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I. Introduction: Reform Without Regulation

During the 1970s the focus of debate about national health policy shifted from issues of access to medical care and the distribution of the cost of care to concern about controlling the total cost of care. The rapid rate of growth of expenditures on medical care during that decade far exceeded the rate of inflation in the general economy, with the result that an increasing proportion of the gross national product (GNP) is now expended on medical care. In 1970 the United States spent 7.6% of its GNP on health care;[1] by 1980 the proportion had increased to over 9.1%.[2]

The conclusion that the marginal cost of care is greater than the resulting marginal health benefits is more distressing to some observers than the rate of growth itself. As a consequence, politicians and policy analysts alike have scrutinized medical expenditures severely. This impulse to scrutinize is startling when one remembers the public and elite attitudes about medical care that prevailed from after World War II until the mid-1960s. During that period, medical care and its providers were held in almost unparalleled esteem. There was faith in medical progress and broad agreement about the value of social investment in medical care. Today, however, our faith in medicine has been rudely and probably irrevocably shaken by evidence that medicine's real influence on the quality of our lives probably reached its zenith with the decline of infectious disease mortality.

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1. U.S. Department of Health, Education & Welfare, Health United States: 1979, at 184 (Public Health Service Pub. No. 80-1232 1980) (table 64).

2. Gibson, *National Health Expenditures, 1978*, 1 Health Care Financing Rev. 1 (Summer 1979).

Critics of national health policy with diverse political and disciplinary persuasions have now reached a broad consensus that the methods used to distribute the individual costs of medical care unacceptably increase social costs.[3] In particular, present forms of financing offer perverse incentives to deliver a quality and a quantity of care that, in the absence of those incentives, would not be provided. Briefly, the present financing system is dominated by third-party payments, either from private insurers, who in 1978 paid approximately 27% of all personal health care expenditures, or from public entitlement programs, which pay approximately 39% of all expenditures.[4] Third-party payments reduce incentives for consumers and providers to economize in consumption. In addition, three provisions in the tax system subsidize, and therefore encourage, the purchase of health insurance and medical care. First, employer contributions to employee accident and health insurance plans are specifically excluded from gross employee income for federal income tax purposes. Second, an individual can deduct one-half of his or her out-of-pocket expenditures on private health insurance, up to $150, from personal income. Last, a taxpayer can deduct all out-of-pocket personal health and medical expenditures above 3% of adjusted gross income from personal income.[5] Tax

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3. *See* P. Starr, Transformation in Defeat: The Changing Objectives of National Health Insurance, 1915-1980, at 23 (1980) (forthcoming in 71 AM. J. PUB. HEALTH). This Article's ideas have fuller expression in a forthcoming book. P. STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE (1981).

4. Gibson, *supra* note 2, at 26 (table 5).

5. Section 106 of the Internal Revenue Code of 1954 provides that employer contributions to an employee's accident or health insurance plans for personal injury or sickness is not included in gross employee income. I.R.C. § 106. Mitchell and Phelps found, by comparison of the magnitude of this tax subsidy with the loading cost of insurance, that "the extent of the tax subsidy is greater than the cost of insurance," effectively giving negative net loading rates. Across all income classes, they found that, at the time of their study, this tax subsidy accounts for 16.7% of the cost of premiums. B. MITCHELL & C. PHELPS, EMPLOYER PAID GROUP HEALTH INSURANCE AND THE COSTS OF MANDATED NATIONAL HEALTH COVERAGE 17 (1974), *cited in* K. DAVIS, NATIONAL HEALTH INSURANCE: BENEFITS, COSTS AND CONSEQUENCES 16 (1975). Obviously, as a perquisite that is not included in taxable income, the provision of health insurance by the employer is worth more to the employee than an equal contribution to income, which must be discounted by the employee's marginal rate of taxation. Therefore, employees are implicitly encouraged to accept more health insurance coverage, even at the expense of wages, because health insurance retains its full face value. This benefit is worth more to the high income employee than to the low income employee due to the graduated rate of taxation.

As noted in the text, in addition to insurance exclusions from gross income, one-half of private expenditures, up to $150, on personal health insurance is deductible from personal income, and all personal health expenditures, including any remaining health insurance costs, above 3% of adjusted gross income is deductible from personal income. I.R.C. § 213(a). Mitchell and Vogel demonstrate that these latter two provisions constitute a

subsidies make a contribution equal to 12% of the national total expenditures on health care. In total, more than one-half of all medical care expenditures are financed either directly through tax subsidies or indirectly through public entitlement programs.[6] Any major reform of the financing and delivery of American medical care must therefore address not only questions of entitlement to services, but also the problems of cost containment.

Proposals for reform vary widely, but each proceeds from this common starting point.[7] For those who seek change with minimal or no expansion of governmental authority, moral exhortation to reduce demand and more sensible economic incentives are appealing. Those who favor modest intervention would rely partly on moral exhortation and economic incentives, but would also impose sanctions such as health system planning or even budget caps. Those who promote more governmental intervention favor centralized budgeting and bargaining structures to negotiate medical fees and rates. At the far end of this continuum, those who advocate maximum intervention would advance a national health service in preference to any combination of public or private insurance and regulation. It is those who are at this left end of the political spectrum that are silent now.

The minimal intervention—or "procompetitive" approach—currently has considerable political and rhetorical appeal.[8] Rising government budgets, coupled with increasingly frequent charges of waste and inefficiency in government bureaucracies, have encouraged some to propose that social service delivery systems be structured to accommodate market incentives. In medical care, those procompetitive proponents predict that a "return" to the market will lead to cost containment, more equitable allocation of

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national program that provides partial financing of health expenditures for all taxpaying Americans. This Internal Revenue Service health plan includes an unusually broad definition of what constitutes a medical expense, *see* I.R.C. § 213(e), and "has a deductible proportional to income and a coinsurance rate that decreases with income." Mitchell & Vogel, *Health and Taxes: An Assessment of the Medical Deduction*, 41 S. ECON. J. 660, 665 (1975). Despite the income-related deductible of this program, the total effect is a regressive financing mechanism, with substantially larger benefits for high income taxpayers. *See* Conrad & Marmor, *Patient Cost Sharing*, in NATIONAL HEALTH INSURANCE: CONFLICTING GOALS AND POLICY CHOICES 385, 404 (J. Feder, J. Holahan & T. Marmor eds. 1980).

6. *See generally Tax Expenditures for Health Care: Hearings Before the Task Force on Tax Expenditures and Tax Policy of the House Comm. on the Budget and Subcomm. on Oversight of the House Comm. on Ways and Means*, 96th Cong., 1st Sess. 16 (1979) (statement of Emil M. Sunley).

7. *See* P. Starr, *supra* note 3, at 25-26.

8. *See* C. SCHULTZE, THE PUBLIC USE OF PRIVATE INTEREST 2-4 (1977).

scarce medical resources, the creation of a more rational delivery system, and delivery of more appropriate and perhaps better medical care. Indeed, the appeal of procompetitive arguments is so broad that the President's Commission for a National Agenda for the Eighties argued confidently that "an expansion of the role of competition, consumer choice, and market incentives rather than government control is more likely to create the much needed stimulus toward greater efficiency, cost consciousness, and responsiveness to consumer preferences so visibly lacking in our present arrangements for providing medical care."[9] Similar claims have received widespread coverage in trade journals,[10] the popular press,[11] and on Capitol Hill.[12] Yet this vision of reform through competition is uncommon among industrialized nations.

The positions advanced under this banner, while labelled procompetitive, are, in fact, diverse and distinguishable. They vary in the degree of change proposed for American medicine, the rationale for such change, and their mechanisms, implementability, and effects. Nevertheless, while three separable threads of procompetitive logic run through these positions, all have interrelated elements.

The first approach would enhance consumer sovereignty. Advocates of this approach believe that the absence of significant consumer cost sharing in insurance is the major problem in medical care. Near-complete prepayment for medical care removes the necessity for both the consumer and the provider to make tradeoffs among different medical services and between medical care and other desired economic goods. It is asserted that even if the consumer is not fully at risk for the cost of medical care, the use of deductibles, coinsurance, and copayment[13] will lead consumers to

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9. REPORT OF THE PRESIDENT'S COMMISSION FOR A NATIONAL AGENDA FOR THE EIGHTIES 78-79 (1980).

10. *See, e.g.*, Christianson & McClure, *Competition in the Delivery of Medical Care*, 301 NEW ENG. J. MED. 812 (1979) (constructive competition helped reduce hospitalization, contain costs, improve access to medical services, focus consumer attention on consumer satisfaction, increase consumer choices and information); Enthoven, *Rx for Health Care Economics: Competition, Not Rigid NHI*, 59 HOSPITAL PROGRESS 44 (Oct. 1978) (although health services market not structured to fit competitive model, restructuring possible to yield more competitive benefits).

11. Huff, *A Little Healthy Competition*, Washington Post, Aug. 26, 1980, § A, at 19, col. 4.

12. *See* Demkovich, *Competition Coming On*, 12 NAT'L J. 1152 (1980); Demkovich, *New Congressional Health Leaders—The Emphasis Is on Competition*, 12 NAT'L J. 1093 (1980).

13. Patient cost sharing devices are proposed as ways to make the consumer more

elect more economically appropriate forms of care. The second view contends that the medical system provides too few acceptable alternatives to "fee for service" (FFS) payment.[14] Medical competition exists within FFS medicine, not between FFS and other delivery and financing models, as would be preferable. Reforms under this second view would encourage the development of groups of physicians, primarily in prepaid group practices (PPGP)[15] as alternatives to FFS medicine. The proponents of the third, and last, view advocate aggressive antitrust rulemaking and litigation to reduce the market power of the present medical providers.

As was stated, these three broad approaches need not be fully independent. Antitrust action could be used to eliminate barriers to the development of competing groups of providers, a result compatible with the provider reorganization approach. The cost sharing approach may be required to allow existing FFS reimbursement to compete with prepaid group practice.

Procompetitive proposals share questionable analyses of the effects of current command and control regulation; they typically

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conscious of the costs of medical care demand decisions, without putting the consumer at risk for the full cost of medical care. Deductibles require that consumers pay full costs of all medical care up to some dollar limit, beyond which the public or private insurer pays in full. Copayment is a consumer utilization fee, charged at such time that medical care is utilized for each service subject to copayment provisions. Coinsurance requires the consumer to pay some portion of the total costs incurred. For an excellent discussion of the effects of cost sharing, see M. BARER, R. EVANS & G. STODDART, CONTROLLING HEALTH CARE COSTS BY DIRECT CHARGES TO PATIENTS: SNARE OR DELUSION? (1979) [hereinafter cited as CONTROLLING HEALTH COSTS]. For a discussion of the administrative feasibility of cost sharing proposals under national health insurance, see Conrad & Marmor, *supra* note 5.

14. Under "fee for service" (FFS) payment, providers are paid on the basis of identifiable, billable procedures performed. This reimbursement may be on the basis of the costs incurred by hospitals, or the charges made by physicians. Most medical care is currently paid for on a FFS basis. This payment method implies that providers can increase their total revenues by increasing the number of procedures performed, knowing that they will be reimbursed for their costs or charges by the patient or the patient's insurer. Because the provider does not often suffer losses from ordering superfluous services, implicit incentives exist under FFS to provide medical services without regard to the costs incurred.

15. Prepaid Group Practice (PPGP) is an alternative payment mechanism intended to address the lack of provider cost awareness under FFS reimbursement. As under insurance, the enrollee pays a fixed capitation rate, and is entitled to medical benefits as needed. Unlike insurance, the enrollee is contracting with an organization that not only finances medical care, but that also accepts responsibility for the delivery of care. The PPGP employs or contracts with providers who provide medical care to the defined, prepaid enrolled population. PPGP revenues are not open-ended. They are a function of the total number of enrollees, not of the number of procedures performed. PPGP is an umbrella term, and encompasses a number of alternative financing and delivery mechanisms, including the Health Maintenance Organization (HMO), Individual Practice Association (IPA), and Foundation for Medical Care (FMC).

compare present circumstances of regulatory disarray with future circumstances of uncorrupted competition. They draw analogies between regulation in health care and regulation in other industries when projecting the impacts of their proposed changes. These analogies, however, ignore or downplay the differences between the market for medical care and the markets for other economic goods, as well as the many different forms of regulation that pervade the medical care sector. In fact, although procompetitive proposals all reject present and proposed command and control regulation, all require "market correcting" regnlation[16] to improve the workings of the market so admired. The aim of this Article is to sort out the distinguishable reform alternatives grouped under the procompetitive rubric. The concern here is to demonstrate not only the important differences among these positions, but the differences in the arguments on which they rely for support.

II. BACKGROUND

Economic market approaches to medical system reform are not intrinsically concerned with cost containment. Rather, they are intended to generate a more appropriate level of medical care utilization uninfluenced by perverse economic incentives. If competitive conditions[17] exist in a market environment, an equilibrium in price and consumption results. This equilibrium is in some sense an ideal allocation of goods and services, technically termed "Pareto optimal."[18]

Attainment of this perfect allocation in the medical care market is frustrated by the fact that the market fails to meet numerous conditions for ideal competition. For example, because of the coverage afforded by health insurance, the decision to consume medical care is not made with limited financial resources. Health insurance purchases are themselves not fully constrained by market mechanisms, since tax subsidies allow market "decisions" on insurance coverage to be made with pre-tax dollars. Moreover, em-

16. *See* A. ENTHOVEN, HEALTH PLAN: THE ONLY PRACTICAL SOLUTION TO THE SOARING COSTS OF MEDICAL CARE 94 (1980).

17. These competitive conditions include: free exit and entry into the market by providers; costless transactions; perfect information on the part of consumers; voluntary purchases by the consumer; limitations on consumer resources requiring that each purchase be traded off against another; inability of producers to exercise market power over consumers or over other providers; absence of collusive behavior by producers; payment of full costs of production of goods or services by producers; and the absence of externalities associated with the provision of the good or service.

18. P. SAMUELSON, ECONOMICS 462 n.12 (10th ed. 1976).

ployer-provided group health insurance prevents consumers from making individual market decisions about the desired level of health insurance coverage, because the consumer-employee accepts the insurance package offered as a perquisite of employment. Many of these conditions that result in market failure might be rectified through procompetitive reform.

Medical care market failures reflect, to some extent, the nature of medical care itself. Medical care *is* different. Improved health, the anticipated outcome of medical care, has positive externalities. This makes medical care a merit good, and, unlike many other economic goods, one that should not be allocated solely on the basis of ability to pay. Equity considerations must enter into any discussion of the allocation of medical care. Market allocation, while more "efficient" in allocating resources in response to "dollar votes," is not directed at equitable distribution. Even subsidies to the poor included in some market-oriented reform approaches may not fully mitigate inequity.

Informed choice by consumers is a precondition to the successful operation of the competitive market. Several characteristics of the medical market, however, work against easy access by consumers to information. First, one can never know when and if illness and recovery from illness will occur. Also, medical care is not a fixed, precise good; its outcome is uncertain, and the treatments associated with a particular set of symptoms or diagnoses can differ substantially.[19] Professor Arrow contends that an economic system cannot operate fully rationally under conditions of uncertainty.[20] One response to uncertainty in the medical care market and the risk it entails has been a demand for insurance. A second response is the creation of an agency relationship between consumers and physicians in which physicians are estimated to influence or control 70% of all demand decisions.[21]

Just as differences exist between the medical market and other economic markets, the regulation of the medical care industry differs from the regulation of other sectors of the economy.

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19. A. ENTHOVEN, *supra* note 16, at 1-12.

20. *See* ARROW, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941 (1963).

21. Although only an estimated 18 cents of every health care dollar pays for actual physician-provided services, doctors influence the expenditure of a much greater portion of that dollar because of their ability to "determine who goes to the hospital, how long they stay, and what will be done for them while they are there." Relman, *The Allocation of Medical Resources by Physicians*, 55 J. MED. EDUC. 99, 99 (1980).

These differences do not lie in the regulatory tools themselves as much as in the number and diversity of regulations emerging from different governmental bodies and affecting the same health actor. Hospitals, for instance, must deal with a series of agencies concerning regulations tied to the subsidy and reimbursement programs on which their existence often depends.[22] Public regulatory bodies review capital expenditures (certificate of need), rates (state rate commissions), and utilization (Professional Standards Review Organizations or PSROs). In addition, medical care providers are subject to standards and licensure requirements imposed by both public and private bodies.

The role of government is further complicated by its monopsonistic purchase of medical care for some segments of the population and the regulation tied to this purchase. This mix of direct regulation and regulation through finance or subsidy is very different from that faced by other industries or economic sectors. Although aspects of health regulation may resemble regulation of public utilities or licensing of television stations, in its totality it has a complexity all its own. While any single comparison of regulatory activity in another economic sector may have some relevance, the sum of multiple and sometimes conflicting regulatory activities in the health care market is on the whole not analogous to that in any other industry.[23]

III. Procompetitive Proposals: Examining the Differences

The three classes of procompetitive proposals listed earlier[24] differ in their assumptions about the medical care market, the medical product, health care goals, and appropriate policy mechanisms. Each of the three views is expressed in current legislative proposals, although the first appears to have passed its peak of popularity, and some proposals incorporate elements of more than one.[25]

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22. *See* Marmor, *The Reform of Economic Regulation: Reactions Regarding Regulatory Choice in Health*, in Issues in Health Care Regulation 316 (R. Gordon ed. 1980).

23. *See id.* at 13.

24. *See* text accompanying notes 13-15 *supra*.

25. One or more of these broad procompetitive approaches has influenced several recent legislative initiatives. During the 96th Congress, particularly the first session in the summer and fall of 1979, when the Carter Administration's Hospital Cost Containment Act of 1979, S. 570, 96th Cong., 1st Sess., 125 Cong. Rec. S2187 (daily ed. Mar. 7, 1979), began to flounder, a number of legislative alternatives to regulatory medical care cost containment arose. Senator Durenberger introduced The Health Incentives Reform Act of 1979, S. 1968, 96th Cong., 1st Sess., 125 Cong. Rec. S15699 (daily ed. Nov. 1, 1979), which provided for a

A. *Enhancing Consumer Sovereignty in Medical Care Consumption Decisions*

It is widely acknowledged that "market failure" exists in med-

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specified fixed dollar amount of deductible employer contributions to health insurance plans with contributions in excess of that amount to be included in employee gross income and, therefore, taxable. The bill mandated a choice of multiple health plans for employees, who then would receive rebates for choosing plans less expensive than the employer contribution. *See* STAFF OF THE JOINT COMM. ON TAXATION, 96th CONG., 2D SESS., DESCRIPTIONS OF PROPOSALS TO RESTRUCTURE THE INCENTIVES FOR COVERAGE UNDER EMPLOYER HEALTH PLANS 16-17 (Comm. Print 1980).

The Health Cost Restraint Act of 1979 was introduced by former House Ways and Means Committee Chairman Al Ullman. H.R. 5740, 96th Cong., 1st Sess., 125 CONG. REC. H9970 (daily ed. Oct. 30, 1979). It embodied the same provisions as the Durenberger bill and, also, contained provisions concerning HMO reimbursement under the Medicare program that were designed to encourage Medicare recipients to choose enrollment in prepaid group plans rather than FFS. *See* STAFF OF THE JOINT COMM. ON TAXATION, 96th CONG., 2D SESS., DESCRIPTION OF S. 1968 AND OTHER PROPOSALS TO RESTRUCTURE THE INCENTIVES FOR COVERAGE UNDER EMPLOYER HEALTH PLANS 12-13 (Comm. Print 1980).

Representative Martin introduced the Medical Expense Protection Act of 1980, H.R. 6405, 96th Cong., 2d Sess., 126 CONG. REC. H532 (daily ed. Feb. 4, 1980), which would have created a "Catastrophic Automatic Protection Plan," funded by general revenues and coinsurance. H.R. 6405, 96th Cong., 2d Sess., *reprinted in National Health Insurance: Hearings Before the Subcomm. on Health of the House Comm. on Ways and Means*, 96th Cong., 2d Sess. 230 (1980). The Plan mandated for families with incomes of less than $10,000 a deductible of $300, plus 20% of the income in excess of $4000, and a deductible of $1500, plus 20% of income in excess of $10,000, for families with incomes of more than $10,000. In addition, the Plan disallowed employers the tax deduction available for qualified health insurance plans unless they offer this coverage to employees. *See id. See also National Health Insurance: Hearings Before the Subcomm. on Health of the House Comm. on Ways and Means*, 96th Cong., 2d Sess. 164 (1980) (statement by Representative Martin).

Representative Jones introduced a bill, H.R. 3943, 96th Cong., 1st Sess., 125 CONG. REC. H2722 (daily ed. May 4, 1979), which would have amended the Internal Revenue Code to disallow an employer's business deductions for costs of premiums of specified employee insurance contracts and mandated catastrophic coverage for health care expeuses over $2000 or 15% of the employee's average adjusted gross income. *See National Health Insurance: Hearings Before the Subcomm. on Health of the House Comm. on Ways and Means*, 96th Cong., 2d Sess. 27 (1980) (statement of the American Hospital Association).

The Comprehensive Health Care Reform Act was introduced by Senator Schweiker. S. 1590, 96th Cong., 1st Sess., 125 CONG. REC. S10656 (daily ed. July 26, 1979). It would have amended the Public Health Service Act of 1977, Pub. L. No. 95-83, §§ 102-104, 105(b), 106, 107, 91 Stat. 383-86 (codified in scattered sections of 42 U.S.C.), and established standards for qualified employer health benefit plans, including catastrophic coverage, and conditions under which employer contributions to employee health insurance could be deducted by employers and excluded from gross income by employees. The bill also mandated a multiple health plan choice for employees and a fixed dollar contribution by the employer, with rebates available to employees choosing less expensive plans. *See* STAFF OF THE JOINT COMM. ON TAXATION, 96th CONG., 2d SESS., DESCRIPTION OF S. 1968 AND OTHER PROPOSALS TO RESTRUCTURE THE INCENTIVES FOR COVERAGE UNDER EMPLOYER HEALTH PLANS 10 (Comm. Print 1980).

Representatives Gephardt and Stockman introduced The National Health Care Reform Act of 1980, H.R. 7527, 96th Cong., 2d Sess., 126 CONG. REC. H4683 (daily ed. June 9, 1980), which would have limited the tax subsidies for employer contributions to health insurance

ical care. Opinions differ, however, about whether the primary basis for market failure is inherent in the nature of medical care itself or is generated by present financing policies. Those who advocate consumer sovereignty adhere to the latter claim. They argue that medical markets fail because consumers never directly face the economic consequences of their consumption decisions. This market failure would be rectified by dramatically reshaping the role of insurance to make patients and doctors cognizant of costs at the time of use of medical care. One instrument to reshape insurance is extensive patient cost sharing through use of deductibles, copayment, or coinsurance.[26] Theoretically, making the consumer responsible for significant proportions of the cost of care at the time of use would generate economizing alertness in both patients and doctors, since presumably the need for alertness would be communicated from the patient to the doctor.

A second way to make consumers aware of the true cost of medical care is to reduce or eliminate the federal tax subsidy that now encourages the purchase of health insurance by employers.[27] Health insurance purchases would then be made with after-tax dollars, as are the purchases of other goods.[28]

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plans; provided tax free rebates to employees selecting health plans costing less than the fixed dollar contribution; provided tax credits for the private purchase of health insurance not through the employer; mandated a catastrophic level of coverage; replaced retroactive, reasonable cost reimbursement with prospective premium payment; repealed existing regulatory structures such as Certificate of Need and Professional Standards Review Organization; mandated health plan choice under Medicare; and provided vouchers under Medicaid.

26. *See* Feldstein, *The High Cost of Hospitals—and What to Do About It*, 48 PUB. INTEREST 40 (1977); Feldstein, *A New Approach to National Health Insurance*, 23 PUB. INTEREST 93 (1971); Seidman, *Income-Related Consumer Cost Sharing: A Strategy for the Health Sector*, in NATIONAL HEALTH INSURANCE: WHAT NOW, WHAT LATER, WHAT NEVER? 307 (M. Pauly ed. 1980).

27. *See* note 5 *supra*.

28. A tax expenditure is a provision in the tax code that is intended to "achieve a particular purpose, claimed to be desirable, other than the measurement of net income under an income tax." Surrey, *Tax Incentives as a Device for Implementing Government Policy: A Comparison with Direct Government Expenditures*, 83 HARV. L. REV. 705, 707 (1970). Proponents assert that tax incentives encourage the private sector to participate in social programs and that tax incentives are simple and involve less government intervention. *See, e.g.*, 115 CONG. REC. S5329-30 (1969)(statement of Senator Percy), *quoted in* Surrey, *supra*, at 716. Surrey, on the other hand, argues that any tax expenditure could be replaced by a direct expenditure. A tax incentive will have some legislative appeal partially because of the asserted advantages of tax expenditures and partially because of the structure of the legislative process—the House Ways and Means Committee and the Senate Finance Committee consider all tax proposals. When tax proposals, however, concern indirect program outlays, as opposed to revenue gathering, consideration by these committees of these proposals defeats the committee system of distributing congressional expertise and affects the administration of the program. *See* Surrey, *supra*, at 728-29. Professor Surrey, in his criti-

Support for these forms of enhanced consumer sovereignty rests on two premises about incentives in medical care. First, the existence of massive prepayment for medical care through health insurance is, in this view, the prime cause of overuse. Because the purchase of insurance represents both a prepayment and a preallocation of consumer resources toward the purchase of medical care, consumers do not have to trade off the cost of medical care against the cost of other desired goods and services at the time of use.[29] From this perspective, first-dollar health insurance—insurance with a very low or nonexistent deductible—is not properly insurance. It does not really spread the risk of high cost, low probability illness, but prepays relatively common, highly discretionary services.[30] Second, tax subsidies lead to the provision of excessive levels of health insurance.[31] Eliminating the tax subsidy for the provision of health insurance by employers will lead consumers to purchase an "economically rational" level of coverage. This level of coverage, combined with cost sharing, will translate into more appropriate levels of demand for and utilization of medical care.[32]

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cism of tax expenditures, further notes that their costs are uncontrollable, unpredictable, and largely hidden in foregone revenues rather than in budgeted outlays. *See id.* at 729-31. Moreover, tax incentives, in general, are intrinsically inequitable in a positive, progressive income tax system. *See id.* at 720-25. For a complete discussion of tax expenditures, see S. SURREY, PATHWAYS TO TAX REFORM (1973).

29. *See* Feldstein & Taylor, *The Rapid Rise of Hospital Costs*, in COUNCIL ON WAGE & PRICE STABILITY STAFF REPORT, Jan. 1977, at 66-67 (well insured consumers choose more expensive medical care than those "not so well insured").

30. Insurance should protect against large losses that are very unlikely to occur—that is, an expensive event that will occur in only a few cases. In such a case, the extent of the risk is so great that very few individuals could afford to suffer the risk, but the likelihood of the event occurring is so small that the pooled risk is minute—and consequently inexpensive—through a risk-sharing mechanism. According to Arrow, "if the costs of medical care are a random variable with mean m, the [ideal insurer] will charge a premium m, and agree to indemnify . . . for all medical costs." Arrow, *supra* note 20, at 960 (emphasis in original). Thus, actuarially, a fair insurance premium will simply be the projected total cost of health care to the population at risk, divided by the number of people in that population. *See id.* at 959-60. Because of administrative costs, or "loading costs," incurred in the provision of insurance, however, the cost to the individual will be higher than the expected benefits from insurance. In spite of this, risk aversion in the face of potentially severe or catastrophic costs causes individuals to insure. The institutionalization of risk-bearing through insurance serves to relieve much of the economic uncertainty associated with accident and disease. Health insurance, however, does not fit the ideal model of insurance. So-called "moral hazard" is present when the consumption of an insured good is altered by the possession of insurance. The implication is that there is a relatively high elasticity of demand or considerable consumer discretion regarding demand decisions. It is this tendency to over-utilize medical services because of prepayment through insurance that concerns cost sharing proponents.

31. A. ENTHOVEN, *supra* note 16, at 19.

32. *See generally* M. Feldstein & E. Allison, Tax Subsidies of Private Health Insur-

The intellectual appeal of the cost sharing component of the consumer sovereignty approach depends partially on one's view of the elasticity of demand for medical services. The elasticity of demand clearly varies for different types of services. Low cost, high probability, discretionary services have the highest elasticity; their use varies considerably depending on costs to patients. The elasticity of demand for high cost care, however, is low, with physicians dominating consumption choices. Given these elasticities, one would expect that cost sharing would primarily affect demand for services of the first type. Nevertheless, low cost, discretionary services are not necessarily the type to be limited. High cost, high technology, high intensity services are partially, and perhaps primarily, responsible both for the rapid rise in medical sector expenditures and for the doubts about the worth of such expenditures. Cost sharing would not directly alter the major pressures toward consumption of this type of care since most episodes of high cost care exceed the limit of any feasible deductible.

The appeal of cost sharing can also vary with one's views on the need for equity in the distribution of care. Cost sharing amounts to a tax or user fee imposed on the sick and is a de facto transfer of wealth from the sick to the healthy. If cost sharing obligations are determined without regard to income, a fixed sum liability will have a greater impact on lower income than higher income groups: "[C]harges whose aggregate levels for a given family are direct functions of utilization only will involve perverse wealth transfers—from the ill to the healthy and, to the extent that the poor (including a significant share of the aged) are less healthy than the rich, from low- to high-income classes."[33] The income-related cost sharing plans do not create this vertical inequity, but they do retain the peculiar horizontal inequity of transferring wealth from the sick to the healthy within income classes.

The major impact of cost sharing may well be on the demand for preventive care. Demand for this type of care is the most highly responsive to price, because it is the most discretionary. The California Medicaid program's experiment with copayments demonstrated that "[t]he inhibiting effect applied to office visits—the bedrock of general medical care—and also to typical diagnostic tests (urinalyses), to preventive procedures (Pap smears), and to

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ance: Distribution, Revenue Loss and Effects 16 (Oct. 1972) (Health Care Policy Discussion Paper No. 2, Harvard Center for Community Health and Medical Care, Program on Health Care Policy).

33. CONTROLLING HEALTH COSTS, *supra* note 13, at 111.

drug prescriptions."[34]

Admittedly, coinsurance may have some desirable cost constraining effect if consumers question the utility of increasing service intensity in the form of increased bed days and superfluous tests. In the absence of upper limits on consumer liability, however, this form of cost sharing imposes serious financial burdens on the catastrophically ill. Enthoven, a champion of restructured competition, contends that cost sharing not only fails to reduce overutilization, but its timing is inappropriate:

> The individual episode of medical care is usually not good material for rational economic calculation. If the patient is in pain or urgent need of care, the transaction is not entirely voluntary. The sick or worried patient is in a poor position to make an economic analysis of treatment alternatives. When my injured child is lying bleeding on the operating table is hardly the time when I want to negotiate with the doctor over fees or the number of sutures that will be used.[35]

Consumers may prefer, and be prepared to pay for, first-dollar health insurance coverage precisely because they do not want to make decisions about economic tradeoffs while under care. When dealing with potentially life and death decisions, which almost invariably involve discomfort, consumers do not want to use economic criteria.[36] "[T]he evidence in Canada and in Medicare in this country is that consumers with their own money will supplement even weak deductibles; the evidence of labor group bargaining, individual health insurance policies, and the Federal Employees options is that people want comprehensive insurance, not strongly cost-shared insurance."[37]

One major effect of mandated consumer cost sharing would be that those who can afford supplementary insurance will choose to purchase it and circumvent cost sharing provisions. Supplementation leads to cost spreading among the affluent, which shifts the

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34. Roemer, Hopkins, Carr & Gartside, *Copayments for Ambulatory Care: Penny-Wise and Pound-Foolish*, 13 MED. CARE 457, 464 (1975).

35. A. ENTHOVEN, *supra* note 16, at 34-35.

36. *See* B. Vladeck, The Market vs. Regulation: The Case for Regulation 4 (May 22, 1980 as revised June 13, 1980) (paper presented at the *Symposium on Health Care Regulation and Competition: Are They Compatible?*, Project HOPE Institute for Health Policy Study). Ironically, if consumers *do* make coverage decisions on an economic basis, based on their assessment of the likelihood of needing care, adverse self-selection consequences may result.

37. McClure, *An Analysis of Health Care System Performance Under a Proposed NHI Administrative Mechanism*, in EFFECTS OF THE PAYMENT MECHANISM ON THE HEALTH CARE DELIVERY SYSTEM 12 (1977) (U.S. Dept. of Health, Education, and Welfare, Public Health Service).

burden of payment to insurers and to the low income patients and potentially reduces equity in access. Those unable to afford supplementary insurance will be subject to the barriers of access imposed by cost sharing.

The powerful consumer preference for health insurance unconstrained by cost sharing also implies that reducing tax subsidies may have little effect on the aggregate level of health insurance coverage. While no doubt affected by tax incentives, the level of first-dollar coverage may not depend solely on that subsidy. Failure to consider properly the Canadian experience with private supplementation in the absence of tax incentives[38] could lead to an over-emphasis of the importance of tax incentives to choices on coverage. If the level of insurance remains unchanged after reducing tax subsidies, that reduction raises the rate of taxation on employment. If reducing the tax subsidy does lower the level of insurance purchased, employees' salaries should be increased to compensate for this loss. This too would represent an increased tax on employment.[39]

A final question regarding the consumer sovereignty approach relates to its structural effects—that is, how the various elements of the approach would affect competition between providers. The competitive market relies on consumer choice between providers on the basis of prices that reflect differences in the provision of services. While cost sharing consumers would be aware of the costs of their decisions and might be deterred from consumption, they would face no incentives to shop for a more efficient medical provider when the charges they pay are uniform for all providers. "The major weakness of the uniform-charge plans as cost control mechanisms is that uniformity allows no scope for price-sensitive consumers to affect provider market shares."[40]

B. Encouraging Alternative Organization of Providers

The second class of reforms would provide incentives to restructure medical care, primarily by encouraging the development of competing groups of physicians. The class is best illustrated by three proposals: Enthoven's Consumer Choice Health

38. *See* Conrad & Marmor, *supra* note 13, at 408-09.

39. *See* W. Lynk, Regulation of the Employer-Employee Relationship: The "Consumer Choice Health Plan", 10-11 (Aug. 1980) (forthcoming in 6 J. HEALTH POL., POL'Y & L.).

40. CONTROLLING HEALTH COSTS, *supra* note 13, at 115.

Plan (CCHP),[41] McClure's broadened definition of health plans,[42] and Elwood's Health Maintenance Organizations (HMO) strategy.[43] These proposals acknowledge that it is socially necessary both to insure against uncertainty and to provide needed access to medical care without requiring patients to make economic decisions at the time care is needed. They propose that consumers be free to choose between annual packages of comprehensive health care, and to either retain the savings accrued if they choose a package offered at a price beneath the payment their employer or the government is willing to contribute for benefits, or pay the difference if they elect a more expensive option. This approach would put the existing FFS form of medical care payment in competition with alternative financing and delivery mechanisms—primarily prepaid group practices—on the basis of their ability to deliver adequate services for a competitive premium price.

Proponents of alternative forms of delivery have several slightly different conceptions of the optimal structure for these alternative organizations. Frech and Ginsburg argue that "HMOs are likely to change the nature of the market for medical care toward greater competition."[44] Moore advocates Primary Care Networks, as implemented by United Health Care of SAFECO Insurance.[45] Evans recommends Physician Based Group Insurance (PBGI) as a means of controlling costs; this system puts primary care physicians at financial risk for their patients by requiring that all costs of medical care ordered by the physician be paid out of funds prospectively allocated for such care.[46] The strategy as a whole, however, depends both on competition between similar systems on the basis of their ability to offer similar benefit packages at competitive prices, and on competition between different health care pack-

41. A. ENTHOVEN, *supra* note 16. *See also* Enthoven, *Consumer-Choice Health Plan* (pts. 1-2), 298 NEW ENG. J. MED. 650, 709 (1978); Enthoven, *Cutting Cost Without Cutting the Quality of Care*, 298 NEW ENG. J. MED. 1229 (1978).

42. McClure, *On Broadening the Definition of and Removing the Regulatory Barriers to a Competitive Health Care System*. 3 J. HEALTH POL., POL'Y & L. 303 (1978).

43. Elwood, Anderson, Billings, Carlson, Houghberg & McClure, *Health Maintenance Strategy*, 9 MED. CARE 291 (1971).

44. H. FRECH & P. GINSBURG, PUBLIC INSURANCE IN PRIVATE MEDICAL MARKETS: SOME PROBLEMS OF NATIONAL HEALTH INSURANCE 58 (1978).

45. Moore, *Cost Containment Through Risk-Sharing by Primary-Care Physicians*, 300 NEW ENG. J. MED. 1359 (1979). *See also* Moore, Martin, Richardson & Riedel, *Cost Containment Through Risk-Sharing by Primary Care Physicians: A History of the Development of United Health Care*, 1 HEALTH CARE FINANCING REV. 1 (Spring 1980).

46. Evans, *Physician-Based Group Insurance: A Proposal for Medical Cost Control*, 302 NEW ENG. J. MED. 1280 (1980).

ages altogether. Enthoven claims that encouragement of competing provider groups establishes ". . . a framework within which providers can offer very different values, depending on the tastes of the patients served."[47] The premium charged by a provider group would thus be related to their ability to control costs, while the group still provides the services that consumers desire.

Proponents of this approach have suggested ways to remove the numerous obstacles to the development and successful operation of alternative delivery systems. These obstacles include the market power and domination of existing providers and provider groups; the cost or charge-based reimbursement under FFS, which provides no consumer incentive to search for lower cost forms of care; the employer-centered provision of a single type and level of health insurance, which prevents consumer choice of alternative health plans; and the difficulty of obtaining the capital financing and enrollees necessary to start alternative health plans.

Perhaps the primary barrier to the development of alternative delivery systems is the prevalence of employer provision of a single health insurance plan to all employees.[48] Like cost sharing enthusiasts, those advocating provider reorganization would weaken the employer link to health insurance by limiting or eliminating the tax subsidy of employer-provided health insurance benefits. Health insurance is typically offered as a perquisite of employment, and if the employee has any decision to make regarding health insurance coverage, it is to maximize the total salary and benefit package when choosing a job. Under existing arrangements, insurers compete with each other to offer the most comprehensive set of benefits to each employer while minimizing the cost of the total benefit package. Employers are assumed to act as relatively informed buyers in this purchase, attempting to maximize benefits at minimum cost.

Both the consumer sovereignty advocates and the proponents of provider competition identify the consumer as the best judge of what insurance to buy. Multiple choice proposals would both increase consumer participation in decisionmaking and increase the opportunities for competitive alternatives to develop. If the employer continues to pay the full costs of employee choices, existing tax law encourages employees to maximize their income by electing

47. A. ENTHOVEN, *supra* note 16, at 67.

48. Enthoven, *Consumer-centered vs. Job-centered Health Insurance*, 57 HARV. BUS. REV. 141 (1979).

the most comprehensive and expensive level of coverage regardless of their perceived need. Conversely, offering fixed dollar employer subsidies to each employee would make the employee aware of and responsible for the fiscal effects of his choice of coverage. If the employee elects a level of coverage costing more than the fixed contribution, the difference must be paid out-of-pocket. Ideally, this out-of-pocket payment would not be deductible for tax purposes from total income, as it is under current law. If the employee elects a level of coverage costing less than the fixed contribution, the difference should be returned to the employee through rebates. This rebate should not be subjected to income tax if the employer-paid subsidy is not taxed. These steps eliminate any tax incentive to choose a higher level of insurance coverage than is perceived by the employee to be necessary. They would, however, produce fundamental irregularities in the income tax structure if cash income from rebates were excluded from gross income.

It is conceivable that the employer contribution could vary on the basis of such factors as the demographic characteristics, social class, or income of the employees in order to make the subsidy actuarially fair. It is important, however, that the subsidy not vary with the choice of the level of coverage and that the election of a more expensive form of care not be implicitly or explicitly rewarded. With that provision, then, proponents of this reform approach argue that fixed-dollar employer subsidies in conjunction with multiple choice of health plans and a limit on the tax subsidy available to health insurance would result in fundamental changes in the medical care financing and delivery system.

Multiple choice by employees is currently mandated in areas that have a federally qualified HMO. The "dual choice" option, however, is not aggressively marketed to employees, and many areas are still unserved by HMOs. Moreover, some established HMOs do not seek federal qualification. The existing dual choice option has therefore had little impact. Regulations require that federally qualified HMOs offer certain benefits. This requirement may reduce the effects of multiple choice where HMOs do exist and may inhibit the development of HMOs. As McClure has stated, "In order for consumers choosing efficient plans to be rewarded, multiple choice arrangements must allow competing plans some flexibility to establish benefits and premiums they believe consumers will find attractive. . . . *Effective market forces are im-*

possible if all consumer benefits and premiums are fixed."[49] The major successful implementation of multiple choice currently in operation is the Federal Employees Health Benefits Program (FEHBP). FEHBP has, however, not been a particularly striking model of cost containment, although it does prove the administrative feasibility of employer-provided multiple health plan choice.

Multiple choice and alternative provider systems could result in a two-tiered system of medical care that divides the poor, who will of necessity choose low coverage, from the relatively affluent, who will choose higher levels of coverage. On the other hand, it may result in a two-tiered system that separates the relatively healthy from the relatively sick, as low cost medical care develops for low risk individuals and a high cost system develops for high risk populations—a dilemma that present forms of employer-provided group insurance do not create. The latter system could be prohibitively expensive for the high risk population, particularly if tax subsidies for the purchase of health insurance are eliminated.

Proponents of systemic reorganization rely on the experience of HMOs in areas of the country where they have a relatively large market share as an analogy for nationwide HMO success. The Minneapolis-St. Paul region is often cited to demonstrate the potential impact of alternative health plans on cost and utilization.[50] Moreover, a recently completed study demonstrated that the costs in a prepaid health plan in Seattle were lower than costs in a competing FFS plan. The study also found that the similarities between the two plans regarding access to care were more striking than the differences.[51] While studies have generally demonstrated lower hospitalization for PPGP enrollees than for those individuals covered by conventional insurance, it is unclear why this difference occurs and whether it has any effect on the local FFS market. Existing studies have not conclusively demonstrated that this lower utilization is not due to enrollee differences through self-selection, a process in which less healthy individuals elect more comprehensive coverage.[52] If self-selection and enrollment of a relatively healthy population is, in fact, the explanation for lowered hospital

49. McClure, *supra* note 42, at 307.

50. *See* Christianson & McClure, *supra* note 10, at 812-18.

51. COMPARISONS OF PREPAID HEALTH CARE PLANS IN A COMPETITIVE MARKET: THE SEATTLE PREPAID HEALTH CARE PROJECT—RESEARCH SUMMARY, *cited in* NATIONAL CENTER FOR HEALTH SERVICES RESEARCH, NCHSR RESEARCH ACTIVITIES (Jan. 1981).

52. Luft, Feder, Holahan & Lennox, *Health Maintenance Organizations*, in NATIONAL HEALTH INSURANCE: CONFLICTING GOALS AND POLICY CHOICES, *supra* note 5, at 129, 130.

utilization in HMOs, then the total effect of HMOs on hospital utilization may be minimal, and the end result may be to encourage development of a high cost system of care for high risk populations and a lower cost system for low medical care utilizers.

In addition to doubts about the efficacy of programs for organizational restructuring, questions arise about the likelihood that the preconditions for successful reform on such a massive scale can be met. Proponents of competitive alternatives acknowledge that it will take time for this competition to develop. In fact, it is estimated that if current circumstances continue, only 10% of the population could be covered by HMOs by 1990,[53] up from the current 4% enrollment rate. The capital needed to support the fledgling HMOs has been difficult to raise, and attempting to attract enrollees who are accustomed to the established FFS system is expensive. The existence of these barriers does not imply that reform outcomes would be less preferable than the current system; they only suggest that it is highly questionable whether the final form of a medical care system incorporating organizational competition will closely resemble the vision of its advocates.

C. *The Antitrust Approach*

The application of antitrust law to the problems of the medical care system is the third approach to reform. Similarities underlie the assumptions about antitrust initiatives and the alternatives discussed earlier in this Article, including a generalized preference among procompetitive advocates for market allocation mechanisms in medical care. The policies prescribed to increase competitive behavior, however, differ. The reformers previously discussed assume that consumers, medical care providers, and financiers are reacting rationally to perverse economic incentives. Thus, restructuring financial systems and altering the reimbursement systems would allow competition to develop on the basis of price. The advocates of antitrust have a different conception of the problem. They contend that collusive behavior on the part of established medical providers prevents the emergence of competition in the market for medical care.

Antitrust law places singular emphasis on the benefits of com-

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53. OFFICE OF HEALTH MAINTENANCE ORGANIZATIONS, UNITED STATES PUBLIC HEALTH SERVICE, PROJECTIONS FOR HMO DEVELOPMENT, 1980-1990 (1980), *cited in* A. Miller & M. Miller, Options for Health and Health Care: The Coming of Post-Clinical Medicine (forthcoming 1981).

petition. Havighurst has stated that "antitrust doctrine leaves very little room to ask whether competition is a good or bad thing. The law presumes that it is the most desirable way to organize and carry on any form of economic activity that Congress has not made exempt from the antitrust laws."[54] The antitrust preference for competition above any other goal implies that any cost containing effects of physician or medical system organization should be rejected if the effects are brought about through a lack of competition or by the domination of the market by a particular group. "Antitrust laws were created and have been enforced to prevent marketplace participants from colluding to disrupt an otherwise effective market. The aim of antitrust interventions is to maintain a competitive market, which is viewed as the ideal."[55]

While responsibility for antitrust enforcement rests with both the Department of Justice and the Federal Trade Commission (FTC), it is the FTC that is most actively involved in studying the medical market. The FTC is concerned with activity that potentially violates section one of the Sherman Act, which prohibits contracts, combinations, and conspiracies in restraint of trade, and with violations of the Clayton Act.[56] Under its enabling legislation, the FTC is authorized to conduct investigations of possible violations of both Acts.[57] "The primary enforcement tool is the 'Cease and Desist Order,' enforceable under threat of civil penalties, court injunctions and contempt citations. . . . The FTC also enacts trade regulations and industry guidelines, recommends Congressional legislation, and seeks to influence other government agencies."[58]

The FTC's ability to initiate antitrust action in the medical care field was enhanced recently by two Supreme Court rulings. In 1975 the Supreme Court in *Goldfarb v. Virginia State Bar*[59] determined that the "learned professions," including the medical pro-

54. Havighurst, *The Antitrust Laws, the Federal Trade Commission, and Cost Containment*, 56 BULL. N.Y. ACAD. MED. 170 (1980).

55. Drake & Kozak, *A Primer on Antitrust and Hospital Regulation*, 3 J. HEALTH POL., POL'Y & L. 328, 330 (1978).

56. Sherman Antitrust Act, ch. 647, § 1, 26 Stat. 209 (1890) (codified at 15 U.S.C. § 1 (1976)); Clayton Act, ch. 323, § 1, 38 Stat. 730 (1914) (codified at 15 U.S.C. § 12 (1976)).

57. Federal Trade Commission Act, ch. 311, § 5, 38 Stat. 717 (1914) (current version at 15 U.S.C. § 45(a)(2) (Supp. III 1979)).

58. Avellone & Moore, *The Federal Trade Commission Enters a New Arena: Health Services*, 299 NEW ENG. J. MED. 478 (1978).

59. Goldfarb v. Virginia State Bar, 421 U.S. 773 (1975).

fession, were not exempt from the antitrust laws.[60] In 1976 the Court ruled in *Hospital Building Co. v. Trustees of Rex Hospital*[61] "that hospitals were sufficiently involved in interstate commerce to warrant federal application of the antitrust laws."[62] The FTC is presently investigating the medical profession to determine if antitrust violations are present, and whether these violations, if present, have been responsible for medical cost inflation. Aspects of that investigation include the anticompetitive impact of the American Medical Association (AMA) ban on physician advertising;[63] the effect of provider influence on the accreditation of medical schools and the consequent control over the supply of physicians;[64] the inhibiting effect of established providers on the growth of physician groups and HMOs;[65] and the anticompetitive impact of physician domination of third-party reimbursement mechanisms.[66]

Fundamental conflicts exist between the traditional practice of medicine and the ideal of antitrust proponents. As Havighurst explains,

> The dominant premise of profession-sponsored reforms in the financing and delivery of medical care—that is, in the economic organization of care—has been that the public should look to the profession rather than to the individual competitive behavior for solutions to any problems that exist. Traditional antitrust doctrine, however, rejects the premise that industry-wide groups can serve as unbiased arbiters of price, quantity, quality, and other economic matters, and demands instead that decisions on such matters be made on a decentralized competitive basis, by producers whose ability to further their own interests is checked by the need to satisfy consumers. Moreover, this principle applies even when it is unclear that market forces can be immediately or totally effective.[67]

Antitrust will support the development of competitive alternatives that are not collusive and do not dominate the market. Antitrust standards, however, will likely be applied to the medical industry when physicians attempt to exercise their market power through boycotts of medical groups, restrictions on how physicians sell their services, prescription of payment methods, or domination of utilization review through insistence on peer review.[68]

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60. *See* Avellone & Moore, *supra* note 58, at 478.
61. 425 U.S. 738 (1976).
62. Drake & Kozak, *supra* note 55, at 340; *see* 425 U.S. at 744-47.
63. Avellone & Moore, *supra* note 58, at 479.
64. *Id.* at 480.
65. *Id.* at 481.
66. *Id.* at 482.
67. Havighurst, *Antitrust Enforcement in the Medical Service Industry: What Does It All Mean?*, 58 MILBANK MEMORIAL FUND Q. 89, 96-97 (1980).
68. Havighurst & Hackbarth, Enforcing the Rules of Free Enterprise in an Imperfect

Havighurst contends that existing financing mechanisms have developed in response to the demands of the profession. "The greatest obstacle to third-party cost containment," he asserts, "is the willingness, even eagerness, of doctors to act collectively to halt, dilute, co-opt, or capture any cost-containment measures that they find objectionable or threatening."[69] The power of organized medicine, in Havighurst's opinion, lies in "the implicit threat of boycott facing any plan which departs from accepted practice without professional approval. . . . Removal of that threat should permit competition finally to stimulate insurers and others to develop more effective cost-containment measures."[70] These cost containment alternatives, however, are themselves acceptable only if they are not collusive in nature. This is particularly applicable to provider domination of third-party payment plans. In recognition of the power that physician groups and medical societies can wield over markets, the FTC's Bureau of Competition in April 1979, ". . . recommended to the Commission that it propose a trade regulation rule to divest organized medicine of control over various health care financing plans."[71] This proposed rule would probably affect not only the Blue Shield physician payment plans but also emerging financial arrangements that either are controlled by physicians or include a large proportion of the physicians in a community. Antitrust law requires opposition to provider control of the market even when that control is alleged to have a beneficial impact on prices. Havighurst suggests that "the insight that the effect on competition, not prices, is the crucial issue will be particularly relevant in deciding whether to adopt a rule governing profession-sponsored IPAs [Individual Practice Association]," one form of physician controlled organization that the rule would probably address.[72] He concludes that applying antitrust law to IPAs is reasonable. "The IPA," he contends, "is simply a way of reorganizing the monopoly's internal operations so that the profession can better protect itself against both government intrusion and competitive

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Market: The Case of Individual Practice Associations 18-19 (Sept. 25-26, 1980) (paper presented at *A Conference on Health Care—Professional Ethics, Government Regulation, or Markets?*, American Enterprise Institute). *See also* Leibenluft & Pollard, *Antitrust Scrutiny of the Health Professions: Developing a Framework for Assessing Private Restraints*, 34 VAND. L. REV. 927 (1981).

69. Havighurst, *The Role of Competition in Cost Containment*, in COMPETITION IN THE HEALTH CARE SECTOR: PAST, PRESENT, AND FUTURE 299 (W. Greenberg ed. 1978).

70. *Id.* at 313.

71. Havighurst & Hackbarth, *supra* note 68, at 6.

72. *Id.* at 15.

developments,"[73] regardless of the apparent effects on price.

The antitrust proposals have some immediate potential for implementation. Unlike other procompetitive reforms, they require no explicit legislative initiative. In fact, if evidence of antitrust violations is present, antitrust action is mandated. Moreover, since antitrust actions can he instituted at a state level, as well as by private citizens, competitive reform through antitrust need not await action by federal agencies.

In considering antitrust potential in the medical industry, however, it is useful to raise issues of the feasibility and desirability of antitrust action. Conceptually, an analysis of the Oregon State Medical Society actions in the 1930s and 1940s suggests that the antitrust laws may play a potentially effective role in increasing competition in the medical industry by reducing the market power of medical stakeholders.[74] Antitrust litigation may also be applicable, and possibly effective, in the case of provider domination of medical school accreditation and the AMA ban on physician advertising, if the adverse impact on competition of these provider activities can be demonstrated. Both of these examples involve national policies promulgated by the Liaison Committee on Medical Education and the AMA. It is possible, therefore, to concentrate antitrust action on identifiable national targets. Arguably, however, antitrust litigation is unlikely to have an appreciable impact on collusive behavior by physicians in individual communities. The absolute number of physicians, physician groups, and medical societies and organizations suggests that the national impact of a few antitrust lawsuits may be minimal. Alternatively, if antitrust litigation does have a pervasive impact on physician behavior in groups, the fear of an antitrust violation may have a paralyzing rebound effect, thereby inhibiting the development of alternative medical plans.

Similarly, proposed trade regulation rules to prevent provider control of payment plans are unlikely to be effective because of the decentralized nature of the medical care system, the many potential sources of violations, and the limited resources available to spend on enforcement activities. The competitive preference of antitrust proponents is premised in part on the failure of current regulations to alleviate the problems of the medical care industry. The

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73. *Id.* at 26.

74. Goldberg & Greenberg, *The Effect of Physician-Controlled Health Insurance:* United States v. Oregon State Medical Society, 2 J. HEALTH POL., POL'Y & L. 48 (1977).

conventional regulatory critique is partially based on the difficulty of constraining a decentralized industry characterized by a large number of diverse provider institutions. Yet antitrust rulemaking appears in that sense subject to the same critique as command and control regulation.

Additionally, efficiency questions aside, the agency's lack of resources and threats from Capitol Hill combine to dilute the likely impact of antitrust approaches to medical system reform. The ultimate impact of antitrust actions will depend on the resources available to the FTC, their ability to target those resources effectively, and the ability of providers to fight antitrust litigation or to ignore FTC trade regulation rules.

Even if capable of implementation, it is also questionable whether antitrust is the sensible response to the problems of the medical industry. While competition may be a desirable means to an end, it is not obviously an end in itself in the medical care industry. Medical care is not a good that should be allocated solely by the market. Even more than other procompetitive approaches, antitrust actions are committed to competition for its own sake, with less regard to its impact on costs and the atmosphere of medical practice. Rather than forcing the FTC to attack the medical care system in the name of idealized competition, the antitrust debate should perhaps return to the legislative arena, where Congress can decide whether the peculiarities of health economics require that some aspects of medical care be exempt from the antitrust laws.

IV. CONCLUSION

The health policy arena is politically unbalanced, with concentrated provider interests juxtaposed against the diffuse interests of consumers. This imbalance alone would imply little or no sustained interest in cost containment or structural reform. The increasing role of the government as financier and purchaser of medical care, however, has concentrated its interest in controlling costs in the medical sector. The health care industry is increasingly alert to the presence of that new player. Like the Voluntary Effort by the hospital industry,[75] procompetitive proposals are efforts to preempt government cost-containment strategies. All of the major re-

75. In 1977, in response to the threat of President Carter's hospital cost containment legislation, the hospital industry developed the Voluntary Effort, a program to voluntarily lower hospital costs without the pressure of publicly mandated cost containment.

form approaches are politically volatile. The role of government in controlling medical costs and changing the patterns of financing and delivering care generates intense ideological struggle. This type of political dispute typically continues until legislative stalemate is broken by major political-electoral realignments.

National health insurance and hospital cost containment have indeed been stalemated health issues. The position of the Reagan Administration in early 1981, however, is clear. As President Reagan stated in his Inaugural Address, "In this present crisis, government is not the solution to our problem; government is the problem."[76] The preliminary Reagan economic program intends to phase out federal regulation of the medical industry: "If competitive forces are to restrain costs, free entry into health care markets is essential."[77] The new administration preference for free market, private sector initiatives, coupled with the new Republican majority in the Senate, could well break the national health policy deadlock. On the other hand, it could merely be the articulated rationale for reducing the regulations that constrain the profits of some parts of the health care sector, with real competition receiving only nominal support.

Procompetitive proposals represent one class of responses to the worrisome directions American medicine has taken in the past decade. Changes that would enhance the market structure in the long run, however, do not provide solutions to the immediate crisis. The encouragement of alternative delivery mechanisms would not solve immediate problems with geographic maldistribution of medical resources. The possible attainment of a long-run market equilibrium would not solve current cost problems. Even if "equilibrium" were possible, it would be slow to evolve[78] and until it did, there might be significant underinvestment in health care by relatively uninformed consumers. One must wonder whether we as a society would be willing to tolerate the effects of consumer miscalculations in their consumption choices regarding levels of coverage under, for example, restructured delivery systems. *Caveat emptor* can hardly be casually applied to medical care.

Finally, procompetitive proposals are not themselves cost-containment strategies, although cost containment is frequently cited

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76. N.Y. Times, Jan. 21, 1981, § B, at 1, col. 1.

77. OFFICE OF MANAGEMENT AND BUDGET, AMERICA'S NEW BEGINNING: A PROGRAM FOR ECONOMIC RECOVERY 6-22 (Feb. 19, 1981).

78. *See* Bovbjerg, *Competition Versus Regulation in Medical Care: An Overdrawn Dichotomy*, 34 VAND. L. REV. 965 (1981).

as the expected result of increased competition. In fact, should market allocation in health care dominate, total expenditures on health could be higher than the current levels, although public costs may be lowered. To the extent that they merely shift costs from the government health budget to the private sector, the fiscal gains are socially illusory.

It is not the purpose of this Article to reject all features of procompetitive proposals. Competitive health plans, multiple health plan choice, provider and consumer cost consciousness, and antitrust activity all may have some place in a larger strategy to rationalize the medical care system. Each of the proposals has some advantages in terms of increasing consumer choice and altering the balance of power between existing actors. As an approach to universal medical care system reform, however, competition alone is inadequate. In fact, one could argue that the most technically feasible way to both rationalize the medical care system and reduce total societal expenditures on health would be to nationalize a public budget for health care and to pass the total costs of medical care through the political budgetary process.[79] Total societal costs might actually be reduced by increasing the program costs to goverument, as long as public authority is, as in Canada, adequately increased. The centralization of regulatory and allocative decisions could well result in a more suitably restrained form of American medicine. That, however, is a discussion about the alternatives to procompetitive proposals, rather than the problems of procompetitive proposals, and is therefore beyond the scope of this Article.[80]

79. *See* Marmor, Wittman & Heagy, *The Politics of Medical Inflation*, 1 J. HEALTH POL., POL'Y & L. 69 (1976).

80. For an exploration of such alternatives, see NATIONAL HEALTH INSURANCE: CONFLICTING GOALS AND POLICY CHOICES, *supra* note 5; A. Miller & M. Miller, *supra* note 53.