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James R. Tallon

United Hospital Fund of New York, President

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Policy Brief

EIGHTH ANNUAL HERBERT LOURIE MEMORIAL
LECTURE ON HEALTH POLICY

New Conundrums: Public Policy and
the Emerging Health Care Marketplace

James R. Tallon, Jr.

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James R. Tallon, Jr., is president of the United Hospital Fund of New York, the nation's oldest federated charity, which addresses critical issues affecting hospitals and health care in New York City. The Fund is active in grantmaking, health services research, educational programs, policy development, fundraising, and voluntarism. Mr. Tallon previously served for 19 years in the New York State Assembly, where he was a leader in efforts to increase access to quality health care and address health care financing issues. He is recognized as a national leader in health care policy development.

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New Conundrums: Public Policy and the Emerging Health Care Marketplace

James R. Tallon, Jr.

There is a fundamentally new dynamic in American health care, one that has yet to be fully experienced but that threatens to leave a large portion of the American population without access to the quality health care they have received in the past. While the federal government has not completely abandoned the goal of assuring universal health care, a goal that dates back to the creation of Medicare and Medicaid in the 1960s and even earlier, the mechanisms to pursue that goal have changed. The implicit contract between government and health care providers—mostly doctors and not-for-profit hospitals—under which subsidized care was provided to those unable to pay has been broken in favor of more market-driven forces that promise a more cost-effective system, but a system that fails to protect a growing uninsured population. This new purchaser-driven system—in which costs increasingly determine the services that are provided—is likely to fall short of providing quality care to all who need it.

Health care is different from other services, and unless this difference is recognized we are in danger of permanently denying quality health care to a significant minority of our population. Regulation of the emerging “free market” in health care is needed and government must assure that role.

Background

To more clearly understand where we now stand, it is necessary to look back to 1965 when the creation of Medicare and Medicaid brought us into the modern era of “universal” health care.

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The American system of financing health care has been fragmented for three decades: Medicare for the elderly and disabled; Medicaid for the poor; an employer-based health insurance system for the working population and their dependents; direct expenditure and sponsorship of services by local and state governments; and categorical funding by the federal government for people who do not have a direct source of financing. The implicit bargain underlying that so-called “system” was that the providers of care—physicians, other health care professionals, and the hospitals in which they worked—channeled these fragmented streams of financing to support a health care system available to the entire population. Of course, the care was not provided on a perfectly equitable basis. There were many deficiencies in care among segments of the population, particularly the uninsured. But the agreement essentially was that in return for having authority to run the health care delivery system, physicians and hospitals undertook the obligation to make certain that the fragmented sources of money were translated into a safety net that more or less served everybody.

There were many elements in that safety net: not-for-profit hospitals; a strong not-for-profit health insurance industry led by Blue Cross/Blue Shield; and the professional obligations that physicians and other health professionals undertook. There was informal cost shifting in the marketplace. Open doors were maintained by municipal and state-operated health care systems. There were explicit reimbursement provisions in Medicare and Medicaid to support so-called disproportionate share hospitals, that is, hospitals that treated larger numbers of uninsured people, where medical residents often had the responsibility of caring for medically indigent patients. Through all of those mechanisms, we somehow patched together a system that provided universal, albeit imperfect, access to health care.

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Clinton Health Care Reform and the Purchaser Revolution

In addition to the safety net of services woven from fragmented streams of financing, American health care had another powerful characteristic. Between 1965 and the early 1990s, health care expenditures grew from 8 percent to approximately 14 percent of gross domestic product. By the time of the 1992 Presidential election, frustration with cost growth and continued concern with large numbers of uninsured persons pushed health care high on the national agenda. The new Clinton administration sought to craft a comprehensive response to both problems: a comprehensive system of financing in which employers would be responsible for providing health insurance coverage for their employees; government would continue prime responsibility for the elderly, disabled, and poor; and various cross-subsidies would ease burdens on parts of the payer community. The result was the Clinton health plan.

President Clinton made the political bet that big business would support comprehensive health reform. Why? Because big business for a generation had been characterized as the victim of cost-shifting in the American health care economy. Large businesses that provided comprehensive health insurance were often asked to pay more for their employees, for the patients who were covered, to make up for some of the deficiencies that existed elsewhere in the system. The White House knew that small business would be opposed to the proposal because of entrepreneurial philosophies among small businesses, an adversarial attitude toward government, and economic fragility in that sector of the market. The bet was that big business would come on board and would influence Congress to support the plan.

In fact, however, big business said no to the Clinton health plan. There were many reasons for the opposition: a philosophical

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aversion to giving government an even larger role in one-seventh of the national economy; and in some cases, perhaps, the specific interests of the firms represented in the councils of business leadership.

The evidence also suggests that something else happened, which makes this almost a turning point in health policy history. While some of us in the center/left of the health policy debate were busy designing a health care system that would both cover everyone and control costs, the larger businesses in the economy were starting to practice in health care what they were practicing in their other business activities. They were reacting to increased competition, both foreign and domestic, and the dramatic restructuring occurring in their core lines of business. When businesses looked at health care, rather than asking, "How much will our benefits cost next year?" they began to ask, "For the following amount of money, what are you prepared to give me? And incidentally, if you'd like my business, why don't you discount that amount by 10 percent." To say that this all occurred just in 1993 or 1994 is to ignore a decade of growing change occurring in the American health care system. But the healthcare marketplace came into sharper focus in early 1994 with the rejection of the Clinton health plan by the business community.

This new attitude by business initiated what has been called the purchaser revolution. Seemingly overnight the power relationships in the health care system changed. Health care providers no longer dominated the terms of trade in the health care system. (Many hospital administrators and physicians will take exception to my assertion that they had been running the system. Of course there were plenty of battles and plenty of efforts to control *them*. But the bottom line is that in a period of less than 30 years spending in health care as a percent of the gross domestic product nearly doubled. Clearly this in part is the result of the power of providers to influence the system.) As we went through 1993-1994 the

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system turned on its head: the people delivering health care—physicians and hospitals—found themselves taking direction from the people who were purchasing care.

The Emerging Health Care Marketplace

One result of the purchaser revolution is the unraveling of the implicit contract under which providers assure care for everyone. In the simplest sense, the fundamental question now is, “*What will it cost to provide services for the people for whom I am responsible as purchaser?*” Hospitals, which have largely been organized through the 20th century as not-for-profit corporations, are seeing a surge toward for-profit ownership and sponsorship. And the insurance industry, previously balanced between not-for-profit and for-profit ownership, is shifting dramatically toward for-profit sponsorship. We are seeing a far more disciplined, purchaser-driven marketplace that is reducing the ability of informal cost shifting to take place. States like New York are moving to deregulate the provision of health care. The individual professionalism and autonomy of physicians is being challenged by the activity of Wall Street investors, who are now acquiring and managing physician practices. Physician practices have become a commodity in American health care, and investors are looking at them as such. Government is retreating from direct sponsorship and financing of local health care services. Those elements of the safety net built since the passage of Medicare and Medicaid are all moving toward carrying less rather than more responsibility for the uninsured.

We are faced, therefore, with a fundamentally new dynamic in American health care. Maybe the simplest way to characterize the difference between a provider-driven health care system and one that is purchaser-driven is simply to observe the following, and it probably comes dangerously close to being a bumper sticker:

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- # *In the provider-driven system a sick person generates **revenue**.
In the purchaser-driven system, a sick person generates **costs**.*

With this fundamentally different way of looking at American health care, our previous thinking about the way public interest and private interest interacted is changing. Government policy must now focus on how to control a process in which market forces are driving providers to be more cost conscious. We have a whole new series of public policy questions to answer.

Those who have thought about American health care recognize the underlying tension between maintenance of quality, control of cost, and provision of access to the system. In the past we put external controls on cost growth. We looked at quality as something to be policed; we looked at the accreditation of institutions and at retrospective review of patterns of care. We also provided supplemental expansions of various kinds of public coverage built into the existing system.

Now we are faced with a genuinely new world in which the struggle between cost control, quality, and access is played out in this fundamentally different environment of the marketplace. There are new conditions:

- # Paul Ellwood and George Lundberg (1996), physicians and distinguished policy leaders in American health care, recently declared the end of the first phase of health care reform, concluding that costs have now largely been controlled in the American health care system.
- # In that same issue of *JAMA*, John Ware et al. (1996) presented empirical evidence of adverse outcomes in managed care plans for both the elderly and the chronically ill.

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- # At the same time, Ken Thorpe (1995), the American Hospital Association (1996), and others argue that 40 million people are now uninsured and that the number will grow, depending on the range of the studies, to from 45 to 67 million people by the year 2002.
- # Furthermore, more than half of the uninsured population in the country within the last year reported difficulty in actually getting care (Donelan et al. 1996).

Those are just some of the changing dynamics of this new health care marketplace.

Future Public Policy Issues

As we look to the future, how might one frame the public policy debate?

Medicaid and Medicare

Medicaid is now attracting debate in Washington. Medicaid was a primary focus of my work in Albany and with the Kaiser Commission on the Future of Medicaid. I have spent a good deal of time working inside what is often called “the program we love to hate.” People tend to think of Medicaid primarily as a companion to Medicare, both of which were adopted in 1965. Some even described it at the time as an agreement between President Johnson and the American Medical Association to do something with respect to the medically indigent so that Medicare would not grow into “socialized medicine” for all of America. Medicaid was set up as a program to provide health insurance to poor people, and 36 million Americans currently rely on it for their health care needs.

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But in reality Medicaid is a multifaceted program, with four major parts: (1) It is health insurance for poor people, mostly women and children, because it has been linked to cash public assistance benefits. (2) Medicaid is also the principal source of financing for institutional care for the elderly and disabled; it pays 50 percent of total U.S. nursing home costs. In a state like New York it pays between 80 and 90 percent of those costs. (3) Medicaid is the source of payment for about one in ten low-income Medicare beneficiaries who need help to pay the premium and co-payment costs of Medicare. (4) And Medicaid has become the principal health care financing source for a large number of Americans with major disabling conditions: serious and persistent mental illness, complex physical disability, developmental disability, or chronic illness, of which HIV infection is the most recent manifestation.

Medicaid is the financing source for the tough problems in American health care, problems that the rest of the system does not want to deal with.

As Congress starts to look at Medicaid, it will be forced to look at Medicare, which is inexorably tied to Medicaid since they are both parts of the larger system of federally financed medical care. We have often considered the crisis of Medicare funding as an intergenerational issue, a smaller working population dealing with a larger dependent population in the future. We ask, in more personal, down-to-earth terms: How will a younger generation of Americans care for their aging parents?

Since Medicaid is currently the principal source of financing for chronic illness and long-term care in the country, it is important to focus both the Medicare and the Medicaid debates into one carefully thought out, coherent long-term policy with respect to chronic illness.

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After the 1994 election Medicaid was discussed in terms of devolution of power and responsibility to the states—giving the states a block grant and allowing them to meet the needs of the Medicaid population; and cost cutting—reducing the amount of money but allowing a greater amount of flexibility. In December 1995 President Clinton, through his veto, rejected that course of action and sent a welfare bill containing drastic change in Medicaid policy back to the Congress. In the summer of 1996 the Republican congressional leadership split welfare reform from Medicaid reform, decided not to advance a Medicaid bill, and allowed the debate in 1996 to focus only on welfare issues.

There was and still remains tension between two alternatives for Medicaid. The first, pushed by the leadership in Congress, is to cap federal expenditures and give total responsibility for eligibility, for benefits packages, and for provider reimbursement systems to the 50 individual states. The second, pushed by the White House, is to continue a national framework with respect to Medicaid, limit the federal government's outlays but keep expenditure rules flexible, and allow an upturn in federal expenditures if there is a downturn in the economy. This would allow eligibility standards to remain federal, with a roughly standard benefits package throughout the nation, but with substantial state flexibility in terms of implementation patterns, the use of managed care, and provider reimbursement systems. I prefer the second alternative.

Whatever the terms of the debate, let me suggest that this debate over Medicaid is critical and cannot be postponed much longer. It will determine how we deal with some of the most complex problems facing the American health care system, particularly as the number of uninsured Americans grows.

The Uninsured

Americans who lack health insurance coverage should also be a major question in Washington. There is no reason to believe that the numbers are going to get any smaller. There is nothing in the current dynamic of health care financing in America that is going to reduce the numbers of uninsured people. I cannot find the logic by which a private sector economy reverses a decade-long trend in reducing health insurance coverage and starts providing larger amounts of health insurance to American workers. I can see debates about avoiding reductions in Medicaid eligibility, but it is hard for me to envision a future of massive expansion of eligibility for Medicaid. We can debate the various trajectories by which the number of uninsured is going to get to 65 million or 55 million or 50 million, but there is no argument that the number will get bigger than it is now.

How do we respond? Karen Davis (1996), president of The Commonwealth Fund in New York, wrote a thoughtful editorial in *JAMA* in which she outlined the various incremental strategies with which we could approach the issue of the uninsured in America. We could, for example, accelerate the phase-in of the Medicaid program for children between the ages of 12 and 18 whose incomes are below the poverty level. Perhaps we could even take on the “radical idea” that their parents ought to get health insurance coverage. Maybe we could focus on children up to higher levels on the poverty standard. Perhaps, building on Kennedy-Kassebaum, we could focus on financing health insurance for workers in transition in the economy. Or perhaps we could even consider the notion of health insurance for early retirees, of whom there are increasing numbers in the country, by letting them buy coverage under the Medicare program. What Davis indicated is that, taken alone or in combination, there are portions of this problem that reasonably could fall within the resources and scope of the political debate in Washington.

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What is most important about all this?

Our political leaders must regain the confidence to tackle the issues.

Clinton health care reform burned many participants in the debate, but that great negative experience must be overcome. The growing numbers of uninsured must bring us back to a more fundamental debate about providing health insurance for all Americans. Most importantly, in this emerging health care marketplace, in which the implicit contract for providers to make health care available to all is no longer in force, it is important that we create alternative mechanisms for providing care to all Americans.

Rules for Managed Care

There is a third major issue before us: What are we going to do about managed care? Managed care means many things across a continuum of models. From discounted fee-for-service arrangements in preferred provider organizations through tightly controlled networks and more open point-of-service plans, managed care carries many definitions.

Whatever the specific model, the American people, individually and anecdotally, are talking about how they perceive managed health care in their experience with the health care system. If there are bubbles of discontent simmering in this system, they are in the emerging public reaction to managed care.

There are two subset issues in managed care that have received a lot less attention.

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Measuring Quality

We have been measuring the quality of health care for a generation. But in recent years our capacity to obtain and understand data has brought greater resources to bear on this question.

The quality assurance debate should focus on sick people.

Many consumer satisfaction surveys have focused on the entire population covered by managed care plans. Yet most of us buy health insurance so that care is available when we or a member of our family is faced with a serious illness. I do not want to diminish the importance of illness prevention, but the core of this debate is what happens to people who are sick. In the new health care marketplace, sickness is equated with cost. With due respect to the health insurance community, one of the great lessons learned is that the best way to succeed selling health insurance is to sell it to healthy people. The first time an individual may realize that she is perceived according to the degree of risk she represents is when she has a serious illness. The new set of dynamics in the health care sector suggests that quality of service may be compromised by concern over cost. Hence, quality measurement must focus on the experiences of sick people, because that is the most challenging test managed care has to meet.

Public Data to Measure Quality

When we were making public policy for a provider-driven health care system, we operated on the assumption that those public policy debates were based on discussion and information which was by definition in the public realm. That does not mean that we did not occasionally have to fight a freedom of information battle to obtain access to information. But the underlying assumption of the law was that information, with appropriate protections for individual confidentiality, belonged to the public.

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As we turn to the model of the competitive marketplace, the relationships among the players within that marketplace—those who finance care and those who deliver it—are spelled out in private contracts, and the terms of those contracts are presumed to be proprietary to the contracting parties. Therefore, organizational changes—and operational performance—are being governed by private contracts. It may be assumed that the information in those contracts is not in the public realm. How much of it *should* be in the public realm? My preference is that a substantial amount ought to be there.

The Role of Government

A funny thing happened on the way to smaller government: the Health Insurance Portability and Accountability Act of 1996, popularly known as the Kennedy-Kassebaum bill. The rhetoric of American politics was in the direction of less government, or devolving some federal government responsibilities to the states. In Washington, however, a bipartisan group of legislators recognized that their constituents were experiencing practical health care problems—the transitional insurance issues addressed in Kennedy-Kassebaum; early discharge of maternity patients; mental health care benefits—and undertook important initiatives at the federal level to set standards in areas that for a generation have largely been state responsibilities. Setting the future rules of the game for managed care seems to be an appropriate issue with which to begin a thoughtful debate in Washington.

An example of practical compromises that may begin to provide the rules of the managed care game can be found in New York. Governor Pataki and the leadership of the New York State Legislature have agreed, with the Managed Care Reform Act (Chapter 705, Laws of 1996) on how to set standards for the way

in which consumers, providers, and managed care organizations will relate to one another.

Conclusion

There are some fairly simple observations that can be made about the way in which public and private interest will interact in this new health care marketplace.

First, for a marketplace economy to operate effectively in the health care sector, rules must be adopted. Government regulations protect us in the stock market, in our consumer transactions, and in many other areas where the market economy works within a framework of public rules. We need to accept the fact that, as the American health care system changes to one in which purchasers have a far greater amount of power, setting the rules of the game must be at the top of the public agenda. The marketplace is likely to be more effective, perhaps even in some respects brutally efficient, in terms of controlling costs than our previous system, in which costs had continued to grow. However, the health care marketplace is different. Most people agree that health care should be available and distributed to all. That is not a standard that Americans impose in most other sectors of the economy. If we continue to espouse that value, and at the same time we desire the efficiency that can be brought about through marketplace discipline, we need to look squarely at the risks that exist in terms of the maintenance of quality, and of access for people who are without a payment source in the system.

The urgent next step is to make the public decisions to guide development of the health care marketplace so that it better serves all of the people. In the era of smaller government, American health care still needs a public role.

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