

MARKET FORCES, COMPETITIVE STRATEGIES, AND HEALTH CARE REGULATION

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In the following article, Professor William White examines the interaction between governmental and private efforts to reform the U.S. health care system. He begins by examining several distinctive features of the U.S. health care system. From there, Professor White provides a historical account of the modern U.S. health care system, focusing in particular on the post-World War II growth of private health insurance providers and the expanding government regulation of the health care industry. Tracking the shift away from regulatory efforts to “market-based,” competitive reforms in the 1980s, Professor White traces the rise of managed care in the 1990s and presents evidence of managed care’s failure to contain health care costs. Professor White concludes by examining some emerging trends in private insurance markets and government regulation of the health care industry, designed to slow the steady upward climb of health care spending.

I. INTRODUCTION

The U.S. health care sector combines a high level of government regulation with continued reliance on market systems for allocating resources. The sheer complexity of our hybrid system makes it easy to lose sight of overall trends in industry organization. At the risk of over simplification, the goal of this article is to examine the interactions between market forces and regulation in shaping the organization of the health care sector from a historical perspective. Specifically, this article focuses on competitive reforms of private health insurance markets since 1975. While national health reform was the subject of ongoing debate during most of the study period, the underlying organization of the health care system is taken as given in order to keep the analysis tractable.

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Section II of the article reviews some of the key characteristics of health care markets from a regulatory perspective.¹ Section III provides institutional and historical background.² Section IV examines two questions. First, what role did interactions between market forces and regulation play in the adoption of competitive reforms for private insurance markets?³ Second, what has been the impact of competitive reforms on the organization and operation of the health care industry and the demand for regulation?⁴ Section V examines the current state of our health care system.⁵ The article concludes in section VI by exploring where we are headed in the face of emerging trends in private insurance markets and recent regulatory proposals.⁶

II. WHAT MAKES HEALTH CARE MARKETS DIFFERENT?

The health care industry has several important features that have combined to create a unique regulatory environment. First, the industry is characterized by major problems with uncertainty.⁷ Second, there are widely shared equity concerns.⁸ Third, the industry has been very dynamic; accompanied by rapid technological change, health care spending has been on a sharply rising trajectory since the early twentieth century.⁹

As discussed by Kenneth Arrow¹⁰ and many subsequent researchers,¹¹ uncertainty in health has posed three principal types of problems. First, there is uncertainty about when health care will be needed. Demand for care is frequently hard to predict and consumers face the risk of low-probability, high-cost events.¹² Illustrative of this is the fact that health care costs are highly concentrated in a small percentage of the population. For example, in 1996, 5% of the population accounted for 55% of total health care spending, while 10% of the population accounted for 69%, and 30% for 90%.¹³ Second, there is uncertainty about what services are needed when illness occurs. Consumers frequently lack the skill and knowledge (and possibly the objectivity) to diagnose and

1. See *infra* notes 7–42 and accompanying text.

2. See *infra* notes 43–89 and accompanying text.

3. See *infra* notes 97–123 and accompanying text.

4. See *infra* notes 124–95 and accompanying text.

5. See *infra* notes 196–217 and accompanying text.

6. See *infra* notes 218–59 and accompanying text.

7. See *infra* notes 10–20 and accompanying text.

8. See *infra* notes 21–27 and accompanying text.

9. See *infra* notes 28–37 and accompanying text.

10. See Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941 (1963).

11. See, e.g., David Dranove & William D. White, *Agency and the Organization of Health Care Delivery*, 24 INQUIRY 405 (1987). See generally Special Issue, *Kenneth Arrow and the Changing Economics of Health Care*, 26 J. HEALTH POL., POL'Y & L. 823 (2001).

12. See Arrow, *supra* note 10, at 948–49.

13. See Marc L. Berk & Alan C. Moneit, *The Concentration of Health Care Expenditures, Revisited*, HEALTH AFF., Mar.–Apr. 2001, at 9, 12 exh.1.

treat illness when it occurs.¹⁴ Finally, not only the demand for care, but also the outcomes of treatments are often uncertain.¹⁵ Consequently, the appropriateness and quality of diagnostic and therapeutic services is often difficult for consumers to evaluate even after they receive them.

Each of these problems with uncertainty has engendered responses in the health care marketplace that have created their own new sets of problems. A pattern of skewed, hard to predict costs has generated a demand for health insurance.¹⁶ The introduction of insurance has raised cost and efficiency issues because it can insulate consumers from price and distort demand.¹⁷ Uncertainty about what services are needed when illness occurs has created a demand for physicians and other providers to serve as consumers' agents, not only to provide specific services, but also to advise on the appropriate choice of care.¹⁸ Reliance on agents has, however, raised issues of agency abuse—acts or omissions by providers for their own benefit at the expense of their patients.¹⁹ Because it is difficult for consumers to assess provider performance, these agency problems have created a demand for regulatory oversight through such means as professional licensure and government quality assurance efforts, which have posed challenges of their own.²⁰

A second key feature of health care is equity concerns. Historically, our system has been unwilling to ration care solely by price.²¹ This has resulted in demands for public intervention and the introduction of large redistributive programs.²² These programs, in turn, have led to hard choices regarding tradeoffs between access, quality, and cost.²³ Nevertheless, unlike most other major industrial nations,²⁴ the United States has never instituted a system of universal health insurance. In 1999, an estimated 18% of the nonelderly U.S. population lacked any form of health insurance coverage.²⁵ At the same time, despite the obvious inequalities implicit in this lack of coverage and “under insurance” of many

14. See Arrow, *supra* note 10, at 951.

15. *Id.* at 951–52.

16. See *id.* at 945.

17. See Thomas G. McGuire, *Physician Agency*, in HANDBOOK OF HEALTH ECONOMICS 461, 481–86 (Anthony J. Culyer & Joseph P. Newhouse eds., 2000).

18. See *id.* at 503–07.

19. See *id.* at 507–13.

20. See *id.* at 469–73, 487–92.

21. Henry Aaron & William B. Schwartz, *Rationing Health Care: The Choice Before Us*, 247 SCIENCE No. 4941, Jan. 26, 1990, at 418.

22. See *id.*

23. See *id.* at 419.

24. See *id.* at 420.

25. See KAISER COMM'N ON MEDICAID & THE UNINSURED, THE HENRY J. KAISER FAMILY FOUND., THE UNINSURED: A PRIMER, (Mar. 2002), available at <http://www.kff.org/uninsured/louder.cfm?url=/commonspot/security/getfile.cfm&PageID=1412>.

other U.S. residents,²⁶ there has been widespread reluctance to explicitly countenance the formal establishment of a “multitier” system.²⁷

A final important characteristic of the health care industry has been its dynamic pattern of growth. There is a long history of rapid expansion, dating back to the turn of the twentieth century.²⁸ Starting from a low base in the early part of the century, by 1929, health expenditures were 3.5% of national income.²⁹ In 1970, they exceeded 7% of national income and in 1980, they had reached 9%.³⁰ In 1990, health expenditures were over 12%, climbing to over 13% in the mid-1990s.³¹ In the latter part of the 1990s, growth rates slowed, and the share of income spent on health care remained stable between 1997 and 1999.³² Recently, the pattern of rapid growth has resumed.³³ Government estimates of spending run as high as 14% for 2001.³⁴

While not the only factor, this pattern of rapid expenditure growth has been closely associated with the adoption of new, cost-increasing medical technologies. New methods of diagnosis and treatment may improve outcomes, but also add to the overall cost of providing care.³⁵ Thus, whereas the nineteenth century physician’s equipment was basically limited to the contents of his black bag, the early twentieth century saw the rise of the technologically sophisticated (and costly) modern hospital as the “doctor’s workshop.”³⁶ The post-World War II era has been marked by a continuation of this trend and the growing use of ever more sophisticated, but more expensive, surgical techniques, diagnostic equipment, and drugs.³⁷

Against this background, a central focus of policy debates has been how to respond to the upward trajectory of health care costs. Simply making a straight line projection of future health care expenditures based

26. P.F. Short & J.S. Banthin, *New Estimates of the Underinsured Younger Than 65 Years*, 274 JAMA 1302, 1302–06 (1995).

27. That is, a system in which there are multiple types of insurance and access to care varies according to the type of insurance to which an individual is assigned.

28. See William D. White, *The American Hospital Industry Since 1900: A Short History*, in 3 ADVANCES IN HEALTH ECONOMICS AND HEALTH SERVICES RESEARCH 143 (Richard M. Scheffler & Louis F. Rossiter eds., 1982).

29. NAT’L CTR. FOR HEALTH STATISTICS, U.S. DEP’T OF HEALTH & HUMAN SERVS., HEALTH, UNITED STATES 1983 177 tbl.68 (1983).

30. NAT’L CTR. FOR HEALTH STATISTICS, U.S. DEP’T OF HEALTH & HUMAN SERVS., HEALTH, UNITED STATES, 2001 328 tbl.114 (2001).

31. *Id.*

32. See *id.*

33. See Katharine Levit et al., *Inflation Spurs Health Spending in 2000*, HEALTH AFFAIRS, Jan.–Feb. 2002, at 172.

34. See CTRS. FOR MEDICARE & MEDICAID SERVS., NATIONAL HEALTH CARE EXPENDITURE PROJECTIONS TABLES tbl.1, available at <http://cms.hhs.gov/statistics/nhe/projections-2001/t1.asp> (last modified Sept. 3, 2002).

35. See Burton A. Weisbrod, *The Health Care Quadrilemma: An Essay on Technological Change, Insurance, Quality of Care, and Cost Containment*, 29 J. ECON. LITERATURE 523, 524 (1991).

36. HERMAN M. SOMERS & ANNE R. SOMERS, DOCTORS, PATIENTS, & HEALTH INSURANCE 67–72 (1961).

37. Weisbrod, *supra* note 35, at 526.

on historical growth rates leads to the conclusion that the sector will soon engulf the national product.³⁸ In this context, as Joseph Newhouse has observed, there is nothing inherently wrong with devoting a growing share of resources to health care.³⁹ But neither is increased spending inevitable. The underlying issue is one of value for money and the opportunity cost of devoting additional resources to health care compared to other goods and services. International comparisons suggest substantial room for discretion.⁴⁰ Other industrial nations have also experienced rising costs.⁴¹ The United States, however, spends far more both per capita and as a share of national income.⁴² A key policy issue is how to appropriately address the adoption of new technologies as costs rise.

III. HISTORICAL CONTEXT

The modern system of health care regulation in the United States has its genesis in the post-World War II era. Prior to World War II, government involvement in either providing or financing care was limited. State and local hospitals and clinics acted as safety net providers in many areas of the country, while there were also a few public programs for special populations such as veterans.⁴³ The vast majority of care was purchased directly by consumers out-of-pocket on a fee-for-service basis in the private market place.⁴⁴

Thus, in 1929, out-of-pocket payments by consumers accounted for over seventy-9% of all health care spending.⁴⁵ Public expenditures, primarily by state and local government on charity care, totaled only 14%, supplemented by a small amount of private philanthropy (under 5%).⁴⁶ Moreover, not only was the allocation of health care resources primarily through private markets, but competition in these markets was basically “patient driven.” Patients and their doctors made decisions about what treatments to buy and where to purchase them.⁴⁷

38. Illustrative of this, the percentage share of national income devoted to health care grew 50% between 1980 and 2000, from 8.8% to 13.3%. Projecting a similar rate of increase into the future leads to the conclusion that health care will account for almost 20% of national income in 2020 and thirty percent in 2040. NAT'L CTR. FOR HEALTH STATISTICS, U.S. DEP'T OF HEALTH & HUMAN SERVS., HEALTH, UNITED STATES, 2003 305 tbl.111 (2003), available at http://www.cdc.gov/nchs/data/health_tables/2003/03hus111.pdf.

39. See Joseph Newhouse, *Medical Care Costs: How Much Welfare Loss?* J. ECON. PERSP., Summer 1992, at 3.

40. Gerald F. Anderson, *In Search of Value: An International Comparison of Cost, Access and Outcomes*, HEALTH AFF., Nov.–Dec. 1997, at 163, 163–71.

41. See NAT'L CTR. FOR HEALTH STATISTICS, *supra* note 38, at 305 tbl.111.

42. *Id.*

43. See PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 289 (1982).

44. I.S. FALK ET AL., *THE COSTS OF MEDICAL CARE* 8–9 (1933).

45. *Id.*

46. *Id.*

47. See David Dranove et al., *Price and Concentration in Hospital Markets: The Switch from Patient-Driven to Payer-Driven Competition*, 36 J.L. & ECON. 179, 182–83 (1993).

While government involvement in the provision and finance of care was low, government regulation nevertheless played an important role in shaping market organization. One particularly important feature was public efforts to assure the quality of health services, especially through occupational regulation of health care professionals. Under the banner of quality assurance and consumer protection, medical licensure laws restricted the practice of medicine to physicians.⁴⁸ This occupational monopoly, which was largely self-administered by the medical profession, had several important implications. First, it made physicians the primary point of entry into the health care system; for most services, a patient had to go through a doctor.⁴⁹ Second, it provided a framework for standardizing medical training and controlling the flow of new entrants into medicine. Third, coupled with a powerful sense of professional legitimacy, it established a basis for enforcing codes of professional ethics and controlling the scope and form of competition in medical markets. Examples included tight restrictions on advertising and opposition to prepaid group practice arrangements in lieu of fee-for-service payment.⁵⁰ Finally, it served as an anchor for extensive systems of voluntary professional self-regulation and an elaborate structure of medical specialty organizations.⁵¹

Medical licensure could have been a powerful tool for regulating the quality of care and imposing professional accountability for clinical performance. While vigilant in monitoring educational credentials, advertising, and payment arrangements, licensure boards made little attempt to directly review physicians' clinical or financial performances. Formal disciplinary actions on quality grounds were rare.⁵² Physicians might be subject to the pressure of their peers, who could affect referrals.⁵³ The primary recourse for consumers, however, was the courts and malpractice litigation, which was both cumbersome and costly.⁵⁴ While the medical community vociferously defended consumers' freedom of choice to select physicians, there was no corresponding effort to collect or disseminate price or quality information to consumers.⁵⁵ Finally, licensure limited consumers' ability to turn to other providers.

These issues have not gone unnoticed by consumers. During the Jacksonian period of the nineteenth century, consumers openly rebelled and licensure laws were abolished in many states.⁵⁶ By the late nine-

48. See STARR, *supra* note 43, at 44–46.

49. See *id.* at 22–23.

50. *Id.* at 128–29, 164.

51. See ROSEMARY STEVENS, AMERICAN MEDICINE AND THE PUBLIC INTEREST 209–17 (1971).

52. See STANLEY GROSS, OF FOXES AND HEN HOUSES 94–115 (1984); see also Paul B. Ginsburg & Ernest Moy, *Physician Licensure and the Quality of Care*, REGULATION, Fall 1992, at 34.

53. See Dranove & White, *supra* note 11, at 408.

54. CHARLES E. PHELPS, HEALTH ECONOMICS 468–75 (2d ed. 1997).

55. Carl F. Ameringer, *Organized Medicine on Trial: The Federal Trade Commission vs. the American Medical Association*, 12 J. POL'Y HIST. 445, 445–53 (2000).

56. See STARR, *supra* note 43, at 57–59.

teenth century, licensure had been reinstated.⁵⁷ In the early twentieth century, challenges to medical authority were not a central issue.⁵⁸ An undercurrent of resentment against professional authority remained, but a much more immediate issue was rising costs.

As documented by the Committee on the Costs of Medical Care, by the late 1920s, increasing use of sophisticated medical technologies and inpatient care placed a growing number of U.S. residents at potentially catastrophic financial risk in the event of major illness.⁵⁹ This generated growing pressure to set up systems of health insurance to protect against this financial risk. In the case of the Committee on the Costs of Medical Care, proposals to increase financial access were combined with proposals to improve the efficiency through managerial innovation.⁶⁰ In particular, the Committee supported prepaid group practices as a way not only to assure access to care, but to rationalize its delivery.⁶¹

Many physicians strongly objected to these proposed innovations as a threat to professional autonomy.⁶² Some, as a matter of principal, even went so far as to oppose any form of insurance.⁶³ Continuing growth in the costs of care, however, made out-of-pocket financing increasingly untenable. The 1940s and 1950s saw a rapid expansion in private health insurance, first through voluntary Blue Cross plans and then through commercial insurance.⁶⁴ Tax subsidies of private employment-based group coverage, which quickly came to dominate the market, provided an added boost.⁶⁵

The growth of private insurance was accompanied by declining direct consumer payments. In 1950, private insurance accounted for 9% of payments for care and out-of-pocket expenditures had fallen to a little over 65%.⁶⁶ By 1960, the share of private insurance had risen to 21%, public spending was 21%, and out-of-pocket payments had fallen to 56% of health care expenditures.⁶⁷

The growing role of private insurance was accompanied by the emergence of insurance regulation as a second important regulatory feature of the health care industry. Operating at the state level, insurance enabling laws sought to assure the financial solvency of insurers and to

57. *See id.* at 102–12.

58. *See id.* at 140–44.

59. *See* FALK ET AL., *supra* note 44.

60. *Id.* at 578–93.

61. *Id.* at 578–82.

62. *See* DAVID DRAKE, *REFORMING THE HEALTH CARE MARKET: AN INTERPRETIVE ECONOMIC HISTORY* 46 (1994).

63. *Id.* at 49.

64. *See* ODIN ANDERSON, *BLUE CROSS SINCE 1929: ACCOUNTABILITY AND THE PUBLIC TRUST* 45 (1975).

65. *Id.*

66. DRAKE, *supra* note 62, at 77.

67. *See* NAT'L CTR. FOR HEALTH STATISTICS, *supra* note 30, at 333 tbl.118.

set parameters on the organization of payment systems and reimbursement of providers and enrollees.⁶⁸

Although by the early 1960s, private employment-based insurance covered the majority of U.S. workers, major groups remained outside the system.⁶⁹ The introduction of Medicare and Medicaid in 1965 marked an important watershed. Together, these programs provided coverage to two key groups outside the workplace, the elderly and the poor, and sought to provide them with financial access equivalent to that available in the private sector.⁷⁰ With their introduction, the government became involved in the large scale provision of social insurance to finance health care purchases. This resulted in a sharp increase in public spending on health care, particularly at the federal level. In addition, over time, both state and federal regulation of the sector increased, as policymakers sought accountability for growing public spending.⁷¹

The combined effect of the expansion of public and private coverage was that by the mid-1970s, the vast majority of care was paid for by third-party intermediaries. Between 1960 and 1975, public spending nearly doubled, rising from 21% to almost 40% of total health care expenditures.⁷² At the same time, by 1975, private insurance had risen to almost 26% of total expenditures and direct out-of-pocket payments had declined to 33%.⁷³

New public and private insurance arrangements, by introducing large third-party intermediaries, had the potential to dramatically transform health care markets and establish new standards of financial and clinical accountability. But a series of accommodations served to limit any efforts to impose accountability. “Patient driven” competition was maintained. By design, insurers were relegated to a passive role, functioning primarily as conduits for funds.⁷⁴ State insurance enabling laws, which remained in force until the early 1980s, precluded private insurers from taking a proactive role. Selective contracting with providers was prohibited, as was using financial incentives to “steer” patients to preferred providers. Medicare and Medicaid adopted similar frameworks. The only (grudging) exception was for Health Maintenance Organizations (HMOs) that used integrated exclusive groups of providers.⁷⁵

On the provider side, incentives for providers to control use were minimal.⁷⁶ Typically, providers were reimbursed on the basis of their

68. SOMERS & SOMERS, *supra* note 36, at 264–69.

69. *Id.* at 366–69.

70. *See* STARR, *supra* note 43, at 372–73.

71. *See id.* at 379–419.

72. *See supra* note 30 and accompanying text.

73. *See* NAT'L CTR. FOR HEALTH STATISTICS, *supra* note 30, at 333 tbl.118.

74. *See* DRAKE, *supra* note 62, at 62–65; STARR, *supra* note 43, at 331–34.

75. *See* STARR, *supra* note 43, at 396–97.

76. For a discussion of early efforts to control costs by private insurers, see SOMERS & SOMERS, *supra* note 36, at 403–25.

costs; thus, the more care they provided, the more they were paid.⁷⁷ The primary method for attempting to impose financial discipline was patient cost sharing through coinsurance and deductibles.⁷⁸ The financial risk associated with these arrangements could sometimes be substantial. The overall impact of insurance was to increasingly insulate consumers from the financial implications of their decisions. Meanwhile, consumers continued to face substantial costs in attempting to gather price or quality information that might have informed shopping. Provider advertising remained largely prohibited and there was no attempt to provide consumers with new, alternative sources of information.⁷⁹

Not surprisingly, costs continued to rise. Health care spending went from 5% of national income in 1960, to 7.9% in 1975.⁸⁰ Several factors played a role. The expansion of insurance contributed to an acceleration in cost growth system-wide. The introduction of Medicare and Medicaid also had the effect of shifting an important part of the burden for cost growth to the public sector. This placed mounting demands on public revenues. In both public and private sectors, cost pressures drew new sets of motivated actors into policy debates.

In the 1970s, the response of private insurance markets to cost increases was largely passive.⁸¹ Initiatives for change came almost entirely from the public sector. In the wake of continued growth, policymakers' attentions began to shift from improving access to containing costs. Important examples included the introduction of all payer rate regulation in a number of states,⁸² national price controls as part of more general efforts to control inflation, and efforts to introduce supply-side controls and rationalize the delivery of services through health care planning.⁸³

These public sector efforts added significantly to regulatory complexity. Against a backdrop of ongoing debates about national health insurance reform, public sector efforts also potentially offered a basis for replacing existing, market-based, arrangements with a comprehensive budget-driven system.⁸⁴ Under such a system, common in many other industrial countries,⁸⁵ expenditures would have been determined through

77. Richard J. Arnould et al., *Competitive Reforms: Context and Scope*, in *COMPETITIVE APPROACHES TO HEALTH CARE REFORM* 3, 7 (Richard J. Arnould et al. eds., 1993).

78. *Id.* at 10.

79. See Ameringer, *supra* note 55, at 445–53.

80. See NAT'L CTR. FOR HEALTH STATISTICS, *supra* note 30.

81. See Clark C. Havighurst, *The Questionable Cost-Containment Record of Commercial Health Insurers*, in *HEALTH CARE IN AMERICA* 221, 227–28 (H. E. Frech III ed., 1988).

82. Kenneth D. Thorpe, *Health Care Cost Containment: Reflections and Future Directions*, in *HEALTH CARE DELIVERY IN THE UNITED STATES* 461–64 (Anthony R. Kovner & Steven Jonas eds., 1999).

83. See Frank A. Sloan & A. Bruce Steinwald, *Effects of Regulation on Hospital Costs and Input Use*, 23 J.L. & ECON. 81, 83–89 (1980).

84. See INST. OF MED., *CHANGING THE HEALTH CARE SYSTEM: MODELS FROM HERE AND ABROAD* 1 (1994).

85. *Id.* at 1–2.

a process of comprehensive government budgeting, rather than being market-driven.⁸⁶

As actually implemented, the net effect of regulatory reforms was to continue to leave the underlying market structure largely intact. While concerned about costs, neither providers nor consumers were comfortable with the idea of an administrative system giving the government a veto in the choice of treatments or providers.⁸⁷ This, in turn, limited the effectiveness of regulatory efforts. Important elements of regulatory reforms, Certificates of Need Laws and Professional Standard Review Organizations (PSROs), for example, continued to remain in place into the 1980s and beyond.⁸⁸ By the late 1970s, however, there was a shift away from regulatory approaches. Reflecting a more general shift in the political climate, policymakers began to turn to what became identified as “market-based,” “procompetitive” approaches.⁸⁹

IV. COMPETITIVE REFORMS

In the face of continued cost growth, the 1980s saw the introduction of a series of new market-oriented public policy initiatives. In addition, private payers and employers emerged as important new players. After rising from 7% to 9% of national income between 1970 and 1980,⁹⁰ health care spending accelerated in the 1980s. By 1988, it was 10.9% of national income, and in 1993, it reached 13.4%.⁹¹ In the public sector, important initiatives included the introduction of the Medicare Prospective Payment System,⁹² a range of state reform efforts, and in the early 1990s, the Clinton administration’s health reform initiative.⁹³ At the same time, finally galvanized into action, private insurers introduced changes that set in motion a fundamental restructuring of relationships in the health care market place, ultimately giving rise to what has come to be known as “managed care.”⁹⁴ This section briefly reviews the general

86. *Id.*

87. See STARR, *supra* note 43, at 381–405.

88. Certificate of Need Laws sought to control costs through controls on capital investments by hospitals. PSROs sought to directly regulate the utilization of services and to identify and control inappropriate use of services. See STARR, *supra* note 43, at 414–16 for further discussion.

89. See Arnould et al., *supra* note 77, at 8–9.

90. See *supra* note 30.

91. See Levit et al., *supra* note 33, at 173.

92. For a description of the Medicare Prospective Payment System, see DAVID G. SMITH, PAYING FOR MEDICARE: THE POLITICS OF REFORM 23–126 (1992).

93. For a summary of the Clinton health reform plan and of the politics of its defeat, see JACOB S. HACKER, THE ROAD TO NOWHERE: THE GENESIS OF PRESIDENT CLINTON’S PLAN FOR HEALTH SECURITY (1997).

94. See Jacob S. Hacker & Theodore R. Marmor, *The Misleading Language of Managed Care*, 24 J. HEALTH POL., POL’Y & L. 1033, 1036 (1999).

rationale for market-based reforms⁹⁵ and then specifically considers developments in private insurance markets and the rise of managed care.⁹⁶

A. Rationales for Competitive Reforms

The basic procompetitive diagnosis of health care cost problems was twofold.⁹⁷ First, delegating care decisions to well-insured consumers, who lacked both the means and the incentives to shop effectively for care, created inherently inflationary distortions in the purchasing system.⁹⁸ Second, these distortions were reinforced by the absence of appropriate provider incentives, as well as the presence of inappropriate restrictions on payer and provider behavior, including insurance rules and bans on advertising.⁹⁹

A common thrust of procompetitive proposals in response to this diagnosis was that by more successfully harnessing market forces, performance could be enhanced, while preserving access and choice.¹⁰⁰ There was the possibility of a win-win situation for consumers and payers; by appropriately restructuring markets, better care could be had for less. Focusing on private insurance markets, three broad types of strategies were put forward.¹⁰¹ The first and most important strategy for purposes of this article, was to reduce reliance on consumers by shifting the locus of control over shopping decisions to insurance plans and replacing “patient driven competition” with “payer driven competition.”¹⁰² The second procompetitive strategy, paradoxically, was to enhance the consumer’s ability to shop for care by improving access to information.¹⁰³ Finally, a third strategy, used antitrust policy to regulate the exercise of monopoly power in health care markets.¹⁰⁴

The basic notion underlying the first strategy, which became the basis for managed care, was that insurance plans could shop more effectively than patients. Compared to patients, plans were better able to realize economies of scale in gathering price and quality information. They were also more motivated than patients because they could keep all savings arising from improved competition, whereas consumer savings are

95. See *infra* notes 97–123 and accompanying text.

96. See *infra* notes 124–95 and accompanying text.

97. See Arnould et al., *supra* note 77, at 7.

98. *Id.*

99. *Id.* at 7, 11.

100. *Id.* at 12.

101. *Id.* at 10. Arnould et al. note reforms on the supply side of insurance markets as a separate issue. In this article, supply side issues are included with discussion of an overall shift to “payer driven” competition.

102. See Dranove et al., *supra* note 47, at 181–84.

103. Arnould et al., *supra* note 77, at 11.

104. *Id.* at 10.

limited by the extent of cost sharing. Finally, by virtue of their size, plans were in a better position to exercise market clout.¹⁰⁵

By harnessing competitive forces and employing plans as agents to shop on behalf of consumers, large gains could, in theory, be achieved from three sources. First, competition could promote more efficient production of services by squeezing out waste, by generating incentives to manage care more effectively, and by making use of preventive services to maintain the health of enrollees.¹⁰⁶ Second, competition could also squeeze down high provider price margins associated with ill-functioning markets.¹⁰⁷ Third, competition could serve to rationalize the adoption of new technology.¹⁰⁸ As an added attraction, proponents noted that by taking consumers out of the loop in shopping for care and delegating decisions about what care to buy, financial barriers to services could be largely eliminated because cost sharing would no longer be necessary to control use.¹⁰⁹

Giving insurers responsibility for shopping introduced a new agency problem. While insurance plans had incentives to aggressively shop for care, they also had incentives to under provide care, and to avoid high risk patients. Moreover, in the face of idiosyncratic consumer needs and preferences, relying on plans for shopping introduced important new coordination problems. Efforts to systematically rationalize health care delivery presented the risk of inflexibility in the provision of services, further threatening access and quality.¹¹⁰

Advocates responded that these problems could be solved by imposing accountability on plans through competition in insurance markets.¹¹¹ In particular, proponents such as Alain Enthoven argued that market discipline could simultaneously be imposed on plans and consumers through a system of “managed competition.”¹¹² Specifically, Enthoven envisioned a system in which individual consumers would be offered a menu of standardized plans and asked to make a premium contribution based on the cost of the plan that they selected.¹¹³ To facilitate their choices, consumers would be provided with appropriate price and quality information to enable them to assess cost and quality trade-

105. David Dranove, *The Case for Competitive Reform in Health Care*, in COMPETITIVE APPROACHES TO HEALTH CARE REFORM, *supra* note 77, at 67, 71–72.

106. See STARR, *supra* note 43, at 395.

107. See Dranove et al., *supra* note 47, at 180.

108. See Michael E. Chernew et al., *Managed Care, Medical Technology, and Health Care Cost Growth: A Review of the Evidence*, 55 MED. RES. & REV. 259 (1998).

109. Sherry Glied, *Managed Care*, in HANDBOOK OF HEALTH ECONOMICS, *supra* note 17, at 707, 712–13.

110. See Harold S. Luft, *Why Are Physicians So Upset About Managed Care?*, 24 J. POL., POL'Y & L. 957, 962–63 (1999).

111. See Dranove, *supra* note 105, at 75–79.

112. See Alain Enthoven, *Consumer Choice Health Plans* (pts. 1 & 2), 298 NEW ENG. J. MED. 650, 709 (1978).

113. *Id.* at 710, 714.

offs between plans.¹¹⁴ The net result would be not only to create incentives for consumers to seek value for money in selecting their insurance, but to provide a way for consumers, through their shopping decisions, to directly impose market discipline on plans.¹¹⁵

The second strategy, consumer empowerment, championed by the U.S. Federal Trade Commission, moved in the opposite direction of managed care.¹¹⁶ Rather than reducing reliance on consumers, this strategy posited that provider performance could be improved by promoting a more proactive role for consumers in the market place for care.¹¹⁷ That is, by reducing information costs about prices and quality, consumers could be empowered to shop more effectively.¹¹⁸ This would increase market discipline and lead to improved efficiency.¹¹⁹ The solution was more, not less, consumer involvement in the market place. In particular, reformers argued for reducing restrictions on advertising to increase flows of price and quality information to consumers.¹²⁰ A corollary implicit in this strategy, which has emerged as an important theme in current debates over benefit design, was that increasing consumer cost sharing could improve market performance by increasing their potential savings from shopping.¹²¹

The third strategy, the use of antitrust laws to regulate the exercise of monopoly power, was also championed by the Federal Trade Commission.¹²² This strategy was consistent with either managed care or consumer empowerment. By seeking to promote competition and limit monopoly, it potentially improved opportunities for shopping by both insurers and consumers.¹²³

B. *The Introduction and Impact of Competitive Reforms*

By far, the most striking impacts of procompetitive reforms in the 1980s and 1990s were the restructuring of public and private payment systems and the rise of managed care. As discussed below, at the start of the 1980s, private insurance markets were dominated by indemnity insurance.¹²⁴ What would come to be known as managed care plans made up a tiny fraction of the market.¹²⁵ By the end of the 1990s, this situation

114. *Id.*

115. *Id.*

116. See Ameringer, *supra* note 55, at 464–68.

117. *Id.*

118. *Id.*

119. *Id.* at 461–66.

120. *Id.* at 461–62.

121. See *infra* notes 225 and 229 and accompanying text.

122. Ameringer, *supra* note 55, at 450.

123. *Id.* at 464–68.

124. THE KAISER FAMILY FOUND. & HEALTH EDUC. & RESEARCH TRUST, EMPLOYER HEALTH BENEFITS: 2001 ANNUAL SURVEY 75 exh. 6.1, available at <http://www.kff.org/insurance/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=13832> (last visited Feb. 11, 2004).

125. See *infra* notes 128–31 and accompanying text.

had reversed. At the same time, reforms on other fronts were also important. In particular, the Federal Trade Commission successfully pursued initiatives to reduce barriers to consumer advertising and expand antitrust enforcement. This section focuses on how managed care transformed private insurance markets.¹²⁶ The final section will discuss the use of antitrust policy and the theme of using information to empower consumers.¹²⁷

Although the term itself did not come into general use until later, a nascent managed care industry already existed in 1980 in a small group of tightly integrated staff/group HMOs.¹²⁸ Promoted by earlier federal legislation, such as the Health Maintenance Act of 1973, these HMOs were widely cited as a reference point by proponents of competitive reforms.¹²⁹

The basic model used by these plans was comprehensive care on a capitated basis, entailing flat annual payments for each enrollee. Once enrolled, participants were provided with care as needed from a closed panel of physicians employed exclusively by the plan. By implementing tightly integrated systems of managerial control, HMOs could rationalize the delivery of care to realize savings. These savings could then be passed on to consumers in exchange for consumers relinquishing their free choice of provider. Despite (or perhaps because of) federal efforts, the popularity of staff/group HMOs proved limited.¹³⁰ As of 1980, existing HMO enrollment was around nine million, or about 4% of the U.S. population.¹³¹

One possible avenue for reform was to replace the existing fragmented system of insurance with a system of managed competition, potentially anchored by group/staff HMOs. What actually happened was rather different. State decisions to alter insurance-enabling laws swept away restrictions on selective contracting and financial steering of patients.¹³² For the first time, private payers began contracting nonexclusively with doctors and hospitals and began using stringent economic incentives to direct patients to these providers.¹³³ These procompetitive reforms, however, were not accompanied by any serious attempt to implement a national policy of managed competition. In the early 1980s, the federal government basically took a passive stance. While some states attempted to initiate reforms, those states faced problems with ca-

126. See *infra* notes 132–95 and accompanying text.

127. See *infra* notes 250–55 and accompanying text.

128. See Hacker & Marmor, *supra* note 94, at 1036.

129. See STARR, *supra* note 43, at 400–01.

130. Federal legislation required larger employers to offer HMOs as an option where they were available, but it also encumbered them with burdensome regulatory requirements. See *id.* 396–98.

131. See GROUP HEALTH ASS'N OF AM., PATTERNS IN HMO ENROLLMENT 7 (1995).

132. See Dranove et al., *supra* note 47, at 181–82.

133. See Robert F. Rich & William D. White, *Health Care Policy and the American States: Issues of Federalism*, in HEALTH POLICY, FEDERALISM, AND THE AMERICAN STATES 23 (Robert F. Rich & William D. White eds., 1996).

capacity and major federal regulatory barriers.¹³⁴ In the absence of systemic government action, what actually emerged has come to be widely described as a system of “unmanaged competition.”¹³⁵ The level of competition increased sharply. The organization of insurance markets, however, remained highly fragmented and opportunities for systematic, informed shopping in these markets by individual consumers continued to be limited.¹³⁶

The rise of unmanaged competition was accompanied by a rapid evolution of new types of insurance products that have generically become known as “Managed Care Organizations” (MCOs).¹³⁷ By the early 1990s, a veritable alphabet soup of new organizational forms existed. Today, major types of MCOs include not only traditional group/staff HMOs, but also network HMOs and IPA (Independent Practice Association) HMOs, Preferred Provider Organizations (PPOs), and Point of Service Organizations (PSOs).¹³⁸ Sorting out the differences between these various types of MCOs is complex, especially given that their organization has been quite fluid. A short discussion serves as useful background for considering organizational trends in the next section.¹³⁹

In varying degrees, all of the main types of MCOs share several features. The single most important distinguishing characteristic is selective contracting and the use of financial incentives to steer patients to providers within plan networks.¹⁴⁰ A second important feature is utilization review and the use of administrative controls to attempt to influence provider behavior (e.g., the use of gatekeepers and treatment protocols).¹⁴¹ A third major feature is the use of novel types of payment arrangements to realign provider incentives.¹⁴² A key example is provider capitation, in which a provider is paid a fixed amount per covered member per month.¹⁴³ Providers assume the financial risk for the costs of caring for these enrollees, creating strong incentives to control utilization. Other related examples include the use of bonuses and withholds.¹⁴⁴

134. Issues for states included fiscal capacity, interstate competition, and administrative capacity. In addition, federal regulations under ERISA sharply limited states' scope of action in private insurance markets. For further discussion, see Rich & White, *supra* note 133, at 23–24.

135. See, e.g., JAMES C. ROBINSON, *THE CORPORATE PRACTICE OF MEDICINE* 35–38 (1999).

136. *Id.* at 42–45.

137. See JON B. CHRISTIANSON ET AL., *MANAGED CARE AND THE TREATMENT OF CHRONIC ILLNESS* 1–2 (2001).

138. See DRAKE, *supra* note 62, at 119–20, 127.

139. See *infra* Part V.

140. Robert F. Rich, *Health Policy, Health Insurance and the Social Contract*, 21 *COMP. LAB. L. & POL'Y J.* 397, 407 (2000).

141. See Debra A. Draper et al., *The Changing Face of Managed Care*, *HEALTH AFF.*, Jan.–Feb. 2002, at 11, 13.

142. See Gloria J. Bazzoli, *Medical Service Risk and the Evolution of Provider Compensation Arrangements*, 26 *J. HEALTH POL., POL'Y & L.* 1003, 1006–07 (2001).

143. *Id.*

144. *Id.* at 1007.

Comparing plan types, one major distinction is the use of exclusive contracts for providers. As noted, staff/group HMOs either hire their physicians as employees or contract for physician services on an exclusive basis.¹⁴⁵ Other MCOs typically use nonexclusive arrangements, allowing a provider to contract with more than one MCO.¹⁴⁶ A second major distinction is the degree to which plans reimburse enrollees for self-referred, nonemergency, out-of-plan (nonplan provider) services. HMOs do not reimburse for these services.¹⁴⁷ PPOs do, albeit while also applying higher coinsurance and deductibles as a means of steering patients to “preferred providers.”¹⁴⁸

HMOs typically have also been distinguished by greater efforts to manage use in in-plan providers, particularly in integrated staff/group HMOs. In contrast, most PPOs serve primarily as contracting agents, shopping for discounts while making relatively little effort to use administrative controls to influence behavior. PSOs are hybrids. They offer their members services from an HMO, combined with coverage for self-referred out-of-plan care subject to higher coinsurance and deductibles. A final distinction is the use of novel payment methods, which are more common in HMOs, especially in the case of capitation.¹⁴⁹

Because of the diversity of organizations and reporting requirements, tracking overall trends in MCO enrollment is difficult. Data quality varies by plan type. Enrollment estimates are most accurate for HMOs because they are considered insurers and subject to associated legal reporting requirements.¹⁵⁰ Between 1980 and 1990, HMO enrollments grew from nine million to over thirty-six million.¹⁵¹ Estimates are much more problematic for PPOs, which, as contracting agents, are not subject to these requirements. PPOs emerged as a major source of coverage in the late 1980s, while by the early 1990s some HMOs had begun establishing PSOs. By 1993, HMO enrollments exceeded forty-two million.¹⁵² They had another growth spurt in the mid-1990s, reaching a peak of slightly over eighty million in 1999.¹⁵³ In 1993, there were also roughly sixty million people covered by PPOs and an additional 1.5 million people enrolled in PSOs.¹⁵⁴ Based on market survey data, the estimated number of individuals with PPO coverage was over 106 million in 1999.¹⁵⁵

145. VERGIL N. SLEE ET AL., *SLEE'S HEALTH CARE TERMS* 276 (4th ed. 2001).

146. *Id.* at 364.

147. *Id.* at 276.

148. Diana Joseph Bearden & Bryan J. Maedgen, *Emerging Theories of Liability in the Managed Health Care Industry*, 47 BAYLOR L. REV. 285, 297-98 (1995).

149. See Arnould et al., *supra* note 77; Glied, *supra* note 109, at 714-16.

150. 42 U.S.C. § 300e(c)(8) (2000).

151. GROUP HEALTH ASS'N OF AM., *supra* note 131, at 7.

152. Press Release, InterStudy Publications, HMO Enrollment Stabilizing, Medicaid Continues to Grow (May 7, 2002).

153. *See id.*

154. THE AMCRA FOUND., 1994-1995 MANAGED HEALTH CARE OVERVIEW 34-35 (1995).

155. AVENTIS PHARM., MANAGED CARE DIGEST SERIES 2001 65 (2002). Note that the number of individuals that PPOs report as eligible for coverage is typically substantially higher than the num-

Totaling estimates of HMO and PPO coverage, an estimated 107.5 million people were covered by managed care in 1993 and 186.8 million in 1999.¹⁵⁶ Subsequently, estimated PPO enrollments have continued to grow. There has been a dip in HMO enrollments, however, which fell to seventy-eight million in 2001.¹⁵⁷

These numbers point to a pattern of rapid MCO growth from a small base in the 1980s. They also suggest that, nationally, MCOs did not really begin to move into a dominant role in private insurance markets until the mid-1990s. Following the collapse of the Clinton health care reform initiative, managed care quickly became the norm for the majority of the U.S. population with private coverage.¹⁵⁸ Consistent with this, employer surveys indicate that the estimated share of covered workers in conventional insurance plans was 73% in 1988.¹⁵⁹ In 1993, managed care had made major inroads, but the share of conventional plans was still 46%.¹⁶⁰ By 1996, it had fallen to 27% and by 1999, conventional plans accounted for only 9% of covered workers.¹⁶¹

Unmanaged competition had implications beyond costs, including implications for consumer access to services and, potentially, for quality. The rise of managed care in the early 1990s was accompanied by a sharp reduction in the rate of growth in health care spending.¹⁶² Health insurance premiums and health care expenditures had been growing at double digit rates since the 1970s.¹⁶³ In the mid-1990s, their growth rate slowed considerably. Between 1993 and 1997, expenditure growth averaged only 5.4% per year and the rate of insurance premium growth plunged to 4.8%.¹⁶⁴ In the wake of this sharp slowdown, expenditures actually fell as a share of national income, from 13.4% in 1993, to 13.1% in 1997, re-

ber of individuals who report that they are covered by PPOs in market surveys of individuals asking about their source of coverage. This is because PPO enrollment data include many individuals with multiple forms of coverage (i.e., individuals who are eligible for multiple plans). For example, based on PPO enrollment reports, the total estimated number of PPO eligible enrollees in 1999 was 180 million. See Press Release, Interstudy Publications, Interstudy's PPO Directory & Performance Report Second Edition Now Available (Sept. 28, 2001).

156. See THE AMCRA FOUND., *supra* note 154, at 34–35; AVENTIS PHARM., *supra* note 155, at 65; Press Release, *supra* note 152.

157. See Press Release, *supra* note 152.

158. See Gail A. Jensen et al., *The New Dominance of Managed Care: Insurance Trends in the 1990s*, HEALTH AFF., Jan.–Feb. 1997, at 125, 126. Public managed care enrollments grew, as well. In 2001, Medicaid HMO enrollment was almost 12 million, while Medicare HMO enrollment was 5.6 million, down from a peak of 6.4 million in 1999. See also Press Release, *supra* note 152.

159. See THE KAISER FAMILY FOUND. & HEALTH EDUC. & RESEARCH TRUST, EMPLOYER HEALTH BENEFITS: 1999 ANNUAL SURVEY 57 (1999), available at <http://www.kff.org/insurance/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=13268> (last visited Feb. 11, 2004). Note that estimates for 1999 are based on slightly different sampling methods than earlier estimates, but the general magnitudes of estimates appear comparable.

160. *Id.*

161. *Id.*

162. See CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 34, at tbl.2.

163. See Levit et al., *supra* note 33, at 174 exh.2, 176 exh.4.

164. See *id.* at 176 exh.4.

maintaining at this level through 1999.¹⁶⁵ Not all of this decline was attributable to private managed care, however. After 1997, the Balanced Budget Act and a marked decline in the growth of public spending, particularly for Medicare, also contributed.¹⁶⁶ As of the late 1990s, however, managed care seemed to be working as an effective cost containment mechanism.

Less heralded, but also important, was the impact of managed care on financial barriers to health care. Consistent with the notion that if patients were taken out of the loop in shopping for care, then there would be less need for cost sharing, direct consumer payments fell. Between 1990 and 1995, the share of total out-of-pocket health expenditures declined from 23% to 17.2%.¹⁶⁷ In the case of hospital services, which involve particularly high levels of exposure to financial risk, the share was already low. But by 1995, it had fallen to 3%.¹⁶⁸ For physician services, direct consumer payments declined from over 35% in 1975, to 27% in 1985, and to 12% in 1995.¹⁶⁹ Between 1995 and 2000, however, the trend leveled out and shares basically remained flat.¹⁷⁰

In spite of managed care's seeming success in curbing cost growth and in improving financial access, its growth in the mid-1990s was accompanied by mounting tensions between consumers and providers and the emergence of a "managed care backlash."¹⁷¹ Early proponents of managed care argued that, through better management, MCOs could promote both quality and efficiency and constrain costs.¹⁷² Critics now challenged these claims with growing intensity and argued that managed care was failing to make good on its promise; rather than delivering managed care, MCOs were delivering "managed costs." Key issues included concerns about provider choice, quality of care, and impacts on provider markets.¹⁷³

Discussions of choice and quality are often intertwined. While sometimes equated in public debates, choice does not necessarily imply high quality care, and it is useful to consider the two issues separately. For most of the millions of consumers new to managed care in the late 1980s and the early 1990s, the impact on choice was unambiguous; managed care reduced choice. For the first time, these people found themselves subject to restrictions on not only which providers they could use, but which services. The phrase "Can I keep my doctor?" became a com-

165. See *id.* at 173 exh.1.

166. See *id.* at 177-78.

167. See NAT'L CTR. FOR HEALTH STATISTICS, *supra* note 30, at 333 tbl.118.

168. *Id.*

169. *Id.*

170. *Id.*

171. Mark A. Peterson, *Introduction: Politics, Misperception, or Apropos?*, 24 J. HEALTH POL., POL'Y & L. 873, 875 (1999).

172. See Dranove, *supra* note 105, at 67-72.

173. See Peterson, *supra* note 171.

mon refrain, as did complaints about utilization review and the use of gatekeeper arrangements to restrict access to referrals.¹⁷⁴

Concerns about new forms of reimbursement contributed to a mounting sense of dissatisfaction. By 1995, a third of all doctors had at least one capitated contract, including 50% of physicians in general or family practice and 45% in general internal medicine.¹⁷⁵ Because these contracts created incentives to withhold services, they raised growing questions about the alignment of doctors' interests with those of their patients, shaking consumers' trust in their physicians.¹⁷⁶

Adding to these concerns was the failure of consumer choice and the vision of managed competition to materialize in private insurance markets.¹⁷⁷ The vast majority of the U.S. population (90%) continued to obtain insurance through employment-based groups.¹⁷⁸ In the workplace, far from facing a menu of standardized plans, most people had very limited options. For example, in 1996, 33% of U.S. residents with workplace insurance found themselves with only one option.¹⁷⁹ Another 16% had a choice between two plans, while only half had access to three or more plans.¹⁸⁰ Hence, for many, the option of switching plans without switching employers was moot. Conversely, if an employer chose to drop a plan, then employees had little choice but to go along. For many employees, to the extent they had control over offerings, it was only indirectly through their ability to exert pressure on employers.

Despite extensive study, the impact of managed care on quality remains difficult to assess. There is strong evidence that, whether or not fully intended, managed care has had profound effects on the organization of health care delivery, the types of services patients receive and from whom they receive them. For example, in local health care markets, the growth of managed care has been associated with reductions in the use of inpatient care, increases in the use of outpatient services, and shifts in the use of selected technologies.¹⁸¹ Other effects include changes

174. See Robert J. Blendon et al., *Understanding the Managed Care Backlash*, HEALTH AFF., July–Aug. 1998, at 80.

175. See David W. Emmons & Carol J. Simon, *Managed Care: Evolving Contractual Arrangements*, in SOCIOECONOMIC CHARACTERISTICS OF MEDICAL PRACTICE 20 tbl. 4 (1996).

176. See David Mechanic & Mark Schlesinger, *The Impact of Managed Care on Patient's Trust in Medical Care and Their Physicians*, 275 JAMA 1693, 1694 (1996).

177. See Susan M. Marquis & Stephen H. Long, *Trends in Managed Care and Managed Competition*, HEALTH AFF., Nov.–Dec. 1999, at 75, 85–86.

178. See PHELPS, *supra* note 54, at 349 tbl.10.5.

179. THE KAISER FAMILY FOUND. & HEALTH EDUC. & RESEARCH TRUST, *supra* note 159, at 45.

180. *Id.* Proportions are similar in 2001. Note that in 1995, 90% of Americans with private insurance obtained it through the workplace. See PHELPS, *supra* note 54, at 349 tbl.10.5.

181. See Glied, *supra* note 109.

in the relative demand for primary care versus specialist physicians,¹⁸² and a decline in the share of physicians in solo practice.¹⁸³

These shifts had significant potential implications for quality. The direction of predicted effects, however, was variable. Consistent with this, results in the literature seeking to directly evaluate the impact of managed care on quality outcomes are mixed.¹⁸⁴ Some studies suggest negative outcomes.¹⁸⁵ But the direction of effects is far from uniform, and impacts go in both directions, providing ammunition for both proponents and opponents.¹⁸⁶

Consumer ire toward managed care, generated by restrictions on choice and new types of payment incentives, undoubtedly contributed to the intensity of debate. Not only have many consumers been prepared to believe the worst, but the literature suggests their hostility may have led to exaggerated perceptions of the evidence against managed care.¹⁸⁷

An additional contributing factor to the negative perceptions of managed care may be a more general trend toward consumerism. The term “consumerism” has been used to encompass a wide range of different aspects of consumer behavior and concerns. From a consumerist perspective, particularly important aspects of consumer discontent are a growing desire to participate in medical decision making and a willingness to challenge the professional authority of physicians and demand increased accountability.¹⁸⁸ One specific factor often cited in explaining these trends is the role of the internet in increasing the availability of information.¹⁸⁹ But more generally, these trends appear to be associated with increasing consumer expectations about performance.¹⁹⁰

One important manifestation of consumerism has been an effort to empower consumers in the marketplace. Examples range from the release of data on procedure-specific hospital mortality rates, to the National Committee for Quality Assurance’s Health Plan Report Card for

182. See Carol J. Simon et al., *The Effect of Managed Care on the Income of Primary Care and Specialty Physicians*, 33 HEALTH SERVICES RES., Part I, 549, 564 (1998).

183. See David Dranove et al., *Is Managed Care Leading to Consolidation in Health-Care Markets?*, 27 HEALTH SERVICES RES. 573, 590 (2002).

184. See Robert H. Miller & Harold S. Luft, *Does Managed Care Lead to Better or Worse Quality of Care?*, HEALTH AFF., Sept.–Oct. 1997, at 7, 13.

185. See *infra* note 186 and accompanying text.

186. See Miller & Luft, *supra* note 184, at 7; see also Glied, *supra* note 109, at 727–45. A related issue not considered here is “spillover” by managed care on other parts of the health care system, for example with respect to access to charity care. See, e.g., Peter J. Cunningham et al., *Managed Care and Physicians’ Provision of Charity Care*, 281 JAMA 1087 (1999).

187. See David Mechanic, *The Managed Care Backlash: Perceptions and Rhetoric in Health Care Policy and the Potential for Health Care Reform*, 79 MILBANK Q. 35, 35–38 (2001).

188. See Kenneth W. Kizer, *Establishing Health Care Performance Standards in an Era of Consumerism*, 286 JAMA 1213, 1213–14 (2001).

189. *Id.* at 1213.

190. *Id.* at 1213–14.

managed care plans.¹⁹¹ Consumerist concerns have also been the basis for regulatory initiatives, including “consumer rights” legislation, which will be discussed in the next section.¹⁹²

Turning to the supply side of the health care market, the coming of managed care triggered massive upheaval. Doctors and hospitals alike found themselves buffeted by growing price competition. In addition, doctors and other providers found their professional authority and autonomy directly challenged by administrative controls, and managed care placed mounting stress on the doctor/patient relationship. Physicians remained patients’ agents, but now physicians were forced to negotiate with MCOs, not only for access to services, but for access to patients, who, in the terminology of managed care, had become “covered enrollees.”¹⁹³ Doctors also had to deal with their patients’ unease and distrust, generated by administrative controls and new payment mechanisms, such as capitation.

Actual impacts varied considerably by location and type of providers. Overall, these shifts had two broad implications for providers’ behaviors. First, the shifts created incentives to increase efficiency and improve performance by trimming costs and realizing economies of scale through consolidation.¹⁹⁴ Second, these shifts created incentives to reposition strategically. For example, doctors and hospitals built political alliances with consumers to oppose managed care as a perceived common enemy, as seen in the area of patients’ rights legislation.¹⁹⁵ A second example, not necessarily in the interests of consumers, was strategic consolidation in order to reduce MCOs’ ability to play providers off against each another and to limit competition.

V. WHERE ARE WE NOW?

In the late 1990s, amidst grave doubts about its impact on quality, managed care seemed to be a resounding success in controlling costs. The last several years have seen a swift change in perceptions. After enjoying a period of unprecedented stability, health care spending and insurance premiums are once again rising rapidly. After growing at an average of 5.4% per year between 1993 and 1997, the growth rate in expenditures edged up to 5.7% from 1997 to 1999, followed by a surge to 6.7% from 1999 to 2000.¹⁹⁶ Preliminary estimates indicate that the

191. See, e.g., N. Y. STATE DEP’T OF HEALTH, CORONARY ARTERY BYPASS SURGERY IN NEW YORK STATE 1997–1999 (Sept. 2002); Nat’l Comm. for Quality Assurance, NCQA’s Health Plan Report Card, at <http://hprc.ncqa.org/index.asp> (last visited Feb. 11, 2004).

192. See *infra* notes 204–05 and accompanying text.

193. PETER R. KONGSTVEDT, ESSENTIALS OF MANAGED HEALTH CARE 475 (2d ed. 1997).

194. See Dranove et al., *supra* note 183, at 575–76.

195. See D. Ted Lewers, *AMA’s Fight for Patients’ Rights Is Only the Beginning*, AM. MED. NEWS, Oct. 2, 2000, at <http://www.ama-assn.org/amednews/2000/10/02/edca1002.htm>.

196. See Levit et al., *supra* note 33.

growth rate will be even higher in 2001.¹⁹⁷ Long run projections suggest this trend could continue for years to come.¹⁹⁸ Simultaneously, health insurance premiums have soared. From 1997 to 1998, premium growth jumped to 6.6%, from an average of 4.8% for the period from 1993 to 1997.¹⁹⁹ Premiums rose again 6.8% in 1998-1999, then 8.4% in 2000.²⁰⁰ For 2001, the estimated rate of increase for employer groups is 11%, and estimates for 2002 are even higher.²⁰¹ As a result, employers face health care spending increases that hearken back to the massive increases of the early 1990s. Moreover, after a long period of decline, this latest upswing has been accompanied by an increase in the percent of uninsured, which rose from 14.2% in 2000, to 14.6% in 2001.²⁰²

In the wake of rapid increases in costs and a rise in the number of uninsured, a consensus has emerged that managed care is no longer working as a cost containment mechanism. From a policy perspective, this raises two key questions. First, what explains this resurgence? Second, what is the proper response to it? In part, managed care may be viewed as a victim of its own success. The same strategies, which were so effective in containing costs, have set in motion powerful forces in provider and consumer markets, which are now undermining managed care's viability. At the same time, fundamental questions exist about managed care's ability to address the effects of technological change and underlying problems with quality of care in an environment of growing consumerism.

Over time, hostility to managed care has evolved into a powerful "backlash."²⁰³ It is becoming increasingly apparent that consumers value choice in its own right, and that many are uncomfortable with a strategy that shifts decision making to payers.²⁰⁴ Adding to this backlash have been the increasingly strident calls for action from physicians and other providers. This has led to growing efforts to introduce new regulation increasing MCO accountability. An extensive array of consumer-oriented reforms has been proposed. In one form or another, many states have passed patients' rights legislation, while the issue has been hotly debated at the federal level.²⁰⁵

197. See CTR. FOR STUDYING HEALTH SYS. CHANGE, DATA BULLETIN NO. 21 REVISED: TRACKING HEALTH CARE COSTS: HOSPITAL CARE KEY COST DRIVER IN 2000 (Sept. 2001).

198. See CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 34, at tbl.1.

199. See Levit et al., *supra* note 33, at 176 exh.4.

200. See *id.* at 178.

201. See CTR. FOR STUDYING HEALTH SYS. CHANGE, *supra* note 197.

202. See Robert Pear, *After Decline, the Number of Uninsured Rose in 2001*, N.Y. TIMES, Sept. 30, 2002, at A22.

203. See Peterson, *supra* note 171, at 875.

204. See Blendon et al., *supra* note 174.

205. See Amy Snow Landa & Tanya Albert, *Congress to Start New Year with Old Health Care Issues*, AM. MED. NEWS, Jan. 14, 2002, at <http://www.ama-assn.org/amednews/2002/01/14/gvsa0114.htm>.

In addition to agitating for legislation, consumers and employers have voted with their feet. A broad shift has occurred toward less restrictive forms of managed care. Enrollments have risen in forms of MCOs associated with less stringent administrative controls, such as PPOs and PSOs.²⁰⁶ Conversely, HMO enrollments have stagnated or fallen, even as HMOs have bowed to market pressures to expand their networks to include more providers.²⁰⁷ Recent physician survey data also suggest a shift away from incentives that may encourage physicians to withhold services and toward incentives that encourage provision of additional care.²⁰⁸ Thus, the trend appears to be towards managed care “lite,” in which plans are reducing controls on utilization and allowing consumers greater choice of provider.²⁰⁹

A second major development has been provider consolidation. Hospital mergers and the formation of large systems have become increasingly prevalent. Between 1981 and 1995, the average level of hospital concentration in metropolitan areas grew by nearly a third.²¹⁰ At the same time, physicians have moved into larger practice settings. In 1986, the share of physicians in solo practice was 38%.²¹¹ By 1995, the share of solo physicians had declined to 24%.²¹² Moreover, for both hospitals and physicians, the rate of consolidation has been greater in local markets with high levels of managed care penetration.²¹³

Both trends point to potential reductions in the ability of MCOs to use competition to control costs. Expansion of provider panels and the reduction of administrative controls have arguably weakened MCOs’ bargaining power with doctors and hospitals. Similarly, whether or not motivated by efforts to improve efficiency, increased consolidation implies greater ability by providers to resist MCO efforts to extract discounts and impose changes in practice patterns.

Setting aside the effects of consumer backlash and provider consolidation, a more basic question has been the underlying viability of managed care to deal with the adoption of new, cost increasing technologies. One interpretation of recent trends offered by commentators, such as Henry Aaron, is that managed care’s initial success came primarily from squeezing out provider rents and slack capacity.²¹⁴ This created large sav-

206. See Dranove et al., *supra* note 183, at 574.

207. See Debra A. Draper et al., *supra* note 141, at 11, 12, 14.

208. See JEFFREY STODDARD ET AL., PHYSICIANS MORE LIKELY TO FACE QUALITY INCENTIVES THAN INCENTIVES THAT MAY RESTRAIN CARE, (Ctr. for Studying Health Sys. Change, Issue Brief No. 48, Jan. 2002).

209. See Draper et al., *supra* note 141, at 14.

210. See Dranove et al., *supra* note 183, at 579–83.

211. *Id.* at 590.

212. *Id.*

213. *Id.* at 586–89.

214. See Henry J. Aaron, *The Unsurprising Surprise of Renewed Health Care Cost Inflation*, HEALTH AFF. WEB EXCLUSIVE, Jan. 23, 2002 at <http://content.healthaffairs.org/cgi/reprint/hlthaff.w2.85v1.pdf>.

ings, which served to temporarily mask costs associated with use of new technologies. Now that opportunities for reducing rents and slack capacity have been exhausted, rising costs are back and managed care faces the daunting task of addressing choices about new technologies directly.

There has been considerable outcry in the popular press about managed care plans' denials of access to new treatments.²¹⁵ There is also considerable evidence that managed care has affected utilization patterns for specific technologies. But the evidence so far suggests that overall, managed care has not been effective in checking the impact of technological change.²¹⁶ Recalling the earlier discussion of the dynamic nature of the industry and the role of technology as a cost driver,²¹⁷ a central question is whether managed care can be modified to address this issue in the future.

VI. WHERE ARE WE HEADED?

Private insurance markets have responded to the challenges of rising costs and consumer and provider pressures in several ways. Emerging trends include changes in marketing strategies,²¹⁸ benefit design, and renewed efforts to manage patient care focusing on high-cost patients.²¹⁹ This section examines each of these trends, explores their possible implications for costs and access, and then considers how they could interact with potential policy responses.

For MCOs, one possible response to rising costs is to return to more draconian forms of organization. Experiments are already underway in some markets, such as southern California, where PacifiCare recently began offering a no frills HMO.²²⁰ A general shift in this direction has yet to develop, however. Instead, insurers' primary response has been to reevaluate their marketing strategies for existing plans.²²¹ In the past, many MCOs aggressively sought volume to improve their bargaining capacity.²²² Recent trends suggest, however, that insurers' focus has shifted from market share to margins.²²³ While mainstream insurers appear to be continuing to offer managed care lite policies with generous benefits

215. Joseph B. Treaster, *Aetna Agreement with Doctors Envisions Altered Managed Care*, N.Y. TIMES, May 23, 2003, at A1.

216. See Chernew et al., *supra* note 108, at 281–82.

217. See *supra* text accompanying notes 28–37.

218. See *infra* notes 220–24 and accompanying text.

219. See *infra* notes 225–37 and accompanying text.

220. See Don Lee, *PacifiCare's New HMO to Limit Choice, Benefits*, L.A. TIMES, Oct. 4, 2002, at C1.

221. See Draper et al., *supra* note 141, at 11–14.

222. Robert Kazel, *Aetna Breaks Cycle of Losses to Post Profits*, AM. MED. NEWS, Mar. 10, 2003, at <http://www.ama-assn.org/amednews/2003/03/10/bisc0310.htm>.

223. See Draper et al., *supra* note 141, at 11–14.

and inclusive networks, they are raising rates and in some cases, pulling out of unprofitable segments of the marketplace.²²⁴

A second, closely related trend is proposals to change benefit design to increase consumer cost sharing.²²⁵ A central theme has been a switch from a so-called “defined benefit” model (the traditional system of committing to provide an employee with a fixed benefit package) to what has been loosely described as a “defined contribution” model.²²⁶ In their purest form, defined contribution proposals provide an employee with a fixed sum of money to be used as desired for purchasing health insurance and/or medical services.²²⁷ In practice, the term has been more elastically defined to include a range of different types of cost sharing arrangements potentially impacting employee premium share, cost sharing for services, or both.²²⁸

So far, implementation of full blown defined contribution models appears to be limited.²²⁹ There has, however, been a general trend in the direction of increased cost sharing. This is particularly true among small employers, as they have struggled to continue to provide coverage in the face of especially high premium increases.²³⁰ Regarding cost sharing of insurance premiums, the simplest variant has been to directly increase employee cost sharing of existing premiums.²³¹ Alternatively, some firms have moved toward offering a fixed contribution, which can be used toward an employee’s purchases of health insurance and making the employee responsible for any difference between the policy it selects and the contributed amount.²³²

In the case of health care services, the thrust has been to reverse the historic trend toward reduced financial barriers to care by placing employees at increased risk for the cost of services. One common way of doing this has been to simply raise coinsurance and deductibles.²³³ An-

224. See Julie A. Jacob, *HMO Profits Rose Overall Last Year*, AM. MED. NEWS, Mar. 4, 2002, at <http://www.ama-assn.org/amednews/2002/03/04/bisb0304.htm>; *HMO Profits Dropped Last Year*, AM. MED. NEWS, June 10, 2002, at <http://www.ama-assn.org/amednews/2002/06/10/bibf0610.htm>.

225. See CTR. FOR STUDYING HEALTH SYS. CHANGE, ISSUE BRIEF NO. 37, DEFINED CONTRIBUTIONS: THE SEARCH FOR A NEW VISION (2001).

226. *Id.*

227. *Id.*

228. *Id.*

229. See CARA S. LESSER & PAUL B. GINSBURG, BACK TO THE FUTURE? NEW COST AND CHALLENGES EMERGE (Ctr. For Health Sys. Change, Issue Brief No. 35, Feb. 2001).

230. See ASHLEY C. SHORT & CARA S. LESSER, CUTTING BACK BUT NOT CUTTING OUT: SMALL EMPLOYERS RESPOND TO PREMIUM INCREASES (Ctr. for Studying Health Sys. Change, Issue Brief No. 56, Oct. 2002).

231. See, e.g., Milt Freudenheim, *High Cost of Being Well: Benefits at a Premium*, N.Y. TIMES, Oct. 16, 2001, at C1.

232. See Press Release, Watson Wyatt Worldwide, Employers Shifting More Health Care Costs To Employees (Oct. 15, 2001), available at <http://www.watsonwyatt.com/news/press.asp?ID=8935>.

233. See, e.g., Kim Clark & Josh Fischman, *Out in the Cold: Healthcare Cost Shock Means Less Coverage for Some, None for Others*, U.S. NEWS & WORLD REP., Nov. 12, 2001, at 53; see also Milt Freudenheim, *A New Health Plan May Raise Expenses for Sickest Workers*, N.Y. TIMES, Dec. 5, 2001, at A1.

other approach, less frequently used, has been to establish Medical Savings Accounts (MSAs), in which a fixed sum is placed in an employee's account to be used to cover health care costs.²³⁴ This is linked to a high deductible catastrophic policy, with the employee responsible for the difference.²³⁵ Either way, the net result of these cost sharing strategies is to expose employees to large out-of-pocket outlays in the event of serious illness.

Finally, a third trend has been to seek ways to reinvent managed care to more truly "manage" care. In particular, there has been wide interest in developing intensive interventions to manage the care of the small group of high-cost patients who account for the bulk of health care spending.²³⁶ Proposals for expanding "disease management" of conditions such as congestive heart failure, diabetes, and asthma are illustrative.²³⁷

From a cost containment perspective, more stringent MCOs and increased consumer cost sharing represent a return to approaches already tried in the past. In the case of more stringent MCOs, a key question is whether recent problems with containing costs have been due primarily to a shift towards managed care lite plans. If instead costs have increased primarily because of problems growing out of provider consolidation and underlying difficulties in controlling the adoption of new technologies, then the impact is likely to be modest at best. Moreover, although anti-managed care sentiment appears to have eased recently, a return to stringent administrative controls could also reignite consumer backlash, making implementation difficult.

In the case of cost sharing, supporters cite evidence from studies, such as the RAND experiment, that greater cost sharing for services could substantially reduce the current level of spending.²³⁸ More importantly, they argue that in the current consumerist environment, the effectiveness of cost sharing could be substantially increased by "empowering" consumers with information about prices and quality.²³⁹ A special focus is the use of the internet to facilitate shopping and informed "self-

234. See Myrle Croasdale, *Insurers Move into Market for Private Employer MSAs*, AM. MED. NEWS, Feb. 25, 2002, at <http://www.ama-assn.org/amednews/2002/02/25/bisa0225.htm>.

235. See *id.*

236. See generally Gray Ellrodt et al., *Evidence-Based Disease Management*, 278 JAMA 1687 (1997).

237. See *id.* at 1691; see also Robert S. Epstein & Louis M. Sherwood, *From Outcomes Research to Disease Management: A Guide for the Perplexed*, 124 ANNALS OF INTERNAL MED. 832 (1996).

238. See Willard G. Manning et al., *Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment*, 77 AM. ECON. REV. 251, 273-74 (1987).

239. See generally REGINA E. HERZLINGER, MARKET-DRIVEN HEALTH CARE 47-96, 245-91 (1997); Paul M. Ellwood, *Crossing the Health Policy Chasm* (Feb. 18, 2003), at http://www.ppionline.org/ppi_ka.cfm?knlgAreaID=111.

directed” care.²⁴⁰ A similar case is also made for facilitating shopping for insurance.²⁴¹

There are several reasons for skepticism. Especially in the case of cost sharing for health services, there is a strong element of *déjà vu*. The failure of deductibles and coinsurance to contain costs under traditional indemnity insurance was, after all, one of the main reasons for shifting to managed care in the first place.²⁴² The idea of motivated, internet-informed consumers is appealing, but the ability of new information technologies to successfully overcome longstanding consumer problems with assessing the cost and quality of care is unclear. In any case, to the extent consumers are protected against catastrophic risk, cost sharing applies primarily to low dollar expenditures, whereas the bulk of health care expenditures are concentrated in the care of high cost patients. As a result, the group that matters most from a cost perspective, the very high utilizers, would be the one least affected.

In the case of cost sharing, for insurance, defined contribution schemes have the potential to implement important elements of managed competition by promoting price sensitive shopping for insurance.²⁴³ But successfully implementing market discipline requires that employees be able to choose between a meaningful selection of competing plans. As discussed, this is an opportunity which many employees continue to lack.²⁴⁴ As a consequence, a major concern is that increased cost sharing could seriously impact access to care without concomitant benefits from containing costs.²⁴⁵ Even if firms do not stop offering coverage, increased cost sharing of insurance premiums could lead to a reduction in take up rates, thus increasing the number of uninsured. Compounding this problem could be a continued shift by MCOs toward a strategy of maximizing margins over market share. If MCOs sharply increase rates at the low end of the market or pull out altogether, then this could further increase the number of uninsured.²⁴⁶ In addition, increased cost sharing for services could lead insured consumers to forego needed care.

New case management techniques could significantly improve quality of care, while potentially helping to contain costs. Several important issues exist, however, with case management as a cost containment device on its own terms. Cost savings are not a foregone conclusion. Adopting best practice standards may forestall costly illness and lead to

240. Tyler Chin, *Fallen Oxford Health Plans Founder Returns with Web Health Insurance Firm*, AM. MED. NEWS, Aug. 14, 2000, at <http://www.ama-assn.org/amednews/2000/08/14/tesb0814.htm>.

241. See Jon Christianson et al., *Defined-Contribution Health Insurance Products: Development and Prospects*, HEALTH AFF., Jan.–Feb. 2002, at 49; Sally Trude et al., *Employer-Sponsored Health Insurance: Pressing Problems, Incremental Changes*, HEALTH AFF., Jan.–Feb. 2002, at 66.

242. See Dranove, *supra* note 105, at 71–72.

243. See Enthoven, *supra* note 112 (regarding features of managed competition).

244. See Trude et al., *supra* note 241, at 69–70.

245. *Id.* at 73–75.

246. *Id.* at 74–75.

more cost-effective treatment.²⁴⁷ But the volume of services may rise, especially if patients are brought into the system at an earlier stage of illness and live longer. Nor is case management inherently less likely to lead to the adoption of new cost-increasing technologies. On the contrary, a system of formalized practice standards could become a powerful vehicle for accelerating the dissemination of new technologies.²⁴⁸ In addition, implementation may be difficult, posing complex coordination problems. For example, experiences to date suggest that payoffs from efforts of MCOs to manage chronic illness have been limited.²⁴⁹

In addition to these issues, it is not clear how compatible more intensive case management is with consumer empowerment. Strategies based on self-directed care ask consumers to take responsibility for selecting providers and choices of treatments. Case management may entail substantial oversight of patients and as a result, may ask them to give up control over important aspects of their care if they become seriously ill.²⁵⁰ Also, in the case of many chronic illnesses, routine low-dollar services make up a key component of effective management. High cost sharing implies either asking patients to make substantial out-of-pocket expenditures for these services, or devising a system of supplemental payments specifically for this type of care. Another potential source of tension is obvious incentives for plans to restrict consumers' choices of the providers for these kinds of services to assure the coordination of care.

Turning to regulatory issues, several recent legislative trends could interact with market trends in important ways. Some aspects of consumerism (e.g., greater consumer participation in decision making) dovetail with proposals to move toward market-oriented defined contribution insurance schemes and increased consumer "empowerment."²⁵¹ Others could move in the opposite direction toward greater government regulation. This is particularly true when coupled with mounting general concerns about the overall ability of the United States to deliver quality care, as captured by the recent 2001 Institute of Medicine (IOM) report *Crossing the Quality Chasm*.²⁵² These general concerns could combine with concerns about managed care to provide a strong impetus for new types of quality assurance regulation. These regulations could impose

247. INST. OF MED., *CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY* 203 (2001).

248. Robert Evans, *Finding the Levers, Finding the Coverage: Lessons from Cost Containment in North America*, 11 J. HEALTH POL., POL'Y & L. 585, 585-616 (1987).

249. See CHRISTIANSON ET AL., *supra* note 137, at 32-35; ASHLEY C. SHORT ET AL., *DISEASE MANAGEMENT: A LEAP OF FAITH TO LOWER-COST, HIGHER-QUALITY HEALTH CARE* (Ctr. for Studying Health Sys. Change, Issue Brief No. 69, Oct. 2003).

250. See generally John B. Christianson & Roger Feldman, *Evolution in the Buyers Health Care Action Group Purchasing Imitative*, HEALTH AFF., Jan.-Feb. 2002, at 76, 76-88.

251. See CTR. FOR STUDYING HEALTH SYS. CHANGE, *supra* note 225; see also Ellwood, *supra* note 239.

252. See INST. OF MED., *supra* note 247.

important new constraints on provider and payer behavior and place a strong emphasis on meeting “best practice” standards of performance.²⁵³

On the supply side of the market, the Federal Trade Commission has recently launched an effort to step-up antitrust enforcement in health care.²⁵⁴ Increased antitrust action could check the trend toward increased provider consolidation and, to the extent it has constrained managed care, enable plans to return to a more vigorous use of selective contracting.²⁵⁵ The ability of provider interests to mount stiff political opposition should not be underestimated, however.

A final issue is the possibility of major health insurance reform. While presently not on the agenda, a combination of continued cost growth and a deterioration of coverage could quickly move this issue to the center of the political stage, other circumstances permitting.²⁵⁶ Once in play, a wide range of alternative proposals could find their way to the table. Without attempting to consider the full array, one option of special interest is individual tax credits.

As of this writing, tax credit proposals have been limited in scope.²⁵⁷ They may well remain so, but they have been of considerable interest to the Bush administration.²⁵⁸ If implemented, tax credits could dramatically restructure private health insurance markets. One key impact could be to move the system away from private employment-based insurance toward a system of individual insurance anchored by the public sector. This could present the possibility of systematically implementing a system of managed competition. Perhaps more importantly, however, a shift toward what amounts to a “voucher” system (i.e., the tax credit) could have broad implications for equity and access.²⁵⁹

253. For examples of recent proposals, see Press Release, U.S. Dep’t of Health & Human Servs., Secretary Thompson Announces Steps to Reduce Medication Errors (Mar. 13, 2003), *available at* <http://www.hhs.gov/news/press/2003pres/20030313.html>.

254. See Reed Abelson, *U.S. to Step up Antitrust Effort on Health Care*, N.Y. TIMES, Aug. 9, 2002, at A1; Timothy J. Muris, *Everything Old Is New Again: Health Care and Competition in the 21st Century*, (Prepared Remarks Before 7th Annual Competition in Health Care Forum) (Nov. 7, 2002), *available at* <http://www.ftc.gov/speeches/muris/murishealthcarespeech0211.pdf>.

255. See Muris, *supra* note 254.

256. See Marica Angell, *The Forgotten Domestic Crisis*, N.Y. TIMES, Oct. 13, 2002, § 4, at 13; Robin Toner & Sheryl Gay Stolberg, *Decade After Health Care Crisis, Soaring Costs Bring New Strains*, N.Y. TIMES, Aug. 11, 2002, § 1, at 1.

257. See JACK HADLEY & JAMES D. RESCHOVSKY, *Tax Credits and the Affordability of Individual Health Insurance* (Ctr. for Health Sys. Change, Issue Brief No. 53, July 2002); Joel B. Finkelstein, *Tax Credits No Quick Fix for the Uninsured*, AM. MED. NEWS, Jan. 13, 2003, *at* <http://www.ama-assn.org/amednews/2003/01/13/gvsb0113.htm>.

258. See Finkelstein, *supra* note 257.

259. See Andrew Dunham et al., *Restoring Medical Markets: Implications for the Poor*, 7 J. HEALTH POL. POL’Y & L. 488, 490–94 (1982); Mark Pauly et al., *Individual Versus Job-Based Health Insurance: Weighing the Pros and Cons*, HEALTH AFF., Nov.–Dec. 1999, at 28, 31–32; Uwe E. Reinhardt, *Employer-Based Health Insurance: A Balance Sheet*, HEALTH AFF., Nov.–Dec. 1999, at 124, 127.

VII. CONCLUSION

In summary, this article has considered interactions between market forces and government regulation in private health insurance markets. Until World War II, consumers paid for most health care services directly out-of-pocket on a fee-for-service basis and the role of government was limited primarily to quality regulation and the provision of charity care. Beginning in the late 1930s and accelerating after World War II, however, rising health care costs, fueled by technological advances and changing social conditions, led to a growing reliance on private insurance to finance health care. These developments were accompanied with growing government regulation of private insurance markets and the emergence of public insurance programs. At first, the focus of regulation was on assuring access to insurance and insurer solvency. As costs continued to rise, however, at least in part as a result of the introduction of insurance, the focus shifted to cost containment. Initially, efforts to contain costs centered on direct government controls on prices and the provision of services. The failure of these efforts, however, was followed by a shift to market-based reforms seeking to harness competition to control costs, and the rise of managed care. At the heart of managed care was the notion that performance could be improved by shifting control over purchasing decisions away from consumers toward health plans, who would have competitive incentives to contain costs while assuring quality. Recently, market developments associated with consumer backlash against plan controls on choice and growing provider consolidation have led to reassessments of this strategy. A number of possible marketplace responses have been discussed here, including changes in marketing strategies, modifications in benefit design and renewed efforts to manage patient care. Key issues for the future are how these strategies may interact and what kind of policy responses they may generate.