On Public Values and Private Regulation: Some Reflections on Cost Containment Strategies

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PUBLIC POLICY DEBATES IN THE HEALTH CARE field continue to consider alternative strategies for cost containment. Participants generally agree on the need to control cost, particularly to achieve other objectives of the delivery system.[1] There also appears to be general agreement on the root causes of rapid cost increases (Fuchs, 1974; Enthoven, 1978a; Enthoven, 1980). There is less agreement on solutions or, more modestly phrased, approaches to the cost problem. While some commentators would propose other alternatives (McNerney, 1980), the two principal approaches now discussed are regulation and competition. The competitive models are referred to in this paper as "incentive systems" or "incentive approaches." The two are briefly described as follows:

1. *Public Regulation.* A strategy begun in the late 1960s and early 1970s, this includes such efforts as certificate of need, budget review, and other general rate-setting programs; the introduction of cost

[1] See, for example, the Overview section of the Introduction to the National Guidelines for Health Planning, appearing at 43 Fed. Reg. 13040 (28 March 1978).

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containment techniques into methodologies used by particular third-party payers such as Medicare and Medicaid; and utilization review, particularly as conducted by quasi-governmental bodies such as professional standards review organizations. The current policy debate includes discussion of the effectiveness of the public regulatory approaches and the utility of continuing them in current or modified forms (Havighurst, 1977; Weiner, 1978; Havighurst, 1978).

2. *Incentive Systems.* This strategy involves modifying or eliminating incentives for costly economic behavior in the purchase of health services, such as the tax treatment of insurance premiums. It further calls for application of techniques to encourage price competition, not among direct providers of service, but among organizational arrangements with responsibility for financing and providing services. These arrangements will be referred to generally as "plans" throughout this paper. Health maintainence organizations represent the most extensive current realization of this alternative. Incentive approaches generally entail some features analogous to those of health maintenance organizations (HMO) (Christianson and McClure, 1979; McClure, 1979; Enthoven, 1978b; Enthoven, 1980).

Planning, as represented by the process established under P.L. 93–641, the National Health Planning and Resources Development Act of 1974, as amended, is sometimes considered a third major cost-containment strategy. However, it seems more realistic to see the planning process, given its current legal structure and authority, as an adjunct to either or both of the other strategies. There is great interest, for example, in the role planning can play in public regulatory programs, both certificate of need and rate setting. Similarly, the 1979 amendments to the federal Planning Act sought to encourage planning agencies to give recognition, where appropriate, to the importance of competition in the organization and delivery of services.[2]

The debate over alternative strategies occasionally takes on religious tones. Because regulation has been the dominant approach to date, proponents of incentive systems may feel it necessary to overstate the benefits of their recommendations. With a growing antiregulatory

[2] 42 U.S.C. s. 300k–2(a)(17) and (b) of the Public Health Service Act, as added by section 103 of P.L. 96–79, the National Health Planning and Resources Development Amendments of 1979.

attitude among the public and in the aftermath of the 1980 elections, support for incentive approaches is likely to grow. The 1980s will probably see a significant effort to reorient public policy away from regulatory and toward incentive strategies.

As the debate continues and efforts to move toward incentive approaches intensify, some perspective is needed. Neither competition nor regulation is to be preferred exclusively. Any single strategy is not likely to be effective in achieving cost containment objectives. However, supporters of incentive systems should recognize that theoretical models must be implemented cautiously, without raising inappropriate expectations about the likelihood of their success. Further, where regulation has been successful, proper acknowledgment is due; and those successes should be built upon rather than ignored. Finally, there should be recognition that public regulation embodies certain significant values which should be retained regardless of the strategy or strategies adopted. Each of these perspective points is considered in more detail in the ensuing sections of this paper.

Ideal Models and Practical Experience

No matter how excellent a proposal appears to be in theory, it will always function less perfectly in reality. Economists particularly, but not exclusively, are used to dealing with "models," ideal constructs which are consummately logical and make perfect sense within a self-contained and insulated system. Translating these models into real-life settings is always more complex than even the most sophisticated simulation modeling would suggest.

Whether frustrating or praiseworthy, people do tend to behave less rationally than one supposes they should. This observation is not intended to discourage the development of models or suggest that they are not useful to public policy. Rather, it is intended to support modesty and caution in predicting outcomes from the application of a particular model. If the ideal does not function perfectly in reality, then discussion of a model's likely impacts and effects must necessarily involve speculation to some degree. In propounding policy positions and strategic alternatives derived from a model, one should therefore be candid about the element of speculation involved.

These observations are valid with respect both to incentive and regulatory alternatives. However, since regulatory approaches have been in actual use for a relatively long time, there is greater understanding of their strengths and weaknesses based on experience. With the possible exception of HMO activities, there is little experience with the actual implementation of incentive systems, so the degree of speculativeness about their effects is necessarily higher than is the case with regulatory strategies.

Experience gained from regulatory programs allows some conclusions about their effectiveness. Sometimes they work, and sometimes they don't; and certain factors seem relevant in determining the success of regulatory outcomes. Among these are the following:

Statement of Objectives. Too complex a set of objectives makes it difficult for regulatory programs to achieve any of them. If a program is to be evaluated based on how effectively it maximizes potentially contradictory objectives, such as cost containment, quality, accessibility, and acceptability of services, the program will not be considered successful.

Whether or not legislative objectives are enunciated with any precision, administrative agencies should be explicit about the goals they pursue within the established legislative framework. Granted, goals can change from time to time and most enabling acts are usually sufficiently broad to allow for that flexibility; but, then, the agency should be quite explicit both about the fact that its goals are changing and about what its new objectives are. Explicitness makes it possible to evaluate the regulatory program in its own terms, using its own measures of success. Critics, in evaluating the effects of regulation, may adopt their own definition of what those objectives *should* be; but, if the agency itself is clear in its statement of intent, it not only forces an examination of those objectives and the efforts to achieve them but also makes it possible and necessary to identify and evaluate the assumptions of critics which may not be shared by the agency (Weiner, 1978).

Review Criteria. Without minimizing the complexity of the behavior of health care institutions, regulatory programs should identify those key factors that are to be the subject of regulatory attention. Too many factors overload the agency's administrative capacity to operate an efficient program and at the same time may involve an unnecessary

intrusion into the management of the institutions themselves. Hospital budget review, for example, should focus principally on bottom-line patient care revenue or cost, without worrying about how the hospital expends its available dollars within individual allowable cost categories (Weiner, 1979a). Similarly, certificate-of-need (CON) programs should focus only on significant cost-provoking decisions and should not expend resources on a multitude of capital or service decisions that are not controversial and do not have significant long-term cost or rate effects (Commonwealth of Massachusetts, 1980). The effectiveness of the program is likely to hinge to a large extent on how well the administering agency can achieve its stated objective with the least amount of direct interference in the internal management decisions of the regulated institution.

Stated somewhat differently, the principal responsibility of cost containment regulation should be limited to establishing an environment of constraint. The regulations of the agency should indicate parameters within which providers function. The precise techniques used by providers within the regulatory constraint—e.g., departmental analysis through systems engineering, reductions in service capacity, introduction of cost-effectiveness analysis to medical procedures—should be a matter of management choice. The regulatory process should be concerned with a greater level of detail only if any of the techniques used adversely affect important public values, for example, if the decision to close an institution leaves the affected population without access to adequate alternative service.

Procedures. With appropriate recognition for due process, regulatory programs should function within relatively limited procedural constraints. Rigid procedural requirements inhibit flexibility in responding to new or changed circumstances. Elaborate procedures also provide opportunities for delay, whether used by affected providers or other interested groups, and could significantly frustrate regulatory objectives. Recent Supreme Court decisions indicate support for allowing administrative agencies substantial flexibility in their procedures.[3]

Comprehensiveness. While functioning within a framework of limited and specific objectives, the broader the program's scope of authority the more likely it is to be effective. Recent research evidence suggests,

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[3] *United States* v. *Florida East Coast Ry. Co.*, 410 U.S. 224 (1973); *Vermont Yankee Nuclear Power Corp.* v. *NRDC*, 435 U.S. 519 (1978).

for example, that CON, a program of limited scope, had tended to be less effective in controlling cost than are hospital rate-setting programs, which directly or indirectly regulate all hospital patient care revenues (Joskow, 1980; Steinwald and Sloan, 1980). Further, implementation of rate regulation applicable only to one or two payers is likely to have less significant cost containment impact than a general charge or budget control program. The broader the program's scope, the less likely the regulated provider is to undertake strategies that favor cost-provoking decisions outside the program's authority (Salkever and Bice, 1976) or that produce inappropriate subsidizations.

Political Support. Experience strongly suggests that, despite apparently general public concern about the cost of health care, there is relatively little political support for cost containment regulation. Such expected natural political constituencies as labor and business have not in fact provided effective support. Indeed, principal political support for cost containment regulation appears to emanate primarily from that part of government responsible for health purchasing functions, such as budget offices or agencies charged with administering Medicare or Medicaid (Weiner, 1979b).

As a consequence, regulatory programs must proceed somewhat cautiously to further their objectives without encouraging significant opposition. The recent experience with budget control in Colorado reinforces the importance of the agency's maintaining political ties to affected constituencies. The difficult questions faced by the administering agency are whether such relationships necessarily convert into a situation of "regulatory capture" and, short of that, what compromises are necessary to maintain program credibility.

These factors, derived from experience, are not exhaustive; nor is this paper the vehicle for elaborating on any of them in significant detail. Their presentation does suggest, though, that the organization and functioning of cost containment programs is more complex, subject to more qualification, and requires more careful strategic thinking than models of regulation might suggest. Early stages of development are not particularly well suited for drawing firm conclusions about a program's efficacy (Biles, Schramm, and Atkinson, 1980). Regulatory programs go through learning curves. A major operational and analytic question is the extent to which experience educates program administration. Willingness continuously to assess program design and undertake redesign is important, although doing it requires a

level of flexibility, both in intellectual capacity and in the availability and deployment of financial and personnel resources, that may be difficult to achieve.

The principles, though, do suggest that regulation should not be discounted as a valuable means for achieving cost containment goals. The experience gained to date in administering regulatory programs points to possibilities for reform that may enhance their effectiveness. Recent evidence of their impact (Biles, Schramm, and Atkinson, 1980; General Accounting Office, 1980; Joskow, 1980; Steinwald and Sloan, 1980) suggests that as they age and understand their ends and means better, they are better able to achieve stated objectives.

By comparison, there has been relatively little experience with incentive alternatives. Ironically, we may already know about most of the problems regulation must face and can therefore begin to develop pragmatic strategies for dealing with them, but we have not yet begun to learn adequately about the operational problems of incentive approaches. Implementation of that strategy will necessarily go through a phase of experimentation, a process of learning about differences between model and reality reminiscent of the development of regulation. In order to avoid frustrating the objective of cost containment, regulation needs to be continued, supported, and improved as seems appropriate during this period. At the same time, adoption of incentive systems should include sufficient ideological flexibility to permit realistic assessments of their strengths and weaknesses. If both strategies share mutual goals, there must be efforts to maintain both as reinforcing devices. The nature of the relationship between the two strategies is discussed in the next section.

Interrelating Regulatory and Incentive Strategies

It is obvious, but worth stating anyway, that the health delivery system is complex and diverse. With so many actors pursuing different objectives and responding to different needs and incentives, it is unlikely that any one solution or strategic approach will be successful by itself in achieving cost containment goals. The complexity of the system, together with the caution and modesty that should attend individual proposals for solutions to the "cost problem," suggests the

need for simultaneous and multiple strategies, with understanding of the mutual relationships and appropriate reinforcement among them.

There is, for example, some recognition that a strategy depending primarily on incentive approaches may require regulatory action to establish the prerequisites for those approaches to function: for example, regulation to stipulate minimum benefits made available through health care plans or to establish tax credits as part of a tax reform proposal (McClure, 1979). There is also recognition that a strategy depending primarily on regulation may implement incentives different from the incentive systems considered in this paper, that is, positive financial incentives to induce cost-saving behavior by providers (Atkinson and Cook, 1980).

Increasing attention, though, is being given to interactions between coexisting regulatory and incentive systems. To date, suggested or attempted definitions of the appropriate relationship between the two have tended to focus on structural issues: how should regulation be structured to encourage the development of incentive approaches? The two principal approaches proposed are as follows:

1. *Incorporating the Value of Competition as a Relevant Consideration in an Otherwise Essentially Regulatory Process.* Both the Utah CON law[4] and the 1979 amendments to the National Health Planning and Resources Development Act[5] include efforts to focus health systems

[4] In 1979 Utah adopted the "Utah Pro-competitive Certificate of Need Act," *Utah Code Annotated,* ss. 26–34–1 through 26–34–21. Section 26–34–2 states: "The legislature also finds that regulation of the growth and development of the health services industry will not obviate the need for maintaining competitive conditions in local markets for health services and for health services financing systems. The legislature also finds that the degree to which competition and consumer choice can constructively serve the public purposes of quality assurance, cost containment and responsiveness to consumers' preferences varies from service to service and place to place. The agencies administering this act shall consider and make findings as to the degree of effectiveness of such forces in adequately protecting the public interest."

[5] 42 U.S.C. s. 300k–2(a)(17) and (b), 42 U.S.C. s. 3001–2(a)(5), and 42 U.S.C. s. 300n–1(c)(11) and (12), as added by sections 103(c) and (d) of P.L. 96–79, the National Health Planning and Resources Development Amendments of 1979.

agencies and state health planning and development agencies on making decisions that encourage competition where it can appropriately function in the health system or at least refrain from discouraging desirable competition. To an extent, though, the support of competition in such structure appears qualified. For example, the planning amendments suggest that, at least within the current structure of the health system, competition is unlikely to be effective in achieving national health policy objectives, which include more than cost containment, within the area of institutional services. The very fact that legislation refers to the need to consider the effect of decisions on competition may be important to highlight and emphasize value preferences for health planning agencies. But unless more precise guidelines are developed to show them how to foster competition or recognize where it can be effective, this approach is unlikely to have more than a limited impact on developing incentive systems.

2. *Exempting Incentive Systems from the Scope of Regulatory Programs.* A second initiative to relate regulation and incentive models is negative in nature: it is expected that resentment of regulation is so high that a promise of exemption will forcefully encourage the development of alternative models. This strategy was also adopted in the 1979 planning amendments, which, with qualification, exempted HMOs from federally-mandated CON programs.[6]

The exemption approach does not, strictly speaking, involve a structural relationship between regulation and incentive approaches. Instead, it envisions two systems functioning in parallel but independently. Further, exemption enticement does not necessarily focus policy development on how to achieve precise changes necessary to permit development of incentive systems. The exemption approach is a passive one; whereas the current structure of the health delivery system requires reliance on active change agents, such as tax reform and antitrust enforcement, to promote the implementation of incentive models.

The exemption approach has a further defect in that it requires identifying with some precision what are the acceptable models to

[6] See 42 U.S.C. s. 300 m–6(b) of the Public Health Service Act, as added by section 117(a) of P.L. 96–79, the National Health Planning and Resources Development Amendments of 1979.

take advantage of the exemption. Without such precision, unintentionally broad exclusions from the scope of regulation may occur. At the same time, such precision may rigidly fix the acceptable models, thereby encouraging the development only of those models which are defined at a given point of time; or the need for precision may require giving over to the regulatory agency itself the flexibility to define exemptions from its own authority, a difficult psychological position for the regulator. In either case, reliance on regulatory exemptions may in fact discourage desirable experimentation with other models or variations.

Because thinking about the structural relationship between regulation and incentive approaches is so new, it is probably too early to draw conclusions about the most appropriate definitions of the relationship. Yet, focusing only on structural aspects of the relationship is probably too limiting. The inquiry is relevant as long as one assumes that both regulation and incentive models can and will coexist in the health system. But, to consider the relationship between the two in more depth, one has to look at regulation more than simply as a programmatic design with certain procedural aspects and anticipated substantive outcomes. Since regulation of health care cost is not a particularly easy political response to a problem, the decision to regulate must represent more than merely a fascination with structure.

The decision to regulate in fact reflects a commitment to a way in which public policy should be made and implemented. Values are implicated in the design and structure of a public regulatory program. They may be imperfectly realized while being implemented, but that does not undermine their significance as goals. In considering the relationship between regulation and incentive systems, the extent to which these values can be realized through the latter system or through some appropriate combination of the two must be examined.

Values in Public Regulation

Three values associated with public regulatory process are particularly significant: political accountability, public participation, and public information. Each is discussed in turn.

Political Accountability

The political accountability of regulatory agencies has been one of the more troubling issues of American administrative law. The federal Constitution, for example, does not provide an independent source for the authority of administrative agencies, as distinct from the Congress, the president, and the Supreme Court. As a result, the legitimacy of decisions rendered by these agencies has been a matter of continuing legal concern (Freedman, 1978).

Intensifying this concern is the virtual inevitability that administrative agencies will be able to exercise fairly broad discretionary powers. The decision to establish such an agency in the first place necessitates mechanisms to hold them accountable in their exercise of that discretion. With those mechanisms in place, when regulation is selected as a means of policy implementation, that choice is accompanied by an assumption that those mechanisms are valuable and useful.

In what way are agencies made accountable for their actions, and what values underlie the way in which accountability is achieved? The traditional structure of accountability involves the relationship among agency, court, and legislature. (More recent efforts to establish accountability directly to the public are discussed, in part, in the sections on *Public Participation* and *Public Access to Information.*)

Judicial review is often considered the principal means of holding agencies accountable. At both the state and federal levels of government, judicial review is available, with narrowly drawn exceptions, to consider final agency decisions or policies (Gellhorn, Byse, and Strauss, 1979; Davis, 1972; Jaffe, 1965). The reviewability of final agency action is presumed. Parties dissatisfied with agency decisions generally seek recourse to the courts, thereby, depending on one's perspective, either preserving the integrity of the regulatory process or further hampering the effectuation of regulatory objectives.

Judicial review, at least in theory, is a relatively limited check on agency action except where clear procedural violations occur. Courts generally express deference to agencies because the legislature has created them to administer programs in complex and sensitive areas of public policy. The agencies are seen to have a level of subject matter expertise not possessed by the court.

Judicial deference to administrative agencies is greatest when the agency is articulating policy. It is common for a court to assert that it will not substitute its judgment for that of the agency as long as the agency is operating within a general grant of legislative authority. Deference is also high where the agency is applying its policy or legal principles, including interpretation of statutory terms, to factual circumstances. In these two areas, judicial review is not a strong and independent source for establishing agency accountability.

The courts feel least bound to defer to administrative agencies where the judges see themselves having at least as much expertise as the agencies themselves: in the determination of legal principles and interpretation of statutory terms. The agency must interpret terms or determine principles in the first instance in order to arrive at a decision. But courts generally reserve to themselves the right to render authoritative conclusions independent of the agency.

What do courts rely on for their authoritative interpretations? Even given the necessarily subjective nature of the task of interpreting the legal framework within which administrative agencies function, courts are principally involved in an effort to determine legislative intent. Underlying this effort is a premise that, since the agencies are created by the legislature, legislative act determines the full scope of their authority. The function of judicial review, then, is principally to determine, using linguistic analysis and legislative history materials as well as other techniques, if the particular action under review is consistent with the scope of legislative authority granted to the agency and is also consistent with the purposes and policies of that grant of authority.

A more explicit expression of the judiciary's view of its responsibility to assure consistency between agency action and legislative intent appears in references to the doctrine restricting the delegation of legislative authority to administrative agencies. Originally, the validity of agency action was measured by the extent to which the agency functioned ministerially, not exercising discretion but executing reasonably explicit legislative directives. The complexity of the problems government needed to address and the desire of legislatures to give agencies more flexibility to handle these problems produced doctrinal revisions allowing greater agency discretion (Stewart, 1975). While acknowledging the realities of modern government, the courts still expect that authority for discretionary decisions can be traced

back to legislative policy and purpose, whether expressed in the statute, in a policy or purposes statement, in committee reports, or even in the administration or history of analogous programs. An excellent example of the techniques by which courts determine legislative intent in the context of a delegation doctrine challenge appears in the *Amalgamated Meat Cutters* case.[7]

The doctrine against delegation has been used to invalidate federal legislative grants of authority only twice—both cases involved the New Deal National Industrial Recovery Act[8]—although one current member of the Supreme Court has proposed using the doctrine to invalidate a provision of the Occupational Safety and Health Act.[9] Nonetheless, courts continue to make reference to the doctrine, probably as a means of underscoring the importance they place on measuring agency policies and actions against legislative policies and purposes. Identifying legislative intent may on occasion be no easy task given the proclivity of legislatures to articulate policies and purposes in an imprecise fashion. Yet, in judicial considerations, legislative intent plays a critical role in defining the scope of freedom agencies have.

Legislatures of course are able to articulate their policies and impose them on agencies without the mediation of the judiciary. Appropriation processes, committee hearings and investigations, amendments to authorization statutes, and the use of legislative review or veto of agency regulations provide more direct means of establishing agency accountability to legislative policy than do the principles of judicial review. The relationship between the Federal Trade Commission and the Ninety-sixth Congress provides a particularly vivid example of the use of a multitude of legislative techniques to show dissatisfaction with an agency's policies and to establish control over its future policy directions.[10] (It is curious to note that, while little objection is raised to the application of judicial doctrines that tie agencies to legislative

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[7] *Amalgamated Meat Cutters & Butcher Workmen* v. *Connally,* 337 F. Supp. 737 (D.D.C. 1971).

[8] *Panama Refining Co.* v. *Ryan,* 293 U.S. 388 (1935); and *Schechter Poultry Corp.* v. *United States,* 295 U.S. 495 (1935).

[9] *Industrial Union Department, AFL–CIO* v. *American Petroleum Institute.* 100 S.Ct. 284, 65 L.Ed.2d 1010 (1980) (the "benzene" case) (Mr. Justice Rehnquist's concurring opinion).

[10] P.L. 96–252, 94 Stat. 374 (1980).

policies and purposes, efforts by the legislature to establish agency accountability directly are frequently criticized as political.)

Ultimately, then, the principal source of agency accountability is *legislative* policy. Administrative agencies are held accountable to those policies. Their policies and decisions are expected to reflect and further the consensus or compromises worked out in the legislative process. Conversely, agency consistency with legislative purpose provides a basis for the legitimacy and acceptability of agency decisions. The administrative process may itself be fundamentally a political one, involving compromises and accommodations worked out among competing and conflicting interests. But, at least in theory, even dissatisfied participants can accept the outcomes of that process if they can be justified by an external referent, legislative purpose.

The regulatory value of political accountability is not found within the administrative process itself but in the relationship between agency and legislature. The structure of the legislative process, in turn, has characteristics relevant to designing incentive systems. The process represents an accepted and presumably acceptable societal mechanism for resolving complex value conflicts. It reflects the complexity of a society in which no one value or set of values predominates, so that policy choices necessarily reflect compromise and accommodation. The process virtually assumes that no single factor motivates a majority of the people. Legislative solutions, therefore, are in their nature complex. On the one hand, this presents problems in plumbing legislative intent. On the other, it is a refreshing reality in a society the very complexity of which invokes nostalgic desires for simple solutions.

Legislative accommodations are often criticized for lacking rationality. The process may produce inconsistent, unclear results as the balance of interests shifts from issue to issue or over time. But, to the extent that rationality implies logic and consistency, it may provide the wrong set of concepts to analyze the legislative process. The process involves resolution of value conflicts. Values are subjective, and the priority assigned to them by individuals is subjective. A study of that process entails looking at the levers available to individuals and groups to further their value structures. The process of accommodation involves an emotional or psychological overlay that cannot be adequately encompassed by "models" or "ideal solutions."

Nonetheless, it is important to recognize that the legislative process has legitimacy, a legitimacy derived from the federal Constitution and state constitutions. It is the principal vehicle for public resolution of complex value conflicts. It reflects the fact that no single value can invariably predetermine policy outcomes. The regulatory process, by derivation, carries that resolution into implementation, undertaking analogous conflict resolution at the administrative level. To the extent that the legislature avoids its responsibilities and moves conflict resolution to the administrative stage, the principles of judicial review discussed above nonetheless indicate that courts will make an effort to discuss legislative policy.

The accommodation represented in regulatory outcomes in the implementation stage must, then, be generally consistent with what the legislature intends. If that is the case, then regulation can be effective in making policy choices that represent an appropriate balance of interests.

Public Participation

In making decisions within the area of their discretionary authority, agencies employ procedures that provide a variety of opportunities for public participation. In a democratic society, participation by the public in governmental decisions may be considered a value by itself. But it serves a number of utilitarian purposes as well. It provides additional possibilities for agency accountability by exposing agency decision-making processes and their outcomes to public scrutiny. It also provides a psychological prerequisite for the acceptability of those outcomes. Further, public participation enables agency decision makers to obtain different perspectives on issues and to obtain information from a variety of sources that may be germane to the decision and is likely to enhance the decision's quality and accuracy.

A large number of the principal developments in administrative law over the last fifteen years involve means for increasing public participation in the regulatory process. Partially to prevent regulatory capture and partially in recognition of the political nature of public regulation as a means of allocating economic resources, legal doctrine has been changing the structure of the regulatory process to permit more equitable access for groups interested in and affected by agency

decisions. Examples of such doctrinal developments include: liberalization of the requirements for standing to participate in agency proceedings[11] and to seek judicial review of agency decisions;[12] judicial review principles that look to whether the agency has given consideration to all "relevant factors" before making even informal decisions[13] and whether it has responded to evidence that would suggest outcomes contrary to those reached by the agency;[14] experimentation with direct agency funding of interest groups to allow views to be represented that might not otherwise be;[15] legislation authorizing courts to award litigation costs to "public interest" advocates;[16] open meeting laws, such as the federal government in The Sunshine Act[17] and state versions thereof; and public information disclosure statutes, such as the federal Freedom of Information Act[18] and state versions.

Health cost-containment regulatory programs generally make significant decisions through processes that include opportunities for public participation. These opportunities include, for example: the use of multimember part-time bodies with responsibility to promulgate implementing regulations; advisory bodies made up of providers, consumers, and technical experts; advisory groups that make recommendations to which the agency is obliged to respond; the right of parties to intervene in proceedings; and the ability of members of the

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[11] *Office of Communication of United Church of Christ* v. *FCC* 359 F.2d 994 (D.C. Cir. 1966); *National Welfare Rights Organization* v. *Finch*. 429 F.2d 725 (D.C. Cir. 1970).

[12] See *United States* v. *SCRAP*. 412 U.S. 669 (1973). *Duke Power Co.* v. *North Carolina Environmental Group, Inc.*. 438 U.S. 59 (1978). Compare, *Simon* v. *Eastern Kentucky Welfare Rights Organization*. 426 U.S. 26 (1976).

[13] *Citizens to Preserve Overton Park, Inc.* v. *Volpe*. 401 U.S. 402 (1971).

[14] *National Tire Dealers & Retreaders Ass'n.* v. *Brinegar*. 491 F.2d 31 (D.C. Cir. 1974).

[15] Examples include: the Federal Trade Commission Improvements Act of 1975, P.L. 93–637, 15 U.S.C. s. 59a(h); 16 C.F.R. s. 1.17 (FTC); 49 C.F.R. ss. 5.41–5.59 (National Highway Traffic Safety Administration); 21 C.F.R. ss. 10.200–10.290 (Food and Drug Administration).

[16] U.S., Congress, Senate, Subcommittee on Administrative Practice and Procedure, Senate Committee on the Judiciary, "Select Bibliography of Congressional Hearings on Public Participation in Federal Agency Proceedings," *Public Participation in Federal Agency Proceedings*. Hearing on S. 2175, 94th Cong., 2d sess., 1976, p. 271.

[17] 5 U.S.C. s. 552b.

[18] 5 U.S.C. s. 552.

public generally to comment on proposed regulations (Weiner, 1979b). Public participation in agency process allows conflicting values and priorities to be played out at the level of agency implementation of legislative policies.

Realistically, of course, one must recognize that people may not participate in agency proceedings even where opportunities exist or that public participation may not make a significant difference to outcomes. Nonetheless, allowing for public participation encompasses important values. It permits agencies that are developing and implementing policy to understand the complexities of the subject matter with which they are dealing. It facilitates their discerning the motivations and concerns of interested and affected parties with a level of refinement not otherwise readily available to them. And it may even enable them to fine-tune their policies and objectives in ways that produce a more effective balance of the values and concerns that are articulated through public participation.

Public Access to Information

Public access to governmentally held information is a significant value in administrative law. The federal Freedom of Information Act and its state counterparts establish a broad presumption in favor of the disclosability of records in agency files to any person who requests them, except for documents falling within a limited number of narrowly defined exemption categories.[19] Basic to the rationale supporting such disclosure acts are the values placed on the belief that informed citizens can participate more effectively in governmental processes and that people have the right to know how and why agencies make decisions that affect them.

Most records which private parties provide to governmental agencies because of regulatory requirements are accessible under these disclosure statutes. In the health field, such records would include cost reports and budget submissions, CON applications, mandatory planning documents, and some case mix data. While a major question exists with respect to the accessibility of physician-specific and hospital-specific

[19] 5 U.S.C. s. 552(a)(3). The exemptions are defined in 5 U.S.C. s. 552(b).

data gathered by professional standards review organizations,[20] substantial amounts of data about the cost and price of care and the types of services and patients cared for at various institutions are available through the medium of public regulatory programs.

Public access to this information promotes a number of utilitarian purposes. While it may be difficult for nongovernmental parties to test the accuracy of data used by cost containment agencies with any rigor, public access to the data at least allows interested parties to make judgments on whether the agency has considered the right kinds of information. Both providers and nonproviders may thereby argue that information relevant to a decision was not given adequate consideration or that the agency established the wrong priorities, as evidenced by the type of information it chose to use or emphasize in arriving at its decision. Access therefore allows interested or affected parties to draw judgments about the policies and values pursued by the agency.

Accessibility serves a different purpose, though, entirely independent of regulatory decision-making. Nonexempt information held by the agency may be considered and used for whatever purpose the requesting party may desire. Under statutes of the Freedom of Information Act (FOIA) type, the purpose for which information is sought need not be stated. Use of information once obtained, except for information that falls within certain of the exemptions but is nevertheless released, is not limited to purposes relevant to the program for which the information was collected in the first place.

Because of disclosure statutes, the existence of health regulatory programs has probably provided the public with the most extensive information available about health services and has undoubtedly significantly effected heightened consumer awareness about differences in the cost, quality, etc., at least of institutional services.

While one can always argue about the quality of data and its usefulness in drawing valid comparisons, these are probably temporary problems. If taken seriously, arguments of that type imply severe restrictions on the nature and amount of data that should be made available to consumers, a position markedly inconsistent with the

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[20] See Omnibus Reconciliation Act of 1980, P.L. 96–499, s. 928, 94 Stat. 2630 (1980). The Institute of Medicine is currently undertaking a study of this issue at the request of two House subcommittees.

assumption market models presumably make about the importance of informed consumers.

Transferability of Values

Description of Incentive Systems

In order to examine the relationship between the values associated with cost containment regulatory programs and incentive strategies, a brief recapitulation is needed of what the incentive models include. The models generally involve at least two principal features: (1) the assumption by an individual of greater financial responsibility for his or her care, either when acting as a direct consumer of health services or when selecting insurance coverage; and (2) the use of prepayment plans analogous to HMOs with responsibility for financing and providing, or arranging for the provision of, certain health services.

The first feature is intended to make consumers or potential consumers of care more cost conscious in their selection and use of services. This end may be accomplished by copayment or by reform in the tax laws to make the economic consequences of choice among plans more visible. Once consumers understand the cost implications of their service preferences, they should be in a better position to determine which services or which of a number of competing financing/servicing plans will be able to satisfy best their preferences.

With respect to the second feature, it is generally presupposed that for the incentive model to serve cost containment ends, the plans will engage in price competition. A corollary assumption is that consumers will generally make their decisions among competing plans based primarily on comparative price. This assumption may have to be modified in light of actual experience. For example, it appears that the higher cost option under the Federal Employees Health Benefit Program is the more popular (McNerney, 1980). Nonetheless, price competition at the level of the plans, not the direct providers, appears to be a fundamental feature of the incentive models.

For the plans to be price competitive, some or all of at least three features must be included in their design. The plans may impose copayment requirements on members or enrollees, so as to allow variations in price structure geared to the individual purchaser's own

assumptions about his or her likely utilization of services. Or the plan may vary benefit coverage, so that purchasers may make selections based on expected utilization of service by specific service types. Both of these methods for establishing price variability are currently used by insurance carriers in tailoring policies to the need or demands of specific purchasers, particularly groups. It does not take a particularly high level of sophistication for purchasers to understand the trade-offs associated with the lower price of the insurance. As the experience of the Federal Employees Health Benefit Program suggests, consumers may be more than willing to forgo lower prices (premiums) for more comprehensive coverage.

The principal vehicle for effective price competition among plans will therefore likely be associated with efforts to induce more efficient means of providing service. Since payment for service represents by far the largest single element making up an insurance premium or HMO capitation fee, reduction in the level of those payments is likely to have the most significant impact on plan price levels. The plans will likely undertake various efforts to control the cost of services provided to members. In some cases, plans may provide services directly; that is, they may own or directly employ the service providers (hospitals, physicians, etc.). In other cases, though, the plans may arrange for the provision of service, relying on contractual relationships with the direct providers, analogous to the way in which Blue Cross plans and some HMOs operate. In the ownership version, the plan's ability to control service cost may be greater. However, in either case, the plans will probably use similar techniques to affect service costs.

Incentive Systems as Private Regulation

To the extent that incentive models are different from traditional proposals merely to manipulate insurance coverage to produce lower premiums, they will be actively concerned with the relationship between plan and provider. A great deal of attention needs to be paid to the ways in which plans will control the cost of care in order to keep their prices down. The control techniques most likely to be used by the plans, though, are those currently employed by regulatory or regulation-related programs: utilization review, periodic review and approval of operating budgets, review and approval of capital ex-

penditures and service expansions or additions, and emphasis on collaborative institutional planning.

In other words, it is probable that the incentive models will encompass the transfer of the present techniques of public regulation into the sphere of private relationships. The models assume the substitution of private regulation of the provider sector by plans in place of public regulation by administrative agencies.

The capacity of private regulation to control cost effectively may depend on factors similar to those which determine the effectiveness of public regulation. For example, the respective negotiating strengths of plans and providers will be a significant determinant of the success of cost control efforts. One difference between the two may be that in the private arena strength may be measured primarily by economic, not political, power.

The nature of the relationship between plan and provider is worthy of more detailed analysis, because it has significant implications for the design or effectiveness or incentive models. A few observations will indicate the importance of the topic. The more plans in a given area, for example, the more likely it is that a limited number of providers can effectively stifle cost control efforts by establishing their own terms of contract. Or, where the providers can negotiate among a large number of competing plans, they may be able to conclude cost-containing agreements with one and pass on additional costs to other plans that may need to contract with them to assure adequate availability of services to members. Negotiations of this type may produce the kind of cross-subsidization for which regulation is routinely criticized.

Further, if cross-subsidization were to occur, consumers motivated by price will gravitate to the plan with the best relationship to providers, thereby allowing providers to control the competition among plans.

On the other hand, the fewer the plans, the better able each is to bargain individually with available providers. But for a plan to have sufficient economic leverage to produce dramatic changes in provider cost behavior, it may have to have such a level of local market domination, as measured by enrollment, that it may already be relatively insulated from competitive pressures.

The most equitable bargaining relationship may very well occur

when each plan owns or deals with only one hospital and one set of other providers. However, this result may inhibit flexibility in service arrangements and produce duplication and underutilization of services. The resulting additional costs to the system will be reflected in overall higher levels of prices for all plans, even though individual variations in price may still allow competition to take place among the plans.

Both public and private regulation involve substantial negotiation between the regulated party and the regulation. The foregoing examples suggest some of the variations in negotiations with private plans. However, unlike the relative freedom with which provider negotiations may proceed with public regulatory agencies, provider negotiations with private regulatory plans are likely to be severely circumscribed by the antitrust laws—that is, in a competitive environment characterized by private relationships, provider strategic responses to regulation are likely to be quite limited.

Public Regulatory Values in Private Regulatory Relationships

At this stage of experience, speculation obviously attends discussions of the relationship between plans and providers and the appropriateness of measures intended to assure cost-effective price competition among plans. However, if the relationship between plans and providers under incentive models involves substitution of private for public regulation, the discussion above concerning the important values associated with public regulation requires us to consider whether implementation of these models will preserve those values.

Briefly recapitulated, those values involve reliance on a process capable of resolving complex value conflicts, of assuring a variety of mechanisms for individuals to participate in working out those resolutions, and of providing access to information that may be used to evaluate the efficacy of the public decision-making process and to make other decisions relevant to the individual, even if unrelated to the operation or objectives of the regulatory program.

The principal decisional vehicle of the incentive models is the consumer's choice among competing health plans. While on the surface the models may appear to assume that choice will usually favor the lowest cost plan, that assumption is not critical to the models (McClure, 1979). Consumers may choose more expensive alternatives

if that satisfies significant noneconomic values they have. The virtue of the incentive models is that the consumer sees more directly the trade-offs between his or her economic values and noneconomic values.

The more difficult question for the models, as it is for public regulation, is the extent to which the plan arrangements can adequately further noneconomic values. If, in a competitive environment, plans are driven predominantly by economic considerations, that may structure their relationship with providers in ways that fail to reflect significant noneconomic values held by some consumers. If no plan furthers certain values emphasized by some consumers, then those consumers really have no choice among plans. At least with public regulation, there are political processes which assure the *possibility* that all important individual values may be furthered, even if ultimately certain ones are discounted in final resolutions. It is not clear that the incentive models hold out the same possibility, which would require individual consumers playing a role more active than simply selecting one from among a number of proferred plans.

The public regulatory system has, at least so far, managed to preserve the diversity of the current health delivery system, albeit in a way sometimes perceived as inconsistent or irrational. To the extent that that inconsistency is a function of shifting accommodations to value conflicts, it may not be undesirable. The incentive models may have difficulty preserving this diversity, particularly if they have the effect of forcing individuals to make decisions solely on economic grounds. Individual consumers who may prefer to foster noneconomic values may literally not be able to afford to do so under this approach. Public regulation takes that into account; the incentive models may not be able to. Neither approach may be right or wrong; but those differences should be stressed, especially since adoption of such labels as "consumer choice" implies the possibility for more diverse choices than the incentive models may be able to produce.

A similar problem occurs with respect to the values associated with public participation. Again, the principal vehicle of participation for incentive models is the individual's choice among competing plans. Yet individuals may have little formal opportunity to participate in structuring the relationship between plan and provider, which is the process during which critical value choices are made.

The incentive models could be adapted to give greater recognition to these values by including more defined opportunities for public

input into the development of plans. But the inclusion of such possibilities before a plan has finally developed assumes that the consumer will commit himself or herself to a particular plan before its final price is determined. A compromise approach would be to have the consumer choose among already formulated plans but then have opportunities to participate in the management of the plan, once established, on an ongoing basis.

The value of public information requires somewhat more detailed consideration in the context of incentive models. Despite reducing the major public decision to a choice among plans, the models still will require substantial data-gathering activities, for at least two reasons. First, a plan has responsibility for establishing efficient patterns of service provision. As was observed earlier, the relationship between plan and provider will probably involve many of the analytic concerns that currently characterize relationships between providers and public regulatory agencies. Consequently, the types of information presently gathered by those agencies respecting the cost, utilization, etc., of providers should still be needed in order for plans to undertake effective contract negotiations or assure the most efficient output from directly controlled providers. In the absence of regulatory authority to obtain such information, plans which rely on contract must have sufficient leverage to assure the right to obtain it.

Further, whether functioning through contract or direct control, the plans will have the same responsibility that regulatory agencies now have to assure the completeness and accuracy of data. Particularly where a plan may choose among providers or provider arrangements with which to deal, these data-gathering responsibilities may be quite substantial.

Second, various types of data should still be available to private individuals or employers as part of their process of choosing among plans. Since that choice would probably not depend exclusively on the price of the plan, knowledgeable consumers will need information about the plan's operations, about the characteristics of the providers with which the plan does business, and about the nature of the relationship between plan and providers. As prudent purchasers of plan services, consumers should also want continuous information with which to monitor the performance of the plans they have selected, to determine where they can do better and whether competing plans are better able to achieve certain values; that is to say, ongoing