

## Regulatory Aspects of National Health Insurance Plans\*

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Congress has been inundated in recent months with proposals for schemes of national health insurance. These proposals raise many questions; among those that have received least attention are ones that may be more familiar to students of public regulation than to professionals in health care. The regulatory questions have to do with managing the likely effects of national health insurance on the price of medical services, and are the subject of this article.

### INTRODUCTION

To grasp these issues, it is necessary to understand the consequences predicted by economic theory of a sudden and substantial increase in the volume of consumer demand for a service. In the short run, the supply of the service, being equal to the previous and smaller demand, will be inadequate and competition for the limited supply will either bid up prices or lead to queues (waiting periods) or other methods of nonprice rationing. In the long run, existing firms or new providers of the service will expand the supply, prices will fall, and queuing and

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other nonprice rationing will disappear.<sup>1</sup> If the time required to expand the supply to meet the new demand is long, the price and nonprice effects of increasing demand will be more serious than if the time is short. Should demanders for some reason lack the usual incentive of a purchaser to economize on the purchase of a good or service, the price effect of temporarily inadequate supply will be aggravated and the return of price to a lower level as supply expands will be retarded.

It seems generally agreed that the skyrocketing costs of health care in recent years in the United States can be traced in significant part to the Medicare and, to a lesser extent, Medicaid programs, which poured vast governmental funds into the demand side of the health care industry while paying virtually no attention to conditions on the supply side.<sup>2</sup> The supply of medical services is difficult to expand rapidly, due in large part to legal restrictions, adopted at the behest of the organized medical profession, which have limited the supply of physicians. The restrictions include stringent licensure requirements, limitations on the provision of medical services by entrepreneurs other than physicians, rules limiting delegation of functions by physicians to nonphysicians, prohibition of advertising by physicians, and others.<sup>3</sup> Such constraints made it impossible for the industry to respond adequately to the large increases in demand brought about by the governmental programs, while the method by which demand was stimulated—government agreeing to pay a large part of the medical expenses of aged and some poor people—weakened the consumer's incentive to economize on medical care by either limiting utilization or seeking out low-cost providers, because money saved in this way would not be retained by him.

Ironically, steeply rising medical costs, although in part a legacy of Medicare and Medicaid, have created seemingly irresistible pressure to replicate these programs on a vast scale. It is no longer just the poor and the aged who have difficulty in meeting medical expenses, but most people. The result has been a spate of bills in Congress to extend federally supported or required health insurance to other, and usually larger, groups in the population.

Many considerations are relevant to an appraisal of such bills, such as the distributive effect—has the bill a progressive or regressive impact

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<sup>1</sup> The resulting equilibrium price, however, will be somewhat higher than before the increase in demand, assuming a positively sloped marginal cost curve.

<sup>2</sup> Cf. Cooper, *Medical Care Outlays for Aged and Nonaged Persons, 1966-1969*, 33 SOCIAL SECURITY BULL. 3, 11 (July, 1970).

<sup>3</sup> See generally ASPEN SYSTEMS CORPORATION, *GROUP PRACTICE AND THE LAW: A DIGEST OF STATE LAWS AFFECTING THE GROUP PRACTICE OF MEDICINE* (1969).

on the distribution of income and wealth? Without considering these and other questions, it is impossible to form a judgment on the ultimate question whether any form of national health insurance is necessary or appropriate. This article, however, is limited to a single aspect of the national health insurance problem—the merits of current proposals in managing the consequences, in particular steeply rising prices, that experience under Medicare and Medicaid teaches can be expected when the federal government enlarges the demand for health services—and to five representative bills:<sup>4</sup> the Long bill (catastrophic health insurance), the Fulton-Broyhill bill (the American Medical Association's "Medicredit" proposal), the Bennett bill (the Administration's proposal), the Pell-Mondale bill, and the Kennedy bill.<sup>5</sup> The provisions of the bills will emerge in due course.

### I. REGULATION OF HEALTH CARE: THE ISSUES

Before proceeding to a detailed comparison of the regulatory provisions of the bills, it will be helpful to make some threshold distinctions among possible regulatory approaches in the health care field and to delineate the major issues raised by each.

A fundamental distinction is that between regulation designed to operate on the demand for health services and regulation designed to operate on supply. An example of the former is coinsurance, whereby the consumer of medical services is required to defray a percentage of his medical expenses but is insured for the remainder. Coinsurance gives the consumer some pecuniary incentive to refrain from making excessive demands and to seek out low-cost services. An example of supply regulation would be a ceiling on physicians' fees.

A further distinction may be drawn on the supply side between what one might term "static" regulation, which takes the existing supply of medical services as given (a ceiling on physicians' fees is such a regulation), and "dynamic" regulation, which seeks to stimulate expansion in the supply of medical services in order to avert the price and nonprice effects that occur when a supply made inadequate by a sudden increase in demand must be rationed.

Each of these broad classes involves a number of specific issues and choices. The main ones follow.

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<sup>4</sup> Thirteen bills were pending at last count. See Office of Research & Statistics, Social Security Administration, Dep't of Health, Education & Welfare, National Health Insurance Proposals Introduced in the 92nd Congress, May, 1971 (mimeographed report).

<sup>5</sup> S. 1376, H.R. 4960, S. 1623, S. 703, S. 3, 92d Cong., 1st Sess. (1971).

## A. Regulation of Demand

1. *Scope and Nature of Benefits.* The broader (number of people covered) and deeper (amount of benefits to which those covered are entitled) the benefits provided by a health care plan, the larger will be the plan's impact on the demand for medical services. The nature of the benefits is also important. If an included benefit is one that most people now buy with their private funds or private insurance, a law requiring provision of the benefit may change the manner in which it is provided or shift the cost to another group, but it will not necessarily increase demand.<sup>6</sup> At the opposite extreme is a benefit (for example, a complete annual physical examination) not widely purchased today with private resources. The inevitable effect of a governmental requirement that it be provided is to increase the quantity of medical services demanded.

2. *Structure of Benefits.* National health insurance plans, like their private counterparts, invariably exclude (wholly or partially) some forms of health service from their coverage, such as nursing home care rendered other than in a "skilled" nursing home. Such a pattern of differential coverage creates an incentive to substitute a covered for an excluded service. One of the problems in the administration of Medicare, for example, has been that people requiring custodial treatment less extensive than that provided in skilled nursing homes have nonetheless been placed in such facilities because Medicare would not reimburse their expenses in less elaborate (and less costly) facilities.<sup>7</sup> Another example is the substitution of more expensive hospital care for less expensive ambulatory care by individuals whose hospital insurance is more extensive than their nonhospital medical insurance, the usual pattern in private health insurance.<sup>8</sup>

3. *Incentives of the Consumer to Economize.* When a service is subsidized, the beneficiary's incentive to economize on its use, both by choice of a low-cost supplier and by avoidance of unnecessary consumption, is weakened. One method of dealing with this problem is to make the beneficiary pay part of the cost of the service, in the form either of a deductible (for example, the patient must pay for the first two days in

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<sup>6</sup> However, by freeing up consumers' resources to spend on other products, a law providing a medical benefit may indirectly increase the demand for health services, since some of the freed-up resources may be used to purchase additional such services.

<sup>7</sup> See, e.g., *Hearings on Medicare and Medicaid Before the Senate Comm. on Finance*, 91st Cong., 2d Sess., pt. 2, at 197 (1970) (testimony of William C. White, Jr., Vice-President, Prudential Insurance Company) [hereinafter cited as *Medicare-Medicaid Hearings*].

<sup>8</sup> See, e.g., H. SOMERS & A. SOMERS, *DOCTORS, PATIENTS, AND HEALTH INSURANCE: THE ORGANIZATION AND FINANCING OF MEDICAL CARE* 176-77 (1961).

the hospital or the first one hundred dollars of physicians' bills) or of coinsurance (the patient must pay a specified dollar portion, or more commonly a percentage, of any medical bill). The incentive effects of the devices differ. The deductible discourages the individual from utilizing a medical service only in the first instance; once he has done so and used up the deductible, he has no further incentive to economize. Both these features of the deductible are undesirable, although the first less obviously so. (By encouraging postponement of medical attention—especially, one may speculate, preventive attention—a deductible may in the long run increase a plan's expense.) Coinsurance is better, but it is no panacea; the consumer's incentive to economize on the purchase of a service remains weak because he pays only a small fraction of its cost.

The likely effectiveness of economic inducements on the consumer of medical services is a matter of some debate. Such a consumer may have less information on which to base an intelligent choice than other consumers, due partly to the technical and uncertain character of the service, partly to the relative infrequency with which particular medical services are purchased by individuals, and partly to lack of competition among the providers. It does not follow that proper incentives would not help, but it would seem that involving other, more knowledgeable entities—such as health insurance companies, unions, and employers—in the purchase of medical services could be an important economizing step. To be sure, the record of such entities in controlling the cost and utilization of medical services is a mixed one. Health insurance companies, including the Blue Cross and Blue Shield associations, appear to have a generally poor record in claims control,<sup>9</sup> while employers and unions have been pioneers in encouraging promising new forms of health care, such as prepaid group practice. The apparent failure of the insurance industry could reflect several factors: organized medicine dominates Blue Cross and Blue Shield, which, in part because of tax advantages, write a substantial portion of the country's health insurance;<sup>10</sup> many health insurers, including Blue Cross and Blue Shield, because they are nonprofit entities, lack normal business incentives to

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<sup>9</sup> This was conceded by industry representatives in their testimony before the Senate Finance Committee. See *Medicare-Medicaid Hearings*, *supra* note 7. See also E. KAITZ, *PRICING POLICY AND COST BEHAVIOR IN THE HOSPITAL INDUSTRY* (1968). The Secretary of HEW has promised a bill regulating the health insurance industry in order to improve its performance in controlling costs, *Hearings on National Health Insurance Before the Senate Comm. on Finance*, 92d Cong., 1st Sess. 97 (1971) [hereinafter cited as *National Health Insurance Hearings*], but at this writing the bill has not yet been introduced.

<sup>10</sup> See, e.g., H. SOMERS & A. SOMERS, *supra* note 8, at 296-97, 319, 324.

perform efficiently; and the costs of monitoring health care, as will appear, are probably high.

## B. "Static" Regulation of Supply

1. *Pricing Systems.* One way to control the costs of health care is to encourage or compel adoption of a pricing system that gives the provider an incentive to economize on services rendered. An example is the pricing system used by prepaid group practice plans. The enrollee pays a single annual charge ("capitation" fee) entitling him to comprehensive health service. Because the provider who charges on a capitation fee basis receives no additional payment for individual services, he has no incentive to perform unnecessary ones; the conflict of interest inherent in fee-for-service pricing, whereby the physician who recommends a treatment profits from rendering it, is eliminated. Professor Kessel has suggested that capitation fee pricing also enables the purchase of medical services at lower prices than fee-for-service pricing.<sup>11</sup> But capitation fee pricing is not without problems. If, as critics of fee-for-service pricing contend, that method encourages excessive provision of medical services, it would seem that capitation fee pricing must encourage inadequate provision of services. Although there is a check built into the capitation system in that skimping on medical attention may increase the long-run cost to the plan by necessitating more costly treatment later, not all necessary or appropriate medical procedures avoid larger future medical expenses (discounted to present value) than they save. (Sometimes the patient, if not treated, will simply die.) One can reply that it is cynical to assume that providers paid by capitation fees make such calculations, but perhaps it is no more cynical than to assume that fee-for-service practitioners perform unnecessary procedures, which of course usually involve some danger to the patient.

2. *Utilization Review.* In principle, it is possible to control utilization directly by disallowing the claims of providers who in the judgment of some appropriate body have rendered unnecessary services. In practice, however, the result is likely to be different, if experience in the public utility and common carrier industries is any guide. For reasons that will be discussed later, public utility (or its equivalent, common carrier) regulation creates incentives to incur unnecessary expenditures. Regulatory agencies are therefore routinely empowered to disallow such expenditures in reviewing the rates of regulated firms.

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<sup>11</sup> Kessel, *The A.M.A. and the Supply of Physicians*, 35 *LAW & CONTEMP. PROB.* 267, 281 (1970).

However, in the vast majority of cases, the exercise of this power is perfunctory and ineffectual.<sup>12</sup> In view of the complexity and detail of business operations and the importance of giving management broad decision-making latitude if it is to be held accountable for business performance, even the most conscientious regulators are reluctant to second-guess routine managerial decisions.

There is scant reason to be optimistic about the results of extending such regulation to the health care field. The decisions are no less complex, and perhaps more so. And there is a long tradition of excluding lay participation in medical decision making. In these circumstances it is no surprise that private health insurance companies have done little to monitor claims. Nor is it surprising that utilization review, under both the Medicare program and current national health insurance proposals, is entrusted to physician panels.<sup>13</sup> Although such delegation may be inevitable, it does not augur well for a vigorous and effective program of cost control. Physicians are likely to be as reluctant as regulators, if for somewhat different reasons, to second-guess (except in extreme cases) the decisions of practitioners—their professional colleagues—especially when, as considerations of cost and practicality may dictate, the members of the utilization review panel are drawn from the same hospital or community as the reviewees.<sup>14</sup>

3. *Construction Controls.* A good deal of the concern about supposed inefficiency in health care services focuses on hospital expansion and improvement, much of which is alleged to be unnecessary. An ostensibly similar concern about overbuilding is the expressed basis for provisions, commonly found in regulatory statutes, requiring that the permission of the regulatory agency be obtained for any new construction or extension of plant. These provisions are a possible model for similar controls over hospitals, nursing homes, and other health care institutions, but again the model is an inauspicious one. Construction controls in the regulated industries have too often been used to prevent the entry of new competitors or to limit the competition of existing ones. Even when administered in perfectly good faith, such controls are a

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<sup>12</sup> For support of these and other assertions made in this article concerning public utility regulation, see Posner, *Natural Monopoly and Its Regulation*, 21 STAN. L. REV. 548 (1969).

<sup>13</sup> For the Medicare provisions governing utilization review, see 42 U.S.C. § 1395x(k) (1970).

<sup>14</sup> Most utilization review committees under Medicare are in-house committees. See R. SCHUMER, HOSPITAL UTILIZATION REVIEW AND MEDICARE: A SURVEY 36 (Office of Research & Statistics, Social Security Administration, Dep't of Health, Education & Welfare Staff Paper No. 8, 1971).

source of delay and expense in meeting new increments of demand.<sup>15</sup> Since the slow pace at which the supply of medical services responds to increases in demand appears to be at the heart of the health care crisis, one fairly shudders at the prospect of borrowing from the regulated industries a device so prone to be misused to retard needed expansions of services.

4. *Price Regulation.* In a number of industries—mainly the energy, transportation, and communications fields—one finds direct and comprehensive controls over pricing, administered by regulatory commissions. The theory of public utility regulation (as this form of regulation is known) is that in markets characterized by pronounced elements of “natural monopoly”—markets in which competition cannot be expected to limit price to cost—government can improve performance by undertaking to ascertain the sellers’ costs and prohibiting the sellers from charging prices higher than are necessary to recover those costs (including a reasonable return on invested capital). Superficially, extension of public utility regulation to the health care field appears to have merit.<sup>16</sup> The market for health services is not adequately competitive, if only because of the extensive monopolistic restraints that organized medicine has been able to impose.<sup>17</sup> The price of many health services, therefore, probably exceeds a reasonable estimate of their cost by a wide margin. Health care meets another traditional requirement for imposing public utility regulation. It is a fundamental, “infrastructure” service—a necessity rather than a luxury good. Furthermore, since high price is the focus of public concern with health care, one may wonder why that problem should not be met head-on.

The argument for extending the public utility type of controls over price to health care should be resisted, however. It both exaggerates the success of those controls in their traditional settings and ignores the differences between those settings and the health care field.

An increasingly critical literature on public utility regulation emphasizes three points:

(1) In order to fix a price that neither starves the industry for capital nor generates monopoly profits, the regulatory agency must be able to

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<sup>15</sup> See Gerwig, *Natural Gas Production: A Study of Costs of Regulation*, 5 J. LAW & ECON. 69 (1962).

<sup>16</sup> Priest, *Possible Adaptation of Public Utility Concepts in the Health Care Field*, 35 LAW & CONTEMP. PROB. 839 (1970), advocates such an extension. A discussion of earlier proposals and of limited attempts by states to regulate hospital prices may be found in A. SOMERS, *HOSPITAL REGULATION: THE DILEMMA OF PUBLIC POLICY* 2-6, 166-70 (1969).

<sup>17</sup> See Kessel, *supra* note 11; Kessel, *Price Discrimination in Medicine*, 1 J. LAW & ECON. 20 (1958).



determine the costs of the regulated firms with reasonable accuracy. The agency cannot simply accept the firm's own determinations; it must make its own. But attempts to determine proper depreciation rates and reserves, optimum leverage, cost of equity capital, allocation of joint costs, and many other cost and financial items encounter intractable problems of cost accounting and investment theory. Furthermore, as will appear, it may be erroneous to assume that the regulatory agency always, or often, actually wants to eliminate monopoly pricing. Once these considerations are understood, it comes as no surprise that empirical investigations have found no significant impact of regulation on price.<sup>18</sup> This finding is balanced, although not offset, by the Pyrrhic victories of regulation, of which a recent example is the shortage in natural gas induced by the too-low price ceiling imposed by the Federal Power Commission in the early 1960s.<sup>19</sup>

(2) Price regulation that is not entirely ineffectual distorts the incentives of the regulated firm. A firm can minimize the impact of regulation on its profits in many ways, such as diversification in order to complicate and thereby thwart regulatory determination of its costs, the substitution of capital for other inputs (the cost of equity capital being less susceptible of effective regulatory determination than other costs), and expenditures designed to increase the prestige or perquisites of the firm or its executives—a type of profit taking not subject to effective regulatory control. The result of such adaptive responses to regulation is frequently higher costs than the firm would have incurred without regulation, a tendency aggravated by the cost-plus character of public utility price setting.

(3) Despite the nominally nonpartisan and independent character of most regulatory agencies, public utility regulation is in fact a political process. It has proved surprisingly malleable by interest groups; and the most durable, unified, concerned, and effective interest group is often the regulated industry itself.<sup>20</sup> The "capture" of regulation by the regulatees has been cited frequently in a variety of contexts. Such agencies as the Civil Aeronautics Board, the Interstate Commerce Commission, and the Securities and Exchange Commission have been characterized persuasively as agencies for the effectuation of cartel pric-

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<sup>18</sup> Moore, *The Effectiveness of Regulation of Electric Utility Prices*, 36 S. Econ. J. 365 (1970); Stigler & Friedland, *What Can Regulators Regulate? The Case of Electricity*, 5 J. LAW & ECON. 1 (1962).

<sup>19</sup> See MacAvoy, *The Regulation-Induced Shortage of Natural Gas*, 14 J. LAW & ECON. 167 (1971).

<sup>20</sup> A recent and penetrating statement of the interest group theory of regulation is Stigler, *The Theory of Economic Regulation*, 2 BELL J. ECON. & MANAGEMENT SCI. 3 (1971).

ing in the industries within their jurisdictions.<sup>21</sup> The dominant interest group need not be the regulated industry, however; it may comprise powerful customers or rivals. So common, indeed, is the manipulation of regulatory rate structures to confer special benefits on particular classes of customers that taxation-cum-subsidization must be considered a major function in fact of the regulatory process.<sup>22</sup> Since the preservation of rate structures containing substantial subsidy elements requires that the firms providing the service be assured a monopoly in the high-price markets in which they recoup their losses on services furnished on a subsidized basis, taxation by regulation aggravates the problem of monopoly—the solution of which is the formal goal of public utility regulation.

Without more, one might hesitate to counsel the extension of public utility regulation; but there are additional, special considerations that argue against its extension to the health care field:

(1) The endeavor to fix appropriate rates for physicians' services would founder on several difficulties less acutely present in the traditional public utility and common carrier industries. The first is product specification. Unless the good or service involved in regulation is specified with fair precision, the regulated firm can substitute a less costly service for the one whose costs were used by the regulatory agency in arriving at a compensatory rate. Physicians' services are even more differentiated and variable than the usual products of regulated firms, such as electrical energy or transportation of freight. Both the range of different services provided by physicians and the range of skill and care with which all but the most routine medical services can be performed are very large.

Furthermore, the attempt to determine a reasonable price for each medical service would encounter grave difficulty. A physician does not purchase inputs in the market and fashion them into a product or service as a steel mill or railroad does. If he did, the cost of his inputs could be added together to provide a first approximation of the cost of the finished product (although, as mentioned, the equity capital input would be difficult to cost). The vital inputs in physicians' services are experience, training, and native skill and judgment; all are difficult to measure. Measurement of the training input, for example, seems relatively straightforward—if one ignores the fact that the cost to the physician of his medical training includes not only tuition and other

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<sup>21</sup> In addition to various studies cited in Posner, *supra* note 12, see Baxter, *NYSE Fixed Commission Rates: A Private Cartel Goes Public*, 22 STAN. L. REV. 675 (1970).

<sup>22</sup> See POSNER, *Taxation by Regulation*, 2 BELL J. ECON. & MANAGEMENT SCI. 22 (1971).

direct expenses but also opportunity costs. The latter consist of the income he could have obtained, during the period of his medical training, had he chosen another occupation, together with the interest on that forgone income computed at an appropriate rate.

(2) The valuation problem is less acute in the case of institutional health care, but there is an even more serious problem. Most hospitals operate at a deficit. The complaint about hospitals is not that they make excessive profits but that they have excessive costs due to imprudent expansion, investment in unnecessary but prestigious facilities and equipment, lack of profit incentives, poor management practices, and other forms of inefficiency.<sup>23</sup> Far from being designed or equipped to cope with problems of this kind, public utility regulation, as mentioned, aggravates any latent tendencies to inefficiency in regulated firms.

(3) Organized medicine has repeatedly demonstrated its political power. Almost uniformly successful in its efforts to control public regulation of the health care industry and shape it to its own ends, it has also succeeded regularly in defeating or emasculating legislative efforts to reduce its privileges. Even organized medicine cannot expect to win every legislative battle, but it is in the nature of powerful interest groups that they can outlast surges of popular concern or indignation that may succeed momentarily in procuring adverse legislation. That is why the eventual capture of regulatory programs by the regulated industries is so common a phenomenon. On the basis of its past success, one can predict that organized medicine would be in a strong position ultimately to dominate any scheme of price regulation imposed on it.

(4) So nearly complete has been the domination of state regulation of health care by organized medicine that a scheme of price regulation, to have any chance of success, would have to be federally administered. Yet the obstacles to effective federal regulation of so dispersed an industry are formidable indeed. The United States contains seven thousand hospitals, thousands of other health care institutions, and more than three hundred thousand physicians, not to mention the great number of other health professionals. With one notable recent exception, the federal government has apparently never attempted to administer so extensive a program of public utility controls as would be required in the health care industry. The typical industry subject to federal public utility regulation is one that has only a few firms, or at most a few major

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<sup>23</sup> See E. KAITZ, *supra* note 9; cf. Havighurst, *Health Maintenance Organizations and the Market for Health Services*, 35 LAW & CONTEMP. PROB. 716, 752 & nn. 98-99 (1970); Newhouse, *Toward a Theory of Nonprofit Institutions: An Economic Model of a Hospital*, 60 AM. ECON. REV. 64, 69-70 (1970).

firms. The exception is the effort of the Federal Power Commission, beginning in the late 1950s, to regulate the prices charged by natural gas producers, of which there are several thousand. That effort is now widely regarded as an expensive and fairly complete failure despite diligent efforts by the Commission's skilled staff to adapt traditional public utility firm-by-firm methods to the exigencies of the situation, as by fixing prices on an areawide rather than individual firm basis.<sup>24</sup>

(5) Even if all of the foregoing problems could be overcome, one could not be confident that public utility regulation would prove to be more than a minor palliative to the crisis in health care. At best, such regulation would prevent profiteering; but health care profiteering is only a symptom of the underlying malaise. The malaise itself is the structure of restrictions noted at the outset of this article, and possibly other factors, that make the supply of medical services respond very slowly to the sharp increase in demand generated by national health insurance programs. The inadequacy of supply would not be cured, or even treated, by a ceiling on prices. Queues of various sorts would replace price increases as the method of rationing the short supply among demanders—hardly a durable or satisfactory solution.

### C. "Dynamic" Regulation of Supply

If restrictions on the supply of medical services are the source of the problem, the solution seems obvious: do away with them. A frontal attack may, however, be politically infeasible. This is suggested by the fact that none of the pending bills mounts such an attack. All prefer oblique approaches.

1. *National Licensing.* An example of an oblique approach is vesting the federal government with part, at least, of the power now held by the states to license physicians and certify health care facilities. Two contradictory goals appear to inform this approach. The first is to make the supply of physicians more fluid by eliminating any barrier to geographical mobility that may be thought to inhere in the power of the states to refuse to recognize licensure by another state as sufficient qualification for practice. The second is to upgrade health care in areas (such as nursing home care) in which state supervision is believed to be lax. The contradiction lies in the fact that raising the standard of health care increases its cost and thus tends to offset the favorable effects on supply of enabling physicians to move more easily to areas of shortage. The tendency of national legislation to set a higher mini-

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<sup>24</sup> See Kitch, *Regulation of the Field Market for Natural Gas by the Federal Power Commission*, 11 J. LAW & ECON. 243 (1968); MacAvoy, *The Effectiveness of the Federal Power Commission*, 1 BELL J. ECON. & MANAGEMENT SCI. 271, 300 (1970); MacAvoy, *supra* note 19.

mum standard than that of many states is illustrated by the Medicare standards relating to nursing homes.<sup>25</sup> A further danger in national licensing is that it offers a tempting target to organized medicine, which, if it secured control of a single nationwide licensing process, might dominate the industry even more completely than it does today.

2. *Competition.* One way of eroding the restraints that inhibit expansion of the supply of medical services is by creating competing alternatives<sup>26</sup> to existing providers that would not be hampered by the traditional restrictions. If the new competitors proved more efficient by virtue of their freedom from those restrictions (on advertising, lay control, pricing methods, delegation to nonphysicians, and the like), the traditional providers would have a competitive incentive to bring about the elimination of the restrictions across the board. Yet by avoiding a direct attack on restrictions, the approach of fostering competitive alternatives may tend to blunt the thrust of political opposition. It has the further advantage of substituting an experimental for a purely analytic approach.<sup>27</sup> If existing restrictions are in fact unwarranted, this would be reflected in the rapid growth of the competitive alternatives; if the alternatives do not thrive, that would be evidence that the restrictions were less important or more meritorious than at present appears, and a firm basis will have been laid for redirecting remedial action.

3. *Subsidization.* It is possible to expand the supply of medical services by providing federal funds for medical training, research, facilities, equipment, or any other perceived bottlenecks. Subsidization should be viewed, however, primarily as a backstop, to be brought into play only if the competitive approach last described fails. Subsidies would increase the cost of any health plan to the United States Treasury, whereas expansion of supply through fostering competitive alternatives would be financed by private capital. The experimental feature of the competitive approach is missing, too; heavily subsidized techniques for relieving the health care crisis would flourish, even if inefficient, if the subsidy were large enough. And like public utility regulation, subsidization is highly subject to political manipulation. Experience in the maritime, agriculture, and other heavily subsidized industries indicates that federal subsidy programs are often inefficient and inequitable.<sup>28</sup>

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<sup>25</sup> See note 7 *supra*.

<sup>26</sup> An example is the "Health Maintenance Organization" of the Bennett bill, discussed in the next section of this article.

<sup>27</sup> On the difficulty of analytically resolving basic issues in optimizing health care, such as the relative merits of capitation fees and fees for individual services, see, for example, H. KLARMAN, *THE ECONOMICS OF HEALTH* 126-31 (1965).

<sup>28</sup> See, e.g., Stigler, *Director's Law of Public Income Redistribution*, 13 *J. LAW & ECON.* 1 (1970).

4. *Educational Restrictions.* Unfortunately, none of the bills deals adequately with the most important cause of inelasticity of medical services supply: the requirement that physicians be graduates of an approved medical school.<sup>29</sup> Until this requirement is rescinded or medical education radically altered, there is little reason for optimism that the supply of medical services can be expanded to keep pace with large increases in demand.

#### D. Politics and Administrative Discretion

The dislocating effect of political pressure on governmental programs designed to achieve efficient results has been alluded to previously. In light of the demonstrated political "clout" of organized medicine, the issue warrants elaboration. One may speculate that, in general, the role of political influence is minimized when the regulating statute is largely self-executing, or at least can be completely executed within a reasonably short period, and maximized when the statute vests broad discretion in the enforcing agency and envisages continuing and comprehensive supervision of the industry. The larger the administrator's latitude in implementing the statute and the longer the expected period of regulatory control, the greater is the likelihood that the industry will be able to undo the effects of the initial legislative action imposing regulation. It can bring pressure to bear on a new front—the administering agency. And it can bide its time until the impulse behind the legislation has spent itself. The regulatory approaches discussed previously can be arrayed on a spectrum defined by these considerations. One extreme is public utility regulation, an indefinitely continuing process in which all crucial decisions are made by the agency. The competitive alternatives approach is the other extreme, for once the organizations enabled by the legislation have been formed there is no further role for an administrative agency to play.

## II. A COMPARISON OF THE BILLS

### A. Regulation of Demand

1. *The Long Bill.* The benefits provided in the Long bill<sup>30</sup> are limited to catastrophic illnesses suffered by people under the age of sixty-five. This is rather narrow coverage. The additional dollars pumped into the demand side of the health industry would be relatively

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<sup>29</sup> See generally Kessel, *Higher Education and the Nation's Health: A Review of the Carnegie Commission Report on Medical Education*, forthcoming in the April, 1972 issue of *The Journal of Law and Economics*.

<sup>30</sup> S. 1376, 92d Cong., 1st Sess. (1971).

few, although not trivial. The Senate Finance Committee has estimated the first-year cost of the program to be \$2.5 billion,<sup>31</sup> compared with total expenditures on health care in the United States in 1970 of more than \$67 billion.<sup>32</sup> In estimating the impact of the proposal it is important to note that catastrophic illnesses suffered by nonaged persons are probably less likely to go untreated than other illnesses, so that much of the expenditure under the proposal would represent a transfer payment from taxpayers to the families of victims of catastrophic illness rather than the purchase of medical services that but for the new program would not have been demanded.

All of the benefits under the program are subject to coinsurance, although two different methods of coinsurance are employed and their incentive effects differ. For hospital and other institutional care, the beneficiary is required to pay a flat amount daily (\$7.50 or \$15.00, depending on the type of institution) toward the institution's bill. This gives him some incentive to shorten his stay but none to choose a lower-priced rather than a higher-priced institution. In contrast, he is required to pay twenty percent of any physician's fee, a method calculated to induce him both to economize on visits to the doctor and to select a lower-priced rather than a higher-priced practitioner. This is much to be preferred to the flat rate as a method of avoiding unwarranted demands for free medical service. Furthermore, unless the flat rates in the Long bill have been carefully synchronized with the percentage coinsurance for doctors' fees, the bill may create an incentive to substitute institutional for ambulatory care regardless of relative efficiency in the particular instance, since the flat rates appear to be low. Flat rates seem a bad idea in a statute in any event, since they can quickly be made obsolete by inflation.

2. *The Fulton-Broyhill Bill.* In the Fulton-Broyhill bill,<sup>33</sup> taxpayers are given credits against their federal income tax liability (and those too poor to pay income tax are given vouchers) for the purchase of approved health insurance policies. The bill contemplates a larger injection of federal funds on the demand side of the health industry than does the Long bill—more than \$10 billion.<sup>34</sup> And since, as in

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<sup>31</sup> *National Health Insurance Hearings*, *supra* note 9, at 279 (excerpt from SENATE COMM. ON FINANCE, REPORT ON THE SOCIAL SECURITY AMENDMENTS OF 1970. S. REP. NO. 91-1431, 91st Cong., 2d Sess. (1970)).

<sup>32</sup> *Id.* at 1.

<sup>33</sup> H.R. 4960, 92d Cong., 1st Sess. (1971).

<sup>34</sup> The nominal cost estimated by its sponsors is \$14.5 billion per year. *National Health Insurance Hearings*, *supra* note 9, at 222. But since the program would replace Medicaid, the actual increment of new demand would be less.

Medicare, benefits would not be limited to catastrophic illness, enactment of the Fulton-Broyhill bill would result in a substantial spurt in the demand for medical services.

The coinsurance provisions of this bill are not attractive from an economizing standpoint. There is no coinsurance of hospital or other institutional inpatient care. Although there is a nominal coinsurance rate of twenty percent for physicians' services and for laboratory and X-ray services, in each case the maximum coinsurance is one hundred dollars per year; the rate thus drops to zero for the remainder of any year in which a family has already received five hundred dollars worth of either kind of treatment. The combination of coinsurance of physicians' fees with the absence of any coinsurance of hospital inpatient care perpetuates the incentive built into existing private health insurance plans to substitute institutional for ambulatory care regardless of efficiency.

3. *The Bennett Bill.* The benefits provision of the Bennett bill<sup>35</sup> is in two parts: almost all employers are required to provide comprehensive health insurance for their employees and the employees' families, and the federal government insures the poor against illness much as the aged are insured by Medicare. Nearly the entire population of the country would be covered,<sup>36</sup> and the benefits would be quite broad. Enactment of the bill would increase the demand for medical services significantly—to the extent of \$6.2 to \$8.2 billion a year.<sup>37</sup> However, most services provided under the bill, except those rendered to the very poor, are subject to coinsurance, usually at the rate of twenty-five percent. The coinsurance provisions of the Bennett bill are superior as economizing measures to those of either of the bills discussed previously, since coinsurance is determined on a percentage rather than a flat-rate basis and since the rate of coinsurance is the same for institutional and for ambulatory care. As in the Fulton-Broyhill bill, there is a ceiling on coinsurance, but it is quite high (five thousand dollars). More questionably, the bill subjects the principal covered services to deductibles.

The Bennett bill contains two additional economizing features. First, health care for the working population is to be financed by employers to the extent of at least seventy-five percent of its cost. Much of this may be shifted back in one way or another to employees; still, employers would have a pecuniary incentive to shop around until they found plans

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<sup>35</sup> S. 1623, 92d Cong., 1st Sess. (1971).

<sup>36</sup> The elderly would remain subject to Medicare. Anyone not old, not poor, and not employed (or self-employed) would be permitted to join plans formed under the bill.

<sup>37</sup> *National Health Insurance Hearings*, *supra* note 9, at 84 (testimony of HEW Secretary Elliot Richardson).



that provided the required benefits at the lowest cost to themselves and their employees. The drive for profits is thus harnessed to provide a force for efficiency and economy in the provision of covered services. Second, the provision of benefits is deferred until July 1, 1973, presumably to enable a reorganization of the supply side of the industry to meet the new demands created by the bill. The period is too short and in any event should be measured from the date the bill is enacted.

4. *The Pell-Mondale Bill.* The Pell-Mondale bill<sup>38</sup> is similar to the Bennett bill in its likely effect on the demand for medical services. It requires employers to provide comprehensive health benefits to employees. It excludes the poor, but unlike the Bennett bill it would not preempt Medicaid. In one important respect, the Pell-Mondale bill is broader in scope than the Bennett bill—it embraces drugs. Like the latter bill, the Pell-Mondale bill would significantly increase the demand for medical services. It lacks coinsurance, an important economizing feature of the Bennett bill, and it contains a detailed specification of covered services (one of which is an annual checkup for everybody).

5. *The Kennedy Bill.* Among the bills considered, the Kennedy bill<sup>39</sup> provides the most extensive benefits; it also lacks the economizing features built into some of the other plans. There is no coinsurance. Employers are not involved in the selection of providers of health services. There is, to be sure, a slightly longer postponement of benefits from the likely date of enactment (to July of the following year); still, on balance, the bill would bring about a greater increase in the demand for medical services, and place greater pressure on price, than any of the others.

## B. Regulation of Supply

1. *The Long Bill.* The Long bill<sup>40</sup> incorporates by reference the standards and procedures employed in the Medicare program to regulate the supply of covered services. These Medicare regulations<sup>41</sup> fall into two broad classes: those governing who may provide services under the program and those governing reimbursement of authorized providers for covered services rendered. The regulation of providers is largely pro forma. Any hospital accredited by the hospital industry's trade association is automatically entitled to provide Medicare services; all licensed physicians are authorized to provide such services in the states in which

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38 S. 703, 92d Cong., 1st Sess. (1971).

39 S. 3, 92d Cong., 1st Sess. (1971).

40 S. 1376, 92d Cong., 1st Sess. (1971).

41 See 42 U.S.C. §§ 1395u, 1395x (1970).

they are licensed. The requirements for extended care facilities and certain other providers are somewhat stiffer, but their administration has been criticized as lax and ineffectual.<sup>42</sup>

Reimbursement of providers of Medicare services is handled by private entities—Blue Cross and Blue Shield and, to a lesser extent, private insurance companies. These intermediaries between the provider of services and the government, which pays for them, are nominated, and often controlled, by hospitals and physicians. Whether for this reason, or because the statutory language governing standards of reimbursement is loose, or, most plausibly, because the intermediaries have been given no financial incentive to minimize the costs of the Medicare program to the government, the control exercised by the intermediaries over either the price or the utilization of physician and hospital services by Medicare beneficiaries has, by all accounts, been minimal. The government, in turn, has exercised little control over the intermediaries. The result has been recurrent waste and extravagance, sometimes bordering on outright fraud.<sup>43</sup>

The failure of these controls is attributed by the Social Security Administration, which administers Medicare, to a combination of inexperience and poor legislative drafting. There is some truth in this; and efforts to repair the deficiencies in the existing Medicare control system are under way.<sup>44</sup> But the structure of regulation is not a promising one. The first layer of regulation, private intermediaries, because of their relationship to health care providers and because of the way in which they are compensated (reimbursement for their out-of-pocket costs with no allowance for profit), have little incentive to exercise stringent cost and utilization control. The second layer of regulation, the Social Security Administration, lacks, and is unlikely ever to acquire, the resources that would be necessary to supervise effectively the millions of claims submitted under the program every year.

In sum, the Medicare controls over the provision of health service have proved weak and are likely never to be strong. Carried over into a new area of service—the treatment of catastrophic illness suffered by

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<sup>42</sup> See SENATE COMM. ON FINANCE, 91ST CONG., 1ST SESS., *MEDICARE AND MEDICAID: PROBLEMS, ISSUES, AND ALTERNATIVES* 91-96 (Comm. Print 1970).

<sup>43</sup> See *id.*, particularly page 116, a ringing indictment largely concurred in by HEW (see *Medicare-Medicaid Hearings*, *supra* note 7, at pt. 1, App. B).

<sup>44</sup> See HOUSE COMM. ON WAYS & MEANS, REPORT ON H.R. 1, *SOCIAL SECURITY AMENDMENTS OF 1971*, H.R. REP. NO. 92-231, 92d Cong., 1st Sess. (1971). Many of the suggested reforms (summarized *id.* at 17-23), however, are either marginal or dubious (including construction and pricing controls akin to those discussed in part II of this article).

people under the age of sixty-five—they are unlikely to prove markedly effective. They are in any event addressed only to the problems of excessive utilization and exorbitant pricing of health services and do not begin to deal with the fundamental conditions, such as scarcity of physicians, that make the supply of health services unresponsive within a reasonable time period to major increases in demand.

2. *The Fulton-Broyhill Bill.* The Fulton-Broyhill bill<sup>45</sup> contemplates no federal regulation of the provision of health services. States are free to regulate health insurance furnished in accordance with the requirements of the bill as they regulate other private health insurance today. The omission of any provision dealing with the supply of medical services from a plan that would greatly increase the demand for such services may appear to defy rationalization. But since the plan in effect merely gives people more money with which to buy private health insurance, there is a certain plausibility to leaving unchanged the existing system of regulating such insurance. And since the credit provided by the plan is partial only (except for the poor), individuals have an incentive to shop around among the various private insurers. The past performance of the health insurance industry, however, reduces one's confidence that competition among the insurers could be depended on to reduce waste and extravagance to manageable proportions. The failure to deal separately with suppliers of insurance to those who pay nothing, and who therefore have no incentive to seek out the low-cost supplier, is another weakness of the plan. An even more serious deficiency is its failure to provide for any form of dynamic regulation—regulation designed to augment the supply of health services. Such a failure seems critical in a plan that would markedly increase the demand for medical services.

3. *The Bennett Bill.* Although the Bennett bill<sup>46</sup> provides for essentially no control over the administration of the required employer plans, the omission may perhaps be justified by the employer's incentive to shop around for the least costly plan. Employers may be more knowledgeable and effective shoppers than the individual consumer of health services. And the employer is not limited to choosing among insurance company plans but may deal directly with providers.<sup>47</sup> One questionable feature of the Bennett plan is that insurance carriers are authorized to

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<sup>45</sup> H.R. 4960, 92d Cong., 1st Sess. (1971).

<sup>46</sup> S. 1623, 92d Cong., 1st Sess. (1971).

<sup>47</sup> In fact, he must do so, for he is required to provide his employees with the option of receiving covered services from a "Health Maintenance Organization" (HMO), a special type of provider discussed later in the text.

collaborate in designing plans that will comply with the requirements of the bill. Such encouragement to collusion, in an industry already deficient in competitive energy, should be avoided.

With respect to the poor, the Bennett bill in essence incorporates the Medicare controls, discussed previously in the context of the Long bill. Some controls with respect to benefits provided the poor may be appropriate. The poor pay nothing and accordingly have no incentive to seek out the cheapest providers; they lack a "proxy shopper" such as the employer in the other part of the program; and they may be poor shoppers, especially for sophisticated services such as health care. For the reasons stated earlier, however, the Medicare controls appear to be of doubtful efficacy, and a better solution may be a combination of coinsurance and provisions designed to increase the effectiveness of competition for consumer patronage.

The Bennett bill authorizes the creation of "Health Maintenance Organizations" (HMOs) empowered to contract with employers to furnish the services required in the employer part of the bill and with poor people to furnish the services to which the bill entitles them.<sup>48</sup> HMOs bear a generic resemblance to prepaid group practice plans<sup>49</sup>—which now have some eight million members in the United States—under which the member pays a capitation fee for comprehensive health services rather than fees for individual services and the physicians who treat him are often salaried employees of the plan rather than independent professionals. The HMO concept in the Bennett bill, however, is broader than prepaid group practice. It is expressly provided that the HMO can be a profit-making enterprise owned by complete outsiders to the medical or other health professions and that it can delegate traditional physicians' functions to nonphysicians. These are two respects, among others, in which group practice plans are currently inhibited by state regulation.<sup>50</sup> The bill proscribes state regulatory impediments to group practice, with one exception (advertising), discussed below.

The HMO concept is a promising if probably insufficient method of expanding the supply of medical services to meet the new demands that the Bennett bill would create. The factors limiting the supply of medical services appear to be primarily the scarcity of physicians, due largely

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<sup>48</sup> For a detailed study of this aspect of the Bennett bill, see Havighurst, *supra* note 23.

<sup>49</sup> For background on prepaid group practice plans, see Note, *The Role of Prepaid Group Practice in Relieving the Medical Care Crisis*, 84 HARV. L. REV. 887 (1971).

<sup>50</sup> See ASPEN SYSTEMS CORPORATION, *supra* note 3; Note, *supra* note 49, at 960-75. For example, in some states a group practice plan may not be implemented unless fifty per cent of the physicians of the area agree to join.

to the cost and length of training required by state law to become a licensed physician, and secondarily the restrictions, also imposed by state law, on the adoption of any method of organizing the provision of health services other than on the basis of fees for individual services rendered by self-employed physicians. The provisions of the Bennett bill relating to HMOs deal, albeit indirectly and probably inadequately, with the first problem (scarcity of physicians) by permitting functions now performed exclusively by physicians to be delegated to nonphysicians by the management of the HMO. It deals with the second problem directly by permitting private entrepreneurial capital, not necessarily furnished by members of the medical profession, to be invested in the health care industry in forms of business enterprise now largely barred as a consequence of state law.

Such an approach, limited though it is, has much to commend it. It is not only likely to be more effective than direct controls of the kind provided under Medicare, which can at best improve the allocation of existing medical resources and can do nothing to augment them, but it is also cheaper since administrative costs are minimized. While the bill could go further and liberate all providers of medical services—not merely those qualifying as HMOs—from restrictive state regulation, that step may be unnecessary. Unless qualification as an HMO should prove difficult (it could be made easier, as will be discussed next), successful formation and growth of HMOs would create great pressure to unshackle other providers from legal restrictions that impaired their ability to compete with HMOs.

The HMO concept embodied in the Bennett bill could be improved, however. First, although it is not altogether clear in this respect, the bill appears to leave intact state regulations forbidding providers of medical services to advertise, even if the provider is an HMO otherwise immune from state regulation. This is a serious omission. Advertising may be indispensable to a new firm fighting for the public's attention, and there is no reason to think that the present context is exceptional in this regard.

Second, the provisions of the bill governing the regulation of HMOs by the Secretary of Health, Education and Welfare seem needlessly elaborate and could discourage their formation. In order to be licensed by the Secretary, an HMO must among other things demonstrate "proof of financial responsibility and proof of capability to provide comprehensive health care services, including institutional services, *efficiently, effectively, and economically.*"<sup>51</sup> The italicized words inject

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<sup>51</sup> S. 1623, 92d Cong., 1st Sess., §§ 604(a)(4), 628(b)(4) (1971) (emphasis added).

an extremely vague and open-ended criterion—a potential source of endless controversy, delay, and expense to the applicant. Worse, it is a potential basis for refusing to license new HMOs that would compete with existing licensees, an abuse to which licensing schemes are traditionally prone.

The criterion is unnecessary. HMOs that were not efficient, effective, and economical would not obtain contracts with employers, and if they failed in this respect they would not be able to enroll poor persons either, because an HMO is required to have at least five thousand paid enrollees before it may be reimbursed for serving the poor.<sup>52</sup> This requirement is designed, appropriately in the main,<sup>53</sup> to prevent inefficient HMOs from establishing themselves in the market in which consumer choice is likely to be least effective—the market for health services for the poor. The requirement is reinforced by a further provision forbidding an HMO to retain a greater part of the proceeds from treating its poor enrollees than it retains from treating its paid enrollees. The employer who contracts with an HMO is thus a “proxy shopper” for any poor people who should happen to enroll with that HMO. With all of this protection, it is not clear why a prospective HMO should have to furnish any more proof of fitness than is required of an applicant for an ordinary corporation charter.

Although the Bennett bill contains no provision for subsidization of HMOs, the Administration apparently will seek legislation providing such subsidies.<sup>54</sup> This seems a mistake, however, since subsidization would prevent a true market test of the viability of the HMO concept.

4. *The Pell-Mondale Bill.* The strategy of the Pell-Mondale bill<sup>55</sup> is broadly similar to that of the Bennett bill. There is no regulation of the required employer plans, except, of course, a specification of minimum benefits. There is a provision for the creation of entities comparable to, although significantly different from, HMOs: “Community Health and Education Corporations” (CHECs). These are private, profit-making corporations that are to provide comprehensive health services on a prepaid basis (like group practice plans and HMOs) but that are also required, to the extent feasible, to construct and maintain

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<sup>52</sup> Technically, an HMO must have a minimum of ten thousand members at least fifty percent of whom are employed. S. 1623, 92d Cong., 1st Sess. § 628(b)(5) (1971). The requirement may be waived upon a showing of exceptional circumstances. *Id.* §§ 628(h)–(i).

<sup>53</sup> One can quarrel with the ten thousand minimum, however; it might foster monopoly in smaller communities. Perhaps HMOs with fewer members would not be viable, but that is a judgment that can and should be left to the market.

<sup>54</sup> See *National Health Insurance Hearings*, *supra* note 9, at 84–85 (testimony of HEW Secretary Richardson).

<sup>55</sup> S. 703, 92d Cong., 1st Sess. (1971).

hospitals and to conduct educational programs under university supervision. Eight of the fifteen directors of each CHEC are to be appointed by the Secretary of HEW, the remaining seven to be elected by the shareholders. Common stock may be issued in the first instance only to states or their political subdivisions or to health care providers, although apparently once issued it may be transferred without restriction.

Without going further, one discerns a serious weakness in the scheme—overspecification likely to discourage the formation, limit the number, and reduce the efficiency of the CHECs. Nonprofit entities are excluded. Large scale and diversification into hospital management and medical education are encouraged despite the diseconomies of scale and of underspecialization that might result. Entrepreneurship is discouraged by limitations on who may be issued common stock, by the government's control of the board of directors, and by the inability of the common shareholders to elect more than one-third of the directors. The purpose of these requirements is not obvious, and their cumulative impact on the growth and efficiency of the CHEC would surely be negative. The bill elsewhere provides for extensive federal financial assistance to CHECs, a questionable feature that would be unnecessary were the concept of the CHEC less rigid and therefore less likely to fail in the market without federal aid.

The method by which such corporations are to be created is also questionable. A CHEC may be formed only in areas where the Secretary determines that one is needed. He is to base his determination of need on seven factors. The problems they raise are illustrated by the following three: "lack of reasonably priced comprehensive health services within the area," "lack of health manpower resources needed to provide health services within the area," and "the willingness of existing providers of health services and health education" to contract with and invest in the CHEC.<sup>56</sup> The first two criteria quoted are nebulous, extremely difficult to apply in practice, and seemingly duplicative. The third criterion (the attitude of existing providers) invites a veto by the local medical establishment in the very areas where CHECs may be most needed. Since the criteria are not even consistent with one another, the ultimate judgment of the Secretary would be largely an arbitrary one and the opportunities for political manipulation therefore considerable.

The bill also provides for the regulation of providers of health services affiliated with CHECs. A physician must be licensed not only by a state but also by the Secretary of HEW. Once licensed by the Secre-

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<sup>56</sup> *Id.* §§ 302(b)(1)-(2), (4).

tary, however, he may practice for a CHEC in any state. The Secretary is also authorized to impose continuing-education and relicensing requirements on physicians employed by CHECs. CHEC-run hospitals are subject to a number of specific requirements as to standard of care provided and, more important, to an essentially open-ended rule-making power in the Secretary, who may impose such requirements as he "finds necessary in the interest of the quality of the care and the safety of patients in the institution."<sup>57</sup> Other health professionals and facilities affiliated with CHECs are similarly regulated. The intended or likely impact of all this on the conditions underlying the inelasticity of the supply of health care is obscure. The provision for national licensing is obviously designed to enhance the geographical mobility of physicians. Yet state licensure requirements are not in fact a serious obstacle to physicians' relocating.<sup>58</sup>

Two additional features of the Pell-Mondale bill should be mentioned. First, the provisions for financial assistance to CHECs address directly (in contrast to the Bennett bill) the problem of the undue time and expense required under existing state licensure provisions to train a physician—but perhaps not effectively. It seems odd to channel aid to medical education to entities whose primary mission is to provide comprehensive health care. More important, financial aid to medical education is a slow and very costly method of augmenting the supply of physicians.

Second, the bill provides for the creation of regional councils (whose members are to be appointed by the Secretary of HEW) that are to regulate the prices and dividends of CHECs and to review state health facility construction plans contemplating federal financial assistance. The earlier discussion of construction and price controls remains applicable here. To be sure, the case for regulating the CHECs' prices is strengthened by the fact that only one CHEC per community appears to be contemplated and by the further fact that, by virtue of the extensive federal assistance to which it would be entitled, the CHEC might have a decisive advantage over any rival providers. In view of the difficulties in subjecting the health care field to price regulation, a

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<sup>57</sup> *Id.* § 308(b)(9).

<sup>58</sup> See Holen, *Effects of Professional Licensing Arrangements on Interstate Labor Mobility and Resource Allocation*, 73 J. POL. ECON. 492 (1965). The author found that state licensure requirements are a far greater barrier to interstate mobility of dentists and lawyers than of doctors. The uneven distribution of physicians around the country is explained, on grounds having nothing to do with state licensing laws, in Rimlinger & Steele, *An Economic Interpretation of the Spatial Distribution of Physicians in the U.S.*, 30 S. ECON. J. 1 (1963).



better solution would be eliminating the monopoly element and permitting more than one CHEC to be formed in a community. But the elephantine specifications for the CHEC are an obstacle here, for many communities would not be able to sustain several entities engaged simultaneously in providing comprehensive medical care, operating hospitals, and furnishing medical training.

5. *The Kennedy Bill.* The Kennedy bill<sup>59</sup> provides for extensive regulation of all covered services, and, since virtually all medical and health services are covered, the entire health care field would be brought under regulation. Like the Pell-Mondale bill, the Kennedy bill provides for dual state-national licensing of physicians and for open-ended control by the Secretary of HEW over health care institutions. Our discussion of such regulations in the context of the Pell-Mondale bill is applicable here, but with an important further consideration. The Pell-Mondale regulations are limited to physicians employed and hospitals controlled by CHECs. Initially, at least, only a small fraction of the nation's physicians and hospitals would be involved. The parallel regulations in the Kennedy bill, in contrast, apply to all physicians and hospitals rendering covered services—in effect, to all the nation's physicians and hospitals. With every physician required to be licensed twice, the already excessive period of time required to become a practicing physician would be further prolonged. And the national licensing standards might be set at a very high level. Combined with the continuing-education and relicensing requirements in the Kennedy bill (similar to those in the Pell-Mondale bill), national licensing could result in an actual reduction in the number of physicians and would at the very least erect new impediments to enlarging their supply. Similarly, detailed controls over institutional providers, apart from all their other costs and consequences, could, by raising standards, diminish the supply of institutional health care.

The Kennedy bill also contemplates comprehensive federal regulation of physicians' fees and hospital charges. The Health Security Board (a new regulatory agency within HEW that would be responsible for administering the plan) would first determine a total national health budget for the coming year, based on total expenditures on health care in the previous year but with important modifications to be discussed in a moment. Out of the total budget, hospitals and other institutional providers, excluding comprehensive health service organizations (akin to HMOs, but again with differences to be elucidated shortly), would be paid on the basis of cost estimates set forth in a prospective budget

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<sup>59</sup> S. 3, 92d Cong., 1st Sess. (1971).

negotiated by each institution with the Board. The institution would in effect be contracting to furnish services at an agreed rate that it could not exceed even if its costs rose after the agreement was made. Comprehensive health service organizations and individual practitioners electing to be paid on a capitation basis would be paid an amount per patient equal to the total budget for the region and type of service involved divided by the number of people in the region receiving such service. From the remainder of the budget, practitioners electing to be paid on the traditional fee-for-service basis would be paid according to a schedule of fees fixed by the Board.

The procedure may appear to allocate funds to physicians and hospitals in a more or less automatic way on the basis of the previous year's total expenditures on health care services, but the appearance is misleading. The initial determination of the total budget indeed has a crucial impact on the fee level but the determination is to a large degree within the discretionary power of the Board. Among other things, the Board can reduce the budget to reflect anticipated (hoped for?) reductions in the cost of health services and can reallocate funds among regions of the country—regardless of the previous year's expenditures in each region—in order to further the bill's expressed goal of reducing regional differences in the real cost of health care. The regional reallocations affect the capitation fee by increasing or decreasing the gross amount of which the capitation fee is a fraction based on population. The Board can also alter capitation fees on the basis of differences in the amount of services rendered to particular population groups and other relevant factors. The amount of the regional budget left over after all capitation fees and hospital costs have been paid sets the upper limit to the total payments that practitioners in the region, who charge on a fee-for-service basis, can collect. The ceiling could be a low one. And it is only a ceiling since actual payments to practitioners could be much lower, depending on the fee schedule set by the Board.

The result, in sum, is that the Board would have considerable power over the pricing of medical services, which it might use to restructure the health care industry in accordance with political judgments or pressures possibly contrary to the consumer interest in efficient health care. The Board could easily discourage fee-for-service practice, regardless of its merits, by fixing fees at a level so low that most physicians were induced to switch to capitation fees or join comprehensive health service organizations. It might be tempted to do so because of the statutory commitment to the comprehensive health service organization and capitation fee concepts and the possibility that without some coercion

these concepts would not fare well against established patterns of supplying medical services. Should the Board, instead of comprising advocates of the concepts embodied in the Kennedy bill, be "captured" by representatives of organized medicine, it could as easily destroy the comprehensive health service organization and capitation fee concepts by fixing capitation fees at an inadequate, and fees for individual medical services at a munificent, level. Either course would be possible, and what is perhaps least likely is that the temptation to manipulate the structure of the industry for essentially political ends would be successfully resisted.

Even if the pricing provisions of the bill were administered with the sole aim of economizing on medical expenditures by preventing reimbursement for exorbitant charges, the administrative costs and disincentive effects of price regulation could well exceed any beneficial effects. It is unnecessary to repeat the previous discussion of the weaknesses of public utility regulation and the special considerations that argue against its extension to the health care field. There are, to be sure, some novel elements in the Kennedy bill's scheme of price regulation: (1) the emphasis on prospective rather than retrospective costing, both in the total national budget and in the budgets for individual institutional providers; (2) the need to determine demand as well as cost in order to fix national and regional budgets; and (3) the use of price control to alter regional patterns of supply. But these features seem inordinately ambitious and likely to complicate far more than they improve the regulatory effort. Estimation of future costs is even more difficult than estimation of actual incurred costs. Measurement of demand is very difficult also. And determination of a price that reconciled the regional purposes of the bill with the goal of preventing excessive charges would probably be impossible. The novel features of the price control scheme may reflect awareness of the inappropriateness of the public utility model, but the draftsmen have not articulated a coherent and workable alternative.

It is just possible, however, that the price provisions in the Kennedy bill have a somewhat different thrust from conventional monopoly regulation. Much of the price increase brought about by Medicare, as noted, has been the result not of waste or greed but of the fact that, when demand rises without a corresponding increase in supply, price will rise as a means of rationing the temporarily inadequate supply. The benefits provisions of the Kennedy bill would have a similar effect on demand. Ordinarily, when demand is temporarily excessive in relation to supply, a price rise is to be welcomed as a means of allocation

superior to governmental fiat or queues. But the Kennedy bill precludes the use of price as a rationing device. The consumer of medical services under the bill pays nothing, no matter how high the price of the service rises. High prices caused by the new demands generated by the bill would not moderate demand but would simply increase the cost of the program to the government. Queues would form as consumers jostled one another for access to the limited stock of health care resources. In these circumstances there is an undoubted appeal in attempting to prevent price from rising, and the scheme of price regulation in the Kennedy bill, keyed as it is to expenditures for health care in the previous year, may be intended to do just that. But there is much to be said against such a scheme. Especially important in the present context is the possibility that a temporary price rise could serve a salutary purpose by attracting new venture capital into the health care field, at least if existing restrictions on investment are removed, as they are in the Bennett bill. And it may be possible to dampen the price effects of a new spurt in demand for medical services, at lower social cost, by working to expand the supply of medical services.

Like the Bennett and Pell-Mondale bills, the Kennedy bill contains elements of "dynamic" regulation designed to augment the supply of health care services. The comprehensive health service organization of the Kennedy bill is generally similar to the Bennett bill's HMO. The major difference is that the comprehensive health service organization may not be a profit-making entity.<sup>60</sup> This is a substantial and unwarranted limitation on the effectiveness of the device. It bars from the health care field the private entrepreneur, who may have much to contribute both in capital and in new ideas and methods for organizing the provision of health care. Like the Pell-Mondale bill, the Kennedy bill envisages substantial direct subsidies to medical education, planning, and other areas of perceived need in the health care field. If the comprehensive health service organization were less restricted, the need for additional subsidization to encourage the necessary expansion in the supply of health care services might be felt less urgently.<sup>61</sup>

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<sup>60</sup> Also, as a technical drafting matter, the bill is less explicit in its preemption of interfering state regulations than the Bennett bill.

<sup>61</sup> I note in passing—properly explored, the subject would extend this paper unreasonably—that the Kennedy bill also contemplates comprehensive price regulation of the prescription drug industry and of retail druggists. This typifies the overambitious character of the bill. It also provides for extensive construction controls, authorizes the government to require providers to provide additional services, and perpetuates the Medicare bias in favor of the skilled nursing home.

## CONCLUSION

Of the pending bills, the Bennett bill seems the most promising from a regulatory standpoint, at least if comprehensive benefits are intended rather than the very limited benefits of the Long bill. Even the Bennett bill, however, could be improved in a number of important details. What is more important, the Bennett bill, despite many promising features, does not really get to the root of the problem in the health care field: the scarcity of physicians. Until that problem is solved, the creation of new demands for health care, as under the Bennett bill, can hardly avoid placing great upward pressure on prices.