

Building a Better Mousetrap: Health Care Reform and the Arizona Program

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In recent years, increasing skepticism about the efficacy of government regulation has produced a regulatory reform movement.¹ Advocates of regulatory reform argue that certain regulatory schemes traditionally administered by the government should be eliminated since consumer welfare is best served when the market is the primary organizer of economic activity.² In addition, reformers have advocated that certain functions that have been traditionally performed by government be transferred to the private sector. Like deregulation, privatization has been urged on both the federal³ and state levels.⁴ Successful deregulation efforts in industries such as

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1. The regulatory reform movement focuses upon both the negative welfare effects of regulation and the positive efficiency gains and consumer benefits that result from reliance on the market as the primary economic organizer. The movement is reinforced by philosophical beliefs. For classic expressions of the political values of free market capitalism and the ways in which government regulation infringes on individual liberty, see M. FRIEDMAN, *CAPITALISM AND FREEDOM* (1962); F. HAYEK, *THE ROAD TO SERFDOM* (1944). For a discussion of regulatory reform as a "movement," see M. DERTHICK & P. QUIRK, *THE POLITICS OF DEREGULATION* (1985); Weiss, *The Regulatory Reform Movement*, in *CASE STUDIES IN REGULATION: REVOLUTION AND REFORM 1* (L. Weiss & M. Klass eds. 1981)[hereinafter cited as *CASE STUDIES*]. See also R. NOLL & B. OWEN, *THE POLITICAL ECONOMY OF DEREGULATION: INTEREST GROUPS IN THE REGULATORY PROCESS* (1983).

2. Most of the initial interest and scholarship focused on regulatory reform at the federal level. See, e.g., S. BREYER, *REGULATION AND ITS REFORM* (1982); *INSTEAD OF REGULATION* (R. Poole ed. 1982); *CASE STUDIES*, *supra* note 1; *REFORMING REGULATION* (T. Clark, M. Kosters & J. Miller III, eds. 1980). State regulatory reform efforts, however, have been increasing. See *Special Project on State Regulatory Reform*, 1985 ARIZ. ST. L.J. 249 (J. Rose ed. 1985).

3. The 1986 Report of the Council of Economic Advisors urges the use of market incentives and privatization. The report states that privatizing transportation, power marketing, postal service, and prisons would enhance efficiency in those areas. See 50 ANTITRUST & TRADE REG. REP. (BNA) 237-38 (Feb. 6, 1986). See also *Promoting the Public Mails*, Christian Sci. Monitor, Jan. 8, 1986, at 13, col. 1; *Ideas Reagan Has Considered*, N.Y. Times, Dec. 27, 1985, at B9, col. 1.

4. Naisbitt, *The Year Ahead 1986 Part II: Profit in Schools, Transit Systems, Prisons*, Tempe Daily News, Feb. 2, 1986, at C3. In Arizona, a bill that would permit private companies to manage adult incarceration facilities was passed both this year and last year, but was vetoed in both years by the Governor. See *Ariz. Capitol Times*, Jan. 29, 1986, at 2, col. 2. The Governor has indicated his support for more experimental, less radical proposals. See *Ariz. Capitol Times*, Feb. 26, 1986, at 1, col. 1.

air and surface transportation,⁵ natural gas,⁶ financial services,⁷ telecommunications,⁸ and securities⁹ have encouraged the reformers to seek

5. Surface transportation: Railroad Revitalization and Regulatory Reform Act of 1976, Pub. L. No. 94-210, 90 Stat. 31 (codified as amended in scattered sections of 15, 31, 45, & 49 U.S.C.); Motor Carrier Act of 1980, Pub. L. No. 96-296, 94 Stat. 793 (codified in various sections of 18 & 49 U.S.C.); Staggers Rail Act of 1980, Pub. L. No. 96-448, 94 Stat. 1895 (codified in scattered sections of 11, 45 & 49 U.S.C.); Household Goods Transportation Act of 1980, Pub. L. No. 96-454, 94 Stat. 2011 (codified in scattered sections of 26, 28, 39 & 49 U.S.C.). Scholars had identified the negative impact of regulation and the benefits of competition in these industries. For an analysis of competition and regulation in the surface transportation field, see A. FRIEDLAENDER, *THE DILEMMA OF FREIGHT TRANSPORT REGULATION* (1969); J. MEYER, M. PECK, J. STENASON, & C. ZWICK, *THE ECONOMICS OF COMPETITION IN THE TRANSPORTATION INDUSTRIES* (1960); Farmer, *The Case for Unregulated Truck Transportation*, 46 J. FARM ECON. 398 (1964). Some scholars have opined that surface transportation regulation resulted from the successful efforts of railroads to have the government eliminate competition. See, e.g., C. FULDA, *COMPETITION IN THE REGULATED INDUSTRIES: TRANSPORTATION* 12, 16, 20-21 (1961); G. KOLKO, *RAILROADS AND REGULATION 1877-1916* (1965); P. MACAVOY, *THE ECONOMIC EFFECTS OF REGULATION: THE TRUNK-LINE RAILROAD CARTELS AND THE INTERSTATE COMMERCE COMMISSION BEFORE 1900* (1965).

Air transportation: Airline Deregulation Act of 1978, Pub. L. No. 95-504, 92 Stat. 1705 (codified in scattered sections of 49 U.S.C.). For analysis of deregulation in the air transportation industry, see R. CAVES, *AIR TRANSPORT AND ITS REGULATORS: AN INDUSTRY STUDY* (1962); L. KEYES, *FEDERAL CONTROL OF ENTRY INTO AIR TRANSPORTATION* (1951); Keyes, *Reconsideration of Federal Control of Entry into Air Transportation*, 22 J. AIR L. & COM. 192 (1955); Levine, *Is Regulation Necessary? California Air Transportation and National Regulatory Policy*, 74 YALE L.J. 1416 (1965).

Studies by active participants in the regulatory reform movement strongly supported the conclusions of this earlier scholarship. See S. BREYER, *supra* note 2, at 197-239; Eads, *Competition in the Domestic Trunk Airline Industry: Too Much or Too Little?*; Moore, *Deregulating Surface Freight Transportation*, in *PROMOTING COMPETITION IN REGULATED MARKETS* 13-96 (A. Phillips ed. 1975). See generally A. KAHN, I & II *THE ECONOMICS OF REGULATION: PRINCIPLES AND INSTITUTIONS* (1970); *THE CRISIS OF THE REGULATORY COMMISSIONS*, (P. MacAvoy ed. 1970).

6. See Natural Gas Policy Act of 1978, Pub. L. No. 95-621, 92 Stat. 3350 (codified at 15 U.S.C. §§ 3301-343 (1982), 42 U.S.C. § 7255 (1982)). This legislation eliminated the authority to regulate the well-head price of natural gas. Studies showed the adverse effect of such regulation, particularly the role that it played in causing the severe natural gas shortage in the 1970's. See S. BREYER, *supra* note 2, at 240-60 (1982); MacAvoy, *The Rationale for Regulation of Gas Field Prices*, and Kitch, *Regulation of the Field Market for Natural Gas by the Federal Power Commission*, in *THE CRISIS OF THE REGULATORY COMMISSIONS*, *supra* note 5, at 152-86. Breyer & MacAvoy, *The Natural Gas Shortage and Regulation of Natural Gas Producers*, 86 HARV. L. REV. 941 (1973). Some deregulatory efforts have included the phasing out of price controls on crude oil. See Montgomery, *Decontrol of Crude Oil Prices*, in *CASE STUDIES*, *supra* note 1, at 187-201. Some suggestions have focused on oil and natural gas pipelines. See, e.g., H.R. 2269, 99th Cong., 1st Sess., 131 CONG. REC. H2742 (1985); Federal Energy Regulatory Commission, Notice of Proposed Rulemaking on Partial Well-head Decontrol, 50 Fed. Reg. 3801 (1985) (to be codified at 18 C.F.R. pts. 154-57, 284).

7. See Depository Institutions Deregulation and Monetary Control Act of 1980, Pub. L. No. 96-221, 94 Stat. 132 (codified in scattered sections of 12, 15, 22 & 42 U.S.C.); Garn-St. Germain Depository Institutions Act of 1982, Pub. L. No. 97-320, §§ 311, 709, 96 Stat. 1469, 1470, 1540 (codified in scattered sections of 12 U.S.C.). Eliminating the barriers to interstate banking has been a recent area of substantial state deregulatory activity. See, e.g., ARIZ. REV. STAT. ANN. §§ 6-321 to 6-327 (Supp. 1985). For a survey of state developments regarding interstate banking, see Falk, *State Regulatory Development and Reform: An Overview*, 1985 ARIZ. ST. L.J. 261, 282-83; Phillips, *Competitive Policy for Depository Financial Institutions*, in *PROMOTING COMPETITION IN REGULATED MARKETS*, *supra* note 5, at 329-66.

8. See Record Carrier Competition Act of 1981, Pub. L. No. 97-130, 95 Stat. 1687 (codified as amended in 45 U.S.C. § 1017; 47 U.S.C. §§ 222, 609 (1982)); Cable Communications Policy Act of 1981, Pub. L. No. 98-549, 98 Stat. 2779 (codified in scattered sections of 47 U.S.C.). States have also been active in deregulating telecommunications. See Falk, *supra* note 7, at 283, 310-11. Many legal and economic commentators supported deregulation. See, e.g., S. BREYER, *supra* note 2, at 285-314. Walters, *Freedom for Communications*, in *INSTEAD OF REGULATION*, *supra* note 2, at 93-133; 2 A. KAHN, *THE ECONOMICS OF REGULATION* 27-51 (1970).

additional regulatory targets. Among the more interesting of these targeted areas is health care delivery.

Considerable literature has suggested that the public would benefit by increased competition and decreased regulation in the provision of health care services.¹⁰ This call for reform of the health care delivery system is not surprising, given the impact of inflation in medical costs on all segments of society. These rising costs particularly threaten the provision of health care services to the indigent and the aged. A succession of government cost control programs designed with the intention of alleviating high medical costs for those least able to afford them has not achieved any significant reduction in the cost of health care. Thus, the fundamental issue in health care today is whether government programs, such as Medicare and Medicaid, will serve society better than a delivery system that mixes greater private involvement with a diminished governmental role and relies more on competition to produce efficient health care.

This article considers that issue. We begin with a discussion of the evolution of the present health care system, focusing on some problems affecting health care delivery and the unsuccessful regulatory responses designed to alleviate them. We then consider the movement for reform, both the economic arguments that support a competitive system and the specific policy changes that would be necessary to implement a workable market-based health care policy. Finally, we analyze Arizona's unique experiment with a mixed health care delivery system as an alternative to Medicaid. We conclude that the Arizona program provides a useful paradigm for reform of health care delivery systems by encouraging competition and incentive-based programs while diminishing the impact of inefficient government regulation.

I. The Evolution of the Health Care System and Its Regulation

Government regulation to protect consumers is only necessary when the market fails to perform that function. Any number of factors may cause market failure, including monopoly power, excessive competition,

9. See Securities Act Amendments of 1975, Pub. L. No. 94-29, §§ 2-24, 27(b), 89 Stat. 97, 97-163 (codified at 15 U.S.C. §§ 78-83 (1982)). Despite 176 years of minimum commission rates, studies have shown that customers would be better served by greater reliance on competition and that regulation amounted to a government enforced cartel. See Mann, *The New York Stock Exchange: A Cartel at the End of its Reign*, in PROMOTING COMPETITION IN REGULATED MARKETS, *supra* note 5, at 301-27; Baxter, *NYSE Fixed Commission Rates: A Private Cartel Goes Public*, 22 STAN. L. REV. 675 (1970). For an excellent comprehensive survey of past deregulation and a road map for future deregulatory issues in the telecommunications, energy, financial services and transportation industries, see ABA Antitrust Section, *Report of the Ad Hoc Task Force on Regulatory Reform* (June 1985).

10. See, e.g., C. HAVIGHURST, DEREGULATING THE HEALTH CARE INDUSTRY (1982); COMPETITION IN THE HEALTH CARE SECTOR (W. Greenberg ed. 1978); *A Special Symposium: Market-Oriented Approaches to Achieving Health Policy Goals*, 34 VAND. L. REV. 849 (1981).

externalities, or high transaction costs.¹¹ Market failure in the health care industry normally involves high transaction costs¹² and is most often attributed to inadequate information for intelligent consumer decisions.¹³ Although this deficiency is the underlying rationale for health care regulation, such regulation is often specifically justified by inefficiencies in the demand for services, supply inefficiencies, restricted governmental expenditures on medical care, and unequal allocation and distribution of health care resources.¹⁴ While an analysis of these justifications for health care regulation is outside the scope of this article, an understanding of the major problems that have faced the health care industry is necessary to understand how the present health care system evolved and is a critical prerequisite for assessing the recent proposals for reform.

A. *Market Failure and Health Care*

The inability of consumers to obtain meaningful information about prospective health care providers is an important source of market failure in the health field. Information concerning the competence and quality of providers is expensive and difficult to obtain. Moreover, consumers are not able to identify appropriate treatments or to question providers knowledgeably before care is delivered. The ordinary health care consumer therefore has difficulty evaluating his alternatives. Consumers confront similar difficulties after the delivery of care in determining whether they have received adequate care. Unlike some market choices, an erroneous health care provider decision could have devastating consequences. In short, the average health care consumer is not capable of determining his needs, identifying his alternatives, evaluating the quality of care received, and judging the price characteristics of the transaction.

A second informational problem faced by health care consumers involves the likelihood of future illness. Accurate prediction is beyond the capacity of both doctors and patients. Therefore, individuals face uncertainty about the costs of future illnesses. This uncertainty creates a great deal of anxiety and financial insecurity for most individuals, who tend to be risk averse. The market response to this insecurity is health insurance: "Insurance is a response to uncertainty, and spreads the risk of financial loss occasioned by treatment of diseases or injuries over both the people who turn out to have little need for health care and those who turn out to

11. See S. BREYER, *supra* note 2, at 15-35.

12. For a general discussion of transaction cost problems, see O. WILLIAMSON, *MARKETS AND HIERARCHIES: ANALYSIS AND ANTITRUST IMPLICATIONS* 1-41 (1975).

13. See Pauly, *Is Medical Care Different?*, in *COMPETITION IN THE HEALTH CARE SECTOR*, *supra* note 10, at 11, 13-30.

14. P. FELDSTEIN, *HEALTH CARE ECONOMICS* 260-62 (2d ed. 1983).

have a great need.”¹⁵ While this market response to a consumer problem alleviates insecurity about future illness, it produces one significant cause of health care market failure—the third party payment problem.

Third parties, such as insurance companies and government programs, pay most health care bills. Third party payment causes market failure because the consumer’s purchasing decision is independent of the price of the medical care provided. This phenomenon, sometimes called “moral hazard” by economists,¹⁶ means that consumers will demand more health care than if they were personally paying for it.¹⁷ Although this consumer conduct is ultimately reflected in higher insurance premiums generally, free rider problems normally preclude an effective market solution.

Free rider problems arise because an individual’s premium costs are not likely to be affected substantially by any change in conduct, and thus there is little incentive to modify one’s behavior. Moreover, the practical effect of this phenomenon is substantially aggravated by the fact that many individual consumers do not directly pay the costs of their health insurance. For many persons, employer funded health insurance is a normal incident of employment. For many other individuals, the government pays the cost of health care through programs such as Medicare and Medicaid.¹⁸ Given these altered incentives, consumers will overutilize medical resources and seek the best possible medical care, without regard to cost.¹⁹

The third party payment system also affects the behavior of health care providers. Since traditional third party payment in the health care industry is a retrospective fee or cost-based reimbursement system, providers’ incentives to be efficient in the delivery of health care are undermined.²⁰ The present system therefore gives providers few incentives to reduce costs or to substitute uncovered procedures that may be more cost effective than insured procedures.²¹ In addition, competition for insurance reimburse-

15. *In re Hospital Corp. of America*, 49 ANTITRUST & TRADE REG. REP. (BNA) No. 1239, at 781, 782 (Nov. 7, 1985).

16. See, e.g., Pauly, *The Economics of Moral Hazard: Comment*, 58 AM. ECON. REV. 531 (1968); Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941 (1963).

17. See P. FELDSTEIN, *supra* note 14, at 260; C. HAVIGHURST, *supra* note 10, at 83-87, 253-56.

18. Unfortunately, these government financed programs were based on the private insurance model despite its deficiencies. See Havighurst, *Competition in Health Services: Overviews, Issues and Answers*, 34 VAND. L. REV. 1117, 1124 (1981).

19. C. HAVIGHURST, *supra* note 10, at 83-87, 253-56; P. FELDSTEIN, *supra* note 14, at 260. Of course, the effect of third party payment on incentives will be smaller if an insurance policy has deductible or co-payment features.

20. C. HAVIGHURST, *supra* note 10, at 54-55, 291.

21. See Kallstrom, *Health Care Cost Control by Third Party Payors: Fee Schedules and the Sherman Act*, 1978 DUKE L.J. 645, 647 (1978); Feldstein, *Hospital Cost Inflation: A Study of Non-Profit Price Dynamics*, 61 AM. ECON. REV. 853, 853-54, 870 (1971); Arrow, *supra* note 14, at 941, 961-62.

ment among health care providers creates inefficiency by encouraging providers to offer the health care consumer the most comprehensive and comfortable care possible. In summary, although third party payment and fee-for-service reimbursement result in a high quality health care system, it is a system in which consumers overdemand, providers overinvest and oversupply, and costs are very high.

One unavoidable problem that contributes to the difficulties in health care is the unique nature of the system and the product: "Basic to the problem is the subtle, elusive and indeed almost undefineable nature of the product."²² In fact, it is doubtful whether the current health care system is really a "system" at all. As one scholar has noted, the existing system is far from unitary and may be described more accurately as a "non-system."²³ Health care delivery really involves a series of interrelated, but discrete, markets. These markets include the patient's demand for medical treatment as expressed through the physician as decision-maker, the demand for the institution in which care is provided, the demand for manpower, the demand for professional health care education, and the supply side of each of these markets. This complex set of interrelationships determines the prices and quantities of available medical care and constitutes the framework for any policy analysis.²⁴

B. *Market Responses*

These informational deficiencies have resulted in a number of market responses. Traditional responses have included the development of health insurance, as discussed above, and of the role of the physician. Due to a patient's limited knowledge, "[t]he doctor is his repository of information and expertise,"²⁵ playing a critical role in the prescription of drugs, selection of tests and specialists, and determining admission and discharge from hospitals.

More recent market responses have been directed at the high costs of health care. Since these rising costs affect insurance companies, employers and individual consumers, market responses to the inefficiencies of the third party payment system have proliferated. These market innovations include the development of health maintenance organizations (HMOs),²⁶

22. Enthoven, *Consumer-Choice Health Plan* (part I), 298 NEW ENG. J. MED. 650, 654 (1978).

23. C. HAVIGHURST, *supra* note 10, at 13-14.

24. See P. FELDSTEIN, *supra* note 14, at 36-38.

25. *In re Hosp. Corp. of America*, 49 ANTITRUST & TRADE REG. REP. (BNA) No. 1239, at 781, 782 (Nov. 7, 1985).

26. HMOs have been viewed as a response to consumer information deficiencies, providing a "degree of quality assurance." C. HAVIGHURST, *supra* note 10, at 81. Milton Friedman has referred to "medical teams," or group practices, as the "department stores of medicine." M. FRIEDMAN, *supra* note 1, at 159.

foundation plans,²⁷ preferred provider organizations (PPOs), the voluntary use of peer fee and utilization review, diagnosis-related groups (DRGs), and other cost containment measures. While some of these market responses have had positive effects in solving problems, as will be discussed below, they have met with many difficulties. For example, their use has raised a number of antitrust concerns.²⁸ More importantly, their success has perversely led to attempts to restrict them through a variety of governmental limitations.²⁹

C. Regulatory Responses

Many regulatory responses to the health care market failure discussed above have been developed. Perhaps the most traditional regulatory response to the health care consumer information deficiency is licensing.³⁰ States generally protect health care consumers by authorizing some agency to license health care providers and impose punishments for disciplinary infractions. Regulatory responses to market failure also include: certificate of need laws,³¹ which are intended to limit overinvestment and overcapacity; rate regulation;³² and a variety of cost containment measures used to monitor utilization and reimbursement such as peer review by professional standards review organizations (PSROs)³³ and fixing prices by categorization of homogeneous services in DRGs.³⁴

27. For a list of features typical of foundation plans, see *Arizona v. Maricopa County Medical Soc'y*, 457 U.S. 332, 339-40 (1982).

28. See, e.g., *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119 (1982); *Arizona v. Maricopa County Medical Soc'y*, 457 U.S. 332 (1982). See generally R. HALPER & J. MILES, *ANTITRUST GUIDE FOR HEALTH CARE COALITIONS* (1983).

29. See *infra* text accompanying notes 62-64.

30. See P. FELDSTEIN, *supra* note 14, at 260; C. HAVIGHURST, *supra* note 10, at 78-79.

31. See C. HAVIGHURST, *supra* note 10, at 53-74.

32. See *id.* at 56-57; Kallstrom, *supra* note 21, at 689-91; Arrow, *supra* note 16, at 966-67.

33. PSROs were established pursuant to the Social Security Amendments of 1972, Pub. L. No. 92-603, 86 Stat. 1329 (codified in scattered sections of 42 U.S.C.). For further discussion, see P. FELDSTEIN, *supra* note 14, at 308-09; Havighurst & Bovbjerg, *Professional Standards Review Organizations and Health Maintenance Organizations: Are they Compatible?* 1975 UTAH L. REV. 381; Havighurst & Blumstein, *Coping with Quality/Cost Tradeoffs in Medical Care: The Role of PSROs*, 70 NW. U.L. REV. 6 (1975). The Social Security Amendments of 1983, Pub. L. No. 98-81, 92 Stat. 65 (codified in scattered sections of 39 U.S.C.) replaced PSROs with Peer Review Organizations (PROs) as part of the Medicare Prospective Payment System. See Enthoven & Noll, *Prospective Payment: Will It Solve Medicare's Financial Problems?* 1 ISSUES SCI. & TECH. 1, 101-05 (1984).

34. DRGs were adopted by Congress in the Social Security Amendments of 1983 as an aspect of the Medicare Prospective Payment System. See Enthoven & Noll, *supra* note 33, at 103-04. Also,

Licensing is not a solution to all of the informational problems faced by consumers. Patients must still depend on doctors to serve as repositories of information and as decision-makers. Moreover, licensing agencies have neither sufficient power nor adequate knowledge to interfere with the physician's decisions except in clear cases of gross wrongdoing or fraudulent behavior. Thus, the government protects consumers from making poor medical decisions through licensing only in that its standards and available disciplinary procedures guarantee some basic level of provider competence and integrity.

Most of the other regulatory responses have also failed to achieve their intended effects. Many studies have shown that certificate of need laws have not been effective in constraining the growth rate of hospital facilities,³⁵ and that they may also retard innovation.³⁶ In fact, some observers regard the imposition of rate regulation as an official recognition that certificate of need laws have failed.³⁷

PSROs have also been ineffective. A study by the Congressional Budget Office (CBO) found that PSROs had not reduced utilization.³⁸ In fact, the CBO concluded that "[t]he program consumes more resources than it saves society as a whole."³⁹ The report is consistent with predictions that PSROs would prove to be inadequate as a resource allocation mechanism,⁴⁰ and would be incapable of making the necessary quality-quantity tradeoffs.⁴¹ Indeed, PSROs may produce more costs rather than contain them.⁴² Moreover, it has been suggested that peer review organizations (PROs), the successors to PSROs, are unlikely to reduce hospital utilization for the same reasons.⁴³

The evidence regarding rate regulation and DRGs is not so dismal. The results, however, do not support their continued use as regulatory

some states have adopted DRGs. For a discussion of New Jersey's experiment with DRGs, see Morone & Dunham, *Slouching Towards National Health Insurance: The New Health Care Politics*, 2 YALE J. ON REG. 263, 264-75 (1985).

35. The classic study is by Salkever and Bice. That study and others are summarized in C. HAVIGHURST, *supra* note 10, at 63-74.

36. See, P. FELDSTEIN, *supra* note 14, at 278.

37. See *id.* at 282.

38. *Id.* at 309. Other studies have reached the same conclusion. See, e.g., Blumstein & Sloan, *Redefining Government's Role in Health Care: Is A Dose of Competition What the Doctor Should Order?* 34 VAND. L. REV. 849, 874-75 (1981).

39. P. FELDSTEIN, *supra* note 14, at 309.

40. See generally Havighurst & Blumstein, *supra* note 33.

41. *Id.* at 20-38.

42. See *id.* at 66. In addition, the administrative costs of a PSRO program may be significant. On both points, see Blumstein & Sloan, *supra* note 38, at 874-75.

43. See Enthoven & Noll, *supra* note 33, at 108.

devices. Although rate regulation has been effective in some states in holding down annual rate increases,⁴⁴ it is not likely that it reduces prices below those that would prevail in free markets. Moreover, rate regulation may prevent price competition and even facilitate collusion.⁴⁵ More important, rate regulation is theoretically deficient as a device for containing the costs of medical care, since any form of price regulation creates perverse incentives regarding efficiency.⁴⁶

The evidence on DRGs suggests that they have been effective in containing costs.⁴⁷ Nevertheless, DRGs have still been subject to criticism. They have been attacked on the ground that their administered, rather than market, nature means that hospitals will not compete by offering lower prices.⁴⁸ Thus, critics predict that DRGs will not substantially affect or reduce inflation in Medicare costs.⁴⁹ On a more fundamental level, DRGs create problems, particularly for indigent patients, that may outweigh their success as a cost containment measure. Some critics claim that patients will be “dumped” and that patients requiring substantial services will be discharged in favor of patients requiring few resources.⁵⁰ DRGs may also increase hospital admissions and costs and create incentives to categorize services in more profitable groups, a phenomenon known as “DRG creep.”⁵¹ Still other potential problems with DRGs noted by commentators include diminished quality of services, restricted access to health care, retarded innovation in the delivery of health care,⁵² increased

44. See P. FELDSTEIN, *supra* note 14, at 304-07.

45. See C. HAVIGHURST, *supra* note 10, at 437.

46. See P. FELDSTEIN, *supra* note 14, at 293, 310; Blumstein & Sloan, *supra* note 38, at 875-79. As such, rate regulation and other forms of health regulation may contribute to overexpansion rather than reducing it. See C. HAVIGHURST, *supra* note 10, at 30-31. This effect, of course, is simply another illustration of the fact that regulation generally produces overinvestment. See Averch & Johnson, *Behavior of the Firm Under Regulatory Constraint*, 52 AM. ECON. REV. 1052 (1962).

47. See Thurow, *Medicine Versus Economics*, 313 NEW ENG. J. MED. 611, 612 (1985); Morone & Dunham, *supra* note 34, at 275-77; Dolenc & Dougherty, *DRGs: The Counterrevolution in Financing Health Care*, 15-3 HASTINGS CENTER REP. 19 (June 1985). These cost reductions, however, may be offset by other cost increases. Professors Enthoven and Noll have stated that “[a] major share of the cost reduction in Medicare will reappear in the federal deficit through reduced tax revenues.” See Enthoven & Noll, *supra* note 33, at 112.

48. Enthoven & Noll, *supra* note 33, at 104. Enthoven and Noll have stated that “[t]hese problems stem from the fact that Medicare’s Prospective Payment System is based on *administered* rather than *market* prices. The DRG prices are not bids by a cost-conscious prudent buyer seeking to elicit just the needed supply of services.” *Id.* at 112 (emphasis in original).

49. See Morone & Dunham, *supra* note 34, at 264.

50. Enthoven & Noll, *supra* note 33, at 105, 107-08; Thurow, *Learning to Say “No”*, 311 NEW ENG. J. MED. 1569, 1571 (1984).

51. Enthoven & Noll, *supra* note 33, at 107, 109-10. Professors Enthoven and Noll report that a new consulting industry is emerging to advise hospitals on how to report cases for the best reimbursement. *Id.* at 109.

52. Dolenc & Dougherty, *supra* note 47, at 20-23, 25-26.

insolvency of urban hospitals, greater cost shifting, and ultimately, persistent medical cost inflation.⁵³

Part of the reason regulatory solutions have not been successful in the health care field is the economic self-interest of the providers.⁵⁴ Despite the poor performance of health care regulation in some regards, it has definitely benefitted one interest group—the providers. Economists have suggested that health care providers, represented by the professional groups and hospital associations, extensively and successfully lobby for legislation that protects their economic position. Regulation therefore serves its common role as a means of transferring wealth from consumers to providers.⁵⁵ The various forms of health care regulation enhance the health care providers' position by increasing the demand for services, securing the greatest amount of reimbursement, reducing the price and increasing the quantity of complementary goods and services, decreasing the availability of substitutes, and limiting growth in supply.⁵⁶ In addition, once such anti-consumer regulation is implemented, the administration of them is dominated by those same providers, who continue to protect their own interests. The administration of certificate of need laws, for example, has been employed by the health care industry to protect existing hospitals⁵⁷ and to discriminate against new competitors.⁵⁸ Similarly, PSROs have been controlled by the medical profession.⁵⁹ Licensing schemes also are dominated by the medical profession, and frequently lead

53. Morone & Dunham, *supra* note 34, at 264. It has even been suggested that DRGs may establish the political conditions for establishing a national public health care system. *Id.* at 280-89. See also *infra* note 55.

54. See Owen, *Interest Groups and the Political Economy of Regulation*, in *INCENTIVES VS. CONTROLS IN HEALTH POLICY* 26 (J. Meyer ed. 1985); P. FELDSTEIN, *supra* note 14, at 308; C. HAVIGHURST, *supra* note 10, at 26; Benham, *Guilds and the Form of Competition in the Health Care Sector*, in *COMPETITION IN THE HEALTH CARE SECTOR* 363-74 (W. Greenburg ed. 1978).

55. Economists have pointed out that provider interest groups seek, or more specifically "purchase," regulation as a means of transferring wealth from consumers to themselves as providers. See Peltzman, *Toward a More General Theory of Regulation*, 19 J. L. & ECON. 211 (1976); Stigler, *The Theory of Economic Regulation*, 2 BELL J. ECON. & MGMT. SCI. 3 (1971). Another theory that has been applied to explain the evolution of regulation involves "new interest group politics." According to this theory, a "dense environment" exists in which "groups find themselves in a network of large well-organized corporate interests whose destinies have become visibly linked." In such an environment, the important political actors are large, the interests are well organized, and the objectives and conduct of the organizations are interrelated. As a result, an instability results that produces increased administrative authority and autonomy for the state agency—the crucial actor. This theory has been used to predict the likely emergence of a national health insurance system. See Morone & Dunham, *supra* note 34, at 285-91.

56. See P. FELDSTEIN, *supra* note 14, at 483-500. See also Owen, *supra* note 54, at 31.

57. See P. FELDSTEIN, *supra* note 14, at 278-79; C. HAVIGHURST, *supra* note 10, at 26-30. As Professor Havighurst explains, the use of health systems agencies was intended to diminish professional influence by providing representation of a broad constituency; nevertheless, provider influence persisted. *Id.*

58. See *infra* text accompanying notes 62-64.

59. C. HAVIGHURST, *supra* note 10, at 35; Havighurst & Blumstein, *supra* note 33, at 9, 45-51.

to professional rather than consumer protection.⁶⁰ Thus, the political economy of health care has produced protectionist legislation that reinforces the claims of critics that society would benefit from a system that relies more heavily on competition.

D. *Some Permissible Conclusions*

The development of the health care system and its regulation permit some conclusions that are important to understanding the need for reform. First, these regulatory responses impose welfare costs because the regulation significantly reduces the efficiency of the health care delivery system. One common anti-competitive effect of regulatory measures is the creation of barriers to entry. A classic example of this anti-competitive effect is licensing, which effectively limits the supply of available health care providers.⁶¹ Similarly, certificate of need laws protect existing providers from potential competitors and thereby result in the limitation of available health care facilities.

Second, although regulation is designed to correct problems that result from market failure, it often interferes further with the efficient functioning of the market. In particular, opponents of competition have used regulation to impair market responses that had arisen to solve problems faced by consumers. For example, although HMOs were designed to ameliorate consumer purchasing disabilities and informational deficiencies, their foes have used state certificate of need laws and federal regulation to retard the development of HMOs,⁶² because they constituted a threat to incumbent providers.⁶³ In some states, PPOs have been subjected to similar restrictions.⁶⁴

Third, the development of the health care system is characterized by the continuing process of action and reaction between market failure and the

60. See C. HAVIGHURST, *supra* note 10, at 89-92. In general, professional regulation protects the regulated provider of the service rather than the consumer. See Rose, *Professional Regulation: The Current Controversy*, 7 LAW AND HUM. BEHAV. 103; Rose, *Occupational Licensing: A Framework for Analysis*, 1979 ARIZ. ST. L. J. 193-200.

61. Most licensing systems create barriers to entry. See Rose, *Occupational Licensing: A Framework for Analysis*, *supra* note 60, at 193-99.

62. See P. FELDSTEIN, *supra* note 14, at 278-79, 346-47; C. HAVIGHURST, *supra* note 10, at 214-24. Statutory changes at the federal level in 1979 mitigated the discrimination against HMOs. *Id.* at 224-30.

63. Historically, the concept of pre-paid health plans was an anathema to the medical profession and the American Medical Association considered both salaried practice by doctors and prepaid medical care unethical. See *American Medical Ass'n. v. United States*, 130 F.2d 233 (D.C. Cir. 1942), *aff'd*, 317 U.S. 519 (1943).

64. See Address by Douglas Ginsburg, Assistant Attorney General, Antitrust Division, Department of Justice, *Antitrust and the New Competition in Health Care*, National Health Lawyers Association, Washington, D.C., reprinted in 50 ANTITRUST & TRADE REG. REP. (BNA) 174-76 (Jan. 23, 1986).

market and regulatory responses to that failure. Although the dynamics of the free market produce actions and reactions in moving toward new equilibria, the process in the health care industry frequently involves the visible hand of government, not just the invisible hand of Adam Smith. Thus, a market deficiency induces a regulatory response, which induces a further market response, or the deficiency produces a market response, which induces a regulatory response. Moreover, the contradictory interests of health care consumers, who seek lower costs, and health care providers, who seek to maximize profits, further fuels this reactive process. In short, regulation often creates additional problems by accelerating market failure or thwarting market responses to such failures, thereby diminishing overall consumer welfare instead of increasing it.

Regulation has failed to solve these problems facing the health care industry.⁶⁵ This failure has not surprised many informed commentators, in light of the distinctive nature of the health care market and the theoretical deficiency of regulation, particularly its creation of perverse incentives. As one commentator has noted, “[t]he regulatory approach is trying to make water run uphill.”⁶⁶ Furthermore, regulation’s lack of a sound methodology and its operation in a political environment creates a substantial likelihood that it will fail to resolve effectively the difficult tradeoff issues that health care raises.⁶⁷ Despite its deficiencies in resolving market failure elsewhere, regulatory solutions have been applied to market failure in the health care industry, leading to predictably negative results.⁶⁸ Professor Havighurst, a leading health care scholar, has suggested that society has not learned from the lessons of past regulatory experiences: “It is curious, to say the least, that mechanisms of economic regulation similar to those that have performed so poorly in other regulated industries—and that, in particular, have caused them to absorb excessive resources—were seized on to correct inflation and excessive growth in the health care industry.”⁶⁹

II. The Movement for Reform

Given the development of such a system and the corresponding regulatory responses, it is not surprising that the health care system has been the subject of severe criticism. What developed was not just a new world of acronyms, but a very complicated, confusing, and expensive system. In

65. See, e.g., Havighurst, *supra* note 18, 1120-22; Blumstein & Sloan, *supra* note 38.

66. A. ENTHOVEN, *HEALTH PLAN 94* (2d ed. 1981).

67. Havighurst, *supra* note 18, at 1120; Havighurst, *Health Care Cost-Containment Regulation: Prospects and an Alternative*, 3 *AM. J.L. & MED.* 309, 313-15 (1977).

68. See P. FELDSTEIN, *supra* note 14, at 282; C. HAVIGHURST, *supra* note 10, at 4, 32.

69. C. HAVIGHURST, *supra* note 10, at 20.

economic terms, this system was characterized by substantial inefficiency and significant negative welfare effects. As a result, many reform advocates proposed heavier reliance on competition and incentive-based policies. First, we shall consider some of the general justifications for implementing a competitive health care delivery system, and then we shall analyze some of the specific policy issues that must be resolved in the search for broader incentive-based policies.

A. *The Benefits of Competition*

Many commentators have argued that greater competition would be socially beneficial,⁷⁰ particularly if it were tailored to the unique market for medical services and selectively permitted.⁷¹ Advocates of greater competition in the health care industry not surprisingly have encountered disagreement and controversy from commentators skeptical of the value of competition.⁷² Professor Havighurst, however, has carefully analyzed the arguments in favor of a mixed, competitive health care delivery system, including various objections to market theory, provider objections to competition, the nature of competition between competing health plans, and other equitable considerations.⁷³ He concluded that “[t]he competitive strategy, in addition to being supported by a powerful theory that is not undercut by the existence of any insurmountable market failure, comes out very well in any realistic comparison with alternative mechanisms for controlling the health care industry’s economic performance.”⁷⁴ It is important to underscore that most proposals for health care reform call for greater competition within the context of a mixed system of competition and governmental regulation, not the conversion to a completely competitive system.

70. *Id.*; COMPETITION IN THE HEALTH CARE SECTOR, *supra* note 18; *A Special Symposium: Market-Oriented Approaches to Achieving Health Policy Goals*, *supra* note 10.

71. *See, e.g.*, C. HAVIGHURST, *supra* note 10, at 97-98; Pauly, *supra* note 13; Blumstein & Sloan, *supra* note 38; Bovbjerg, *Competition versus Regulation in Medical Care: An Overdrawn Dichotomy*, 34 VAND. L. REV. 965 (1981); Enthoven, *Consumer Choice Health Plan* (parts 1 & 2) 298 N. ENG. J. MED. 650, 709 (1978).

72. *See, e.g.*, Ginzberg, *The Grand Illusion of Competition in Health Care*, 249 J. A.M.A. 1857 (1983); Ginzberg, *Competition in Health Care: A Second Opinion*, HOSPITALS, Mar. 16, 1982, at 81. *Cf.* Weisbrod, *Competition in Health Care: A Cautionary View*, in MARKET REFORMS IN HEALTH CARE 61 (J. Meyer ed. 1983); Marmor, Boyer & Greenberg, *Medical Care and Procompetitive Reform*, 34 VAND. L. REV. 1003 (1981); Rosenblatt, *Health Care, Markets, and Democratic Values*, 34 VAND. L. REV. 1067 (1981).

73. *See* Havighurst, *supra* note 18, at 1130-43.

74. *Id.* at 1157. In fact, Professor Havighurst believes that the 1979 amendments to the Public Health Service Act marked a transition to a more competitive system since Congress expressly recognized the value of competition and directed regulators to give appropriate consideration to competition in making their regulatory decisions. C. HAVIGHURST, *supra* note 10, at 137-38, 224-30, 263-85.

Advocates of greater competition assert that the performance of the health care delivery industry would be significantly improved by the creation of competing health care delivery plans and financing mechanisms from which the consumer could intelligently choose.⁷⁵ By insuring the development of competing alternative delivery systems that would greatly expand consumer choice, competition would operate "[a]s a vehicle for turning the health care industry's fragmentation into a virtue."⁷⁶

Successful alternative plans would produce the best economic value and the approach to health care desired by customers. Health care providers that satisfied their customers in terms of quality and economy would survive and profit; providers that did not meet the standard demanded by the health care consumer would fail. Such a competitive system would create incentives for allocative and transactional efficiency, would increase productivity, and would encourage innovation in preventive care and health education.⁷⁷

The experience with HMOs provides a good example of the benefits competition would produce.⁷⁸ HMOs are one of the many types of health care plans and financing mechanisms that might emerge in a competitive environment. More broadly, Enthoven's "Consumer Choice Health Plan"⁷⁹ is but one of many innovative proposals.⁸⁰ If such competitive strategies were pursued and permitted to flourish in a non-regulated environment, no shortage of alternative plans would arise. Absent artificial governmental or professional barriers to entry,⁸¹ the market will create incentives for better health care delivery innovators to produce better health care delivery mousetraps.

75. See P. FELDSTEIN, note 14, at 326-28; C. HAVIGHURST, *supra* note 10, at 13-14; Enthoven & Noll, *supra* note 33, at 113; Enthoven, *Consumer-Choice Health Plan*: (part 2), 298 NEW ENG. J. MED. 709, 709-10 (1978). Competition would be among the various organized plans as well as between those plans and the fee-for-service sector. See Enthoven, *Competition of Alternative Delivery Systems*, in *COMPETITION IN THE HEALTH CARE SECTOR*, *supra* note 10, at 262-73. In addition, insurance companies might limit their dealings to efficient providers through some type of closed panel health care alliance. See Havighurst, *supra* note 18, at 1128-29.

76. C. HAVIGHURST, *supra* note 10, at 13.

77. P. FELDSTEIN, *supra* note 14, at 328-30.

78. See, e.g., P. FELDSTEIN, *supra* note 14, at 347-49, 398; C. HAVIGHURST, *supra* note 10, at 114-17; Enthoven & Noll, *supra* note 33, at 115-16; Havighurst, *supra* note 18, at 1125-27.

79. See Enthoven, *supra* note 75.

80. Commentators have identified and discussed several of these proposals. See P. FELDSTEIN, *supra* note 14, at 327-28; C. HAVIGHURST, *supra* note 10, at 396-406; Marmor, Boyer & Greenberg, *supra* note 72, at 1016-21; Enthoven, *supra* note 71, at 710.

81. It is important to ensure, however, that existing providers not be permitted to use regulation, as they previously have, to inhibit the development of new delivery mechanisms. See Finkler, *Changes in the Certificates-of-Need Laws: Read the Fine Print*, in *INCENTIVES VS. CONTROLS IN HEALTH POLICY*, *supra* note 54, at 132. The author focuses upon the possibility that certificate of need laws might be used to restrict the development of free-standing ambulatory surgical centers. He also points out that the same potential problem exists regarding free-standing emergency centers and home health agencies. *Id.* at 140.

Finally, any movement toward a more competitive health care delivery system must be sensitive to the transitional problems that may arise. The market failure that has always characterized health care delivery, particularly the informational deficiencies, cannot be ignored.⁸² Thus, advertising the various delivery and financing system alternatives would be one important prerequisite to effective health care competition.⁸³ Traditional professional objections to advertising must also be eliminated since such restrictions only aggravate market failure. Informational deficiencies may even require that consumers receive some type of knowledgeable assistance in making their purchasing decisions. Third parties who provide such assistance should possess comprehensive information about available choices or actually act as purchasing agents in choosing an appropriate plan for consumers. Other transitional problems include rethinking the role of planners and regulators and insuring flexibility in the configurations of the various alternate plans.⁸⁴

B. *Towards Broader Incentive-Based Policies*

As advocates of reform continued to examine the health care delivery system, they recognized that effective reform required more comprehensive changes in governmental policy. Further examination of the health care industry produced significant new information regarding the operation of the health care system,⁸⁵ the impact of government programs, and changing economic conditions.⁸⁶ Moreover, government policies that increase the demand for health care and stimulate its supply, combined with widely available insurance, have produced a steady increase in the relative share of resources devoted to health care.⁸⁷ Current advocates of reform now focus on these fundamental industry problems in their continuing search for a system of incentive-based health care policies.⁸⁸

82. See Havighurst, *supra* note 18, at 1148-52.

83. See P. FELDSTEIN, *supra* note 14, at 330.

84. See Havighurst, *supra* note 18, at 1152-57.

85. For example, the new evidence suggested that "[m]ost employees have little, if any, choice in health care plans" and that where choice existed, "the deck [was] typically stacked against the less expensive plans" despite consumer preference for less expensive coverage. MARKET REFORMS IN HEALTH CARE, *supra* note 72, at 5.

86. A recent study indicates that the continuing increase in health care costs is not simply a result of increases in doctor and hospital charges, but reflects general inflation, greater utilization of health care as a result of the increased real income, and population growth. Virts & Wilson, *The Determinants of Rising Health Care Costs: Some Empirical Restatements*, in INCENTIVES VS. CONTROLS IN HEALTH POLICY, *supra* note 54, at 67. See also Meyer, *Health Care Policy: Historical Background and Recent Developments*, in INCENTIVES VS. CONTROLS IN HEALTH POLICY, *supra* note 54, at 2.

87. Meyer, *supra* note 86, at 1-2.

88. Not surprisingly, these continuing developments have also prompted proposals for reregulation. A leading suggestion would involve state regulation of hospital rates payable by both public and private third party payors. See Havighurst, *The Debate Over Health Care Cost-Containment Regulation: The Issues and the Interests*, in INCENTIVES VS. CONTROLS IN HEALTH POLICY, *supra* note 54, at 9, 18-24. Commentators have suggested that hospital rate regulation might be sought by non-profit

In light of comprehensive research undertaken by the American Enterprise Institute's Center For Health Policy Research (AEI),⁸⁹ health care reformers now use four basic principles in developing a broad, incentive-based approach: (1) a system of sharing costs that encourages people to economize on the use of routine health services, while offering greater protection from the costs of serious illness; (2) federal aid to low income people that increases with need; (3) fixed, instead of open-ended, federal subsidies to those unable to purchase adequate health insurance; and (4) fair competition among alternative health plans.⁹⁰ Several recent legislative proposals apply these principles⁹¹ and, if passed, would significantly change the nature of health care delivery and financing. In order to assure that the current system of federal and state regulation does not impede the effectiveness of these proposals in the event that they are adopted,⁹² subsequent restructuring of the existing health care regulatory framework may be necessary. In addition, although these proposals promise benefits, they also create administrative complexity and adverse selection problems,⁹³ which must be resolved. These proposals and the recent research focus upon reforms in federal tax law, Medicare, and Medicaid.

1. *Federal Tax Law*

Numerous health reform advocates have identified the critical link between tax policy and meaningful health care reform.⁹⁴ Reformers are primarily concerned with the exclusion of employer contributions from taxable employee income and the deductibility of such contributions, which have two important effects.⁹⁵ First, this tax treatment results in

hospitals to curtail competition from recently expanding for-profit hospitals. See Fanara & Greenberg, *Factors Affecting the Adoption of Prospective Reimbursement Programs by State Governments*, in INCENTIVES VS. CONTROLS IN HEALTH POLICY, *supra* note 54, at 144. This support for reregulation may again illustrate the demand for regulation by existing providers to further their own self-interest. See *supra* text accompanying notes 62-64.

89. See, e.g., INCENTIVES VS. CONTROLS IN HEALTH POLICY, *supra* note 54; MARKET REFORMS IN HEALTH CARE, *supra* note 72.

90. Meyer, *supra* note 72, at 4. The AEI Center has also identified a multi-faceted strategy for implementing these principles. *Id.* at 5.

91. *Id.* at 5; Sullivan, *Administrative Problems with Proposals for Health Care Reform*, in MARKET REFORMS IN HEALTH CARE, *supra* note 72, at 225-40 (summarizing the characteristics of the various proposals).

92. See Gibson & Reiss, *Health Care Delivery and Financing: Competition, Regulation and Incentives in MARKET REFORMS IN HEALTH CARE*, *supra* note 72, at 243.

93. See Sullivan, *supra* note 91, at 239-40.

94. See, e.g., Taylor & Wilensky, *The Effect of Tax Policies on Expenditures for Private Health Insurance*, Sullivan & Gibson, *Tax-Related Issues in Health Care Market Reform*, and Phelps, *Tax Policy, Health Insurance, and Health Care*, in MARKET REFORMS IN HEALTH CARE, *supra* note 72, at 163, 185, 198; Gensheimer, *Reform of the Individual Income Tax: Effects on Tax Preferences for Medical Care*, in INCENTIVES VS. CONTROLS IN HEALTH POLICY, *supra* note 54, at 53-66; C. HAVIGHURST, *supra* note 10, at 387-96; Enthoven, *supra* note 75, at 709, 711-12.

95. See Taylor & Wilensky, *supra* note 94, at 163-64; Sullivan & Gibson, *supra* note 94, at 185-

substantial revenue losses to the government. Second, and more important, “[t]he exclusion effectively reduces the price of insurance to consumers and thereby provides an incentive for employees to purchase more insurance than they would if they were using taxable income.”⁹⁶ As a result, employees utilize more medical care and providers respond by increasing prices as well as the level of service.⁹⁷

Recent research indicates that the impact of tax policy on expenditures for private health insurance is significant.⁹⁸ Some estimates suggest that the current law results in an annual twenty-five billion dollar subsidy to health care, exclusive of Medicare and Medicaid, and is likely to grow further.⁹⁹ While social policy may support tax subsidies for health care,¹⁰⁰ a reform effort intended to increase consumer and provider efficiency is necessarily undermined by federal tax law. Thus, reform advocates propose changes in the laws in order to achieve efficiency gains.¹⁰¹

2. Medicare

Reformers have also called for changes in Medicare. Proposals seeking to change the provider and recipient incentives created by Medicare would redesign benefit and reimbursement options and offer a voucher-based system.¹⁰² Redesigning benefits would result in increased cost-sharing between patients and hospitals and would discourage overutilization of resources. Altering reimbursement mechanisms to use prospective

86.

96. Taylor & Wilensky, *supra* note 94, at 163. See also *supra* notes 15-18 and accompanying text.

97. Sullivan & Gibson, *supra* note 94, at 185.

98. Taylor & Wilensky, *supra* note 94, at 180-82. Taylor and Wilensky argue that there would be positive short run and long run effects on efficiency from limiting the tax benefits of employer contributions. *Id.* at 179-82; See also MARKET REFORMS IN HEALTH CARE, *supra* note 72, at 5-6. Other commentators feel that the effects may be more ambiguous, depending on the adjustments that employees make in their health insurance regarding deductibles, copayment rates, coverage limits, and the scope of benefits. See Phelps, *supra* note 94, at 207-12, 219-20.

99. Phelps, *supra* note 94, at 200; Sullivan & Gibson, *supra* note 94, at 185.

100. See, e.g., Phelps, *supra* note 94, at 199-201.

101. Since the tax treatment of employer contributions accounts for the most significant portion of lost revenues and increased utilization, most of the proposals for change have focused on this aspect of tax law. The proposals have also included several types of ceilings on the tax-exemption for employer contributions, cash rebates to employees, and tax credits. See Sullivan & Gibson, *supra* note 94, at 187-90, 193-96. Other broader proposals have involved the medical expense deduction, the tax-exempt status of hospitals and health insurers such as Blue Cross and Blue Shield, charitable contributions, and the tax treatment of bonds, as well as state and local income, sales, and property taxes. *Id.* at 196-97; Phelps, *supra* note 94, at 198-99, 217-18. In addition, one commentator has analyzed the elimination of these various tax preferences for health care in the broader context of individual income tax reform. See Gensheimer, *supra* note 94.

102. See, e.g., Ginsburg, *Market-Oriented Options in Medicare and Medicaid*, in MARKET REFORMS IN HEALTH CARE, *supra* note 72, at 103, 107-16; C. HAVIGHURST, *supra* note 10, at 416-19; Enthoven, *supra* note 75, at 712-13. A recent congressional report supported Medicare vouchers as a beneficial reform. See Phoenix Gazette, Feb. 21, 1986, at A4, col 2.

payment and capitation would encourage provider efficiency. Voucher based systems enhance individual choice by creating incentives for consumers to seek low cost providers, although such systems create certain competitive and adverse selection problems.¹⁰³ Given the impact of any Medicare reform on low income and aged persons, further proposals should be conditioned upon solving these problems.

3. *Medicaid*

Perhaps the most interesting target of the health care reform movement is Medicaid. Adopting the market-oriented approach of health care reform, several states have implemented experimental programs creating cost-conscious incentives for Medicaid recipients, providers, and the states.¹⁰⁴ As a result, the “[s]tates through Medicaid are a major testing ground for restructuring the health care system.”¹⁰⁵

In recent studies of the alternative financing and delivery mechanisms developed by the states, three primary objectives for Medicaid reform have emerged.¹⁰⁶ First, these experiments in incentive-based policies must have a positive impact, or at least no negative impact, on access to and the quality of health care. Second, these new programs must create financial incentives that encourage participation by providers. Third, these reforms must contribute to the control of Medicaid expenditures. Three recent studies performed by the AEI Center for Health Policy Research¹⁰⁷ identify some of the more significant state experiments, describe and compare their operation, and reach some preliminary conclusions regarding their promise and problems.¹⁰⁸

A 1983 study¹⁰⁹ identified several state and county Medicaid programs specifically aimed at encouraging cost-consciousness on the part of providers, recipients, and governmental entities. The study analyzed the development of primary care networks, case management systems, and

103. See Ginsburg, *Market Oriented Options in Medicare and Medicaid*, in *MARKET REFORMS IN HEALTH CARE*, *supra* note 72, at 112-16.

104. The federal government has facilitated these experiments in two ways. First, the Department of Health and Human Services (HHS) has exercised its statutory authority to waive certain Medicaid requirements. For a description of the waiver process, see P. HAYNES, *EVALUATING STATE MEDICAID REFORMS 3-4* (1985); D. FREUND, *MEDICAID REFORM: FOUR STUDIES OF CASE MANAGEMENT 3-6* (1984); Gibson, *Quiet Revolutions in Medicaid*, in *MARKET REFORMS IN HEALTH CARE*, *supra* note 72, at 80-81. In addition, HHS has given the states seed money to finance these experiments. See P. HAYNES, *supra*, at ix.

105. P. HAYNES, *supra* note 104.

106. *Id.*

107. *Id.*; D. FREUND, *supra* note 104; Gibson, *supra* note 104, at 87-101. See also *RESTRUCTURING MEDICAID: STATE AND LOCAL INITIATIVES* (S. Sullivan & R. Kern eds. 1983).

108. See D. FREUND, *supra* note 104, at ix.

109. Gibson, *supra* note 104.

alternatives to institutional long-term care¹¹⁰ in Oregon, Massachusetts, New York, Michigan, Colorado, and Arizona.¹¹¹ The study concluded that the development of primary care networks and case management, the increased use of cost-sharing, and the provision of community-based alternatives to institutional care represented a significant beginning in the long term restructuring of Medicaid.¹¹² More important, the state experiments under study successfully achieved more cost-effective care, better access for eligible persons, and more predictability of costs and reimbursements than traditional Medicaid programs.¹¹³

Another study of Medicaid reform in 1984¹¹⁴ examined four pilot projects in Michigan (Wayne County), Utah (Salt Lake, Weber, and Utah Counties), Kentucky (Jefferson County), and California (Santa Barbara County).¹¹⁵ The study inquired into the proper allocation of risk to providers, the relation between program design and quality of care, the establishment of grievance procedures, and program management.¹¹⁶ Each of the four programs was analyzed with respect to its political environment, constituency support, eligibility, enrollment, program administration, utilization review, and quality assurance.¹¹⁷ Each of the programs showed promise in achieving cost containment,¹¹⁸ despite some initial start-up problems and growing pains. Those administrative and management problems normally were a function of the program size and the rate of implementation.¹¹⁹

A 1985 study of Medicaid reform examined case management and capitation experiments in New York (Monroe County), Florida, Missouri, Minnesota, New Jersey, and California (Santa Barbara and Monterey Counties).¹²⁰ The study focused on the state programs' organizational structure, eligibility, legislation and waivers, provider characteristics, payment systems, provider incentives, covered services, beneficiary incentives,

110. *Id.* at 75. In particular, the study focused on a variety of state models involving federal waivers and state legislative action that limited free choice of providers and incorporated alternatives to open-ended reimbursement. *Id.* at 87-97.

111. *Id.* at 87-93.

112. *Id.* at 100-01. The study concluded that the programs surveyed represented "the first major efforts by the states to think decidedly differently about how to provide and finance medical services for the indigent—with both cost and quality as primary considerations." *Id.*

113. *Id.*

114. D. FREUND, *supra* note 104.

115. These particular programs were selected because of their geographical diversity and because they had not been part of any major evaluation by the federal government. *See id.* at 2.

116. *Id.* at xi.

117. *Id.* at 6-12. Each of the four programs is described in detail. *Id.* at 13-70. The study concludes with both a textual and tabular comparison of the programs. *Id.* at 71-83.

118. *Id.* at 20-26, 35-36, 48-52, 67-69.

119. *Id.* at 26-27, 36, 52-53, 69-70.

120. P. HAYNES, *supra* note 104.

and administrative functions.¹²¹ Although the examiners concluded that it would be premature to draw any firm conclusions from these experiments, the studies did indicate utilization and cost reductions.¹²² Moreover, the report also concluded that the programs created a competitive environment in terms of risk sharing between providers and the state and federal governments, that prepaid capitation systems had a significantly different effect upon providers than payment methods not involving financial risk, and that adequate planning, preparation, and program testing were critical to ensure the successful development of a program.¹²³

These state experiments demonstrate that Medicaid remains an important and vital frontier in health care reform. The states, with the support of the federal government, are creating better health care mousetraps. By implementing such innovative programs, the states are fulfilling their appropriate role in our federal system by serving as laboratories for governmental innovation.¹²⁴ Initial operational problems limiting the success of the programs are not discouraging, given their experimental nature and the complexity of the health care delivery problem. More important, these experimental programs suggest that a very different type of health care delivery system may emerge in the future. The crucial characteristic of these state Medicaid cost containment programs remains their incorporation of greater competition and the simulation of a free market among providers to increase overall efficiency.

III. The Arizona Indigent Health Care Program

Perhaps the best example of a state health care program integrating the private market characteristics advocated by health care reformers is the Arizona indigent health care plan, which alters incentives to encourage lower prices, without compromising the provision of quality health care to the indigent. Known as the Arizona Health Care Cost Containment System (AHCCCS),¹²⁵ the Arizona program is the first in the nation to use prepaid capitated health plans to provide health care to Medicaid eligible

121. *Id.* at 2-8, 17-36.

122. *Id.* at 13.

123. *Id.* at 13-16. The report also concluded that a variety of factors caused each state to modify its program during implementation, that several operational and financial considerations influenced the willingness of providers to participate, and that setting appropriate rates was a complex task in all cases for both technical and political reasons. *Id.*

124. See Babbitt, *State Regulatory Reform—A Gubernatorial Perspective*, 1985 ARIZ. ST. L.J. 253, 253-55.

125. See ARIZ. REV. STAT. ANN. §§ 36-2901 to 36-2917 (1985); ARIZ. ADMIN. COMP. R. R9-22-101 to R9-22-1002 (Supp. 85-5 1985). Much of the information contained in this section of the article was provided to the authors by the AHCCCS Administration.

persons and others on a state-wide basis. AHCCCS is an innovative program in Arizona because it established uniform standards for state-supported indigent care and a minimum health care service package. From a national standpoint, AHCCCS is innovative because it uses a prepaid health care delivery network instead of a fee-for-service Medicaid program.

Before the formation of AHCCCS, Arizona had no Medicaid program to provide care for the indigent.¹²⁶ A prolonged political controversy over state participation in Medicaid culminated in 1980 when the counties responsible for providing indigent health care could no longer provide such services because of increasing health care costs. Thus, the counties appealed to the Legislature for help. The Legislature responded by creating AHCCCS, a prepaid, capitated health care system jointly funded by the state, the counties, and the federal government.¹²⁷ Although day-to-day administration was initially the responsibility of a competitively selected outside administrator, the AHCCCS Administration, an independent state agency, currently operates the program.¹²⁸

AHCCCS is a natural outgrowth of the health care reform movement described throughout this article. The Arizona program incorporates freedom of choice for eligible members, competitive selection of providers, shared risk between the state, providers, and patients, and contract monitoring as a substitute for regulation. The AHCCCS program combines market forces to enhance efficiency and cost containment with government regulation of standards to ensure quality of care and administrative equity. This mixed system is designed to provide quality mainstream health care to eligible people, to contain costs, and to provide a stabilized annual base from which the state, county, and federal governments can predict the amount of funding necessary for the provision of indigent

126. Prior to statehood in 1912, the counties were responsible for indigent health care. In 1974, the Arizona legislature passed a bill authorizing the state to join the federal Medicaid program, but failed to provide funding to implement that law. The counties therefore remained responsible for indigent health care. The counties sought help from the state because the health care costs for indigent care had risen approximately 15% per year from 1975 to 1980, from \$58.6 million in 1975 to \$122.6 million in 1980. The counties predicted their health care costs would reach \$255.2 million by 1985.

127. AHCCCS was originally a three year experiment, terminating on September 30, 1985. In 1985, the legislature extended the program through September 30, 1987.

128. The AHCCCS Administration initially included a small division within the Arizona Department of Health Services, which set policy, wrote rules and regulations, and acted as a liaison with various levels of government. The program was designed with the understanding that the state would select a private company, through a competitive process, to administer the day-to-day operations of the program. The first such outside administrator under contract was McAuto Systems Group, Inc. (MSGI). Later, MSGI and the state became involved in a contract dispute and MSGI's contractual relationship with the program terminated on March 15, 1984. At that time, the Legislature created a new state department, the Arizona Health Care Cost Containment System Administration, which combined the responsibilities previously assigned to the Department of Health Services and to the contract administrator.

health care services. An indirect objective of AHCCCS is to serve as a prototype for other states wishing to convert their fee-for-service indigent health care programs to prepaid programs.

A. *Cost Containment and Incentive-Based Features*

Through statutory and regulatory guidelines, AHCCCS provides a framework within which private sector contractors provide services to eligible people. The AHCCCS program includes six major devices for realizing its objectives: health plan networks of primary care physicians to share the risk and to authorize and supervise care rendered to recipients; competitive bidding to select the AHCCCS health plans; prepaid capitated payments to the health plans; capitated payments by the Health Care Financing Administration (HCFA) to the State of Arizona; the use of nominal copayments; and certain restrictions on the choice of providers.

1. *Prepaid Capitated Contracts*

Prepaid capitated health care contracts control health care costs by placing both the health plans and the state at risk. Under prepaid capitated health care contracts, contractors agree to provide specific health care services for a fixed price per member per month. The health plans are paid by AHCCCS based upon the agreed monthly rate, regardless of the actual number of members who receive care from the health plan or the amount of health care services provided to any one member. Similarly, HCFA provides money to AHCCCS based on capitation rates that are fixed at 95% of the estimated cost of services currently delivered in Arizona under traditional fee-for-service arrangements. The state is therefore able to control its health care expenditures by establishing in advance the amount of health care expenditures to be paid out based upon the number of enrolled members.

Additionally, the state is placed at risk through reinsurance. Reinsurance is a mechanism under which the state and the health plans share the financial burden for the catastrophic or unusual medical costs incurred by enrolled members that exceed predetermined levels.¹²⁹

129. This form of reinsurance is known as administration reinsurance, and contrasts with contractor acquired reinsurance, under which a plan purchases insurance from a private company. Under the current administrative reinsurance scheme, the state bears 80% of costs incurred per individual member in excess of a specified level while the contractor bears 20% of those costs. The reinsurance levels are based on the size of the enrollment of a particular plan and currently are \$10,000 per member for plans with enrollments of 1-999 members, \$20,000 per member for plans with enrollments of 1000-9999 members, and \$30,000 per member for plans with enrollments of 10,000 members or more. AHCCCS has proposed reducing the maximum from \$30,000 to \$20,000 and the co-insurance to 90% and 10% or 95% and 5%, depending on the service, because reinsurance applies to Medically Needy or Medically Indigent (MN/MI) members without Medicare coverage. Thus, the state would effec-

2. *Nominal Copayments*

Another unusual feature of the AHCCCS program is the use of nominal copayments by members to discourage overuse of certain medical services. These nominal payments apply to routine doctor's office and home visits (\$1),¹³⁰ elective nonemergency surgery (\$5), and nonemergency use of the emergency room (\$5). Although these amounts are small and may be waived if the member is unable to pay, the AHCCCS Administration believes that copayments have had a positive effect in deterring overutilization.

3. *Selection of Providers*

One of the most innovative features of the AHCCCS program is its use of competitive bidding for the award of prepaid capitated contracts, the first statewide use of such a competitive selection process. Competitive bidding was designed to insure reliability and fairness in the selection of the AHCCCS health plans.¹³¹ Under this process, the plans submit bids with rates per member per month for each of the various groups of members served by AHCCCS. Figure 1 provides an overview of the AHCCCS competitive bidding process.

Implementing the competitive bidding process required the development of the Request for Proposals (RFP), which contains all the information, requirements, and specifications necessary to compete for selection as an AHCCCS health plan. The RFP also creates a framework that governs the entire process. Performance standards were developed to ensure that the RFP reflected the intent of the program.¹³² These standards describe performance expectations and minimum levels of achievement, and serve

tively assume a greater risk for a group of members that traditionally have higher medical costs. The limits and the co-insurance with regard to persons categorically eligible and MN/MI with Medicare would not be changed.

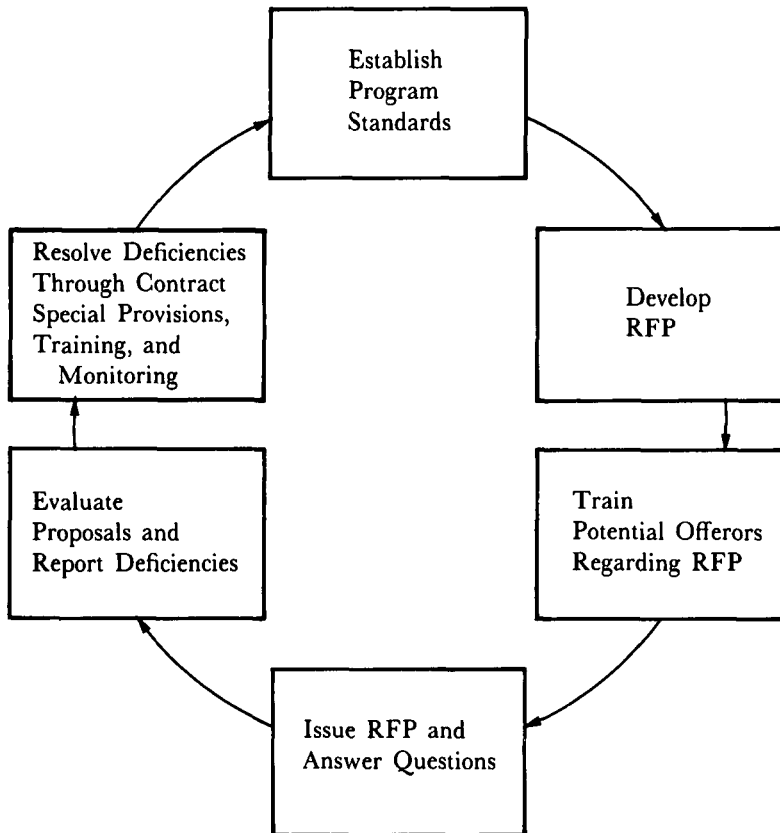
130. The copayment for office visits applies only where the member requests an appointment. Office visits scheduled by the doctor are excluded, as are early and periodic screening, diagnosis treatment services (EPSDT), which are for persons under 18 years of age and are required by federal law.

131. In addition, the AHCCCS process had to comply with both HCFA and Arizona legal requirements.

132. In general, performance standards provide for: (1) assurance of continuity of services; (2) maintenance of required service quality; (3) development of the cooperative environment between the offeror and the agency; (4) administration of the purchasing function fairly, equitably and efficiently; and (5) the soundness of the offeror's organization to assure the purchase of services consistent with established costs, quality, and performance criteria.

FIGURE 1

Overview of the AHCCCS Competitive Bidding Process



as the basis for the contractual scope of work and the evaluation of proposals.¹³³ In designing standards, the general objectives of the AHCCCS Administration were to develop clear, accurate, and uniform standards that maximized competitive and innovative service delivery and that were useable by health plans in preparing their proposals. In particular, effectiveness of both the RFP and ongoing contract administration necessitates the development of standards that are transferable and acceptable, equitable, enforceable, and valid and reliable.¹³⁴ AHCCCS developed

133. Standards have long existed in RFP procedures. Usually such standards either (1) have not been expressly stated in the RFP, (2) have not been agreed to by critical players in developing the RFP, (3) have not been made sufficiently specific and comprehensive to be useful in judging proposals, or (4) have not been the primary focus of evaluation.

134. "Transferable and acceptable" mean that the standards can be taken from the RFP and

standards in six areas: administration, subcontracting, organization, program service, program operation, and finances.¹³⁵ Upon finalization of the performance standards, the RFP was assembled.

After issuance of the RFP, AHCCCS holds a bidding conference. At the conference, the health plans may obtain clarification of the RFP and technical assistance in preparing their proposals. This information is crucial since contract awards are based on the bidder's compliance with established standards. This conference reflects the AHCCCS program priority to maintain as much open communication with the health plans as possible.

After the conference, AHCCCS receives and evaluates health plan bids. Evaluation involves a multi-step process. First, proposals must meet the criteria established by the RFP.¹³⁶ Second, the technical and fiscal merits of each conforming proposal are independently evaluated by a panel of qualified professionals. Proposals are then ranked by technical, fiscal, and AHCCCS past performance factors, as well as by prepaid capitated rate bids.

AHCCCS evaluates the bids based on a plan, given to interested bidders as part of the RFP, to ensure that contracts are awarded to plans best able to provide low-cost quality care.¹³⁷ The plan, which is composed of a

incorporated both into the contract and into the operation of offerors in the health plan operation. "Equitable" means that a standard applies equally to all offerors. "Enforceable" means standards that are capable of enforcement and that include design criteria that facilitate enforcement. Finally, "valid and reliable" mean that the standard must measure and control the object of its design and account for variations due to the nature of the program component.

135. Administrative standards specify certain requirements in the areas of financial resources, minimum health care benefits, quality of care, staffing requirements, and penalties for conduct inconsistent with either the final contract or AHCCCS rules and regulations. Subcontracting standards guide the health plans in meeting the health care network requirements. The AHCCCS program recognized that a majority of health plans would use subcontractors (e.g., primary care physicians, hospitals, pharmacies) to deliver required services. Organizational standards were developed in the areas of enrollment, marketing, difficult patient arrangements, reinsurance, records, retention, and reporting requirements. These standards provided specifications for critical areas where the health plan and the AHCCCS program would interact on a recurring basis. Program service standards ensure that each health plan was aware of the exact health care services that were required. The standards detailed the geographic coverage of services for each county and defined minimum health care networks. Program operation standards establish the functional requirements for a health plan. Standards were specified for quality assurance programs, utilization review programs, complaint and grievance processes, and member relations (i.e., referral procedures, appointment procedures, and member handbooks). Financial standards establish a baseline requirement for the financial stability of health plans, such as equity per enrollee and working capital ratio.

136. Each proposal is screened for that purpose. A proposal that is incomplete may, at the option of the Administration, be rejected as unresponsive. Unresponsive offerors are not allowed to supplement or add to their proposal after the closing date specified in the RFP.

137. In performing this evaluation, the primary methodology is to measure the degree to which a health plan's proposal deviates from a standard. This process of discrepancy analysis places a health plan's stated performance proposal on a scale. There is no reward for exceeding a standard, maximum points are awarded for meeting the standard, and specific points are subtracted if the standard is not met. The evaluation criteria were designed to be as quantitative as possible to reduce the role of

series of performance indicators based on the priority aspects of the standards,¹³⁸ focuses on seven criteria. First, a health plan must have adequate financial resources. Since HMOs generally take several years to show a profit, health plans must demonstrate sufficient financial resources to support their operations until they become self-sufficient. Second, a health plan must have an adequate health care network to provide all covered services to eligible members. The health care network is composed of primary care physicians, specialists, outpatient health services, pharmacies, medically necessary transportation services, dental services, inpatient hospital services, emergency services, medical supplies, and early and periodic screening, diagnosis and treatment (EPSDT) services.¹³⁹ Third, a health plan must have an accrual-based accounting system that meets accepted accounting standards and practices and that provides for the routine accumulation of data specific to the operation of a prepaid capitated health plan.¹⁴⁰ Fourth, a health plan must have an adequate quality assurance (QA) program that continuously and effectively monitors performance to ensure that the delivery of cost effective medical care to AHCCCS members does not compromise the quality of the care. Fifth, a health plan must have an adequate management organization to coordinate, direct, guide, and account for the provision of services. The management team must have demonstrated capabilities to operate a prepaid capitated health plan. Sixth, a health plan must have an adequate automated or manual management information system (MIS) to monitor, track, and report critical data. Prepaid capitated contracts require a high degree of information control, accuracy, and validity.¹⁴¹ Finally, a health plan must submit an adequate capitation proposal that includes utilization rates, unit cost rates, and adjustments to net capitation based on third party recoveries, reinsurance, and deferred liability. For a health plan to be successful, it is critical that these capitation characteristics be actuarially sound. After evaluation, AHCCCS selects the successful health plans and develops special conditions for contract performance based upon any

guesswork and personal impressions in the evaluations.

138. The standards themselves were not expressly incorporated in this plan because of a concern that offerors would tend to bid to the standard rather than developing a comprehensive proposal. AHCCCS selected pertinent indicators for evaluation since it was impossible to evaluate every component of each proposal.

139. These latter services are for persons under 18 years of age and are required by federal law.

140. These data include, but are not limited to, tracking and accounting for incurred-but-not-reported liabilities (IBNRs), tracking and reporting utilization data by date and type of service, and preparation of detail of claims payable.

141. Specifically, subsystems for utilization reporting, IBNRs, prior authorization, and case management must be operational.

minor discrepancies between the performance criteria and the plan's proposal.¹⁴²

Quality of care is thus guaranteed by the AHCCCS system of competitive bidding, since a health plan that wins a contract award has demonstrated that it has the proper administrative expertise and resources to manage the risks of a capitated contract. In addition, the criteria and standards used in the process of evaluating potential providers' plans are used for on-going contract management to test health plan performance. As a part of this process, there are frequent site visits and target reviews of specific standards.

B. Eligibility and Enrollment

One significant achievement of AHCCCS is its establishment of uniform standards of eligibility for health care services. Prior to AHCCCS, the counties administered the eligibility programs. Since each county had separate rules and regulations, qualifications for services and the benefits available varied from county to county. Thus, establishment of AHCCCS meant the creation of uniform, statewide eligibility criteria and services. Moreover, the performance standards used in the competitive bidding process require potential providers to meet basic requirements to ensure the plan's ability to serve its members properly and uniformly.

AHCCCS provides health care to two basic groups of people: categoricals, primarily recipients of Aid to Families with Dependent Children (AFDC), Supplemental Security Income (SSI) benefits, and persons who qualify as Medically Needy or Medically Indigent (MN/MI), provided that they meet asset and income criteria established by state law. Of the 162,126 persons served by AHCCCS as of February 1, 1986, AFDC recipients accounted for 49% (79,007), SSI recipients 21% (34,794) and MN/MI members 30% (48,325). Table 1 compares AFDC, MN/MI and federal poverty income levels.

Determining eligibility for categoricals is simple: Any person determined to be eligible for AFDC by the state Department of Economic Security (DES),¹⁴³ or for SSI by the Social Security Administration, is automatically eligible for AHCCCS.¹⁴⁴ Individuals who do not receive

142. If a health plan fails these tests, it is either penalized with a financial sanction or required to develop and implement a corrective action plan. This constant reference to the standards provides the base needed to ensure continued contract compliance.

143. In addition to AFDC applications, DES also processes applications for three groups eligible under the Deficit Reduction Act: (1) single and dual parent low income households in which the woman is pregnant; (2) children under five years of age; (3) infants born to categorically eligible women, and a fourth group: (4) persons eligible under the Pickle Amendment, primarily SSI recipients who lost benefits due to a cost-of-living adjustment to their income.

144. AHCCCS receives federal aid to help provide for the health care of categorically eligible

TABLE 1
Qualifying Annual Income Levels by Household Size

Household Size	AFDC	AHCCCS MN/MI (Net)	Federal Poverty Definition
1	\$ 2,076	\$ 3,200	\$ 5,912
2	2,796	4,266	7,637
3	3,516	4,810	9,002
4	4,236	5,354	11,987
5	4,944	5,898	13,750
6	5,664	6,442	15,550
7	6,384	6,986	17,000
8	7,104	7,530	19,587

Source: Arizona Health Care Cost Containment System Office of Public Information.

Note: Figures as of January 1986.

AFDC or SSI can qualify for AHCCCS through the MN/MI process if they meet asset and income criteria established by state law.¹⁴⁵ The AHCCCS eligibility system for the MN/MI is a needs-based entitlement process that is administered by county government.¹⁴⁶ To ensure continuity of care and enrollment stability, newly determined categorical members are guaranteed six months of enrollment.¹⁴⁷ MN/MI members have the same enrollment status as categorical members except that they are not guaranteed enrollment and must reapply every six months.¹⁴⁸

When a person is determined categorically eligible, that person goes to

people.

145. AHCCCS receives no federal aid for the care of MN/MI members.

146. AHCCCS requires that county governments receive a signed application from the applicant or the applicant's designated representative. The county must then conduct a personal interview with the applicant or the designated representative unless there is a medical reason that would make an interview impossible. Before a determination of eligibility can be made, AHCCCS requires evidence of the applicant's income, resources, residency, and household composition to the county eligibility worker in the form of documented evidence or collateral evidence from a third party source. Oral evidence of income will suffice if no other evidence is available.

147. Individuals in long term care settings or members who are developmentally disabled may be certified eligible for a period of twelve months.

148. Categorically eligible members have retroactive coverage to the first day of the month in which they applied for either AFDC or SSI benefits or in some cases for the previous three months. When a person is declared categorically eligible the test applied is whether this person would be eligible if he or she had applied for benefits during the previous three months. If so, then AHCCCS will pay any medical benefits that the person may have accrued during that time. MN/MI members have only one day retroactive coverage limited to emergency services from the date that the county notifies AHCCCS of that person's eligibility. DES reviews the eligibility of AFDC recipients once a year. People declared MN/MI are reconsidered for eligibility every six months.

an AHCCCS enrollment office¹⁴⁹ and selects a health plan serving his or her geographic area.¹⁵⁰ The AHCCCS enrollment office informs the member of the available health plans and provides the member with marketing materials that the health plans have provided.¹⁵¹ AHCCCS assigns persons determined eligible by the counties through the MN/MI process and those categorically eligible persons who do not choose a health plan to a plan based on a mathematical formula.¹⁵² With respect to both categoricals and MN/MI members, enrollment takes three to six additional days after actual health plan choice. During the interim, both groups of members are treated on a fee-for-service basis, which constitutes a state liability.¹⁵³ Finally, for a three or four week period once each year, all AHCCCS members have the right to change health plans if they have maintained their eligibility.¹⁵⁴

149. The person presents an AFDC Decision Notice, a SSI Award Letter, or the AHCCCS enrollment notice at the enrollment office. There are 65 enrollment offices scattered across the state. Of those, nine are operated on a full time basis and 56 are operated on a part time basis. Nine of the enrollment offices are located in buildings that also house DES eligibility offices. 13 enrollment offices are in county health department buildings, nine are in medical clinics, seven are in buildings that also house county eligibility offices, and six are located in community hospitals. In addition to being directed to an enrollment office, AHCCCS mails newly determined categorically eligible persons letters informing them of their right to select a health plan. Those persons have ten days from the date AHCCCS was notified of their eligibility to select a health plan.

150. There are five contracting health plans each in Maricopa (Phoenix) and Pima (Tucson) counties, the state's largest, and four in Mohave County. There are at least two full county contracting health plans in each of the remaining counties, except Yavapai County, which has one full county plan and two other plans serving selected areas of the country. At least five health plans serve more than one county.

151. New members are encouraged to contact the individual plans, discover what services they offer, and determine if their present doctor is affiliated with any of the plans. The new member is given an AHCCCS member brochure that describes the program, services available, and the member's responsibilities such as choosing and using a primary care physician to obtain services.

152. Factors in the formula included the ranked order of bids by amount from the lowest to the highest, the medical risk of the member, and a county rate code of which there are 11: AFDC, SSI blind with and without Medicare, SSI Disabled with and without Medicare, SSI aged with and without Medicare, Medically Needy with and without Medicare, and Medically Indigent with and without Medicare. Since those members without Medicare represent a greater medical, and therefore financial, risk, their assignment distribution among health plans is done on an equal basis. Those with Medicare are assigned on an unequal basis, giving the greater percentage to the low bidding health plan.

153. The contracting health plans have health care financial responsibility only for those AHCCCS members actually enrolled with them.

154. The period in which to change health plans is usually in mid-August through the first week in September. All members are sent letters in English and Spanish in advance of this open enrollment period and are informed of their right to change plans. Those members who do not change health plans remain with their present plans unless the plan loses its contract.

To change plans, a member must go to an AHCCCS enrollment office and sign a form. AHCCCS will visit incapacitated members during the open enrollment process. There have been three open enrollment periods during which a significant, but declining number of members changed plans. There were 35,000 changes in the first period. However, 15,000 of these were members of the Maricopa Health Plan, which lost a portion of its contract. In that first year, members were allowed to change plans more than once, each transfer counting as a change in plan. In the 1984 open enrollment period, 14,800 members changed plans and in 1985, 9994, approximately six percent of the total AHCCCS membership, changed plans. The decline in the number of people changing plans is a

C. *Monitoring the Quality of Care*

AHCCCS assures the on-going continued quality of care by strict monitoring of health plan performance. This monitoring system uses annual medical audits conducted by the AHCCCS Medical Director's Office in conjunction with an outside firm selected through competitive bidding. Three audits have been conducted thus far. Since AHCCCS has discovered and resolved a variety of administrative problems as the program has matured, the scope and depth of these audits have been, and probably always will be, in a process of evolution.¹⁵⁵

The first AHCCCS audit was carried out under contract by the Accreditation Association for Ambulatory Health Care (AAAHC). AAAHC teams visited the facilities of nineteen health plans under contract and also visited individual providers in each plan. The evaluation of the health plan was based on peer review, using the AAAHC's customary standards, and concluded that AHCCCS recipients were receiving medical care that was equivalent to that provided to non-AHCCCS patients.¹⁵⁶

AHCCCS personnel and AAAHC physician-surveyor teams completed the second audit in September 1984. This audit, which made several improvements over the first one,¹⁵⁷ consisted of interviews and medical record reviews at 63 provider sites.¹⁵⁸ Although the second audit had several shortcomings,¹⁵⁹ the results were positive, again indicating that

reflection of the maturation of the AHCCCS program and the increasing knowledge of the members. All open enrollment health plan changes take effect October 1, the beginning of the next fiscal year.

If there is no break in eligibility for categorical members and MN/MI members, they are automatically kept in the same plan. If there is a break in eligibility, the member's enrollment is suspended. When the member regains eligibility, his or her enrollment is reactivated if that same plan is still available for his or her zip code area.

155. The first audit was sketchy, but provided a basis for a more complex audit in the second year of the AHCCCS program. The second year audit led to the creation of a statistically valid audit for the third year, which will be used as a baseline for comparisons with audits conducted in future years.

156. The basic design for this first audit, however, was clearly wanting. The statistical validity of the selected sample of providers was not addressed, and no quantifiable results were produced. The audit teams reported their general, subjective impressions of provider compliance with AAAHC standards and advised each plan of observed deficiencies. There was no documentation that could be used for quantitative analysis or for subsequent comparison.

157. Two new components were added. First, an AAAHC physician-surveyor, who met with the plan's Medical Director or designee, reviewed each prepaid health plan's Quality Assurance Plan. Second, joint educational workshops were held to provide the contracting plans with consultation, education, and direct assistance in quality assurance procedures.

158. The sample size for the second audit was also enlarged, covering a total of 1223 records at the 63 sites. The absence of quantitative data on the variability of quality across providers precluded the determination of required sample size for specified levels of confidence and precision, but the tally sheets employed in this second audit did provide the means for a rough, after-the-fact assessment. Another major improvement in this audit was the prior preparation by AHCCCS and AAAHC staff of standardized forms to be employed in the medical record reviews. Consequently, the results of the medical record reviews by both AAAHC and AHCCCS staff were documented quantitatively, and were accordingly available for subsequent analysis.

159. One problem that arises in designing an audit is the absence of any single, generally accepted

AHCCCS delivered care to its members that was equal in quality to that received by non-AHCCCS patients.¹⁶⁰

AHCCCS staff and AAAHC physician surveyors completed the third audit, a further improvement,¹⁶¹ in July 1985. The major focus of the third audit was the on-site review of 3525 patient medical records at eighty-five individual provider sites. The audit consisted of six distinct components: peer review of quality of care,¹⁶² analysis of lower back pain, analysis of hypertension diagnosis,¹⁶³ evaluation of physical facilities and environment,¹⁶⁴ analysis of the frequency and timing of services required for certain persons,¹⁶⁵ and review of sensitivity to patient concerns and

standard for measuring the quality of care in a comprehensive way. There was no key standard to be estimated by the audit, and there were no data available on the variability of quality across the various AHCCCS providers. For these reasons, the degree to which the findings from the selected sample were generalizable to the AHCCCS program on a statewide basis could not be determined with any degree of precision. Moreover, some of the original data recorded by the AAAHC physician-surveyors at provider sites in that audit proved to be unuseable for subsequent analysis by AHCCCS staff. The summaries of the record reviews for each plan, which were provided by the AAAHC after completion of the reviews, were clear and legible, but there were inconsistencies across the physician-surveyors in how the original tally sheets were filled out. Thus, it was possible to produce estimates of the variability in quality across plans, but not across the individual providers within a plan.

160. For a summary of the second audit findings and a summary of the design, see Bostrom & Rafferty, *Quality of Care Under AHCCCS*, 143 *WEST. J. MED.* 6 (Supp. 1985).

161. First, although AAAHC physician-surveyors again provided peer-review assessment of the quality of care by auditing medical records, the audits were more sharply focused than in prior years. In this audit, the physician-surveyor teams again used the established AAAHC quality assessment worksheet for reviewing patient records and for evaluating each provider site, but they also completed worksheets based on two diagnosis-specific paradigms that had been prepared by the Office of the Medical Director and agreed upon by the AHCCCS Medical Directors Association. Second, AHCCCS staff members audited records to evaluate the frequency and timing of EPSDT services performed. EPSDT was selected for this special emphasis because of the current federal interest and concern regarding this activity and because child-related problems have recently been given special priority by Arizona state government. Third, sample size was given more explicit consideration than was possible during the preparation of the prior audits. As a result, the data collected in the current audit then permitted after-the-fact determination of the precision level of individual parameters at the 95% level of confidence.

162. AAAHC physician-surveyors conducted peer review of 1836 patient records at 85 provider sites using general AAAHC quality-of-care criteria.

163. Hypertension and low back pain were chosen for the review because they are complaints that are frequently dealt with by physicians. The physician-surveyors audited 239 records of patients who had a diagnosis of low back pain at 75 provider sites, based on AHCCCS developed medical criteria. In addition, they audited, at 83 provider sites, 436 records of patients who had a diagnosis of hypertension, using diagnosis-specific paradigms that were developed by the Office of the Medical Director and approved by the AHCCCS Medical Directors Association.

164. AHCCCS staff members performed these evaluations at 85 individual provider sites.

165. The audit included a separate sample of 1689 patient records at 83 sites with respect to the frequency and timing of EPSDT services for patients under the age of 26. The EPSDT component was introduced to provide baseline data on the timing and frequency of the EPSDT services being provided to younger AHCCCS members. The EPSDT periodicity recommendations are themselves relatively new to Arizona, and the procedures for selecting patient records and for extracting EPSDT data from those records had not previously been tried. The EPSDT component of the audit was accordingly viewed as exploratory. Thus, although inter-plan comparisons of EPSDT results were not made, the results are still useful at the statewide level of analysis since they draw attention to specific EPSDT service categories in which improvement is most needed.

administrative matters.¹⁶⁶

Overall, the third year audit found that health care rendered to AHCCCS members paralleled care provided to the insured and self-pay populations. In addition, the audit evaluated performance on five of the six separate components. Although the scores varied, they reflected the delivery of quality health care by the AHCCCS providers.¹⁶⁷ After the completion of the third audit, AHCCCS referred the results of the audits to the contracting health plans to use as teaching tools for their physicians and as a guide for development of appropriate corrective measures for further improving the quality of care provided to AHCCCS members.¹⁶⁸

The two diagnosis-specific paradigms are also new, and they bring a more tightly focused approach to the annual AHCCCS audits. Such an approach is at the forefront of the current state-of-the-art of ambulatory care quality assessment. Accordingly, the initial use of the paradigms was also viewed as exploratory. The samples of patient records that were drawn for the paradigm reviews were not large enough to warrant inter-plan comparisons, but the statewide level results are still useful and informative. In addition, the experience gained from the use of the paradigms in this audit will be invaluable as this type of approach is expanded in future AHCCCS audits.

166. At each provider site, the physician-surveyors reviewed, with respect to established AAAHC standards, items such as credentials, medical-recordkeeping practices, observation of patient rights, and other quality-related characteristics of the setting and provided their conclusions in narrative form.

167. With regard to the overall performance of the prepaid health plans on the AAAHC checklist, the scores varied from 36 to 95. Relatively high scores were recorded at the statewide level on legibility of records (95%), presence of a treatment plan (87%), and appropriateness of diagnosis or assessment (84%). Relatively low statewide scores were recorded on presence of diagnostic summary or problem list (36%). Overall scores for the plans on the provider site evaluations component varied from 70 to 100. On a statewide basis, relatively high scores were recorded for the storage of temperature and light sensitive drugs (99%, 96%), availability of appointments (96%), orderly and professional surroundings (95%), and exam-room privacy (91%). Relatively low scores were recorded for existence of an office policy on broken appointments (49%) and routine waiting time (65%). The EPSDT reviews showed physicians were doing relatively well in documenting weight, height and physical examinations of patients, but improvements needed to be made in vision, hearing, speech, tuberculin testing, and dental referrals. The statewide element scores on the EPSDT audit ranged from 5% to 95%. As mentioned above, however, these two elements do not appear on the recommended periodicity schedule. Also among the lowest ratings were urinalyses (15%), tuberculin tests (20%), dental referrals (23%), speech, hearing, and vision tests (29%, 30%, and 31% respectively), and dental follow-ups (35%). The higher ratings were for measurement of weight (95%), height (82%), physical exams (81%), and follow up to general referrals (79%). The reviews of records for patients with low back pain showed high scores for general examinations (81%) and documentation of therapy (89%), with lower scores for sensory motor examinations (54%), X-rays (49%), and documentation of patient history (41%). Reviews of records for patients with hypertension showed high scores for documentation of therapy (92%) and measurement of weight (89%), but there was a need for improvement in eye examinations and documentation of certain tests such as blood pressure and urinalyses. The lower scores were for measurement of patient height (24%), funduscopic exam (32%), blood pressure, both arms (43%), and documentation of assessment of end organ damage (49%).

168. In addition, the extensive data collected during the audit also provide a fertile field for further quality-of-care research, and the AHCCCS Office of the Medical Director will carry out a number of such studies during the contract year. For example, the audit findings suggest a possible association between audit scores and such factors as whether the plan is hospital-based and whether it uses an IPA versus a staff-model type of organizational structure. Staff-model plans accounted for the four highest scores on the AAAHC Checklist, and the five hospital based plans also outperformed most of the non-hospital-based plans. A number of other plan characteristics are also of interest in this respect. It would be useful to know, for example, whether scores on the audit are associated with such variables as plan size, changes in plan enrollment, voluntary disenrollment during open-enrollment

D. *Evaluating the Overall Success of AHCCCS*

Evaluating the overall success of the AHCCCS program involves two distinct inquiries. The first inquiry focuses on the success of AHCCCS from a management perspective, identifying the problems that the AHCCCS program has encountered, the measures adopted to eliminate or mitigate these problems, and the lessons learned from these experiences. The second inquiry, which focuses on AHCCCS from a substantive standpoint, examines the success of the AHCCCS program in containing costs and delivering quality health care to its members.

1. *Administrative and Managerial Success*

Simply stated, AHCCCS is a managerial success because it has survived. At the outset, AHCCCS was embroiled in a substantial political controversy concerning the original outside program administrator.¹⁶⁹ In addition, AHCCCS has confronted a number of administrative and operational problems as it began and developed. To a certain extent, these problems were typical of the early problems evident in the Medicaid experiments in other states. In addition, these early problems were especially distinctive to Arizona since prepaid indigent health care had never been tried on a scale as large as AHCCCS.¹⁷⁰ Nevertheless, AHCCCS successfully resolved most of these problems.

The most significant problem encountered by the AHCCCS program involved the dispute with the initial independent program administrator and the difficulties involving the health plans and the counties. The dispute with the administrator arose largely because its contract with the state was vague with respect to both its obligations and compensation and because considerable confusion arose between the Department of Health Services and the administrator regarding day-to-day operations. In addition, the scale of the program and the speed of its implementation caused considerable difficulties.

The state takeover of the AHCCCS program, when AHCCCS was created as an independent state agency in the spring of 1984, eliminated most

periods, and rural versus urban locations. Preliminary explorations of some of these possible relationships did not reveal strong associations, but this is not surprising in the absence of formal statistical control for the possible influence of other, related variables. Accordingly, analysis of the audit data using more sophisticated statistical techniques, including multiple regression, will be carried out by the Office of the Medical Director during the current contract year. That research will also explore the relationship between audit results and the various characteristics of individual providers within the plans.

169. See *supra* note 128.

170. Thus, AHCCCS did not have the opportunity to gain advice or appropriate examples from Medicaid programs implemented in other states.

of the problems caused by the dispute and also marked the beginning of the development of solutions to the other significant problems. Among the first steps taken by the new state administration was to contract with Peat, Marwick, Mitchell & Co. to audit the counties' MN/MI eligibility process and to conduct financial reviews of the contracting health plans. Based on these independent audits, financial problems in two of the larger health plans came to the attention of the state, which took further action to solve those problems.¹⁷¹ Thus, regular auditing and management assistance enabled AHCCCS to resolve the most serious problems presented by financially unsound and poorly managed health plans.

A continuing priority of AHCCCS remains the resolution of its management and administrative difficulties. In addition to recruiting experienced personnel, other corrective measures have been implemented. First, AHCCCS has restricted the eligibility process for MN/MI members, which has added integrity, uniformity, and stability to the program.¹⁷² Second, as discussed above, AHCCCS increased monitoring the financial affairs of contracting health plans to assure that state, county, and federal funds are spent properly and to guarantee continuity of care for AHCCCS members. To that end, all contracting health plans are now required to file quarterly financial statements and certified annual audits. Third, AHCCCS augmented the annual survey of physicians to measure the quality of care being delivered to AHCCCS members. Fourth, AHCCCS redesigned its fee-for-service claim forms so that all areas of each claim are examined at one time. In addition, AHCCCS is now redesigning the entire claims payment system, with the intent of streamlining the process and paying claims on a more timely basis. Fifth, AHCCCS redesigned the process under which health care plans bid on AHCCCS contracts. The process now gives detailed knowledge of the innerworkings of each plan and ensures that each plan has a thorough knowledge of what will be required during the course of its contract. Sixth, AHCCCS

171. Based on preliminary findings by Peat Marwick, the AHCCCS director requested that two of the larger health plans choose medical management firms to assist them. As a result of this process, one of the health plans filed a Chapter 11 petition in the bankruptcy court in 1984. The plan's managers saw a stream of revenues, but failed to estimate and accrue their incurred but not reported liabilities (IBNRs). Those liabilities, mostly in the medical specialty areas, are usually not noticed for four to six months. As a result, the plan misinterpreted its financial position and made unfortunate compensation and investment decisions. Subsequently, the plan was reorganized and purchased by a consortium, which is now operating the plan as an effective AHCCCS provider. AHCCCS cancelled the contract of the other large health plan in March 1985. In July 1985, AHCCCS also cancelled the contract of a smaller health plan that faced similar financial difficulties. Members in the cancelled plans were transferred to another plan in the area.

172. It is no longer sufficient to walk into a county eligibility office, verbally proclaim indigency, and walk out a member of AHCCCS. If the Legislature chooses to expand AHCCCS, this improved eligibility process will also provide a sound basis for future coverage, which will be free from the budgetary uncertainties that marked the program's first three years.

has established a client advocacy office to help members resolve problems informally, increased the staff in the grievance and appeals section to help members and providers, and hired two people with law enforcement backgrounds to investigate cases of fraud and abuse. Finally, AHCCCS has initiated a process to collect "encounter data,"¹⁷³ a task that is required by the federal government, but which is extremely difficult in prepaid medicine.

These corrective measures reflect the significant lessons that have been learned during the first three years of the AHCCCS experiment. One major lesson is that adequate time must be allowed for the program planning and development process.¹⁷⁴ Another lesson is to ensure that the state agency and the health plans employ personnel who are skilled and experienced in prepaid health operations. Third, health plan credentials must be scrutinized to ensure that each plan has the financial and administrative expertise to operate successfully a quality health care delivery system.¹⁷⁵ Finally, the program administrator must be a skilled and vigilant contract monitor, supported by appropriate fraud and abuse detection systems, comprehensive financial and compliance audits, encounter data reporting systems, and protective medical quality assurance programs.¹⁷⁶

2. *Substantive Success*

The AHCCCS program has been a success because it has contained costs and delivered quality medical care to its members. In addition to the internal audits discussed above, two external studies have shown that significant improvement in the delivery of health care services to the poor of Arizona.

The Flinn Foundation conducted a study that compared health care delivery systems before and after the introduction of AHCCCS, characterizing Arizona as a national laboratory in which to study a new form of health care delivery.¹⁷⁷ The Flinn Report established that AHCCCS

173. "Encounter data" involves identifying the name of the person and the provider, the time and place of the visit, and the purpose for which medical services were sought.

174. This lesson is consistent with the AEI Medicaid studies discussed above. *See supra* notes 106-24 and accompanying text.

175. In particular, a plan must have adequate capitalization or financial backing, an appropriate actuarial and rate setting process, proper financial reporting especially of IBNR claims, vigorous utilization control, and prior authorization programs.

176. Quality assurance programs must include structured reviews of the health plans' quality assurance programs, on-site reviews of health plan providers, and monitoring of grievances and appeals by plan members and providers.

177. The study was conducted in conjunction with the Robert Wood Johnson Foundation and Lou Harris and Associates. The Flinn report consisted of two surveys, conducted in 1982 and 1984, in which 3600 people were interviewed. *See* Flinn Foundation, *Health Care for Arizona's Poor 1982-1984* (1985) (unpublished report on file with the *Yale Journal on Regulation*).

significantly improved the delivery of health care services to the poor in Arizona. Specifically, the report stated that “[t]hose Arizona poor eligible for the AHCCCS program reported significant gains in access to health care compared with their experience in 1982.”¹⁷⁸ The study found that the “[p]roportion of Arizona’s poor children seeing a doctor increased dramatically from 58.9% in 1982 to 75% in 1984.”¹⁷⁹ Persons who have no other source of medical care dropped from 15.3% in 1982 to 5.2% in 1984 of those eligible and enrolled for AHCCCS.¹⁸⁰ The report also showed that AHCCCS members are generally satisfied with the quality and accessibility of the medical care received under the program.¹⁸¹ The report concluded that:

[f]rom the patient’s perspective, the AHCCCS program seems to be working. It has improved access to health care for the people it serves and, by and large, they are pleased with the care that they receive. . . . Clearly the introduction of the AHCCCS program has profoundly altered the availability of health care for the poor in Arizona. The very structure of the health care system and the way care is paid for have been reconfigured.¹⁸²

Not only did the AHCCCS program improve the level and quality of indigent care, but another study’s preliminary results indicated that the program did so at lower cost than a traditional Medicaid program.¹⁸³ Moreover, neither the external studies nor the internal audits uncovered any evidence that the Arizona program caused a shift of non-emergency

178. *Id.* at 3.

179. *Id.* at 2.

180. *Id.* at 3.

181. In contrast, the report also concluded that for the poor exceeding AHCCCS eligibility standards, access to care decreased and dissatisfaction with care increased. Thus, “[i]n 1982, Arizona’s poor trailed the nation by most measures of health care access. In 1984, for those enrolled in the AHCCCS program the gap is closing. For those ineligible, the gap widened.” *Id.* at 3.

182. *Id.* at 1, 3.

183. This outside study, which was prepared by Stanford Research Institute for HCFA, compared AHCCCS with a traditional Medicaid program. *See* SRI International, Evaluation of the Arizona Health Care Cost Containment System (July 1985) (on file with the *Yale Journal on Regulation*). In determining that AHCCCS reduced costs below a traditional Medicaid program, the study reviewed the first two years of the AHCCCS program. *Id.* at 44. Depending on the method used, the study estimated the program’s overall savings for fiscal year 1984 to be as high as 5.1%, even though a complex new program such as AHCCCS may have had high initial costs. *Id.* at 1, 45. The fiscal year 1984 savings ranged from .8% to 5.1%. 1983 savings ranged from -2.4% to 3.9%.

[T]he magnitude of the savings depends both on the perspective from which one approaches the analysis (AHCCCS program, federal or state government) and the standard (retrospective or prospective) that one uses to estimate the cost of a traditional Medicaid program for Arizona. . . . In addition, the estimates were prepared on the basis of incomplete data, following generally accepted actuarial procedures, which required assumptions concerning the magnitude of undocumented liabilities of the program.

Id. at 44, 45.

care to hospital emergency rooms where the care is significantly more expensive, a problem that has arisen in other states.¹⁸⁴

Thus, the AHCCCS program has survived the controversy that surrounded its birth and initial operation. It has contracted with fifteen health plans, which have subcontracted with over 6400 providers, to provide health care to eligible Arizonans. As of February 1, 1986, AHCCCS was serving 162,126 people. Moreover, AHCCCS is on sound financial footing. This fiscal year is the first one in which AHCCCS has not been required to ask the Legislature for supplemental funding.¹⁸⁵

The AHCCCS program has gained nationwide attention for cost-effective delivery of quality health care, and several other states are contemplating developing programs based on the AHCCCS model. Wisconsin has begun implementing a prepaid indigent health care program.¹⁸⁶ California is starting a prepaid experiment in San Diego County, and Pennsylvania is starting an experiment in Philadelphia. AHCCCS personnel have worked with other states in the planning aspects of these experiments. In addition, commentators have suggested using the AHCCCS program as a model for restructuring Medicare as well as Medicaid.¹⁸⁷ One analysis concluded that AHCCCS is "conceptually superior" to Medicare and Medicaid, achieves efficiency in the consumption and production of health services, and provides a vehicle for relatively easy transition on a national basis.¹⁸⁸ Federal officials have also praised the AHCCCS program and characterized it as a model for other states and the federal government.¹⁸⁹

Based on this success, Arizona may expand the AHCCCS program model. First, the Governor and other state officials have advocated extending the current AHCCCS program to cover children under fourteen years of age from families whose income and other assets exceed the current MN/MI eligibility requirements, but do not exceed the federal

184. This problem stems from the refusal of private sector physicians to see non-emergency Medicaid patients and results in driving up the cost of care. Since AHCCCS requires health plans to have networks of physicians in advance of receiving contracts, that problem is avoided. Thus, all AHCCCS members have access to doctors and need not rely on costly emergency room treatment.

185. The current budget is \$271,312,928, which includes \$141,553,496 from the state, \$61,835,721 from the counties, and \$66,677,771 from the federal government. AHCCCS also receives revenues from interest earnings and third party collections.

186. Milwaukee and Dane (Madison) counties already have been converted to mandatory prepaid coverage for AFDC residents. The rest of the state will be converted to mandatory prepaid coverage on a county-by-county basis. Once all AFDC recipients have been converted to prepaid medicine, other Medicaid groups will be brought into the program.

187. See Ingelhart, *Health Policy Report: Medicare Turns to HMO's*, 312 NEW ENG. J. MED. 132 (1985); Vogel, *An Analysis of Structural Incentives in the Arizona Health Care Cost-Containment System*, 5 HEALTH CARE FINANCING REV. 13 (1984).

188. See Vogel, *supra* note 187, at 13, 18-19.

189. See *Health Care Faces 'Disaster'*, Phoenix Gazette, Jan. 27, 1986, at A1, col. 4.

poverty level.¹⁹⁰ The Legislature recently enacted a version of this proposal to expand AHCCCS. Another potentially far-reaching expansion of AHCCCS under consideration would use the AHCCCS model for the development of a reasonably priced health insurance system for the working uninsured. Such a proposal would target full time employees of firms with less than twenty-five employees in order to provide affordable health care insurance to those otherwise unable to afford commercial insurance. The cost would be borne by the employer or the employee, or shared between them. Like AHCCCS, the program would involve a network of HMOs to provide preventive and acute health care services. Both of these extensions of the AHCCCS model would respond to the decline in access to care in Arizona for non-AHCCCS eligible persons.¹⁹¹ Building on the proven successes of the AHCCCS program, these extensions provide methods for improving the overall health of Arizonans.

AHCCCS has proven that competitive bidding is a viable method for providing indigent health care. AHCCCS has also shown that risk sharing between the public and private sectors is a viable method of containing health care costs and delivering quality medical services. Moreover, AHCCCS has developed quality assurance and utilization review programs that can be replicated in other states. In addition, AHCCCS demonstrates the viability of the prepaid medical plan concept in both urban and rural settings. As the medical profession adapts to the changing economic environment, prepaid medicine will become more widely accepted.

Finally, from a health care reform perspective, AHCCCS has important implications for indigent recipients of health care and the public and private providers who serve them. For recipients, AHCCCS means that mainstream medical care, rather than the public clinic form of medical care formerly delivered by the counties, is available to indigents. AHCCCS health plans are community-based networks that provide mainstream medical care to indigent patients. Thus, eligible members may see private sector physicians in their own neighborhoods, and the patients must assume an active role in their own health care, including the selection of a health plan and a primary care physician.

In the case of the providers, public providers such as counties with their own hospitals restructured their operations into HMOs to bid on AHCCCS contracts, and private physicians organized to bid competitively on contracts. In addition, many private sector physicians who previously had little involvement in indigent health care delivery became significantly involved and would be at financial risk for their care. Physicians had to

190. These figures are shown in Table 1.

191. See Flinn Foundation, *supra* note 177.

restructure their practices to suit the case management form of health care delivery. In addition, they had to be prepared to present their patient records for peer review to ensure that care had been delivered and that it met acceptable standards.

Conclusion

The AHCCCS program, the various state Medicaid experiments, and the more general reforms in health care all demonstrate that competitive innovation can control health care costs and improve access to quality care without direct government intervention. Although economic pressure on health care has served as a catalyst for reform, society must not become so preoccupied with cost containment that it ignores the social issues involved in health care delivery. As Lester Thurow has stated, "The federal government used to view health care as a social problem. Today it views it almost solely as a budget-deficit problem. The shift in perspectives is important. Social problems can be left to fester; budget-deficit problems require more immediate solution."¹⁹² Thus, the fundamental task is to ensure that the social problem not fester.

As reform efforts continue, we must focus on the problem of access to quality health care on several dimensions. We must be sensitive to the special problems of the aged and the indigent. In addition, the current system does not provide adequate coverage of catastrophic illness or provide for long-term care. Moreover, we must recognize that there are a substantial number of persons whose incomes fall below the federal poverty level, but who are not generally eligible for public health care programs. In Arizona, we have expanded the AHCCCS program to some of these persons. Yet the problem regarding access to health care is much broader. We must focus on a much larger group of persons who lack adequate health care either because they are not provided with employment-related health insurance or they cannot afford their own coverage. Designing a system to provide health care insurance at a reasonable cost to such persons or their employers must be a future priority.

Finally, difficult issues must be resolved. First, society must realize that a real conflict exists between economic efficiency and medical efficacy.¹⁹³ Although most medical procedures produce benefits, they may be outweighed by the costs. Moreover, the best medical care is not always that which uses every known experimental technique.¹⁹⁴ We must also

192. Thurow, *supra* note 47, at 611.

193. See Schwartz & Joskow, *Medical Efficacy vs. Economic Efficiency: A Conflict in Values*, 299 *NEW ENG. J. MED.* 1462 (1978).

194. See Thurow, *supra* note 47, at 614.

confront questions of relative need, such as whether we should prefer liver transplants for alcoholics over more extensive prenatal care for needy mothers, or whether artificial prolongation of life for the terminally ill is more important than long term care.¹⁹⁵ In addition, the economic resources available for health care are not unlimited.¹⁹⁶ The problem therefore involves more than the choice among alternative forms of health care, but requires a choice between spending on health care or on other societal needs.

Ultimately, the most difficult social problems are in fact economic ones since they involve allocation of limited resources. The market, however, cannot resolve these questions in a socially acceptable fashion. Thus, their resolution is left to the political process. Solving these problems will not be easy. We believe, however, that the same innovative spirit and analytical determination that has made the AHCCCS program an economic and social success will produce solutions for these remaining problems.

195. These decisions also involve significant medical ethics issues.

196. Thurow, *supra* note 50, at 1569.