
PREMISES FOR A MEDICAL MARKETPLACE

A Neoconservative's Vision of How to
Transform the Health System

by David A. Stockman

Prologue:

David Stockman became a national phenomenon when he emerged, shortly after Ronald Reagan's election, as the most visible figure ever to hold the directorship of the powerful Office of Management and Budget. Brash and brilliant, Stockman gained further notoriety through a recent Atlantic Monthly article that detailed where he thinks administration policies will lead the nation and what steps must be taken to get there. His vision, like that of President Reagan, features economic growth through reduced taxes, less government, and a strong military. But in the health field, Stockman is far out in front of other members of the administration in his commitment to a new prescription to transform the nation's third largest industry along lines that reflect the president's strong belief in competition, free enterprise, and the private sector. Stockman holds that position by virtue of the substantial time and serious thought he devoted to the subject while a member of Congress. His strong commitment to this set of ideas led to his cosponsorship of the National Health Care Reform Act of 1981 with Rep. Richard A. Gephardt (D-Mo.). Shortly after Mr. Reagan won the 1980 presidential election and before Stockman resigned his Michigan congressional seat to become director of OMB, he set out his views on health care during a conference at Project HOPE. His remarks there remain the most unvarnished public articulation of the premises upon which he bases the need to create a health competition model in the United States. His premises called for franchising consumers, redistributing income in a form of fixed and controllable monetary subsidies, placing at financial risk those who purchase new technology and construct medical facilities, structuring provider competition, marketing health care on a retail basis, and creating a self-organizing provider market.

Ever since the 1980 election swept Ronald Reagan into office, the philosophers and pundits have been asking whether the Republican triumph signifies a permanent political alignment, or whether it was simply a transient interlude, a vote of collective exasperation with the status quo that may be rather quickly reversed in the next election, or in subsequent elections, with no permanent imprint. Of course, everyone has a viewpoint on that question. For myself, I would like to suggest that the answer depends on whether we succeed in changing the fundamental agenda of ideas around which the struggles of politics occur and out of which the public policies in this or that area—health, transportation, macroeconomics—are conceived, crafted, and executed.

The mandate handed to President Reagan derived from an overwhelming vote of “no confidence” on the part of the American electorate in the previous government. Too much inflation, too little economic and employment growth, too much government in the form of high and excessive taxes and intrusion were the ingredients of the Democratic administration. These failed policies derived in turn from the core of liberal Democratic ideas that have dominated the public policy agenda and the public debate for a couple of decades. This core idea can be embellished in a variety of ways, but I think it breaks down into a fundamental notion: that the preponderant majority of perceived socio-economic problems, like inflation, or excessively high black youth unemployment, or scarcity of rental housing, or escalating medical costs, originate in the failure of the private socioeconomic order. By the same token, the majority of liberal solutions requires corrective or remedial action initiated by governments and in recent years, the federal government in particular.

I would like to suggest, as a way of moving into this whole health care policy topic, that the fundamental core idea is essentially wrong. The permanent realignment that people are speculating about today will occur only when the conservative administration demonstrates the error of this “core approach” in every domain of public policy that is of importance to the American people; and only when we propose substitute diagnoses, substitute solutions based on a different idea. Furthermore, the health care policy domain dramatizes the error of that basic liberal notion in spades. If, as a Republican administration, we fail to change the basic premises and assumptions which have animated the national health care policy for a couple of decades; if we are content simply to recalibrate existing policies with better attitudes and management—such as rooting out fraud or something of that sort in Medicaid—we will do nothing meaningful about the perceived problems in the health care area, particularly escalating medical costs, and we will, therefore, do nothing to warrant a continued mandate from the electorate.

As I approach the question of what kind of health care policy this administration should formulate, I do it from a basic and generic context. What is to me the most obvious feature of the existing national health policy that we have in this country is that it is based on an inherent tension, if not an outright contradiction. Half of the status quo policy, or the existing policy—the half that is oriented towards the demand side of the equation—essentially rests on the idea of subsidize and spend. The direction, of course, is towards ever-increasing comprehensiveness and universality and ever-increasing debt, in terms of the subsidies that promote spending for health care throughout our system, both through Medicare and Medicaid and through the tax subsidies that have grown automatically over the years. Until recently, any discussion of national health insurance or some comprehensive national health plan moved strongly towards the extension of this basic principle.

The ultimate extension, of course, is the Kennedy national health insurance bill, because that involved a complete expansion and enormous increase in the depth of subsidy in the system. But even some of the lesser programs that have been proposed over the last decade embodied the same direction. The mandated private health insurance coverage idea that the Nixon administration proposed in the early 1970s moved that way, obviously. The proposals that we deal with occasionally in Congress to expand Medicare coverage or Medicaid, as in CHAP (Comprehensive Health Assessment Program), also would obviously expand this basic impulse in the system. I would even suggest that the “subsidize-and-spend” principle is automatically built into the system simply in the form of the open-ended tax subsidy that we have in the IRS (Internal Revenue Service) code, because as marginal rates continue to rise, the real value of that subsidy rises with it; and the preference for more extensive, more costly, more comprehensive, more deeply subsidized health coverage increases because of the tax benefit.

The other half of this national health policy that we have, at least implicitly, today—the half that focuses on the supplier or provider side of the equation—is based on the essential principle which I would call “command, control and contain.” The ultimate of that is the central national health budgeting which was contained in the national health plan proposed by Sen. Edward Kennedy (D-Mass.). Lesser tools, lesser means to that same end of damping down the rising costs and pressures in the system are obviously manifested in approaches such as hospital cost containment; provider fee limits, which are increasingly attractive to some people; certificate-of-need, which is a way of controlling one of the factor inputs into the health spending or cost equation; utilization review, which is another way of containing costs within the system; and the health planning system.

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The great question that we must confront first and foremost, before we even begin to propose a set of alternative assumptions and then alternative policies that would flow from them, is: how did liberal policy get itself into the unenviable—and, in my view, the untenable—position of having one foot on the brake and the other foot on the accelerator, pushing harder and harder on both at once? This is the fundamental posture of our national health policy today. Until we can figure how that happened and how we can extricate ourselves from that position, we will not be able to begin to construct a new approach. My answer is that liberal national health policy ended up in the “accelerator-brake” situation as the system became more and more unstable in terms of its costs, and in terms of the excesses and inefficiencies that were being built in. Such policy ended up in that position because it harbored too many fundamentally wrong assumptions about what health care is. I would like to list four of these assumptions and then suggest how they can be changed, dropped, or reformulated. This exercise should help point us in the basic direction that we ought to move.

The fundamental assumption that is built into the whole cost containment, planning, certificate-of-need, revenue control, and free control approach on the supply side, that grew incrementally and unevenly over the last decade, is that the excessive costs that everyone agrees to, or laments, stem primarily from the private excesses of providers. Physicians, for instance, are greedy, or they strive for ever higher incomes, and so their rates get too high and the quantity of services they deliver becomes too great. At the institutional level, hospitals suffer a kind of institutional impulse or greed of the same sort. If they are proprietary hospitals, their profits are too great. If they are nonproprietary, their search and quest for prestige is too unrestrained. In either case, they suffer from a kind of mysterious complex which drives them to build more and more facilities, expand to more and more beds, invest in more and more technology, until the costs become prohibitive for that institution and for the system as a whole.

The first way to respond to that assumption is to simply admit that it is ideological claptrap and not analysis. It ought to be set aside, and we ought to look for something more reasonable and something that has more explanatory power. I have been trying to do that. A lot of economists have been trying to do that over the last four or five or even ten years. The logical conclusion that most fair analysts come to is that the reason why we have this enormous or excessive cost growth in the system has nothing to do with the motivation, or the character of providers as individuals, or the dynamics of their institutions; but has much to do with the reimbursement system that sets the economic context in which

they function. What we ought to start doing is not impose a cap on the pressure cooker, so to speak, but analyze carefully the reimbursement system to see whether it can be recalibrated so that the motivation that generates behavior which is not good for the whole, or not good for the system, is removed. We should examine the reasons why a physician might run a patient through a Medicaid mill, or test excessively, or overhospitalize, or overtreat. We should look to see whether or not we can revise the incentives that might generate inappropriate behavior both at the individual and the institutional provider level. We ought to ask whether or not we can afford in this country to continue to treat health care as a free good—which we do essentially when we go to comprehensive reimbursement insurance—or a no-cost sort of notion at time of delivery and at the time of decision making by both the provider and by the patient.

A second fundamental error or defective assumption that put liberal policy in the untenable straddle that it is in today, is the assumption that the health care sector, the delivery side and the supply side of the market in particular, can be efficiently and effectively regulated by government agencies and by bureaucratic mechanisms. We ought to know enough by now to say that on both empirical and theoretical grounds, the assumption is wrong; and that is one reason why health care policy has to change so drastically. On theoretical grounds, we should have known it before we got started. It is obvious that it is tough enough to regulate a commodity which is homogenous, uniform, and stable technologically. The Department of Energy, about which I know a little, tried that with gasoline, a simple commodity. One gallon is like the next and there has not been much technological change in gasoline in the last few years. Nevertheless, they found it almost impossible to regulate gasoline in terms of its allocation and distribution to the points where there was demand or need in the market. In the case of health care, we are dealing obviously with just the inverse in the spectrum of economic goods. We are dealing with something that is very supple, subjective; something that is subject to enormous change in terms of technology, in terms of treatment theories, in terms of particular therapies, in terms of diagnostic tools and techniques. It is really a constant flux of change that is imbued with a deep subjective element, with regard to the ultimate professional judgment that lies behind each and every decision that is made. Given that type of commodity, it is impossible to think that we could ever regulate effectively when it is clear from the records of the past that we cannot even regulate homogenous, simple, and nonchanging commodities. But even if we do not want to dwell too long or too deeply on theoretical and abstract argument, we now have ten years worth of empirical evidence we can examine. When we examine that

evidence, it is clear that the theoretical argument should have been solved ten years ago, and we could have avoided ten years' worth of disappointment, waste, and maybe even counterproductive activity. The fact is, almost every one of the regulatory surrogates that we have created to perform in efficiency-inducing, or cost-containing, or investment-planning functions in the health care delivery system, in my judgment, has not worked. The latest and most dramatic example is in the case of the Professional Standards Review Organization program (PSRO), which was one way of containing cost by containing utilization. A Congressional Budget Office study^r suggests that it costs 120 percent more to administer the system than even the most generous estimate of the actual measurable cost savings resulting from that system.

We see the same thing with the certificate-of-need program. I will not go into all of the economic analyses that have been done on this program, but my own conclusion in reading them is that it has not contained costs to any measurable degree. It has not contained investment at all. It has just diverted investment into unregulated or less regulated channels. That, of course, is something that happens in all regulated markets, as students of surface transportation regulation or any other kind of regulation know. The certificate-of-need is an attempt to franchise a system that cannot be franchised. Both on empirical and theoretical grounds, the whole planning-control-containment effort has not worked because it is based on faulty assumptions.

A third defective or erroneous assumption in the liberal national health policy we have had, has been to couple the issues of access to health care with issues of income redistribution, and the assumption that by compounding the two, or interrelating the two, you end up with no problem to worry about. To elaborate, it is assumed in any kind of comprehensive national health insurance system—whether it is the Kennedy “tax and spend” variety through a centralized government program, or some mandated private sector coverage—that you are going to have a major amount of income redistribution occurring in the process. This assumption is based on a view that such proposals tend to be designed in a way that most people will pay the same amount of premium or tax. Yet we know from experience and logic that use of the output of that system—the services and the coverage—will be highly differential. That is, some people are going to be benefiting much and paying relatively little and others will be paying relatively much and benefiting hardly at all.

The danger of that whole approach, which has been inherent in most proposed national health plans, is simply this: it is one thing for society to decide that it does not like the income distribution resulting from the market, and, therefore, to make efforts to recalibrate or balance that

distribution through fixed cash or monetary transfers, because you can control that. The Social Security retirement system is a good example. The average beneficiary gets \$450 a month. It is fixed. It is controllable. You know how much to tax. You know how much to redistribute, and the whole thing should be easily managed, if not financed. The same is true with some of our means-tested income transfer programs. We can devise eligibility criteria. We can establish benefit levels and we can be sure that the intended beneficiaries are getting the fixed monetary transfer that we intended. It is quite another thing entirely to go into the income transfer business through the back door by providing not fixed monetary transfers but open-ended service contracts, and, in this case, an open-ended comprehensive health service contract. That is nothing more than a prescription for a gigantic collective moral hazard that sooner or later will bankrupt the system. Society has no control over how much is being transferred because that is determined by how much is demanded. With an open-ended health service entitlement or contract, given what we know about the elasticity or almost infinity of possible demand for health care, you can see the point that I am making. Yet that idea has been basic in most of the kinds of health care plans that we have talked about in the past. There has been confusion between trying to provide entry for people in the system on the one hand, and the whole question, Is a health service contract a viable means to redistribute income? The first objective, in my view, is appropriate if you know what you are doing and design the approach properly. The second objective is a disaster in that if you walk into it unknowingly, you are going to end up with the kind of problems that Great Britain and other nationalized redistributing health care systems have today.

The fourth error of assumption that exists in current liberal national health care policy is the assumption that health care is unique. It is considered a sort of spiritual or social or collective good. It is not thought of as an economic good. Therefore it has to be thought about, treated, regulated, and managed by society in a unique way that departs from the way in which markets normally handle other economic goods. That assumption partly comes from ideology and partly from the profession. What is the effect of assuming that health care is somehow not a basic economic good responsive to economic laws of dynamics? The effect of this has been to rule out all of the potent self-regulatory mechanisms that we rely on in almost every other market for almost every other good or service, to help deal with the inherent problem of unlimited demand for goods and limited resources in order to supply those demands. The effect of that has been to rule out competition in any meaningful economic sense in the health care sector, because to some ideologists of the left it seems unseemly, and to practitioners of traditional medicine,

it seems unprofessional.

The effect also has been to rule out investment risk on the grounds that profits should not be made from institutional health care services or at least should not be relied on for the majority of our institutional health care services. Besides that, the idea of a bankrupt hospital just seemed beyond the pale to most people who thought about it. But the bankrupt hospital is implicit in the notion of investment risk and the allocation of health care capital by markets in the normal way.

Another derivative of the idea that health care is a spiritual rather than an economic good is the notion that consumer choice and consumer decision is unimportant or could not be relied upon to play a major economizing role in the system. This reasoning is that while consumers may be savvy about most things, such as betting on the Super Bowl winner or the horse races or buying a new car, they are incompetent to even make elementary decisions and choices about health care; and so the consumer choice mechanism would not play a role in the system. The result of all this, it seems to me, is obvious: we have a total system that is out of control, a system that no one is satisfied with, not payers, not analysts, not consumers. Therefore, we must rethink the basic premises and ask whether we can once again make health care an economic good, or at least whether it has the potential to be treated as an economic good; so that we can bring into play those self-regulatory, economizing, efficiency-producing mechanisms that we rely on in all other sectors. These are the four basic assumptions that interweave, intertwine through the whole liberal health care policy approach we have created. The outcome is not viable. The solution is not viable on its own terms because the assumptions are not viable. What we must do before we start writing legislation or issuing new rules and regulations from health departments or even formulating blueprints for a tangible particular national health care plan, is to reconstruct an alternative set of basic principles and premises from which concrete policies can then flow.

In my view, there ought to be five basic premises on which a better health care policy, and hopefully a more satisfactory outcome, can be structured. The first premise that we must accept is the need to enfranchise consumers. They must be put back into the business of making economic choices about both the quantity and the quality of health care services that they desire. The only way to take this step is to either end or transform the comprehensive benefit entitlements or coverages that our reimbursement system encourages, subsidizes, and even foists upon people today. There has to be an element of consumer choice. There has to be the opportunity to choose less, rather than more, and to benefit from it in a tangible economic dollar-and-cents way.

The second premise is that any kind of national health care solution that we construct is going to involve some degree of income redistribution. That cannot be avoided, since there is never going to be a perfect match between what people pay and what people receive in any kind of system. Therefore, whatever subsidies or income transfers we provide ought to be made available in the form of fixed monetary subsidies with a fixed dollar amount attached to them that will be visible, debated, and changed, if need be, but nevertheless that are inherently controllable because they are in fixed monetary terms and not an open-ended contract.

The third premise that we must install is that in an age of high-technology medicine, where we are moving to the point of investing \$10, \$20, and maybe even \$30 billion a year in medical facilities and in costly medical equipment, we are never going to get efficient use of the progress that we can make technologically unless decisions about those investments are made on an "at risk" basis. You are not going to plan your way into a perfect fit between CAT scanners and people who need CAT scans. You are never going to plan your way into a perfect fit between the unpredictable number of babies born each year, distributed as they are according to demographics and population distribution, and the number of maternity ward beds that you have among the thousands of hospitals in the country. This was brought home to me in my first congressional term. There was a great discussion about the fact that the Department of Health, Education and Welfare published regulations specifying that it would not be efficient for any hospitals having less than 1,000 deliveries per year to keep open their maternity wards, and that all hospitals with less than 1,000 deliveries ought to close their maternity facilities and send their patients elsewhere. That was a nice, simple, crisp, uniform rule that could apply across the entire country to all institutions; but as I started to look at my own district, I became a little nervous. There was not one hospital in my entire congressional district of 500,000 people that qualified, according to this rule-based notion of how maternity ward investments should be made. At first I thought it was a Democratic plot to depopulate my district, given that I had been elected at a young age and perhaps could look forward to considerable tenure. But then I realized it was just planning gone amuck because it was attempting an impossible proposition. Planning alone will not work. Franchising will not work. But something has to control the level of investment or otherwise you are going to get too much. It seems to me that only the "at risk" for-profit principle can bring about the efficient investment of an increasingly capital intensive delivery system that will most benefit the health and welfare of the American people in the future.

The fourth premise on which any kind of plan ought to be centered is

the notion of healthy provider competition and marketing of health care plans on a retail basis. As long as we have no real provider competition for the patient's health dollar and as long as there is no real marketing—which is the method by which information and choices and alternatives are disseminated—there will be no real consumers. Consequently, the system will be unable to tap the enormous shopping resources, choice resources, economizing resources of those consumers. The idea that health care has to be delivered by the government via one carrier, or by employers through one contract, must be rejected. We ought to allow everyone to get into a retail market, and once we establish a retail market among the consumers, we will automatically and perforce get fierce competition among various provider units. That will lead to marketing efforts to attract consumers and the dissemination of information that they need in order to function effectively in that kind of system.

The fifth premise is that we ought to build any plan on the *laissez-faire* notion of a completely self-organizing provider market. One of the great experiments that has failed obviously and patently in the last ten years was the government's effort to stimulate health maintenance organizations (HMOs) by writing hundreds of pages of regulations as to how they would be incorporated; how they would employ people; how they would deliver services; what services they would cover; and the like. The kind of competitive health care system that I am talking about requires moving 180 degrees in the opposite direction, where government specifies nothing. I do not know whether the most efficient delivery mechanism is a closed-panel HMO, a specialty or an open-panel HMO, a loose or tight independent professional association (IPA), an insurance company that integrates with delivery, or a group of doctors that integrates with financing and marketing. There is plenty of room for experimentation and the test of time. The test of success and the test of consumer satisfaction will be indicated by how the consumers vote with their dollars to resolve those questions. There is probably no one vehicle, or one prototype, that is appropriate for all people, for all circumstances, for all markets. But the main principle I mean to enunciate here is that the government should not write a blueprint for what a qualified marketer or qualified entrant into this market looks like. That ought to emerge spontaneously from testing and experimentation in the marketplace.

Those are the basic five principles that I recommend to replace the erroneous principles upon which today's failing policy is based. I am not talking about a total revolution. Upon reflection, there are two additional points that I would like to make in terms of pursuing these future objectives. They could be called compromises with liberal

policy. One is, in any kind of consumer choice market—whether those consumers are using vouchers provided by employers that are subsidized through the tax system, at least to a limited level of subsidization, or are using purchasing power vouchers supplied through Medicare or Medicaid—that any qualified plan, competitively offered in the marketplace, does need to provide some catastrophic coverage. Such coverage ought to be required by the government. In other words, the first-dollar and middle corridor for routine services and not-so-routine services ought to be entirely shaped by consumer choice. If some want first-dollar comprehensive coverage, some carrier will offer a plan. If others want major medical coverage, in which all routine costs are financed out-of-pocket or at risk, somebody will offer a plan of that sort. But when you get to the low frequency episode of illness affecting two percent of families that have \$5,000-plus bills every year, government must make some provision for mandatory coverage of that kind of exposure. If not, society ends up in a situation where the public sector—the taxpayer, or the treasury—has to absorb the cost on an ad hoc basis or through some kind of public assistance program. As a society we are simply too humanitarian to deny people with very serious illnesses the best facilities and the best treatments that our system and our society can provide. The fact is that many will be tempted to go bare even for the low frequency, one out of 100 or one out of 1000 cases. Because of that, it is a clearly demonstrated empirical fact that we ought to require any plan, as a qualification for entering this retail market, to offer catastrophic coverage. That is easily said, but rather difficult to do, because you have to define the threshold. Once you define the threshold you have to know what counts in terms of services and costs incurred before you reach the threshold. That is not an insurmountable problem. It is a technical problem and I would think some threshold in the range of \$3,000-\$5,000 would be satisfactory.

The other compromise I would make with liberal policy involves the free-rider problem and the adverse selection problem. These must be dealt with if we are going to have a system that operates on an annual open-enrollment basis. I am not as much persuaded as is Alain Enthoven that there are people who make a profession of moving in and out of plans and timing their heart attacks, or serious injuries, on the basis of whether they are in a major medical plan or a comprehensive HMO in 1981 versus 1982. I am persuaded, however, that there are problems in that area. These can be mitigated by establishing at least two requirements for any plan, be it a direct provider or insurance-type offering. One is that there must be open enrollment so that neither providers nor plans can “select out” the person with chronic illnesses and high exposure to medical costs. Second, the plans need to be community-rated on the basis of some fairly simple economic or geographic market

areas in which plans would be offered at retail. If you accept some formulation of these two ideas—nondiscriminatory enrollment and community rating on a geographic basis—you can mitigate these problems.

There is now a new opportunity to shape a kind of public policy that would give our society a viable alternative to the kind of big government suffocation of private society that has been emerging both in this country and many others since World War II. That opportunity must be capitalized upon, now that the conservative party has been given an opportunity to present public policies based on a new diagnosis and on a new set of principles that we can hope will work. If we do not get results though, we will not have the mandate for very long.

Following Mr. Stockman's address, he elaborated on several points during a question-and-answer period and also addressed other issues. That dialogue follows:

Q: Would you elaborate on your third premise, placing purchasers of technology at risk as a means of avoiding the unnecessary expansion of technology?

A: I would make two comments. First, frankly as a prediction, I see a gradual transformation of hospital ownership or management under the kind of system that I'm talking about. And that is I think most hospitals will become parts of for-profit health care marketing operations or they will become for-profit on their own. That's a long way down the road. Second, the whole idea of a retail market where consumers have dollars and buy annual plans implies if a provider organization invests too heavily in beds or equipment and can't fill the beds or utilize the equipment efficiently, their cost structure will require premiums that aren't competitive in the marketplace. When their premiums aren't competitive, their cash flow declines because their enrollment declines; sooner or later such an organization will reach the point of bankruptcy or be bought out by someone who believes they can run the operation better. I think you've got to have that threat in the system because it's the most powerful disciplining force there is on the individuals who make decisions about whether to add beds or add an open-heart facility.

Q: Did I understand you correctly that implicit in the plan you outlined is the elimination of cost-based reimbursement?

A: That's right.

Q: If the health care system is based upon an assumption that providers of services will be operating on a basis of risk and gearing their actions on the Profit mode primarily, how would services that might not be profitable be provided, such as emergency services, some forms of technology, services to poor people?

A: That's a good question, but I think it is really two separate questions.

One question involves how society deals with people who have insufficient income or resources to buy even minimal coverage. That problem is solved easily and in the same way society provides for people who can't buy enough food. Society provides food stamps. Or for the people who have insufficient housing services, government offers housing subsidy programs. The only thing I'm saying in the case of Medicare and Medicaid is that the income transfer function those programs perform today should be performed in a different form. Instead of backing each Social Security recipient with \$1,300 worth of Medicare, we should give them \$1,300 or whatever amount is settled upon, to buy their own coverage among an array of alternatives. This is a social policy choice. Some individuals will want to be very generous and make these subsidies very large; others would be flint-hearted and minimize the subsidies; and others, like myself, would be neoconservatives and make the subsidies just large enough to cover a social safety net, but not large enough to cause massive redistribution of income in the society. The question asked how services would be provided that may not be profitable. My answer is that if there is demand for a service, sufficient demand, then someone will meet the demand and they will do so profitably. I can't think of any service that was ever demanded by a real person with dollars in his pocket—as opposed to a bureaucrat who thought it should be demanded but nobody in the real world complied—that hasn't been supplied when the demand presented itself. In the kind of a system that I'm talking about, there will be a lot of integration, either very tight and direct between insurers and marketers and providers, or a looser form. There will be integration because that's the only way you can bring about utilization control, cost control, and discipline. Some providers won't like that and some insurance companies won't like that, but I already see a lot of insurance companies getting into the provider business, and I see a lot of providers understanding that the alternative is government controls rather than private controls. If pressed, providers probably would be more willing to accept private control.

Q: I have more of a comment than a question, but I'm sure you'll want to answer anyway. (The comment came from Walter McClure, a respected advocate of the medical marketplace model.) I don't think the technical problems which you have mentioned are so easily solved, like the adverse selection issue. For that reason I would recommend that we increment our way to a national program, rather than try to impose competition all at once by something as ambitious as the Gephardt-Stockman bill. For instance, we might begin with voluntary action in the middle class; that of course will require private sector cooperation. The most powerful thing that we need to ask the president to ask the private sector is to start implementing these competitive principles. I mean, let's experiment with multiple choice. Let's see if we

can't galvanize the private sector, give it some clear direction, legitimacy, and motivation by some public leadership before we rush into legislation.

A: Your idea about phasing is so good that we included it in the Gephardt-Stockman bill. We actually do start with what might be called the middle class or the employed groups, and then we allow for a gradual transformation of Medicare through which individual beneficiaries could opt out with a voucher into the competitive market. Thirdly, for the most troublesome area, the most troublesome market and group to deal with, the Medicaid program, we hold that off for five years in hopes that a number of competitive entities will be developed that the Medicaid beneficiary could buy into.

Q: *Under your plan, what would you do in the case of union contracts, particularly with unions like the United Auto Workers and the United Steel Workers?*

A: I've seen the answer to that problem used many times in Congress; it's called "hold harmless." Frankly, that is probably not what the ideal design would do, but that's what we did in Gephardt-Stockman. We said, "Take the best health plan offered and put a cap on tax deductibility slightly above that." This approach doesn't solve the problem of too much income being provided in fringe benefits, but a cap is imposed in terms of future upward growth in the system. Once a union member takes the \$2,200, or whatever the accurate amount is, and realizes that he has the flexibility to buy only as much health care as he needs and can take the difference in cash, I don't think there will be too much dissatisfaction among the rank and file.

Q: *Do you believe, as does Alain Enthoven, that government must prescribe a minimum set of benefits if it is to set up a fair medical market?*

A: I disagree very strongly with Professor Enthoven on that point. Once the government specifies a standard benefit plan, then the issue reverts to Congress and the bureaucracy on a permanent basis. That would be the case because once you put in law what should be a part of a standard benefit package, Congress will be subjected to about 500,000 doctors and other providers and all manner of institutional providers who want to make sure that their kinds of services are included. That generates violent arguments about whether ophthalmologists ought to be reimbursed or optometrists; whether podiatrists are worthy of reimbursement or not; and on and on.

Notes

1. *The Effect of PSROs on Health Care Costs: Current Findings and Future Evaluations*, Congressional Budget Office, 1979.