

SYRACUSE UNIVERSITY  
MAXWELL SCHOOL OF CITIZENSHIP AND PUBLIC AFFAIRS | CENTER FOR POLICY RESEARCH

# Policy Brief

Fifth Annual  
Herbert Lourie Memorial Lecture on Health Policy  
**Pursuing Health-Care Reform:  
The Promise and the Pitfalls**

*John K. Iglehart*

**No. 1/1994**

*Herbert Lourie Memorial Lecture on Health Policy*

The Herbert Lourie Memorial Lecture on Health Policy, sponsored by the Maxwell School of Citizenship and Public Affairs of Syracuse University and the Central New York Community Foundation, Inc., honors the memory of Herbert Lourie, M.D. Generous contributions from his family, friends, colleagues and former patients have endowed this memorial lecture series. Past lecturers include Arnold S. Relman, M.D. (1992); Bruce C. Vladeck, Ph.D. (1991); Uwe E. Reinhardt, Ph.D. (1990); and Fred Frohock, Ph.D., Peter Black, M.D., and Daniel Callahan, Ph.D. (symposium 1989).

The Policy Brief series is a collection of essays on current public policy issues in aging, health, income security, metropolitan studies and related research done by or on behalf of the Center for Policy Research at the Maxwell School of Citizenship and Public Affairs.

Single copies of this publication may be obtained at no cost from the Center for Policy Research, Maxwell School, 426 Eggers Hall, Syracuse, NY 13244-1090.

© 1994, Syracuse University

## Pursuing Health-Care Reform: The Promise and the Pitfalls

---

*John K. Iglehart*

In developing health care reform proposals, it is important to recognize that our health care system has evolved over a long period of time and reflects values in which Americans believe deeply—values like pluralism and entrepreneurialism, consumer choice, limited government, and low taxation. Any major reforms will assault, or at least do some violence to, these values. Nevertheless there's a gathering consensus that reform of the fractured health care system to which Americans have grown accustomed is necessary, based on two overriding concerns: an uninsured population of approximately 35 million people, more than half of whom are adults holding full-time jobs; and medical care costs that continue to rise more than twice as rapidly as the consumer price index. These problems have festered for over a decade. The obvious change in the equation is a restive middle class, concerned about the uncertainty of its health insurance arrangements, and a new President who has staked his political future on making these arrangements more secure.

President Clinton brings to this task a strong belief that federal policy should create a framework that encompasses all health insurance arrangements, not just those that are sponsored by government and financed through taxation. This represents a fundamental change in national health policy. During twelve years of Republican rule, the federal government defined its responsibility in the health care field only as far as the publicly financed programs, largely Medicare and Medicaid, without any responsibility to create a framework under which the whole system would operate. Clearly there is a direct link between public and private financing of health care through cost-shifting, which has increased over the years. The President proposes to transform the system that is today dominated by private decision-making and financing to one that places the federal and state governments in far more central regulatory roles in relation to how resources are allocated and how the system functions.

I base this assertion on a belief that the health insurance purchasing cooperatives, or alliances as they're commonly called, through which most people would acquire their health insurance coverage, would be at least quasi-public entities, accountable to government. In this regard the President is moving government policy to more nearly resemble that of governments in Europe and Japan, to establish a framework through which resources flow, usually to private institutions

*Herbert Lourie Memorial Lecture on Health Policy*

and providers. Only in the United Kingdom does government own the sources of production, like hospitals. In most industrialized countries about 70% to 90% of the resources flow through public treasuries, in one way or another, or through quasi-public social insurance funds, as in Germany. In the United States about 42% of resources flow through the public treasury, and clearly that percentage will increase if anything resembling the Clinton health insurance proposal is enacted.

Ironically, European governments are somewhat relaxing their hold on their health insurance systems, striving to ease the pressure on their public treasuries by introducing consumer cost-sharing and encouraging private insurance, while offering consumers more choices of health plans and benefits. Thus, while the United States moves toward greater compulsion, European systems, which have long been more directive with their populations, are moving in the opposite direction.

What are the politics of President Clinton's plan? The overriding objective of the President's health care reform plan is to achieve universal health insurance coverage by 1998 for every American citizen, without imposing broad-based taxes to finance it. This plan reflects the strong American preference for low taxation, although the United States currently has the lowest tax rate among the industrialized nations. Relatively little new tax money would flow directly through federal and state governments; rather, it would flow through the alliances. Through a series of interconnected initiatives, the Clinton administration proposes to achieve universal coverage by requiring employers to provide coverage to their employees, with subsidies to help small businesses. All individuals, regardless of their health status, would be required to carry health insurance coverage. The organizational cornerstone of the plan would be a national network of state-sanctioned health insurance purchasing alliances which would manage competition among accountable health plans on behalf of consumers. Only individuals who work for corporations that employ more than 5,000 people would be outside the system. One of the reasons why the plan is so complicated is that it builds on the traditional American employer-sponsored insurance system to determine the appropriate subsidies, and to structure a plan of accountability and a host of other implementation challenges that add complexity to the plan. But it's similar to the plan that President Nixon proposed about twenty years ago, in that it is employer-based. The fact that a Democratic President with control of both houses of Congress is proposing an employer-sponsored plan rather than a single payer approach is a mark of the conservative drift in politics over the last twenty years. But it is also a compliment to the political savvy of a President who recognizes that a single payer plan is probably unacceptable in our society at this time and who has settled for an employer-sponsored plan.

What are the challenges to reform? Broad scale reform poses a very difficult challenge for the President. Interests that thrive on the almost trillion-dollar health economy are hardly going to roll over and play dead if they feel threatened by policies they oppose or at the very least feel uneasy about.

The appeal of the President's initiative must further be balanced against the recognition that almost 85% of the population already has health insurance, and that most Americans are well satisfied with the care they receive. Indeed, there's an intriguing dichotomy of the views of individuals regarding their own health care arrangements and their repeated expressions of anxiety about being able to pay for health care in the future. Not long ago, two public opinion experts looked at 27 separate survey questions on these issues related to personal satisfaction; half of these surveys related to the 1970s. They found that between 70% and 95% of Americans reported personal satisfaction with care provided by their doctors and their hospitals. On the other hand, almost 9 of every 10 Americans surveyed expressed themselves in favor of fundamental change or complete overhaul of the health care system.

Why are individuals who express high levels of satisfaction with their own medical care reaching such radical conclusions about the need for reform? That is something of a mystery, a mystery that public opinion experts have not been able to answer, at least to my satisfaction. Is it a misunderstanding about how the system operates? Is it concern over the high costs, or the millions of uninsured? Or is there another explanation?

I think an important dimension here is what I have come to call "the medical experience." Most Americans in any given year don't use the health care system, thankfully, but those who need it and use it really come to treasure it. I've had some experience with that in the last several years, and it has fundamentally changed my mind about the health care system, and about physicians and their role in society. When you need it, you need it, and suddenly the concerns about costs, the cost-effectiveness that economists rail about, pale in the face of serious disease. If you have had such a health emergency, you can appreciate what I mean.

Another difficult hurdle for the Clinton administration is persuading Americans to accept two unpopular but inevitable realities of universal access. One is an expansion of government's authority to regulate the system, no matter what reform plan is enacted. And the other is an acceptance of some redistribution of income to subsidize expanded coverage. Traditionally, Americans are very uncomfortable with the notion of redistribution.

This is a special time, I think, in our history in relation to health reform. To underscore that point I would simply mention the attitudes of the chairmen of three major committees that will be instrumental in enacting or in considering health reform legislation. These are three legislative veterans who have tried and failed to enact national health insurance over the last several decades—Congressmen John Dingle and William Ford, and Senator Edward Kennedy—all of whom support the Clinton plan more or less. In the past, all three of these legislators have favored and have sponsored reform plans that would finance medical care coverage through a single payer, but all three now are prepared to accept the President's argument that, whatever its merits, a measure requiring such a massive shift of privately paid care to tax-based financing simply will not happen.

Let me cite several of the leading issues that will be discussed as this debate unfolds.

- È Many of the most difficult issues revolve, not surprisingly, around money. One is the power of monopolistic regional alliances. While the President's plan ostensibly allows large employers to remain self-insured, a powerful set of rewards and penalties would force almost all payers to obtain health insurance coverage through regional alliances. In that case, some of the alliances, particularly in large metropolitan areas, would have more money flowing through them than many state governments. And these are institutions that do not even exist today! A more likely alternative would be to limit the scope of purchasing alliances to smaller businesses, up to, say, 100 employees, which includes about 30% of the population. Most employers are reluctant to turn over what they perceive as their monies, or monies that they share with their employees, to a regional alliance in return for health insurance coverage. They simply don't trust government. They want to keep that money in their own hands.
  
- È An important issue, particularly to the economists, is the absence of a tax cap. The Clinton plan advocates many of the concepts of managed competition, but it does not recommend what many economists believe is the strongest incentive for consumers to make smart economical choices when selecting their health insurance coverage—a limit on tax-free employer contributions set at about the level of the price of the lowest-priced plan that meets federal standards.
  
- È Another contentious issue is price control. Obviously, weakened market incentives will translate into less cost containment. President Clinton selected another option, a comprehensive system of federal price controls on premiums, to achieve the plan's extremely ambitious cost containment goals. In recent years health insurance premiums have been rising at 10% to 15% annually. By 1996, under the Clinton proposal, health insurance premiums would be allowed to rise by no more than the consumer price index, around 3%, plus a cushion of 1.5%. By 1999 health insurance premiums would be allowed to increase by no more than the CPI. These price controls would be the first line of attack, not a mere backstop as advertised, and there's no country in the industrialized world that has been able to constrain the growth of medical care expenditures at anything near the level that the President is proposing. Within the American context, the main problem with price controls is that this nation's experience in a variety of industries shows that they are ultimately ineffective. Price controls lead to wasteful economic decisions. Uniform proportion premium increases would reward the fat and punish the lean.

## **The Evolving Health Care System**

I am writing a series of pieces for *The New England Journal of Medicine* about the U.S. health care system. I find that while Washington's emphasis is clearly on the reform activities of the

Clinton administration, rapid changes are already occurring at the delivery level, to which Washington policy makers may be largely oblivious.

The change agents vary by market and region of the country. In my observation, there is no established pattern. The agents of change include:

- health insurers who are administering plans and transitioning into managed care;
- employers who pay for care;
- and providers who are seeking to insure their institutional survival or their individual survival, as well as their own incomes and livelihoods.

The basic transformation that is occurring all over the country is a shifting of financial risk from the payers of care to the providers of care in a variety of ways. Fee-for-service medicine is giving way to care that is financed through capitated fixed-monthly premiums for a comprehensive set of medical services. Hospitals and physicians are reorganizing and integrating their professional relationships in order to provide services on this basis. These changes in the status quo are profound and may be equally important to the changes wrought by legislative reform. The organizational changes that are occurring at the delivery level, through private sector decision making, perhaps aided by the rhetoric of Washington, are striking. Traditionally physicians and hospital have been at best reluctant partners in an uneasy relationship because doctors act independently within the hospital. Even though physicians' decisions account for a large fraction of hospital expenses, it is hospital administrators who are largely responsible for their institutions' financial liability.

Beyond a variety of federal policies that are placing new financial pressures on this relationship, the development that is pressing most forcefully on hospital-physician relationships is the shift to managed care, promoted particularly by the private payer. Indeed, over the last 20 years or so, while the federal government has exhorted and encouraged people in the private sector to turn to managed care, it has done a rather dismal job of structuring Medicare and Medicaid to encourage beneficiaries of those programs to enroll in managed care. But that's coming.

One of the most interesting studies of this movement to managed care was conducted by the University Hospital Consortium, a group of 61 university-based teaching hospitals.<sup>1</sup> The consortium recently constructed what it characterized as a market-evolution model that identified

---

<sup>1</sup>For a summary of this study, see John K. Iglehart, "Health Policy Report: The American Health Care System—Teaching Hospitals," *The New England Journal of Medicine* 329 (14): 1052-1056 (September 30, 1993).

*Herbert Lourie Memorial Lecture on Health Policy*

a four-stage process by which managed care becomes the dominant model of delivery and financing in a community. Tables 1 and 2 depict the various stages and indicators of evolution.

In Stage I, the term “unstructured” describes the traditional fee-for-service system in which there is virtually no managed care, and HMO penetration is less than 10%. It is the system as it evolved privately in our society on a laissez-faire basis. Syracuse, New York, is a member of the University Hospital Consortium, and was described as at Stage I at the time of the study.

Stage II is a loose framework which emerges around the development of health maintenance organizations, affiliation of hospitals into provider networks, and greater interest by payers in manipulating and influencing the system. This stage is characterized by the proliferation of health maintenance organizations (HMOs) and preferred-provider organizations (PPOs), formation of the first provider “networks,” bed capacity declining uniformly across competitors, and managed care penetration or enrollment in HMOs somewhere between 10 and 30%. Pricing begins to change: discounting becomes important, basing prices on per diem payment also becomes more important, and fee-for-service begins to dwindle.

Stage III is a period of great turmoil in the system, during which HMO enrollment accelerates, primary care physicians have a central role in managing health care resources, the use of specialists diminishes, and physicians' fees are heavily discounted. In addition, managed care or HMO enrollment grows to somewhere between 30% and 50%.

Finally, in Stage IV of the market-evolution model, we have integrated hospital-physician systems which compete to provide comprehensive services to a defined population of eligible enrollees. Using this particular model the researchers identified only the Twin Cities of Minnesota as having arrived at Stage IV, where at least half of the people are enrolled in managed care plans, there are fewer HMOs, there are fully integrated systems of providers and also integrated systems, or at least solidified, provider-payer alliances. There is some direct employer-provider contracting, which means taking the middleman, in this case the insurance carrier, out of the equation. Pricing changes to cost per covered life per health system. The basis of purchasing changes, and the basis of competition becomes partly price and partly outcomes, although the outcome measures are crude at best, but evolving.

This market-evolution model is significant because it documents that health care is being transformed throughout the country, in markets large and small, through managed care—without federal legislation. The chief distinguishing characteristic is the pace of change.

Health care markets are evolving all over the country, and one of the important things to remember about this evolution is that it seems to be inexorable. Once a community begins moving down the road to managed care, the forces at work are such that there is no turning back. Thus



far, no community has returned to a lower percentage of enrollment in managed care than in the previous year.

To compete in the future, hospitals will be forced to squeeze their costs, place a new priority on primary care, and become part of an integrated health care system that enrolls patients on a capitated basis. I was surprised, while researching the teaching hospital, that this evolution is starting to occur with teaching institutions. Over the past years they have been the most resistant, I think, to basic change, and have remained very resilient—they've been able to maintain their cash flows, been able to continue business pretty much as usual—but that is changing.

To add to the pressures applied by payers, hospital administrators are also being influenced by new technologies that are moving patients out of the hospital and into ambulatory care settings. Between 1981 and 1991, according to American Hospital Association data, total annual admissions to community hospitals dropped from 36.5 million to 31 million. The financial consequences of this decline were softened considerably because virtually all these hospitals realized explosive growth in outpatient visits, surgical procedures, and revenues. In a recent survey, hospital administrators predicted that by the year 2000 hospitals will derive half of their net patient revenues from outpatient services. There are many different medical specialties that have participated in this shift to outpatient surgery: ophthalmology, podiatry, gastroenterology, dermatology, internal medicine, and plastic surgery. Outside the hospital there has been substantial growth in the number of freestanding, ambulatory surgery centers and other ambulatory care centers and diagnostic imaging centers.

Let me refocus for a moment on the medical profession. One of the underlying changes which is already taking place, particularly in the private sector, and which is a main tenet of most government reform proposals, is to place providers at greater financial risk, based upon their professional behavior. But when you reverse the incentives in this fashion you may also place the patient at risk. It has struck me, as the debate has unfolded, how little reflection there has been on this reversal of incentives for the provider.

Under fee-for-service, doctors are compensated based on the amount of services they provide to a patient. When you reverse that, you impose on the physician-patient relationship a fixed, capitated monthly premium, where the physician or the health plan with which he or she is affiliated contracts to be responsible for taking care of patients for so much per member per month. Obviously, the physicians and/or the health plan are placed at risk financially for providing care as negotiated and contracted, in a legal sense, to that patient during that period.

About twenty years ago, when Congress was debating what became the Health Maintenance Organization Act of 1973, one of the major issues which was particularly articulated by organized medicine, but also shared by members of Congress, was what would happen to the quality of care if indeed the incentives were reversed—what would happen to the behavior of the doctor and

*Herbert Lourie Memorial Lecture on Health Policy*

what would happen to the patient in terms of the care that he or she received? Today we hear very little of that talk. I can't say that I've heard one person mention it in Washington, either the American Medical Association or a legislator. Twenty years ago the American Medical Association in effect said, "fee-for-service today, tomorrow, forever." You no longer hear that kind of sharp-edged rhetoric coming from the AMA either. Clearly things are changing.

Marcia Angell, executive editor of *The New England Journal of Medicine*, has labeled this changing relationship that physicians are facing today as placing doctors in the role of "double agents," agents for their patients and agents for society. Under this emerging model, physicians are expected to decide whether the benefits of treatment to their patients are worth the costs to society. Every doctor must decide whether he or she is comfortable with this fundamental change in role. We seem to be moving toward a society that expects the doctor to become a double agent in terms of prudently considering costs. We ought to give that one a lot of thought, because it clearly changes the nature of professionalism. In one way, it says that we hold physicians to be professionals above all else, that we as a society are comfortable with putting the doctor in this role, and are comfortable with the notion that his or her professionalism is strong enough that the risk to the patient-physician relationship is acceptable. I think that is an open question about which there appears to be very little discussion in Washington.

The late social reformer Wilbur Cohen used to say that America takes bold new social strides every thirty years. He included the enactment of Social Security in the mid-1930s and the passage of Medicare and Medicaid in 1965 during the Great Society era. If that is indeed true, 1995 or thereabouts may well be the year that the United States joins the community of nations in universalizing access to medical care.

**Table 1. Four Stages of Market Evolution by Which Managed Care Becomes the Dominant Method of Delivery and Financing in a Community**

	<b>HMO Penetration</b>	<b>Pricing</b>	<b>Basis for Purchasing</b>	<b>Basis of Competition</b>
<b>Stage I: Unstructured</b>	<ul style="list-style-type: none"> <li>• Dominated by major indemnity insurers</li> <li>• Few provider "systems"</li> <li>• Long-standing power of teaching and university hospital</li> </ul>	Fee for service	Encounter, cost of claim	Service, technology
<b>Stage II: Loose Framework</b>	<ul style="list-style-type: none"> <li>• Proliferation of HMOs/PPOs</li> <li>• Beginning formation of provider "networks"</li> <li>• Bed capacity declining uniformly across competitors</li> </ul>	Discount, per diem	Encounter, cost of claim	Service, technology
<b>Stage III: Consolidation</b>	<ul style="list-style-type: none"> <li>• Shakeout of marginal players</li> <li>• Emergence of a few dominant HMOs</li> <li>• Formalized "systems" developing</li> <li>• Provider-payer alliances forming</li> </ul>	Per diem, per case, physician capitation	Cost per covered life per health plan	Price
<b>Stage IV: Managed Competition</b>	<ul style="list-style-type: none"> <li>• Fewer HMOs in each regional market</li> <li>• Fully integrated systems</li> <li>• Solidified provider-payer alliances</li> <li>• Direct employer-provider contracts</li> </ul>	Cost per covered life per health system	Beneficiary health status, total health care cost	Price/outcomes

HMO = Health Maintenance Organization; PPO = Preferred-Provider Organization; IPA = Independent Practice Association.

**Table 2. Market-Evolution Indicators\***

Each stage has distinct identifying characteristics. Early stage markets may have characteristics that span several stages, whereas the characteristics tend to align more completely in advanced markets.

	<b>Employers</b>	<b>HMOs</b>	<b>PPOs</b>	<b>Providers</b>	<b>Physicians</b>
<b>Stage I: Unstructured</b>	<ul style="list-style-type: none"> <li>• Purchase from major indemnity insurers</li> </ul>	<ul style="list-style-type: none"> <li>• 0% – 10% penetration</li> </ul>	<ul style="list-style-type: none"> <li>• Emergence of plans</li> </ul>	<ul style="list-style-type: none"> <li>• Long-standing power of teaching and university hospitals</li> <li>• Few provider "systems" of any kind</li> </ul>	<ul style="list-style-type: none"> <li>• Independent practice</li> </ul>
<b>Stage II: Loose Framework</b>	<ul style="list-style-type: none"> <li>• Coalition formed to evaluate providers</li> </ul>	<ul style="list-style-type: none"> <li>• 11% – 30% penetration</li> <li>• Lead HMOs emerge</li> </ul>	<ul style="list-style-type: none"> <li>• Proliferation of plans</li> </ul>	<ul style="list-style-type: none"> <li>• Bed capacity declining uniformly across competitors</li> <li>• Formation of provider networks</li> </ul>	<ul style="list-style-type: none"> <li>• IPAs without utilization management (UM)</li> <li>• Prepaid groups develop to serve HMOs</li> </ul>
<b>Stage III: Consolidation</b>	<ul style="list-style-type: none"> <li>• Strong incentives for managed care</li> </ul>	<ul style="list-style-type: none"> <li>• 31% – 50% penetration</li> <li>• Shakeout of marginal players; emergence of dominant HMOs</li> </ul>	<ul style="list-style-type: none"> <li>• Plans narrow</li> <li>• Networks</li> </ul>	<ul style="list-style-type: none"> <li>• Formalized networks developing</li> <li>• Provider-payer alliances forming</li> </ul>	<ul style="list-style-type: none"> <li>• IPAs with UM</li> <li>• Groups rapidly form and grow</li> </ul>
<b>Stage IV: Managed Competition</b>	<ul style="list-style-type: none"> <li>• Direct employer-provider contracting</li> </ul>	<ul style="list-style-type: none"> <li>• &gt;50% penetration</li> <li>• Few HMOs in each regional market</li> </ul>	<ul style="list-style-type: none"> <li>• Plans act like HMOs</li> </ul>	<ul style="list-style-type: none"> <li>• Competing regional provider networks</li> <li>• Solidified provider-payer alliances</li> </ul>	<ul style="list-style-type: none"> <li>• IPAs, physician hospital organizations (PHOs)</li> <li>• Large multi-specialty groups</li> </ul>

\*The UHC has classified the cities in which it has members as follows: Stage 1—Chapel Hill, N.C.; Gainesville, Fla.; Omaha, Neb.; Lexington, Ky.; Toledo, Ohio; Galveston, Tex.; Little Rock, Ark.; Harrisburg, Pa.; Syracuse, N.Y.; Columbia, Mo.; Augusta, Me.; Charlottesville, Va.; and Morgantown, W. Va.; Stage 2—Dallas; Columbus, Ohio; Hartford, Conn.; Philadelphia; Salt Lake City; Cincinnati; Houston; Seattle; Chicago; Atlanta; Birmingham, Ala.; Cleveland; St. Louis; New York; Indianapolis; New Orleans; Oklahoma City; Richmond, Va.; Middlesex, N.J.; Nashville; Pittsburgh; and Newark, N.J.; Stage 3—Sacramento, Calif.; Los Angeles; Orange, Calif.; San Diego, Calif.; Denver; Portland, Ore.; Riverside-San Bernardino, Calif.; San Francisco-Oakland; Milwaukee; Tucson, Ariz.; Worcester, Mass.; Washington, D.C.; Detroit; Madison, Wis.; Boston; Albany, N.Y.; Baltimore; and Fort Worth, Tex.; and Stage 4—Minneapolis-St. Paul.