HMOs, Competition, and the Politics of Minimum Benefits

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OBSERVERS OF FEDERAL POLICY-MAKING HAVE long noted the tendency of policy fads to acquire a long train of fellow travelers and advocates of convenience as they march eastward across the Potomac. Over the last seven years, for example, the national goal of energy independence has been putatively pursued by a mysterious coalition of corn farmers with alcohol stills, supplicants to the Highway Trust Fund, and ailing automotive giants. National security has always been a favorite, justifying everything from welfare steamships to hothouse sugar mills. When added to the drive for "free trade, but fair trade," any Washington lawyer worth his salt can weave a patriotic bunting to clothe even the most humble special interest appeal.

Health care policy, of course, has never been immune from this sort of private interest masquerade. In the 1970s, the push for cost containment was used to whitewash all manner of otherwise antisocial behavior on the part of the government and the various provider groups scrambling for the federal health dollar. Although the Congress has apparently rejected expanded regulatory efforts designed to control hospital costs, it still smiles daily on a wide range of appeals from provider and consumer groups that are justified as cost-reducing measures.

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In the last two years, a new banner has been raised on the federal health policy scene in the form of proposals to inject *competition* into the market for health care financing. Predictably, a wide range of interests have now taken to automatically incorporating an appeal to competition into their justifications for more even-handed (i.e., favored) treatment within the heavily regulated health care delivery structure. Given the novelty of the notion, such efforts have met with mixed success. To date, in fact, the only real victories won under the competition banner have been the growing list of dispensations—such as certificate-of-need (CON) exemption and favorable treatment under Medicare—awarded to health maintenance organizations (HMOs) because of their perceived accordance with the competitive model.

To most observers such legislation is not considered to be of a special interest nature; on the contrary, HMOs, because of their assumption of normal investment risk in the health care marketplace, are viewed as fundamental elements of the brave new world envisioned by competition advocates. The Carter administration, for example, in a position paper on competition and its role in health care, cited its efforts to foster the growth of HMOs as the main evidence of its commitment to the competitive ideal. Moreover, all the empirical evidence available to date in support of the viability of the competitive model is based on experience in those markets, such as Minneapolis and the West Coast, where the establishment of HMOs has generated economic competition between prepaid plans and the traditional fee-for-service (FFS) system. All in all, far from being just a special interest entree for HMOs, the competitive model appears to be inextricably linked to the fate of the HMO movement.

A Market of Competing Prepaid Plans

According to Alan Enthoven, the *doyen* of the "competition" movement, and many other proponents of the market strategy, a market composed solely of competing prepaid health care plans is the best feasible formulation of the strategy. In his view, the market must in fact be biased toward the formation of prepaid plans lest unique characteristics of the market for health care financing render the market strategy unworkable.

First, according to Enthoven, the market for health care services

is fraught with consumer information deficiencies. In order to overcome the inability of consumers to choose between complex presentations of widely differing health insurance offerings, the market should be constrained so as to limit the number of choices to a set of roughly similar plans competing on the basis of price and quality for a standard set of benefits (1980a:81).

This, in turn, will cause the market to tend toward a structure of competing, vertically integrated provider groups. Because competitors will not be allowed to segment the market through product differentiation, only those who successfully control both investment and service utilization will survive. Explicit utilization controls, such as provider decisions to withhold or delay care, will in general be more successful in restraining utilization than more indirect methods, such as copayment requirements or deductibles that are small relative to the total cost of service. Thus, it is anticipated that comprehensive, prepaid plans will emerge the victor in any head-to-head battle with more loosely organized FFS providers once the allowable product offering has been suitably constrained (Enthoven, 1979:2, 1980a:5).

Nor, according to Enthoven (1979:4–6; 1980a:80), are information defects the sole justification for imposing minimum benefit constraints that ultimately lead to market dominance by prepaid plans. In the absence of fairly high minimum benefit requirements, the market would suffer from severe preferred risk selection. That is, low-risk persons would gravitate toward lower-option plans providing only bare-bones emergency coverage, while high-risk persons would gradually sift out into the high-coverage plans. The results would be that the insurance character of the market would be broken, and the cost of providing comprehensive benefits would soon be prohibitively high.

A related problem is that of "free riders," who could be expected to "game" the system if choices were wide and annual changes between plans were allowed. The notion is that those who are well would select low-cost coverages until such time as high-cost elective surgery or treatment were imminent. At that point, they would switch over to a comprehensive plan, receive the needed services at little or no additional cost, and then return to the low-option plan during the subsequent enrollment period. Hence, high-option plans would find themselves experiencing costs far in excess of collected premiums (Enthoven, 1979:2; 1980a:79).

In summary, Enthoven would hold that *only* a market where benefit choices were severely constrained—hence a market that would over

time perforce evolve into a sort of "duelling HMO" model—can introduce competition into health care financing without creating a whole new raft of problems.

Another argument for the competing prepaid plan model of competition has been advanced by McClure (1979, IV:50–59). Noting the traditional tendency of physicians' groups to act in concert on economic issues, he raises the specter of pervasive provider collusion and subsequent market failure, unless steps are taken to prevent the providers in the community from unanimously resisting the efforts of financing plans to effect cost controls. To prevent such collusion, McClure argues that strict limits should be placed on the percentage of physicians that can be involved with any one plan in each HMO area. In addition to the effect of forestalling collusion, of course, such a step would provide a direct stimulus toward a market of competing closed panel health care plans.

These criticisms may be valid, but the legislative future of *competition* is not necessarily bright. It may well prove, as these analyses suggest, that a market of competing prepaid plans offering standardized benefit packages is the optimal form of competition. There is still, however, the question of how to get from here to there. For, while the models with which the competition notion is being sold are, at the least, internally consistent, the same cannot be said of the *political process* through which any solution of this sort would be implemented.

If anything, the track record of the Congress to date suggests that the key design elements of the new market system—the rules by which providers compete—will be the brokered outcome of a process whereby existing market participants will attempt to give as little away as possible in exchange for the opportunities and problems of a more wide-open market for health care goods and services. In such an environment, I will argue, legislation contemplating a market solely composed of prepaid plans along the lines enunciated by Enthoven and McClure is the *least likely* outcome of congressional deliberation over injecting competition into the health care field.

The HMO Movement: Competition with Whom?

One major reason why a market composed solely of competing HMOs is unlikely to be generated by an act of Congress lies in the fact that

HMOs will not be judged in a vacuum, solely on arguments related to the desirability of internalizing investment risk or on the incentives for HMOs to promote preventive care strategies. Rather, they will be judged on the basis of whether their track record to date offers strong and compelling evidence that what HMOs sell is itself so inherently desirable that all other types of competitors should be barred from the race. On this point, the historical record is, at best, mixed.

The HMO movement—or more generically, the development of health care financing on a prepaid capitation basis by a closed panel of health care providers—did not begin as a competitive response to the presence of FFS practitioners; instead it began for the opposite reason: a dearth of other means of providing health care to impoverished or isolated communities.

The modern precursors were born in the slums of the eastern seaboard when mutual aid societies of ghetto immigrants pooled their resources to hire physicians who otherwise would not practice in the ghetto for financial reasons. Although such plans were common in the nineteenth century, they eventually faded away as traditional physicians, in response to the alleviation of poverty in the ethnic communities after the turn of the century, moved into these areas to establish more traditional FFS practices.

The next major growth area for prepaid plans was the physician-sparse West Coast, where the huge influx of workers to man the vital defense industries during the Second World War far outstripped the ability of local physicians to provide needed health care services. Kaiser Industries, for example, faced with a lack of adequate physician manpower to provide care for its imported workforce in its steel plants and shipyards along the coast, sponsored the establishment of Kaiser Plans in Oregon and California, with enrollment at first restricted to its own employees.

After the war, these plans went public and began to effectively compete against the traditional physician community for patients. Yet, the original motive for creation of all of these plans can hardly be described as competition for patients in the health care marketplace. Instead, the plans were at first effective natural monopolies, created because markets abhor a supply vacuum.

In fact, the only prepaid plan of any size created before 1947 in direct competition to traditional practice was the Ross-Loos Plan in Los Angeles, established in 1929. Yet, this plan neither sought nor

achieved a major market share among the insured population; instead, it was content to accept those families willing to eschew the free choice of a traditional physician, offered by other insurers, in favor of the prepaid plan.

The real competitive drive for patients in these markets came, not from the prepaid plans, but rather from the traditional medical community, which viewed the prepaid plans, both from an economic and professional perspective, as threats to continuation of their prevalent mode of practice. The competitive response of traditional medicine proceeded on a number of fronts.

The most common was a long string of probable antitrust violations designed to starve the prepaid plans out of the marketplace. The Oregon State Medical Society, for example, made a habit, until admonished by the Justice Department, of expelling all members of the medical society who did business with the prepaid plans. In general, the professional response, as embodied in the American Medical Association's (AMA) Code of Ethics as early as 1932, was to declare contract practice and competition for patients unethical for a member physician and to discipline transgressions through formal and informal procedures.

It is thus ironic that organized medicine *as a body* entered into a strong economic competitive effort with the prepaid plans by promoting their own prepaid plan alternatives, generally known either as individual practice associations (IPAs) or foundations for medical care (FMC)s, to draw patients interested in prepaid plans away from the HMO heretics. A classic case in point, described by Goldberg and Greenberg (1977), is the competitive response of the local medical society to the entrance of the Kaiser Plan into the Pittsburg, California, area in 1953. Citing Gabarino (1960), they note that Kaiser's decision to appeal to the giant U.S. Steel plant in the area for enrollments produced a hurried decision to form a "Doctor's Plan" to be marketed to the employees before their deciding vote on health benefits selections. The physicians sponsored full-page newspaper ads and even went so far as to park participating doctors and their wives in the company parking lot to leaflet the membership, augmented by a sound truck exhorting the employees: "retain your family doctor"; "don't be a captive patient." In the end, the fact that the "Doctor's Plan" lost the deciding vote by a 4 to 1 margin does not diminish the obvious competitive zeal of the traditional medical community.

At about the same time, the desire of the Kaiser Plan to dilute

criticism from the traditional medical community induced it to undertake a number of seemingly competitive ventures. First, it instituted a requirement of "dual choice," whereby the Kaiser Plan would only be offered to employees if the employer also agreed to offer a second plan giving employees the option of selecting FFS practitioners. This backfired to a certain extent because it allowed dominant FFS insurers to effectively freeze Kaiser out by refusing to have their plans offered as a choice alongside Kaiser. For example, in Portland, Oregon, the Oregon Physician's Service, the local Blue Shield plan, simply refused to participate in dual-choice arrangements; while the competing Blue Cross plan would participate only if it was guaranteed a 75 percent enrollment share.

A second effort, generated by the active refusal of many hospitals in HMO plan areas to provide admitting privileges to HMO physicians, was the decision by Kaiser to build its own hospitals instead of relying on local facilities used by FFS practitioners. While both these actions are consistent with the notion that Kaiser was attempting to solidify its competitive position in the marketplace, the alternative hypothesis cannot be rejected: that the decision by Kaiser and other large HMOs to draw back into their own facilities and, in the Kaiser case, to eschew head-to-head competition with FFS insurers for total employee group enrollment evidenced a desire to de-emphasize *economic* competition between prepaid plans and the traditional sector in favor of an enhanced promotion of the differences between prepaid plans and the traditional sector in terms of *medical practice style.* As Goldberg and Greenberg (1977:78) note in describing the California market:

> In some respects, for instance, Blue Cross competes more vigorously with Blue Shield than it competes with Kaiser since Blue Cross and Blue Shield must compete initially for the designation of the employer's health insurance offering. It is also interesting to note, however, that Kaiser generally does not react to any competitive response Blue Cross might make because Kaiser already offers comprehensive benefits and reviews carefully hospital admissions and length of stay. Furthermore, Kaiser has a policy against advertising and charges what it believes to be the lowest premium consistent with its standard of medical care.

This approach to competition on the part of Kaiser, and to a certain extent the other large, established HMO plans, provides the key to

analyzing the likely fate of HMOs under a relatively unconstrained regime. For unlike the FMCs, IPAs, and other physician-sponsored HMOs that have sprung up in response to Kaiser, Group Health, and other major prepayment plans, the traditional HMOs refuse to meet head-to-head on price with traditional insurers; rather, they effectively compete against the entire fee-for-service system via product differentiation.

The rationale for the sort of competition preferred by the traditional HMOs is captured nicely by Christianson (1978:1):

> The notion that competition among health care providers can help control costs would seem to contradict the historical evidence. In the past, competition among providers for patients has contributed to the excessive performance of surgery, the proliferation of expensive and underused equipment, and the construction of excess hospital beds [citation omitted]. Since these and other outcomes of "provider competition" have contributed to rising health care costs, why should competition between traditional providers and alternative organizations for delivering care, such as HMOs, now be encouraged?

The answer, according to Christianson, is that this second sort of competition "can restructure the incentives and influence the decisions of traditional participants in the medical care marketplace to the benefit of business and other consumers." Thus, as HMO advocates Ellwood, Malcolm, and Tillotson (1979:1) conclude:

> The competitive health system strategy requires three main elements:
> —creating forms of health delivery systems that are more efficient than the present system, and that are hence able to compete on price, benefits, access, and style of medical care;
> —such units must be installed across the country; and
> —once the majority of health care providers in any given community are involved in competing alternative delivery systems, the workability of the approach can be evaluated.

Thus, they came down squarely on the side of a finding of inherent desirability in the HMO style of practice. Moreover, they effectively concede that a wide-open market for health care financing, unless operated under the sort of constraints proposed by Enthoven and McClure, would fail to generate the desired competition model in

the natural evolution of things. That is, the proposed constraints, whether or not they are sufficient conditions for the establishment of a market of competing prepaid plans, are at least necessary conditions.

In order for the Congress to accommodate this vision, then, it will be forced to rig the rules of any competitive game in order to ensure that prepaid plans win. Given the likely resistance of other groups (e.g., traditional insurers, hospitals, and physicians), it would take a strong conviction on the part of the Congress that prepaid health care delivery had intrinsic merits. To date, the history of federal involvement in the HMO movement offers little evidence that such a conviction will soon materialize.

HMOs, Competition, and the Congress

The congressional fascination with HMOs began during the Nixon administration, as the result of that administration's frantic search for a method of appearing to deal with exploding costs under Medicare and Medicaid without atypically resorting to heavy-handed, sector-specific cost control regulation.

HMOs, at least in theory, filled the bill nicely. They were private enterprises, at risk in the free marketplace, and held out the promise of keeping the politically powerful traditional medical practitioners in line with a decentralized barrage of good, clean Republican competition. Yet, because of their reformist aura, they could be sold to a Congress drifting increasingly leftward due to the political polarization attendant on the administration's other preoccupation, Vietnam. In fact, in Nixon's special health message to the Congress in February of 1971, touting HMOs as the solution to the problem of rising medical care costs, the word *competition* is conspicuously absent. Instead, Nixon extolled their potential as a "new method for delivering health services," characterized as having a "strong financial interest in preventing illness." The proposed demonstration projects designed to test their effectiveness under a dual choice model would generate a "health care supermarket" in which the notion that there were economies of scale in the group practice of medicine could be tested. By 1973, when legislation effecting Nixon's proposed demonstration program was imminent, the rhetoric grew bolder: HMOs were now

a "promising innovation of group medical centers" that would ultimately "reform the health care delivery system."

Even while debating the HMO demonstration program, the Congress had already enacted legislation allowing HMOs into mainstream federal health policy by establishing a favorable arrangement for prospective payment of HMOs enrolling Medicare and Medicaid beneficiaries. The *quid pro quo* at that time, of course, was that HMOs were subjected to facilities review and approval under Section 1122 of the 1972 Social Security Act Amendments. In the same year, the Senate passed and sent to the House a bill that went far beyond the administration's original proposal, calling for $1.3 billion to launch a full-scale commercialization project for HMOs and other prepaid plans.

The House, accepting for the moment the administration's conviction that such an effort was far too costly, failed to consider the measure; and it died when the Ninety-Second Congress adjourned.

By 1973, however, the House was ready to go to work and produced a bill modeled more closely along the lines of the original administration proposal. Yet, several new wrinkles crept in, setting the stage for a debate that continues to this date. In its efforts to make the bill more flexible, the administration was pushing for the broadest possible definition of an organization eligible for assistance in order to promote diversity in plan structure (and, not incidentally, to open the door for assistance to physician-sponsored plans, lest the AMA and its legislative muscle derail the entire effort).

The Congress, however, urged on by such groups as the American Public Health Association, approached the bill like a committee bent on designing a horse and produced a far narrower definition of a "qualified HMO" than the administration had hoped for. The bill produced by the House-Senate conference committee established a definition of an eligible plan that was so restrictive only some 20 of the 133 extant HMOs would qualify. The balance were relegated to the lesser status of "health service organizations" and "supplementary HMOs," whose access to the federal funds—and to the highly important overrides of troublesome state laws—was sharply restricted compared with the benefits attendant on federally qualified HMOs.

This outcome was probably the result of the high degree of confusion then prevalent over what HMOs were, what the bill was likely to do, and what the future direction of federal efforts affecting the overall

delivery system would be. For example, the Senate committee report on the bill states the objective of the legislation as an effort to "increase options available from the point of view of the consumer" but "not . . . to remake the delivery system." Yet, paradoxically, the committee believed that HMOs would in the future "largely eliminate many of the problems presented by the prevalent fragmented solo practice model."

A second seeming paradox is found in the bill's treatment of the copayments question. The HMO Act allows federally-qualified HMOs to require only nominal copayments for covered services. Copayments, of course, are instituted for the sole purpose of introducing price sensitivity—i.e., price rationing—to services that might otherwise be overutilized. Yet, the report explicitly states the intent of Congress that such copayments should be "no barrier to care"; instead, they were "solely a device to enable an HMO to market its benefit package at a competitive price." The net effect of this provision was to proscribe copayments as a means of controlling utilization but to condone them as a sort of under-the-table premium increase for qualified plans.

The Congress did, however, seem to have an inkling of the likely natural market outcome of its experimental delivery system, as demonstrated by a reference to the distinction between qualified and "supplemental" HMOs. The committee argued for its decision not to provide the latter with start-up funds on the grounds that they would occur naturally in the marketplace without help; qualified plans meeting the committee's specifications, on the other hand, were not expected to survive without significant direct federal support.

Thus, far from being interested in the potential of HMOs for generating competition, the Congress was instead attempting to outwit the normal functioning of a competitive marketplace and install in the field its own horse, which, while more reminiscent of a camel, was nevertheless expected to win the race with liberal applications of financial dope. Subsequent federal efforts in the HMO arena lend credence to the view that despite the rhetoric, federal efforts to promote HMOs have precious little effect in promoting competition in the marketplace.

In 1979, for example, the Health and Environment Subcommittee of the House Interstate and Foreign Commerce Committee produced and pushed through the House a bill reauthorizing the Health Planning Act. The most controversial feature of the bill was a section

providing a sweeping exemption from certificate-of-need laws for all "providers of ambulatory and inpatient care on a prepaid basis." This broad exemption was justified by its sponsor, Congressman W. Philip Gramm (D-Texas), in the name of competition; i.e., that the degree of investment risk assumed by HMOs and other such plans was, due to the normal operation of market forces, an effective discipline against overinvestment in facilities and equipment, obviating the need for a surrogate regulatory discipline.

The broadness of the definition of an entity eligible for the Gramm Amendment exemption was not unintentional. It held out the promise that any health care financing entity which assumed risk for its own investments could effectively exit the regulatory maze of facilities franchising and compete in the open market. By further exempting from CON (certificate-of-need) requirements the activities of non-HMO hospitals that provided services primarily to such providers, the Gramm Amendment language was, in effect, a procompetitive loophole through which a truck could be driven.

While the broad language of the Gramm Amendment survived the House, it proved too much for the House-Senate Conference Committee, which severely restricted the exemption's scope by allowing the exemption only for HMOs with enrollment in excess of 50,000 persons. Only a handful of HMOs—notably such giants as Kaiser, Group Health Association of Puget Sound, the Health Insurance Plan of New York, and the other long-established traditional HMOs—were thus released from the market entry barriers of the certificate-of-need laws. The balance, including new plans that might start up to compete against the established HMOs, remained subject to the CON entry restraints.

In fact, it could be argued that, given the persistence of CON requirements for new prepaid plan entrants, the 1979 Health Planning Act exemption, far from being procompetitive, granted the traditional HMOs a major new tool to preempt the field in those areas in which they were already established, obviating the need for whatever new HMO-style entities might otherwise materialize in competition.

The Minimum Benefits Route

The contention that the Congress would willingly bequeath the entire market for health care services to competing prepaid plans is very

difficult to support based on this history. While halting steps have been made in the direction of promoting HMOs that might not otherwise arise, these efforts have been justified more in terms of remedying prior discrimination against prepaid plans than because they are preferred competitors per se (see, for example, Goldberg and Greenberg, 1977).

It is possible, however, that during the course of consideration of legislation to promote competition in medical care markets, the Congress might unconsciously predispose the market toward the competing prepaid plan model by imposing either high minimum benefit requirements or outright benefit package standardization. As noted earlier, the inability of financing entities representing loosely organized FFS providers to constrain service utilization to the level achieved by prepaid plans could place them at a decided disadvantage over time.

Enthoven would argue that this would be a desirable outcome. Enthoven (1980a:45–50) distinguishes the practice styles of FFS practitioners and prepaid plans as the tendency of FFS providers to perform services that increase costs in excess of marginal benefits. Thus, unless FFS practitioners could adjust their practice styles to the utilization levels experienced by prepaid plans, he would argue that FFS plans should *not* survive in a cost-conscious competitive market.

Here, I believe, lies the crux of the problem. In essence, Enthoven argues that many of the amenities that accompany the FFS practice system today—such as short waiting times for services; free choice of physician and hospital; and the exercise of individual preferences respecting, for example, decisions of whether or not to hospitalize—bear costs far in excess of their true utility to consumers. As such, they are quirks of the current incentive structure rather than the outcome of conscious consumer choice.

An apposite view would be that this thesis should be put to the test in the marketplace. Stockman (1980) has argued that failing to allow individuals to choose among a wide range of different delivery modalities and practice styles would forestall the tremendous potential for innovative approaches to health care financing that might otherwise arise. Moreover, he argues that these amenities have, in certain instances, positive value for consumers.

The trade-off then—if there is one—is between different sorts of costs associated with different market formulations. On the one hand, a wide-open market with only minimal benefit package constraints

would promote provider innovation. The standard benefits market, by contrast, would forestall many of these innovations, which would largely result from product differentiation. On the other hand, the wide-open market would induce individuals to sort themselves out to some extent on the basis of perceived risk and degree of risk aversion. In such a market, Enthoven argues, comprehensive benefit plans could not survive (1980a:79).

The question, then, is whether the costs associated with obviating product innovation are greater or less than the costs associated with creating a bias against plans that offer relatively comprehensive benefits. Interestingly, the Congress has, at least to date, tended toward the view that comprehensive benefits per se are a more desirable feature than freedom for innovation. As the record shows, however, this congressional tendency generates additional costs that must be factored into the equation.

Minimum Benefits and the Congress: Medicare and Medicaid

Posturing about comprehensive national health insurance aside, the Congress has shown a bias toward expansive definitions of allowable benefits under those programs where the federal government has control over benefit specifications.

Since at least 1950, the Congress has been hard at work adding ever wider benefits to government-financed health programs. The original Aid to Families with Dependent Children (AFDC) program, enacted in 1935 under the Social Security Act, contained a simple income disregard for the amount of bona fide health care expenditures, i.e., expenditures for health care were deducted from the income of families in determining eligibility. In close cases, this practice effectively passed through, dollar-for-dollar, the health care spending of the poor. The Social Security Act Amendments of 1950 converted spending for medical care for the poor to a vendor payment system. Thus, rather than merely passing through medical care expenditures, the Social Security system made direct payments to health care providers for needed health care services for the AFDC-eligible poor. In 1960, the Kerr-Mills Act expanded both benefits and eligibility under the vendor payments program, including, for the first time, low-income aged persons without children in the home. Six years later,

this program was dramatically expanded by the enactment of Medicare and Medicaid.

As originally conceived, Medicare was to be simply a program of hospital insurance for the aged. By the time it emerged from the House of Representatives, however, physicians' services were also covered. The Medicaid component, calling for a sweeping program of medical care services to low-income Americans, was also added by the House version. Since enactment Medicare has been amended seven times, and Medicaid nine times. In each instance, either eligibility has been expanded or required benefits have been substantially upgraded.

In 1968, Medicare benefits, originally covering ninety days of hospitalization annually, were upgraded by adding a *second* ninety days of coverage, called the "lifetime reserve," upon which the aged could call in any given year if the original ninety-day coverage was exhausted. At the same time, Medicaid was amended to include the "early and periodic screening, diagnosis, and treatment" (EPSDT) program, a major effort to provide a full range of comprehensive care to eligible children.

Shortly thereafter, in 1972, two large new blocks of eligibles were added to Medicare—those receiving disability insurance and those with end-stage renal disease. In addition, those receiving Supplemental Security Income, except in certain instances, were made eligible for Medicaid.

During the balance of the 1970s, virtually every Congress has added on to this growing laundry list of coverages and benefits. Chiropractors' services and the services of podiatrists are allowed in many instances. Psychiatric services have been expanded widely, particularly in Medicaid, and optometrists, skilled nursing facilities, and dentists have been able to have their services added on to the list.

Even in the budget-conscious 96th Congress, efforts were made to add to the federal programs laundry list. Legislation passed the House calling for, among other things, the expansion of both eligibility and mandatory services for children under Medicaid, the addition of the treatment of planter's warts, the provision of pneumococcal vaccine, new home health benefits, expanded dental services, ad infinitum. When budgetary considerations threatened enactment, the ingenious ploy of loading in benefit additions to the Omnibus Budget Reconciliation Act—the bill designed to reconcile spending with budget

totals by *reducing* federal outlays—nearly succeeded. In the end, a number of the proposed additions survived the House-Senate conference on the budget.

The Implications for Legislation to Promote Competition

The most direct indication of the unfortunate congressional tendency to load up the cart with new goodies is the Health Maintenance Organization Act itself. In order to qualify for federal subsidies and the boon of "dual choice" requirements for employers, "qualified HMOs" must offer an incredible array of services, including extensive mental health coverage, treatment for alcohol and drug dependency, home health services, family planning, infertility services, and optometry services for children. To the extent that few, if any, other insurers offer anywhere near this package, federally qualified HMOs often find themselves, despite cost-reducing utilization patterns, at a severe competitive disadvantage. In fact, many have held out the benefit requirements of the HMO Act as one of the major impediments to the nationwide development of health maintenance organizations. Even advocates of a market of competing prepaid plans, notably McClure (1979, IV:120–121), have commented on the disadvantages of too narrow a definition of elegible entities and benefit offerings.

Given this tendency on the part of the federal government to promise all things to all people, those who promote high minimum benefits or standardized packages must be given pause. For over and above the questions of the potential for market innovations and of whether wider choices would offer consumers greater utility (for an excellent discussion of this point, see Meyer, 1980:7–10), there is the plain political question of whether Congress, faced with the task of determining what the minimum package would be, would so load up the requirements as to make the task of financing health care fabulously expensive.

To be sure, Enthoven (1980a:143–144), among others, is not unaware of this potential problem. He notes that a means must be found to minimize the "gatekeeper" role of government in this and other respects. Yet, this problem is not merely a technical design point that can be forever resolved during consideration of enabling legislation. For, if the government is given a determining role in

deciding what the market shall offer, it will retain that right in perpetuity. Moreover, as the evidence to date shows, it will not fail to exercise that right frequently in the name of equity, i.e., constituency-group appeasement.

The Stakes Are Far Too High

If anything, legislating minimum benefits in a program that covers all Americans will have a far more pervasive effect than the experience to date in Medicare, Medicaid, and the HMO Act. The great majority of competition schemes envision that whatever qualifying requirements are enacted for plans will, by virtue of leveraging the Internal Revenue Code and the Social Security Act, become a blueprint for virtually all saleable health insurance in the United States.

Faced with such a prospect, the various provider constituencies—and the victims of peculiar diagnoses known affectionately on Capitol Hill as the "Disease-of-the-Month Club"—will be motivated by more than sheer convenience or desire. They will be motivated by the impulse for survival. For to be left off the minimum benefits list will be, perforce, to shift for themselves in a world where whatever federal preferences they now have will be dissolved. To chiropractors, podiatrists, psychologists, naturopaths, faith healers, and other practitioners outside the "physician" umbrella, getting into the game via congressional mandate will make the difference between prosperity and perpetual fringe status.

It is possible that the heavy political pressure of the traditional organized groups and institutions—including, of course, the HMOs, who have not been notorious for welcoming mandates to include nontraditional providers—will keep these groups off the list for a time. Yet, sheer economic necessity will force these groups to return again and again until they are finally successful. Arm in arm with those desperately needing kidney dialysis, interferon treatments, and every other imaginable group of "outs," they will form a coalition to force reopening of the minimum benefits question. Eventually—and inevitably—the wheel will be greased.

The "Third Best" Options

Given this political reality, it may well be time to set aside the pursuit, among health care theorists, of the optimal "second best"

market structure—of either the constrained market form preferred by Enthoven or the regulatory "second best" promoted by such commentators as Altman and Weiner (1978). Instead, it may be necessary to turn to a "third best," from which can be distilled a solution that provides for some constraints on adverse selection and free riders; some constraints on plan innovation and product differentiation; some bias against FFS solo practitioners; and some risk that, left to themselves in an open system, the American people may spend more, rather than less, on health care.

Unless such an accommodation is reached, the result of pushing procompetition legislation through the Congress may well be far different from what the proponents anticipate. Either the legislation will melt under the heat generated by warring factions, or else whatever market-based incentives the approach might generate will be buried under the special interest trophies won in the competition for inclusion on the minimum benefits list. It is hard to see how either outcome would be an improvement over the present morass.

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