a massive social service system to provide primary and secondary care to the poor by arranging for private insurance, and even some public programs like Medicare, to cross-subsidize the care hospitals provide to indigents. In 1984, one estimate states that some \$5.7 billion of uncompensated care was provided by hospitals, of which \$1.7 billion represented charity care and the remainder bad debts.¹⁰⁴ Admittedly, reliable data are lacking. For example, the

102. See, e.g., Arrow, *supra* note 29.

103. R. Evans, *supra* note 95, at 7.

104. Mulstein, *The Uninsured and the Financing of Uncompensated Care: Scope, Costs and Policy Options*, 21 *INQUIRY* 214, 219 (1984).

boundary between charity and bad debt care is to some degree a matter of accounting convention.¹⁰⁵ Moreover, although some care provided to individuals able, but unwilling, to pay is collectible, hospitals lack incentives to pursue these debts. These reservations aside, there can be little doubt that considerable health resources are diverted to the poor and uninsured because hospitals act as de facto social service agencies. As hospitals increasingly compete for the patient base of HMOs, self-insured employers, and PPOs, they will almost certainly reduce the funds they use to subsidize care provided to the uninsured. As each payer insists on the lowest price, discretionary hospital budget items like uncompensated care will be sacrificed.¹⁰⁶

There is a compelling case for restoring, at a minimum, the quantum of health care services displaced by competitive reform. With some thirty-five million citizens without health insurance and nearly one-half of the poor ineligible for Medicaid, the population vulnerable to the erosion of cross-subsidies is considerable.¹⁰⁷ Furthermore, those figures underestimate the true social cost of weakening the health care safety net. Lost wages, reduced income taxes, increased health costs due to reduced early detection and treatment, and new demands on other social services represent some of the additional consequences of tightening indigent-care budgets.

Refocusing the rhetoric of the debate would be helpful here.¹⁰⁸ Provid-

105. The extent to which hospitals classify uncompensated care as bad debt or charity care varies considerably and does not appear to rest on any accepted standard. *Id.* at 219-20.

106. It has been argued that, despite private cross-subsidy's inefficiency, it must be kept because more redistributive plans are politically inexpedient. *See, e.g.,* Schuck, *Designing Hospital Care Subsidies For the Poor*, in UNCOMPENSATED HOSPITAL CARE: RIGHTS AND RESPONSIBILITIES 12, 80-83. However, recent events in the health care industry make this claim unrealistic. As discussed in this section, the drop in profit margins caused by competition has greatly diminished private support of indigent care. As open-ended cost-based reimbursement seems unlikely to return, we should make indigent care part of the public debate.

107. In 1984, 35.1 million people, 17% of the population under age 65, had no medical insurance, public or private. Only 46% of those below federal poverty standards are currently eligible for Medicaid. B. FURROW, S. JOHNSON, T. JOST & R. SCHWARTZ, *supra* note 79, at 569. Although the original intention of sponsors of the Medicaid program was to encourage states to extend coverage to all indigent persons, *see, e.g.,* 42 U.S.C. § 303 (1969), *repealed* Pub. L. 92-603, 86 Stat. 1484 (1972), state and federal budget reductions and eligibility rules have caused Medicaid coverage of the poor to decline. *See* Dallek, *Health Care for America's Poor: Separate and Unequal*, 20 CLEARINGHOUSE REV. 361, 362-63 (1986).

108. Recent efforts to expand public health insurance programs have focused on concerns about "catastrophic" coverage for the elderly. On July 22, 1987, the House of Representatives, by a vote of 302-127, passed H.R. 2740, 100th Cong., 1st Sess., to amend Title XVIII of the Social Security Act to provide protection from catastrophic medical expenses under the Medicare program. 133 CONG. REC. H6545 (daily ed. July 22, 1987). Recipients must meet a \$520 annual hospitalization deductible in 1987 and a \$500 annual prescription drug deductible in 1989. There is no long-term health care (nursing home or home care) coverage. Home care visits are covered for only 35 days. There is a limit of \$1043 on Part B out-of-pocket expenses. The Congressional Budget Office has estimated that the new benefits will cost \$33 billion over five years. *House Passes Catastrophic Protection Plan*, HEALTH LAW. NEWS REP., Aug. 1987, at 1. Though it serves a laudable objective, this costly program does not significantly alleviate the problems of the uninsured and the indigent. The considerable

ing displaced indigent care can be distinguished from proposals to put new welfare burdens on society. What was once provided by private subsidies should not be withdrawn simply because public agencies must now do the redistributing. Moreover, additional indigent health care funded from part of the competitive dividend resulting from more efficient delivery systems, redirected provider incentives, and other sources does not entail new social outlays. One might even hope that the policy debate could consider that the health care system could produce a more equitable distribution of the fifty billion dollar tax subsidy effected through exclusion of employer health insurance contributions.¹⁰⁹ In sum, policymakers, confronted with a fundamental reordering of the health care system, should be encouraged to see competition as affording opportunities to increase basic health services to the poor and not as a ploy to exacerbate, *sub silentio*, existing inequities in access to care.¹¹⁰

One common misconception finds greater support for indigent care inconsistent with competition among providers and health plans. Indeed, one argument forcefully advanced on behalf of all-payer rate-setting schemes is their success in spreading the costs of indigent care.¹¹¹ However, there is no reason why states employing competitive approaches cannot finance expanded indigent care while also equitably distributing the financial burdens of that care.¹¹² Some states, for example, levy a tax on the net revenues of hospitals to finance indigent care, yet encourage competition among health plans. Notably, Florida's indigent-care pool is not linked to any rate-setting program.¹¹³ Thus, the considerable savings real-

enthusiasm for this type of proposal reflects the political difficulties of restricting health care financing in a manner that will provide a minimum level of health care.

109. Enthoven, *Health Tax Policy Mismatch*, HEALTH AFF., Winter 1985, at 5, 7.

110. Embedded in these issues is the question of what kind of health care policy reform is preferable given limited resources and political constraints. For example, legislation to grant the elderly catastrophic coverage carries significant costs, is not progressively structured, and does little to alleviate the problem of care for indigents. See *supra* note 108. At the same time, it is a politically popular form of social insurance that is closely aligned with traditional conceptions of social insurance in the United States. See, e.g., Marmor, *American Medical Policy and the Crisis of the Welfare State: A Comparative Perspective*, 11 J. HEALTH POL. POL'Y & L. 617 (1986).

111. See, e.g., Calkins, *Assuring Access In a Changing Health Care System*, 63 BULL. N.Y. ACAD. MED. 93, 97-98 (1987). But see Meyer, *supra* note 66, at 178-80 (all-payer rate-regulation does not eliminate cost-shifting; rather, it moves costs to Medicare and hospitals, thus producing only slight decline in overall health care costs). A recent study shows that costs continue to be shifted under all-payer regulation, but that overall health care costs nevertheless decline. Zuckerman, *Commercial Insurers and All-Payer Regulation: Evidence on Hospitals' Response to Financial Need*, 6 J. HEALTH ECON. 165, 180 (1987).

112. See Meyer, *supra* note 66, at 180-83 (proposes voucher system to replace existing indigent-care reimbursement methods, as it would encourage use of such efficient delivery systems as HMOs and PPOs). New York has provided for expanded indigent care in its all-payer regulation, which has resulted in a 22% rise in total bed-days devoted to uninsured care from 1982 to 1985. Thorpe, *supra* note 66, at 399.

113. Lewin & Lewin, *Health Care and the Uninsured*, 1 BUS. & HEALTH 9, 13 (1984).

ized by employing selective contracting in state Medicaid programs may be used to support efforts to provide care to those affected by the reduction in hospital cost shifting.

There are, however, reasons to doubt that without federal incentives or compulsion states will adopt competitive strategies for financing care for the medically indigent. Even less promising are prospects that state indigent care programs would seek to offset lost care previously supplied through hospital cost shifting. Despite their capacity to realize cost savings, capitated programs incur high start-up and administrative costs.¹¹⁴ The ability¹¹⁵ and willingness¹¹⁶ of most states to undertake costly innovations in financing indigent care is highly questionable. States participating in the Medicaid program have been unwilling to pay for the medically indigent: most states have failed to expand eligibility or to adopt the highest allowable income limits and have declined to cover all optional eligibility categories.¹¹⁷

In sum, selective contracting and other competitive techniques can help introduce efficiency and improve the operation of public programs as well as private financing systems. However, failure to address the loss of cross-subsidies and continued neglect of the medically indigent may prove competition's downfall. Unless steps are taken to resolve these issues as competitive reform measures are adopted, political support for those measures may wane.

C. *Teaching Hospitals*

Teaching hospitals in the United States provide a number of unique health care products financed in large part by the general patient revenues of those institutions. These include graduate medical education, research, the testing of new technologies, and certain highly specialized services.¹¹⁸ As with uncompensated care, price competition among acute care hospitals will erode the margins that teaching hospitals currently use to cross-subsidize these special products. Unless academic medical centers develop specific mechanisms to finance testing, teaching, and research extramurally, they will have little choice but to reduce significantly expenditures devoted to those products.

114. See Freund & Neuschler, *supra* note 23, at 27–29.

115. See Schuck, *supra* note 106, at 78–80 (indigent-care subsidies should be organized federally because of federal leverage and regulatory control, federal administrative capacity, and need to avoid state competition to lower welfare benefits); see also Thompson, *supra* note 22, at 655–62.

116. Bovbjerg & Kopt, *Coverage and Care for the Medically Indigent: Public and Private Options*, 19 *IND. L. REV.* 857, 898–99, 912–13 (1986).

117. *Id.*

118. Colloton, *Competition: The Threat to Teaching Hospitals*, in *FINANCING HEALTH CARE: COMPETITION VERSUS REGULATION* 131, 140–42 (D. Yaggy & W. Anlyan eds. 1982).

Although the existing health care financing system may overproduce these products or inefficiently allocate resources to their production, it does not follow that a public policy of benign neglect is appropriate. The positive externalities of research, testing, and some aspects of medical education make it likely that market mechanisms will systematically underfund their production.¹¹⁹ Not only is a market-based approach unlikely to devote sufficient resources to these services, but it places the onus of withdrawing cross-subsidies primarily upon the teaching hospitals. Placing that responsibility on such diverse and decentralized institutions raises questions of efficiency and equity. Therefore, though some may argue that existing cross-subsidies produce too many specialists or wastefully favor certain kinds of technologies and modalities, these problems do not justify the lack of a coordinated national policy to permit some subsidization to counter the problem of externalities. Even so, state and federal authorities appear content to await proof that a catastrophic problem is at hand.

Instead of waiting, there are several possible approaches to the problem of underfunding education, research, technological experimentation and highly specialized services. A fund for research and teaching services provided by public hospitals might be financed out of a surcharge on the premiums of all insurance and delivery plans.¹²⁰ Alternatively, teaching and research might be supported out of general tax revenues. Of course, difficult problems remain. For example, such a program must assure that the more efficient teaching hospitals are rewarded. Then, too, the identity of the fund administrator and the existence and details of the review system remain open questions, as does the means by which we insulate the system from political pressures, especially pressures from entrenched medical interest groups. The great public benefits associated with medical research and medical education, at least to the extent that research and education encourage greater physician diversity and wider dispersal of practice locations, require that the policy debate begin to address these problems.

IV. Promoting Competition Does Not Eliminate the Need for Governmental Regulation

Several factors contribute to the need for regulation of some aspects of the health care market. First, information is difficult to gather and ana-

119. An externality occurs when someone produces a good or service that has effects on others. Products such as research and the testing of new technologies are examples of positive externalities—undertakings that produce benefits for which the producer cannot collect. The case for governmental subsidies for those activities is usually strong. Whether there are similar external benefits in funding a greater number of physicians, however, is controversial among economists. P. FELDMAN, *supra* note 15, at 405–07.

120. Colloton, *supra* note 118, at 215.

lyze and is asymmetrically distributed among patients, providers, and payers.¹²¹ Individual consumers and even sophisticated third-party payers find it difficult to determine when services are needed and which services are the most cost effective. Second, insurance markets are subject to adverse selection and are highly sensitive to such vagaries of the legal system as changing malpractice standards. Finally, the industry's history of trade restraints and the public's longstanding acceptance of the sovereignty of the medical profession suggest that competitive health care markets are highly vulnerable to professional collusion. While part of competition's appeal lies in its capacity to mitigate market failures, underlying imperfections of the kind described above persist even in competitive health markets. These characteristics of health care help identify some areas for government intervention. A few examples of procompetitive regulation are discussed below.

A. *Improving the Flow of Information*

Providers, concerned about malpractice risks, reputations, and competitive positions, have strong incentives to keep secret all quality and outcome data. Indeed, organized medicine has actively resisted governmental efforts to improve information flow. For example, hospital trade groups and the American Medical Association (AMA) have opposed efforts to require that PROs make public practitioner-specific information.¹²² The government can help alleviate information problems in several ways. As both the regulator of health professionals and institutions and the purchaser of health services, the government can efficiently gather, process, and distribute information that is comprehensible and that will help competitive markets function. For example, public agencies can monitor health and medical outcomes. They could then pass along to buyers both aggregate information reflecting the efficacy of different kinds of delivery systems or treatments and provider-specific information that could help buyers make judgments on price, quality, and utilization.

Governmental agencies are best equipped to provide such information

121. Information in health care is costly and difficult to acquire because of its complexity, the uncertainties surrounding diagnosis and treatment, and professional efforts to limit its availability and use. See Greaney & Sindelar, *supra* note 16, at 528-31. In addition, physicians, by virtue of their training and direct experience with the patient, have far greater information about the nature and severity of an illness and treatment options than do either patients or payers. *Id.*; see also P. FELDMAN, *supra* note 15, at 260; Pauly, *The Economics of Moral Hazard: Comment*, 58 AM. ECON. REV. 531 (1968).

122. See *Hospitals Rap Release of Mortality Rate Data*, AMERICAN MED. NEWS, Mar. 21, 1986, at 1; see also *The Patient Has a Right to Know*, N.Y. Times, June 15, 1984, at A18, col. 1. Attempts to secure release of such data under the Freedom of Information Act have been unsuccessful. *Public Citizen Health Research Group v. HEW*, 668 F.2d 537 (D.C. Cir. 1981).

at low costs and, where necessary, to preserve confidentiality or place limitations on the dissemination of disclosed information. Unfortunately, efforts by the Department of Justice and others to compel the release of peer review data concerning practice patterns, utilization, and outcomes have been only partially successful.¹²³ Legislation designed to improve information flows has also neglected the competitive benefits of wider dissemination. The recently enacted Health Care Quality Assurance Act¹²⁴ empowers the federal government to gather information on disciplinary actions undertaken by hospitals, state boards, and other bodies, but severely restricts disclosure of that information. The Act specifically prohibits disclosure to employers, insurers, and the public¹²⁵—the very groups that could use such information to make more informed and cost-effective choices of providers.

Recent problems with Medicare risk-contract HMOs¹²⁶ might also be reduced were the government to improve information flow. The quality and marketing practices of such HMOs have lately been questioned. Alleged abuses include the use of misleading promotions and the failure to advise beneficiaries of their options and rights.¹²⁷ These abuses stem from inherent problems with market-based programs in which consumers cannot gather and use information as effectively as they must to make rational choices. Indeed, as suggested below, even sophisticated individuals may best be represented by agents, such as employers and third-party payers, who have the time and experience to bargain effectively.¹²⁸ Moreover, if unscrupulous practices become the norm, scrupulous providers will suffer from the bad reputation of the unscrupulous.¹²⁹ For these rea-

123. See Letter from J. Paul McGrath, Assistant Attorney Gen., to Carolyn K. Davis, Health Care Financing Admin. of the U.S. Dep't of Health and Human Servs. (June 25, 1984) (discussing proposed regulations authorizing disclosure of hospital-specific information while protecting confidentiality of individual practitioners, utilization, and practice patterns) (on file with author). Reversing its earlier position, the federal government has recently authorized the release of hospital mortality data. See *HHS To Release Hospital-Specific Mortality Data*, HEALTH LAW NEWS REP., Sept. 1987, at 1. Governmental failure to collect information from private groups, share information within, or release information to the public has contributed greatly to inadequate physician monitoring. See Kusserow, Handley & Yessian, *An Overview of State Medical Discipline*, 257 J. A.M.A. 820, 823-24 (1987).

124. Pub. L. No. 99-660, 1986 U.S. CODE CONG. & ADMIN. NEWS (100 Stat.) 3743, 3784 (to be codified at 42 U.S.C. §§ 11101-52).

125. *Id.* at 42 U.S.C. § 11134(b).

126. Medicare risk-contract HMOs provide all Medicare benefits for a fixed cost for each enrollee, bearing the risk if actual costs exceed the fixed payment. As of March 1, 1987, about three percent of the Medicare population were enrolled in such HMOs. MINORITY STAFF OF SENATE SPECIAL COMM. ON AGING, 100TH CONG., 1ST SESS., *MEDICARE AND HMOs: A FIRST LOOK, WITH DISTURBING FINDINGS* ii (Comm. Print 1987).

127. *Id.* at 712, 2025.

128. See *infra* notes 148-60 and accompanying text.

129. See Akerlof, *The Market for "Lemons": Quality Uncertainty and the Market Mechanism*, 84 Q.J. ECON. 488 (1970) (consumers, often risk-averse, make market decisions based in large part on general reputation, especially where specific information is lacking).

sons, the government should at least set standards and marketing controls for HMOs. It might prove better still for the government to exercise its buying power to negotiate regulated capitation contracts for plans serving Medicare beneficiaries.

B. *Using Licensure and Other Regulatory Tools to Promote Quality of Care*

The rapid growth of competition also requires that public agencies regulate professional competence more carefully. Many private quality-assurance mechanisms in medicine, such as professional norms and informal protocols, referral practices, and informal peer oversight, at present have only limited effectiveness.¹³⁰ They would prove even less effective in competition-driven markets.¹³¹ Quality-assurance mechanisms regarded as capable of dealing with difficult information and enforcement problems are principally regulatory and controlled by governmental agencies.¹³² Although increased governmental supervision of quality standards may at first seem incompatible with competitive markets, regulatory intervention is essential to overcome market failures that could undermine the effectiveness of competitive reform.

There are reasons to doubt the effectiveness of existing regulatory mechanisms. Restrictions on the availability of new physicians and the ability of nonphysicians to practice have been relaxed considerably in recent years. As a result, many new practitioners have entered the market.¹³³ However, governmental licensure, an important means of controlling the quality of professional services and reducing the need for other forms of intervention to assure public safety, has not effectively adjusted to the changing health-care-professional labor market. For example, a large percentage of new physicians have graduated from medical schools outside the United States; in nine states, over forty percent of all new medical licenses were awarded to foreign medical graduates.¹³⁴ State licensing

130. See Jost, *supra* note 61, at 12-19.

131. Private groups reviewing quality control are likely to lose their autonomy as third-party payers bargain directly over competitive variables. Organizational hierarchies controlled by payers are likely to replace or assume greater control over profession-sponsored bodies, though they will still need professional expertise.

132. See Jost, *supra* note 61, at 58-60.

133. The number of physicians in the United States has steadily increased, outstripping the percentage growth in the nation's population since 1970. In 1970 there were 137 medical doctors per 100,000 people, while in 1980 there were 172 and in 1982 there were 184. BUREAU OF THE CENSUS, U.S. DEP'T OF COMMERCE, STATISTICAL ABSTRACT OF THE UNITED STATES 103 (1986). For the year 2000 one estimate projects a ratio of 233 doctors per 100,000 people. See Tarlov, *supra* note 98, at 23-25.

134. DEPARTMENT OF HEALTH AND HUMAN SERVS., OFFICE OF THE INSPECTOR GEN., OFFICE OF ANALYSIS AND INSPECTIONS, MEDICAL LICENSURE AND DISCIPLINE: AN OVERVIEW 5 (1986) [hereinafter MEDICAL LICENSURE].

boards and private credentialing entities lack the information and ability to assess adequately the credentials and abilities of these practitioners. A recent governmental study concluded that state licensing boards are inadequate for the task of assessing the medical education offered by foreign schools and that testing and residency programs do not appear to have improved significantly quality assurance through licensure.¹³⁵

Similarly, both public licensing agencies and government reimbursement programs have been extraordinarily lax about sanctioning incompetent physicians. A significant number of health professionals are incompetent or suffer some impairment of their ability to practice.¹³⁶ In spite of this problem, state and federal governments have all but abdicated responsibility for disciplining physicians. A report by the Office of the Inspector General of HHS concluded that state licensing boards are highly ineffective in imposing disciplinary sanctions based on incompetence or malpractice.¹³⁷ Despite estimates that up to 75,000 physicians are impaired or incompetent, boards revoked licenses only 255 times in 1984 and 406 times in 1985.¹³⁸

The states' ineffectual record in disciplining physicians is traceable to a number of factors. Most importantly, state boards have severe financial constraints that limit greatly their ability to police physician competence.¹³⁹ Other elements include the legal standards and procedures applicable in such proceedings and the inadequacy or absence of mandatory reporting requirements and information-sharing procedures among private and public entities involved in health care quality supervision.¹⁴⁰ Medicare and other public reimbursement programs also have failed to eliminate providers who have been found incompetent or impaired. This

135. *Id.* at i.

136. The Department of Health and Human Services has estimated that between 5% and 15% of all physicians are impaired because of alcohol or drug dependency, incompetence, or failure to keep abreast of developments. See *Rural Rides*, *ECONOMIST*, Apr. 11, 1987, at 29; see also Brill, *Curing Doctors*, *AM. LAW.*, Sept. 1985, at 1, 13.

137. *MEDICAL LICENSURE*, *supra* note 134, at ii.

138. See *Rural Rides*, *supra* note 136, at 30.

139. In 1986, the Inspector General's office reported a sharp increase in disciplinary actions by state boards. Brinkley, *State Medical Boards Disciplined Record Number of Doctors in 1986*, *N.Y. Times*, Nov. 8, 1986, at A6, col. 1. It is not clear that this rise reflects a significant increase in enforcement. *Id.*

140. *MEDICAL LICENSURE*, *supra* note 134, at 14-18. Although the number of disciplinary actions against physicians has increased recently, the increase in major actions, such as revocation, suspension, and probation, has been quite small. Kusserow, Handley & Yessian, *supra* note 123, at 822. The Office of the Inspector General concludes that budget constraints, inadequate information-sharing, and legal obstacles prevent state boards from policing physicians adequately. *Id.* at 822-24; see also Derbyshire, *How Effective is Medical Self-Regulation?*, 7 *LAW & HUM. BEHAV.* 193 (1983); Dolan & Urban, *The Determinants of the Effectiveness of Medical Disciplinary Boards: 1960-1977*, 7 *LAW & HUM. BEHAV.* 203, 210-16 (1983) (efficacy of medical licensing boards inversely proportional to physician dominance, though all lack substantial efficacy); Jost, *supra* note 61.

record underscores government's neglect of minimum quality standards. In the past, reimbursement has rarely, if ever, been refused to providers on the basis of incompetence or impaired ability to practice medicine. Although the Inspector General of HHS recently exercised his authority to refuse reimbursement to a handful of rural physicians, the litigation and political resistance from the AMA generated by this action illustrate the obstacles to improved governmental oversight.¹⁴¹

Thus, state and federal authorities have not adapted the necessary licensure and other regulatory mechanisms for ensuring quality in order to keep pace with the demands of changing conditions in health care labor markets. Although political impediments may hinder their progress, governmental agencies are well-positioned to use these tools to help consumers overcome information problems. Moreover, by doing so they may lessen the need for more invasive forms of quality regulation.

C. *Providing Incentives for Using Cost-Effective Delivery Systems*

A superficially appealing argument claims that now that competition has arrived government should treat all insurance and delivery systems equally. It is argued that the time has come to eliminate laws encouraging development of HMOs, such as those permitting federally-qualified HMOs to mandate that employers offer the HMO option or those requiring equal contributions.¹⁴² While there may be cause to review the effectiveness of those laws, it is premature to discard the policy of encouraging consumers to choose more cost-effective health systems.

First, in the near term it is unlikely that health plans will compete sufficiently with orthodox delivery systems to discipline most markets.¹⁴³ Although alternative delivery systems have grown rapidly, it may be some time before they approach the critical mass necessary to change overall practice styles, influence the path of new technological development, and

141. See *Rural Rides*, *supra* note 136, at 30. The Department of Health and Human Services recently acceded to a number of the AMA's procedural demands. *Doctors Gain Rights in Medicare Quality Reviews*, N.Y. Times, May 12, 1987, at 1, col. 2.

142. Health Maintenance Organization Act, 42 U.S.C. §§ 300e to 300e-7 (1982). The HMO Act permits federally qualified HMOs to require employers with 25 or more employees to offer one staff or group model HMO and one IPA model HMO. 42 U.S.C. § 300e-9(b) (1982 & Supp. 1987). Such employers are also required to make contributions to HMOs equal to contributions made to other insurance plans offered by the employers. The original HMO Act has been criticized as ineffective, if not actually harmful, in promoting HMOs. See, e.g., H. FRECH & P. GINSBURG, *PUBLIC INSURANCE IN PRIVATE MEDICAL MARKETS: SOME PROBLEMS WITH NATIONAL HEALTH INSURANCE* (1978). However, 42 C.F.R. § 110.808(a) (1986) lessens some of the more objectionable effects by, among other things, limiting HMO payments by the employer to the amount that would be paid under a collective bargaining agreement or some other employer-employee contract.

143. As of mid-1986, only 12%-13% of the privately paying market was enrolled in some form of HMO, PPO, or other health plan. Enthoven, *Managed Competition in Health Care and the Unfinished Agenda*, HEALTH CARE FINANCING REV. 105, 105 (Supp. 1986).

affect input costs. Second, it is unrealistic to assume that long-established health care relationships, preferences, and attitudes can be quickly overcome in local markets merely by making available the option of choosing an alternative delivery system.¹⁴⁴ A health plan, like any new entrant in a competitive market, faces learning curves, economies of scale, and reputational entry barriers that may take time to overcome.¹⁴⁵

As discussed above, litigation and the changing regulatory climate have mitigated, but not eliminated, the principal obstacles confronting alternative health care systems. However, tax policies, private trade restraints and governmental policies that favor the purchase of comprehensive indemnity health insurance continue to have an important influence in slowing the pace of procompetitive change in the health care industry.¹⁴⁶ Consequently, encouraging consumers to choose cost-effective delivery plans remains justified. In essence, laws favoring alternative delivery systems are a second-best means of countering long-standing but politically unassailable policies that have fostered wasteful reimbursement methods. Besides favoring the retention of regulations favoring HMOs and other competitive plans, this reasoning supports new policy initiatives. Tax incentives should be provided that encourage employees to choose more efficient plans. Also, incentives for employers to offer multiple health plans and other forms of affirmative regulation can help plans gain wider acceptance.

D. *Regulating to Avoid Risk Selection and Other Insurance Market Failures*

Competition advocates dispute which regulatory mechanisms are needed to prevent risk selection and other market failures associated with insurance markets. As critics of competitive reform have noted, insurers may find it far easier to earn profits by seeking out healthy consumers who will have less costly claims than by operating more efficiently.¹⁴⁷ Similarly, adverse selection can occur: less healthy consumers will choose more comprehensive plans, thus forcing disproportionately high risks on some in-

144. See Luft, Maerki & Trauner, *The Competitive Effects of Health Maintenance Organizations: Another Look at the Evidence from Hawaii, Rochester, and Minneapolis/St. Paul*, 10 J. HEALTH POL. POL'Y. & L. 625 (1985) (finding no widespread cost-containing response in communities with sizeable HMO enrollments and concluding that local systems' reactions and responses to increased competitive pressures may be slow).

145. See P. FELDSTEIN, *supra* note 15, at 344-45, 353-55 (discussing effects of consumer information, business group and union attitudes, and professional resistance on acceptance of HMOs); Enthoven, *supra* note 143, at 112-13.

146. For an excellent analysis of tax incentives and their effect on health insurance, see Enthoven, *supra* note 109. On private restraints of trade, see *supra* notes 55-63 and accompanying text.

147. See, e.g., Rosenblatt, *Health Care, Markets, and Democratic Values*, 34 VAND. L. REV. 1067, 1084 (1981).

surers. These phenomena, called biased selections,¹⁴⁸ tend to cause competition to unravel, decreasing the social benefits of insurance as the healthy stop subsidizing the sick and, ultimately, undermining the risk-spreading function of insurance.¹⁴⁹ Health insurance markets are subject to other problems as well. Individuals may free-ride on the availability of health insurance, signing up for certain health coverage only when they expect to need care shortly. In addition, market segmentation is possible; health plans may design their benefits, tailor promotions, or locate providers in ways that reduce competitive interaction among plans.¹⁵⁰ While some product differentiation is desirable, excessive segmentation may undermine price competition among plans.

One approach to these problems, proposed in Alain Enthoven's Consumer Choice Health Plan (CCHP), relies on extensive government regulation of health plans.¹⁵¹ Comprehensive federal requirements would standardize benefit packages, require community rating by actuarial categories, set enrollment practices, and assure minimum quality standards for all health plans.¹⁵² Apart from the political problems associated with the sweeping legislative changes CCHP requires, it may be criticized because it would unnecessarily burden competitive pricing and benefit-package designing. In addition, it is unclear that CCHPs would be effective in the long run. Community rating, for example, is not a particularly effective means of redistributing medical care from high-income to low-income individuals.¹⁵³ It may also be economically inefficient by reducing the overall amount of insurance purchased as more low-risk purchasers are driven to self-insure.

Clark Havighurst¹⁵⁴ and, recently, Enthoven himself¹⁵⁵ have suggested that employers, third-party payers, and other sponsors can be relied upon to take steps to guard against the risks described above. According to this view, employers act as informed purchasers and counteract the insurance market's deficiencies. This approach effectively shifts to employers the re-

148. The term biased selection refers to situations in which an insurer draws a set of enrollees from a risk pool with such high or low utilization rates that premiums and claims diverge. Biased selection may be adverse or favorable depending on whether premiums exceed claims-related expenses. Although health insurers necessarily subsidize some of the ill, biased selection can lead to inequities and barriers to expanded health insurance coverage because insurers must raise premiums or leave the market. See T. McGuire, Financing and Reimbursement for Mental Health Services 9-11 (January 26, 1987) (unpublished paper) (on file with author).

149. Wilensky & Rossiter, *Patient Self-Selection in HMOs*, HEALTH AFF., Spring 1986, at 66.

150. Enthoven, *supra* note 143, at 110.

151. A. ENTHOVEN, *supra* note 32.

152. *Id.*

153. P. FELDMAN, *supra* note 15, at 155-59.

154. Havighurst, *Competition in Health Services: Overview, Issues and Answers*, 34 VAND. L. REV. 1117, 1154-56 (1981).

155. Enthoven, *supra* note 143, at 106.

sponsibility for assuring cross-subsidization of the sick by the healthy and to the government the subsidization of the poor by the rich. These assurances leave uncertain the speed with which sponsors will begin to negotiate efficiently with health plans, the extent of government's role in promoting effective purchasing by sponsors, and the controls against risk selection and other problems that will be needed for those not represented by effective sponsors. The proponents of this approach need to insure that public and private resources will prove adequate.

Finally, HMOs are already subject to state and federal regulations governing minimum benefit packages, enrollment practices and, to some extent, rate setting.¹⁵⁶ As HMOs and other alternative delivery systems become more important, they may be regulated more. At the same time, self-insurance is increasing as large employers create their own health financing systems.¹⁵⁷ As discussed above, many regulatory restrictions applicable to HMOs and indemnity plans do not apply to self insurers.¹⁵⁸ The precise effects of this mixed regulatory environment are not yet well understood. However, it is widely recognized that exemption from state regulation has created strong incentives for employers to choose self-insurance.¹⁵⁹

Some claim that preempting state regulation, by encouraging low-risk groups to self-insure, undermines state capacity to spread risks and expand access to health care.¹⁶⁰ It is more plausible that small employers, forced to bear the increasing costs of state regulation by the spread of self-insurance, will drop health coverage altogether. There is no evidence that today's regulatory environment will reward efficient delivery systems and there is every reason to suspect that it will penalize those unable to avoid regulation. If so, a coordinated approach to health insurance deregulation may be necessary to ensure the viability and credibility of market-based solutions in health care.

156. See *supra* note 50.

157. See, e.g., McDonnell, Guttenberg, Greenberg & Arnett, *Self-Insured Health Plans*, 8 HEALTH CARE FINANCING REV. 8 (1986) (50% of all employees with employment-related health plans participate in self-insured plans); Goldsmith, *Death of a Paradigm: The Challenge of Competition*, HEALTH AFF., Fall 1984, at 5.

158. See *supra* notes 29-54 and accompanying text.

159. See, e.g., Rosenblatt, *supra* note 147.

160. Law & Ensminger, *Negotiating Physicians' Fees: Individual Patients or Society? (A Case Study in Federalism)*, 61 N.Y.U. L. REV. 1 (1986) (federal preemption of state regulation may result in higher fees and lower accessibility).

Conclusion

Competition has come upon our health care system with little public debate and has, at best, a weak political consensus in its support. We have at present an enormously diverse and often inconsistent regulatory regime that in some respects is still highly inhospitable to competition. In addition, the regulatory apparatus seems poorly equipped to deal with some of the most difficult problems precipitated by the changes occurring in American medicine.

Some obstacles to competitive reform have readily identifiable, though not costless, solutions. Increased governmental efforts can help in a number of areas. Greater attention to licensing, certification, and quality review programs along with efforts to collect and disseminate data may help overcome information problems and improve the performance of purchasers in the market. Enhanced antitrust enforcement may deter private restraints of trade. Procompetitive legislation could repeal or meliorate such laws as those inhibiting selective contracting, regulating capital expenditures, setting administered prices, and perversely encouraging inefficient care through tax burdens. Clearly, these are difficult problems, but they are at least susceptible to reform. Other problems facing competitive change appear less tractable. Assuring a decent minimum of care for the medically indigent, addressing the malpractice problem, and avoiding excessive market segmentation by risk are challenging problems that will require thoughtful responses as markets mature.

This Article has argued that competitive change is not self-effectuating. With an unclear political consensus behind it, competition is vulnerable to proposals that promise more immediate and more visible reform. If competition advocates remain content with piecemeal deregulation and remain reluctant to address the disruptive effects of competitive change, their revolution may prove short-lived.