The Microregulation of the Health Care Marketplace

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The most eloquent criticism of fee-for-service medicine is not attributable to Alain Enthoven but rather to Bernard Shaw (1963 [1911]: 1), who wrote, "That any sane nation, being observed that you could provide for the supply of bread by giving bakers a pecuniary interest in baking for you, should go on to give a surgeon a pecuniary interest in cutting off your leg, is enough to make one despair of political humanity."

Nearly a century later this concern still seems apt, but one wonders what Shaw would have thought of managed care. To consider this further, we need a new metaphor because bakers are still reimbursed on a "fee-for-loaf" basis. There are indeed only a few products and services in the economy that are paid for through a fixed annual fee regardless of how much is consumed (insurance being the obvious exception). One that comes to mind is the "extended warranty" that electronic and automotive retailers solicit after the sale of one of their products. Perhaps Shaw would have begun his assessment as follows: "That any sane nation, being observed that you could provide for the proper working order of a VCR by giving Sony a modest annual sum, should go on to give HealthNet the same bounty to provide for the care of a cancer patient and a Christian Scientist. . . ." (How Shaw would conclude we can only guess.)

One of the charges given to me and the other participants in this volume is to assess whether concerns about managed care are warranted. Before doing so, I should lay some personal experiences on the table: I was born in an HMO (the Group Health Association in Washington, DC) and have been in an HMO (mainly Kaiser) every year of my life save one.

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During my one year in the fee-for-service world, my wife had a baby. Much of that year was spent fretting and writing to the carrier about which costs would be covered and which would not. I couldn't wait for the next open enrollment period.

Having said this, I believe that the concerns about managed care are valid, that the backlash is real (although somewhat overblown), and that private managers and public policy makers need to act, although it will be argued that the actions they will be forced to take will make our health care system far more regulated than it already is. This regulation, I further argue, will originate more from the private than the public sector. The irony should not be lost: unleashing the free market will result in more regulation and less freedom for doctors and patients alike. Not that this is necessarily bad; as Shaw pointed out, unleashing doctors on unsuspecting, income-enhancing patients has had its own serious shortcomings. But one should not view a procompetitive health care system as a panacea for those who wish medicine to be rid of overarching bureaucracies. The opposite is much closer to the truth.

Why must this be? Largely, it is because the incentives inherent in a capitated system, particularly one where sufficiently effective risk adjustment is a pipe dream, are scary. The fact is that embodied in capitation are two profoundly strong incentives: (1) to skimp, and (2) to select healthier enrollees (for health plans) and patients (for providers).

Aside from the merger frenzy, which is an economy-wide phenomenon, the most salient trend in health care of late has been the disposing of risk. Health plans are at financial risk because employers give them a fixed payment per year per enrollee. They have responded by shifting this risk onto providers groups through incentive reimbursement schemes; the provider groups, in turn, have established similar incentives for member providers. Health plans have also shifted risk onto enrollees through such means as higher copayments, gatekeepers, lists of covered treatments, drug formularies, and the like. Individual practice associations (IPAs) and Network model HMOs have been most active in these areas because they have little direct control over the providers on their panel (who are usually contracting with several other HMOs as well) and because they lack any semblance of a corporate culture since, as Gertrude Stein once commented about the city of Oakland, "there is no there there." (This is why I prefer group/staff model HMOs for myself.)

I believe that these rather stark incentives and activities inevitably lead to heavy regulation. But what do we mean by the term *to regulate*? Here is how it is defined in the *American Heritage College Dictionary* (1997):

(1) "To control or direct according to rule, principle, or law"; (2) "To adjust to a particular specification or requirement"; (3) "To adjust for accurate and proper functioning"; and (4) "To put or maintain in order."

In another article (Rice 1999), I distinguish between two kinds of regulation: "micro" and "macro." Microregulation is what we normally think of as embodied by the first definition: direct control. Macroregulation, on the other hand, is more indirect. As indicated by the other three definitions, it implies a more indirect kind of control: the setting of ground rules to meet particular goals.

Other developed countries, much more so than the United States, rely on macroregulation. The classic example is the use of regional global budgets, under which health care providers generally are free to practice as they wish. There is little direct oversight of the provision of care, but there are strict controls on unit prices paid out. Another example is tight control over the diffusion of medical technologies.

What we are seeing increasingly in the United States is more microregulation. This, perhaps surprisingly, is the inevitable result of more competition. One of the successes of increased competition in the 1990s has been a diminution in health care inflation rates, which has resulted largely from consumers' focus on health plan premium rates. A key reason for this sensitivity is that IPA and Network model HMOs often have overlapping provider panels, which means that premiums may be the only apparent difference between alternative plan choices for consumers.

Now that health plans compete largely on the basis of price, they need to find ways to control their costs. Broadly speaking, the three ways to do this are to control prices, quantities, or total expenditures. The last of these is difficult to achieve directly since a health plan has no way to set a global budget; rather, a single payer is needed to achieve this. Consequently, the emphasis has been on the first two.

Beginning with quantity, we see a proliferation of microregulatory quantity controls in managed care plans. One example is preadmission certification of hospital stays. This involves having the physician contact a health plan employee in order for the stay to be covered. If there is a disagreement, a cumbersome appeals process can ensue. Another example is requiring that a patient see a primary care gatekeeper before going to a specialist. To enforce this, health plans must examine every case. If the claim is denied the patient can then appeal, resulting in further administrative costs. In general, microregulation means that someone is watching over a large percentage of physician and patient activities.

The main way that prices can be controlled is through incentive reim-

bursement schemes. These, however, will inevitably lead to microregulation since it is necessary to monitor whether providers are skimping. A new tool for addressing the problem of skimping are health care report cards, which increasingly are administered not only to health plans, but provider groups as well. The idea is to provide consumers with appropriate measures of performance, such as consumer satisfaction, clinical quality performance, and service performance like waiting times.

Although requiring plans and providers to give out this information makes a great deal of sense, it will result in even more microregulation. Health plans and provider groups will be under a great deal of pressure to produce "good" numbers on their quality and satisfaction scores. This, in turn, is likely to lead to attempts to fudge their scores. Since this is an unacceptable outcome from a policy standpoint, I argue below that some quasi-regulatory body will have to conduct detailed audits of claims, medical records, and survey results to ensure that information being provided to consumers and their employers is accurate.

Even more of this microregulation will be required to monitor the provision of services. In 1997, President Clinton formed the Advisory Commission on Consumer Protection and Quality in the Health Care Industry, which later came out with a proposed "Consumer Bill of Rights and Responsibilities." The central theme of the document is that measures must be taken to overcome the natural inclination of capitated health plans and provider groups to underprovide services. Regarding the oversight of providers, the Consumer Bill of Rights and Responsibilities recommends that health care providers do the following:

- Discuss all treatment options with a patient in a culturally competent manner.
- Discuss all current treatments and their alternatives, including risks, benefits, and consequences.
- Allow patients to express preferences about future treatments.
- Disclose to consumers such things as compensation methods and ownership or financial interests in health facilities by providers. (Rice 1999: 84)

Carrying out such a mandate would seem necessary to assure that the incentives of capitation do not lead to the underprovision of care, but it involves an oversight of the interaction between the doctor and the patient that epitomizes microregulation (ibid.: 84).

What we are left with is a situation in which both health care firms and government are forced to engage in expensive and intrusive micro-

regulation: firms, to ensure that they can keep their costs down, and government, to ensure that quality is not compromised in the process. This is the odd result that comes from relying more heavily on market involvement in health care.

Contributors to this volume are also asked to provide something useful to public policy makers. I don't have too much to offer in this regard because I believe that the trends noted above are likely to intensify. The managed care backlash, although real, runs smack against two other strong forces: consumers' desires to keep their costs down, and the apparent impossibility of enacting fundamental health care reform. If one accepts that, at least in the medium term, there will be no fundamental reform but rather tinkering on the edges, then it would seem likely that consumers' desires to pay less will prevent the managed care backlash from getting very far.

Many analysts, myself included, believe that fundamental reform could result in a more efficient and fairer system at a lower cost, as a number of other Western countries have shown. But given the power of special interest groups and the way political campaigns are financed in the United States (which would require an essay of its own), it seems quite unlikely that we will be able to get from here to there.

If we therefore believe that any reforms will be incremental rather than fundamental, what can we recommend to policy makers? As argued, recommendations designed to control the negative impacts of capitation will inevitably lead to more microregulation—a price, I have argued, that we simply have to pay. There are a few such regulations that can be carried out by the public sector—none particularly novel but also none which have been implemented nationally—that should help. Here are two:

First, health plan members should be allowed to sue their plans. Plans argue that they should not be liable because they don't provide medical care, but their argument is unconvincing. Plans set the rules by which providers are paid and consumers receive services. If following these rules results in harm, the plan very well may be at fault. Allowing such lawsuits would provide a strong incentive for them not to go too far in devising cost-cutting procedures that may have adverse health consequences.

Second, government should get more involved in the oversight of health plan and provider report cards. A hallmark (although certainly no guarantee) of effective competition is reliable information. Unfortunately, health plans and providers are in a position where they benefit

from good report cards—and at the same time provide the vast majority of information contained in these cards. This is an extraordinary conflict of interest. The fact that a small amount of this information is now being audited by nonprofit organizations does little to quell concerns about the objectivity of these data. There is a strong role for government to oversee this process to assure that consumers are receiving accurate information about health plans and providers.

These and similar policies are not what the industry—or, for that matter, most proponents of health care market competition—have in mind. They are necessary, however, because the managed health care system that we have devised in the United States contains incentives to cut costs that are just too strong to ignore.

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