Viewpoint

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Health Care Reform and Market Discipline–Federalism Strikes Back

PUBLIC POLICY DECISIONS in health care are silently but steadily moving out of Washington, D.C. Even as federal health policy seems to have reached a stalemate, state and local officials across the nation, as well as employers, unions, insurance companies, hospitals, and doctors, are busy trying out new and different ways to restrain health-care costs. The federal stalemate seems to result equally from disenchantment with old ideas and suspicion of anything new. Although there is a growing disenchantment with the current system of direct cost controls on doctors, hospitals, and other "providers" of services, Washington is reluctant to try "incentives-based market reforms" that might restore some semblance of supply-and-demand discipline to the health-care industry.

Today, after one more year in which health-care costs raced ahead of the overall inflation rate, it is plainer than ever that the complex system of government controls has failed to do its job. It has failed because it has overlooked the three fundamental forces that have driven up the costs of health care: first, open-ended federal tax subsidies for the purchase of ever more comprehensive insurance, which inflates the demand for health-care services; second, retrospective cost-based reimbursement of doctors and hospitals by both government and private insurers, which in effect rewards (and thus entrenches) inefficiency; and third, ironically, government regulation itself, which tends to confirm the status quo, protecting those who provide too much health care too expensively and impeding innovative efforts to lower costs.

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The new "incentives" approach promises to correct many of these problems. It seeks to induce prudent buying of health-care services, both direct and through insurance, as well as vigorous review of claims by the employers, insurers, and governments that pay them. Instead of trying to fix the prices that providers of health services may charge on the costs they incur, this approach simply aims to make it in the providers' own best interests to hold down both costs and prices. If, for example, consumers are given a range of health-care plans to choose from and allowed to reap the savings when they choose an efficient plan, something like a market discipline can be restored to the industry.

The reluctance to shift to market reforms results partly from the traditional practice in the health-care industry of reimbursing efficient and inefficient providers on a cost-plus basis—and partly from the fact that putting any direct price on "saving lives" (and therefore on human life) goes against the grain. Nevertheless, the reforms are gaining ground, even though comprehensive national legislation to bring them about is stalled. The pressures of falling revenues and rapidly rising health-care costs, combined with state laws prohibiting budget deficits, are turning state and private health-care programs into a testing ground for these "new" approaches.

State and Private Sector Initiatives

Interest in what the states might do about health costs has been helped along by the Budget Reconciliation Act of 1981. That act allows federal regulators to grant waivers for the states to experiment with cost-containment innova-

tions in their Medicaid programs. Some states have begun to steer Medicaid patients toward economy-minded health-care providers or even to cut profligate providers from the program entirely. Other states are acting as "prudent purchasers" of the various laboratory services and medical devices that they pay for under Medicaid.

In Wayne County, Michigan, for example, the state Department of Social Services is launching a pilot program that contracts with "primary care physicians" (general practitioners, internists, pediatricians, obstetricians) to oversee the total care of Medicaid patients. Under the program, developed in cooperation with the state medical society, the state will bar the most expensive health-care providers from participating if they fail to mend their ways. Arizona, to take the only state without a Medicaid program, is developing an imaginative system for serving its indigent population in a cost-effective manner. The Department of Health and Human Services (HHS) will give the state a fixed annual grant for this purpose; and the state will use competitive bidding to select "case managers"—full-service providers such as clinics, health maintenance organizations (HMOs), and multi-specialty groups of physicians—who will offer services on a prepaid annual per capita basis. These "capitation" payments put the winning bidders at risk, in contrast to the Michigan program which allows participating physicians to charge on a fee-for-service basis as long as their bills stay within an acceptable range. And finally, several states have received waivers from HHS to run community-option programs offering long-term care to selected patients outside the usual hospital or "rest home" setting. Oregon's program seeks to reduce institutional care by providing support services so that a person can remain at home.

Other initiatives have come from the private sector. Several employers around the country have adopted a "cafeteria line" approach to employee health insurance, which allows workers to pick the benefit package that meets their particular needs while giving them incentives to reduce their consumption of health care. Employees at TRW, American Can, and the Educational Testing Service who choose plans with less comprehensive insurance coverage and greater than ordinary employee cost sharing are given "credits" that they can use to purchase other specified benefits (or can sometimes convert to cash).

Both Mobil Oil and California's Mendocino County schools are running incentives or bonus plans that pay cash rebates to members of employee groups for keeping health-care costs down. Under the Mobil plan, for each month that a group's health bill falls below a fixed employer payment, the employees are credited with the difference (there is no offset for months in which the total bill exceeds the payment). Other companies have started "wellness" or preventive health programs: Kimberly-Clark, Control Data, IBM, and Johnson & Johnson are all encouraging changes in life style by providing exercise facilities and health education (on how to reduce stress, stop smoking, control weight, eat properly, and so on). Still other companies are themselves providing direct health care for their employees (Gillette) or turning to "self-insurance" (Caterpillar, John Deere), or providing information on low-cost health-care providers (Pratt & Whitney).

Labor unions and some insurance companies are also active. Indeed, in many communities, all these groups have formed coalitions with health-care providers (and sometimes with governments and academic experts) to stem the rising tide of health-care costs. Not all of these efforts—and not all of the efforts mentioned earlier—are equally successful, of course, and not all tend toward market discipline, but all provide evidence that something is happening in the field outside the orbit of Washington, D.C.

A Quiet Revolution in "Entitlements"

Under the Tax Equity and Fiscal Responsibility Act of 1982, some of the costs of Medicaid and Medicare are being shifted from the federal government to, respectively, the states and to the employers of workers over sixty-five years old. A more subtle shifting of costs, this one a continuing development, arises because of a false economy: government reimburses hospitals only partially for their services to Medicare and Medicaid patients; the hospitals then make up the shortfall by charging more to patients covered by private insurance. The result is that employers and consumers face higher prices, paying for Medicare and Medicaid less visibly, but

no less surely, than if taxes were raised to finance full government reimbursement.

In a sense, the necessity of federal budget cutbacks has become the mother of state and private sector invention. The most direct victims of the cost shifting, state governments and private employers, are desperate for ways to contain their costs without reneging on commitments to citizens and employees. In health care as elsewhere, the expansion in "entitlements" has created a kind of social contract that we now find harder and harder to keep.

Increasingly, therefore, our social programs are breaking with the related concepts of entitlement and open-ended federal willingness to pay. In health care the growing awareness of the need to limit open-ended payments policies and to provide care in the most cost-effective setting, can be seen in at least five areas: (1) greater cost sharing by patients under federal programs; (2) tougher efforts by those who pay the bills to "discipline" the practice patterns of hospitals and doctors, including more use by employers of health-care utilization review panels; (3) greater reliance by the states on HMOs for their own employees; (4) innovations in hospital organization, such as satellite clinics, surgicenters, and special emergency centers; and (5) the increase in multispecialty group practices of cost-conscious physicians. Almost all the players in the system are beginning to see the need for "gatekeepers" to limit the consumption of health care and for economic incentives that will lead to cost-benefit tradeoffs—lest payments become so open-ended that they are unaffordable.

The only holdouts are the players in Washington. Today Congress probably would not even be willing to pass a law ratifying the changes that have already taken place, let alone one that would advance the process. To talk of changing entitlements, to talk of limiting the patient's freedom to choose a doctor, to talk of costs and benefits in "saving human lives" is to take a one-way ticket out of Congress. But around the country, new forms and new relationships are developing, largely unnoticed by the federal policy community. The "cafeteria plan" and the "case management" program are feasible small-scale endeavors to do what needs to be done, but what Congress would find so difficult to spell out in law. The gradual devolution of spending authority to lower levels of government, along with continuing changes in the delivery and financing of health care, has brought about—albeit quietly—a kind of new federalism, even though the "New Federalism" proclaimed in Washington some months ago remains moribund. The fact is that our federal system is alive and well in Detroit and Arizona and Oregon and Mendocino County. And not only there. Every governor, every state legislator, every community leader knows that state and local governments and the private sector are where the action must be in the future—no matter whether they agree to Reagan's grand swap, no matter what the Congress does.

Will We Ever Learn?

While Congress may not pass comprehensive health-care reforms any time soon, that does not mean that we have to do without a blueprint. If our decentralized innovations are going to lead to overall reform, they must be consistent with an overall plan. In my view that plan should be built on three principles: fixed rather than open-ended federal subsidies for health care, more cost-sharing by consumers who can afford to pay, and further deregulation of the health-care system. By heeding these principles, we should be able to ease health cost pressures without jeopardizing either the quality of care or consumers' rights to whatever care they are willing to pay for (directly or indirectly).

Our task will be made more difficult, however, by some of Congress's recent actions. The health-care provisions of the new Tax Equity and Fiscal Responsibility Act are a characteristic, and depressing, attempt to place band-aids over broken bones. The statute is an *omnium gatherum* of measures that shift costs to employers and patients, extend the grip of federal regulation in a vain attempt to close so-called loopholes, cut back reimbursement to providers, and reduce benefits. To put it in words of one syllable, there is no way this will work.

First, as already noted briefly, costs are shifted to employers, who now must offer employees aged sixty-five to sixty-nine and their dependents—all previously covered by Medicare—the same health-benefit plan they offer to younger workers. Costs are also shifted to the poor, who will help pay for their Medicaid

benefits through "nominal" cost sharing for standard services and, in the case of nursing home residents, by giving the government a lien on their homes. Who ever heard of a nominal cost that remained nominal when the government was involved? And foreclosing on the homes of the elderly poor seems an odd way for the government to be providing legally mandated benefits for its citizens.

Second, the new law extends the current federal controls on doctor fees and hospital room charges to such ancillary costs as lab tests and x-rays (these are the controls that have worked so well that a night in the hospital now costs two to four times as much as a night at the Ritz). It also sets a complex formula for determining "target" hospital rate hikes for Medicare patients, adjusted by a nicely inflationary index of hospital wages and prices. It prohibits payments for "ineffective" drugs (nudging open the Pandora's box of interference with diagnostic decisions). And it provides for an arbitrary one-month delay, beginning in September 1983, in the interim reimbursement to providers, which means that the September bills will get shoved into (you guessed it) the first month of fiscal year 1984—a brilliant way of holding down 1983 expenditures.

The new law is not all bad—just almost. It does provide for "prospective" payments to hospitals for services under Medicare, by urging HHS to set up a budget for payments during the coming fiscal year on a "that's all there is, there isn't any more" basis. But it does not provide any way to make sure that the budget sticks. Nor is there any assurance that a prospective budget, even if it sticks, will improve efficiency rather than lower the amount or quality of services. The law also establishes a more equitable system of Medicare reimbursement for HMOs, one that allows the government to reimburse HMOs on their customary basis of prospectively paid fixed amounts for each member. But greater use of HMOs by the elderly, while desirable in itself, may not do much to encourage overall health-care cost containment: although HMOs have a cost edge at present, they may well have that edge because their members are younger and healthier than the average. A system of medical vouchers for Medicare patients might do much more, by allowing a variety of new health plans—including some like the case management or preferred provider schemes noted above—to compete with HMOs and the traditional Medicare plan for taxpayers' dollars. (Congress considered but dropped a proposal of this sort in 1981–82.)

The Road to Reform

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And we also tend to underestimate the likelihood that regulation simply will not achieve its goals, quite aside from its costs. Often we wind up shifting costs or causing them to change form, so that regulation seems to be working when in fact the costs are merely being swept under the rug—as when hospitals shift the unreimbursed costs of treating Medicare cases to other patients. Worst of all, we let the "success" of this shifting blind us to the real need for structural reform over the long run.

Our blueprint for future action should reject the failing regulatory model (a model, by the way, that is implicit in any comprehensive national health insurance plan) and adopt the market orientation suggested here. Congressman Richard Gephardt's bill (H.R. 850) does this to a good extent, as do bills introduced by Senator David Durenberger (S. 433) and Senator Orrin Hatch (S. 139). Gephardt himself speaks of his bill as a work plan for reform, subject to modification or step-by-step enactment.

The Reagan administration has not endorsed any of these bills, nor has it come forward with one of its own. In fact, in its desperate search for quick and palatable savings,

it has gone the way of its predecessors. Still, it has shown some restrained interest in market-oriented health-care reform, including aspects of the above proposals. But it could do much more. Without calling for sweeping federal legislation, it could:

- support a ceiling on the chief open-ended subsidy for health care—the total exclusion from employee taxes of employer contributions to health insurance;
- revamp Medicare to provide better protection against catastrophic health expenses, along with greater cost sharing for routine expenses;
- adopt "prospective" payment for Medicare on a one-year trial basis, to be followed by a system giving Medicare recipients vouchers they could use to enroll in any qualified plan;
- expand existing efforts to deregulate the health-care system and give the states more freedom to experiment with cost control initiatives under Medicaid; and
- use existing antitrust law to encourage competition among health-care plans and providers.

While some of these would require new legislation, others would require only the creative use of existing authority.

Indeed, there are bits and pieces in several earlier laws—the Planning Law Amendments of 1979, the Budget Reconciliation Act of 1981, and the Tax Equity and Fiscal Responsibility Act of 1982—which, taken together, give the executive branch a mandate to relax regulatory requirements. The administration should use this mandate to reduce barriers to innovation—and it should then prod Congress, in turn, to help the favorable trends along by limiting the tax-free status of employer contributions to health insurance (to take just one of the five suggestions above).

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In short, even though the federal government does not need a comprehensive national health-care plan, it ought to have a clear and consistent health-care policy. Such a policy must involve getting the signals and incentives to the health-care market right, for a change, and then removing the government as an obstacle to cost containment. There is no reason to support the unattractive provisions of the Gephardt bill (features such as "health courts" and a "health benefits assurance corporation") or of any other proposal. The policy's purpose is simply to make sure that every step the administration does take is in line with the long-run objective of restoring market discipline to the health-care industry. We may want to take a leaf from the book of the airline deregulation advocates, who first achieved step-by-step administrative reform and then eventually got Congress to ratify it; or we might learn from communications deregulation advocates, who failed to win broad legislation but nonetheless seem to have had an influence on the recent Justice Department plan for increasing communications industry competition. Why race with horns blaring down the main street when a quiet drive down a country lane will do just as well—and the main street may not lead where one wants to go after all?

IT IS TIME, in other words, for a minimalist approach to health-care reform. But minimalism should not be confused with "do-nothingism." Unless the package contains each of the key elements of a market-oriented system—a limit on open-ended tax subsidies, voucher-type reimbursement for Medicare and Medicaid, and increased regulatory flexibility—it will not succeed.

The Reagan administration has taken some limited steps on the last of these. But, so far, it has shied away from the first two. I suspect it has shied away because it is both frightened by the prospect of a comprehensive plan for reform and worried about the political fallout, and perhaps because its commitment to the New Federalism blinds it to the successes of the old variety. Be all that as it may, it is clear that in dozens of local developments around the country—perhaps hundreds—a new model is being developed and tested; it is clear that we will not get comprehensive legislation in the near future; and it is crystal clear that the time for the incremental steps that must be taken in Washington is *now*. Let us get started, lest fears of comprehensive reform make us all prisoners of the status quo. ■