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A Katz and J Thompson
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The Role Of Public Policy In Health Care Market Change

by Aaron Katz and Jack Thompson

Abstract: Market forces appear dominant in the transformation of health care systems across the United States. However, in many markets public policy remains an important factor—guiding, facilitating, and in some cases prompting change. This paper reviews how the debate over health care reform acted as a catalyst in local health care financing and delivery systems, and how other public policy tools are affecting the fifteen markets studied in the Community Snapshots project. We then discuss prospects for public policy in the near term and the longer term, using two scenarios to illustrate possible future roles.

Unprecedented market changes are taking place in communities across the United States in the aftermath of vigorous national and statewide debates about health care reform. Although the public’s elected representatives have largely rejected comprehensive, government-led system reform, the public sector is still affecting the nature and pace of health care market changes. In some communities these effects stem from aggressive governmental activities; in other locales the market is transforming in a hands-off policy environment. The different approaches reflect each community’s unique political and cultural histories, the balance of power among interest groups, and the local forces that are driving change.

This paper discusses the role of public policy in fifteen health care markets nationwide that were part of The Robert Wood Johnson Foundation’s (RWJF’s) Community Snapshots study.¹ This study, part of RWJF’s Health Tracking initiative, endeavored to capture the process of change in the fifteen localities and assess its impact on the people who live there. After an overview of health care reform during 1994-1995 as context for this study, we discuss the role of public policy—including national and state reform deliberations—in the changes observed in the fifteen markets. We begin with our observations about the relative importance of public policy in the changes taking place in the various markets. We then briefly review how five types of policy tools are affecting these fifteen markets. Finally, we present two scenarios to illustrate the prospects for possible future roles for public policy in the changing health care marketplace. We emphasize that this presentation is based primarily on the impressions of persons interviewed in the fifteen communities, not on an analysis of cause and effect.

For purposes of this paper, we take public policy to be “whatever governments choose to do or not to do,”² The absence of action is not the absence of policy. A mayor’s or legislature’s political agenda that does not include “health,” or “health care” is as much a statement of policy as is a president’s
proposal to reform the entire health care system.

**Context for market change.** Between 1988 and 1994 many states studied—and some enacted—policy initiatives to reform their health care systems, to control costs and expand access to care. These efforts diverged from previously narrow strategies (for example, certificate-of-need or rate regulation) by combining policy tools in a coordinated fashion, which may have reflected a more explicit understanding that problems were connected, a more complex environment because of market changes, or a sense that piecemeal strategies did more harm than good.

When the federal government rejected comprehensive reform in 1994, states lost momentum as well. States that already had enacted reform laws repealed, delayed, or otherwise retrenched from major portions of those statutes. States that had been developing comprehensive reform strategies ceased those efforts, and states that were waiting for Congress to act abandoned such expectations. The change of political leadership in state capitals and on Capitol Hill in November 1994 further hastened this shift away from comprehensive reform.

Absent a blueprint for comprehensive reform, policymakers are left with traditional health policy tools but a nontraditional environment in which to apply them. State regulation of individual hospitals and physicians may be less relevant as more are owned or employed by multistate systems. Public programs for the uninsured may be less effective as safety-net providers are forced to join managed care plans that compete for paying, not nonpaying, patients. Tax-exempt status for hospitals and health maintenance organizations (HMOs) may no longer lead to the provision of community benefits, as nonprofits are forced to compete directly with for-profits and to focus on the financial bottom line.

Although most policymakers dropped comprehensive health care reform as a viable approach, providers and health plans in many markets had already begun to prepare for managed competition in anticipation of reform. That is, the prospect or threat of reform hastened—or even prompted—moves to consolidate between and among insurers and delivery systems and to create the structures necessary to assume financial risk for enrolled populations in response to growing pressures from purchasers.

Indeed, the characteristics of state and federal comprehensive reform plans mirrored the market trends that, in some of the Snapshot markets (such as Minneapolis/St. Paul), began more than a decade earlier: rising economic power of purchasers, increasing prevalence of managed care, and expanding use of payment methods that shift financial risk to vertically integrated networks of providers. As Paul Ginsburg explains in his overview paper, the congruence of reform proposals with the existing direction of market changes was widely noted by Community Snapshot interviewees.
Persons interviewed reported that the role of public policy in the fifteen Snapshot markets is primarily defined or led by state policy agendas. Federal policy, particularly potential Medicare cuts and Medicaid block grants, was viewed most often as having possible but not yet real effects. Local policy agendas were identified as important in only a few markets. Thus, this discussion focuses on state policy.

**Relative Importance Of Public Policy In The Snapshot Sites**

The Community Snapshots study examined markets in fifteen states. Persons interviewed in these markets identified three influential state policy initiatives most often: serious consideration or enactment of comprehensive reform legislation; implementation of Medicaid managed care; and (to a lesser extent) implementation of managed care for public employees. Using these “leading” public policy initiatives, we divided the markets into three general categories according to how large a role public policy has played in market changes (Exhibit 1).

**Small public policy role.** The six small-role markets include three whose states did not consider comprehensive reform legislation between 1990 and 1995 (Columbia, Houston, and Indianapolis). Iowa (Des Moines) and Missouri (St. Louis) debated health care reform in 1993 and 1994, respectively. However, observers did not attribute market changes to these deliberations, perhaps because their short duration (one legislative session) was insufficient to convince market players that reform was an important policy direction. In addition, although St. Louis and Indianapolis have begun to implement Medicaid managed care, neither initiative was far enough along in mid-1995 to be a significant force (Missouri had also just moved nearly all state employees into managed care, which may soon affect the St. Louis market).

South Carolina, which received a Medicaid Section 1115 waiver but is not planning to implement its program, is developing a voluntary Medicaid managed care program in 1996. Texas has submitted a request for an 1115 waiver program that would be phased in from 1996 to 2001; Houston’s program would go on line in 1997. Strong, conservative medical professions, lack of interest in managed care among purchasers, and more restrained state policy cultures may be reasons why public policy was seen as less important in these two states. Fargo/west central Minnesota is in the small-role category, despite Minnesota’s 1992 reform law and a high penetration of managed care, largely because this market is dominated by Fargo-based providers, and managed care has not yet reached this rural area.

**Moderate public policy role.** Public policy has played a moderately
### Exhibit 1
Relative Roles Of Public Policy Tools In Community Snapshot Markets

<table>
<thead>
<tr>
<th></th>
<th>Comprehensive reform</th>
<th>Medicaid purchasing</th>
<th>Public employee purchasing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Small public policy role</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Columbia, SC</td>
<td>None</td>
<td>1115 waiver approved but dropped; voluntary HMO enrollment planned for 1996</td>
<td>None</td>
</tr>
<tr>
<td>Des Moines, IA</td>
<td>1993, defeated</td>
<td>1915(b) waiver, primary care case management being replaced by new managed care waiver</td>
<td>State employees, planning for more aggressive strategies</td>
</tr>
<tr>
<td>Fargo, ND/west central MN</td>
<td>1992 (MN), passed 1995 (MN), revised None (ND)</td>
<td>1115 waiver (MN) implemented in 1995</td>
<td>State employees (MN), managed competition None (ND)</td>
</tr>
<tr>
<td>Houston, TX</td>
<td>None</td>
<td>Selective hospital contracting; None 1115 waiver, mandatory managed care in 1997, approval pending</td>
<td></td>
</tr>
<tr>
<td>Indianapolis, IN</td>
<td>None</td>
<td>1915(b) waiver, primary care case management in 15 counties; mandatory HMO enrollment planned for 1996</td>
<td>None</td>
</tr>
<tr>
<td>St. Louis, MO/IL</td>
<td>1994, defeated</td>
<td>1915(b) waiver (MO) in 5 counties; 1115 waiver (MO and IL), mandatory managed care, approvals pending</td>
<td>MO employees, managed competition</td>
</tr>
<tr>
<td><strong>Moderate public policy role</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Albuquerque, NM</td>
<td>1992, defeated 1994, defeated</td>
<td>1915(b) waiver, planned implementation in 1996</td>
<td>City and county employees, coordinated purchasing</td>
</tr>
<tr>
<td>North central FL</td>
<td>1993, passed</td>
<td>Voluntary HMO enrollment; 1115 waiver, mandatory managed care, denied by legislature</td>
<td>State changing self-funded plan administration</td>
</tr>
<tr>
<td>Orange County and San Diego, CA</td>
<td>1993, initiative defeated 1994, initiative defeated</td>
<td>1915(b) waiver, mandatory managed care, planned implementation in 1996 in 13 counties</td>
<td>State employees, managed competition (CalPERS)</td>
</tr>
<tr>
<td>Wilmington, DE</td>
<td>None</td>
<td>1115 waiver, mandatory managed care planned in 1996</td>
<td>None</td>
</tr>
</tbody>
</table>

An important role in Albuquerque, north central Florida, Orange County, San Diego, and Wilmington, primarily because of public-sector purchasing strategies. California is pushing hard toward Medicaid managed care and has one of the nation’s most aggressive programs for purchasing public.
## Exhibit 1  
Relative Roles Of Public Policy Tools In Community Snapshot Markets (cont.)

<table>
<thead>
<tr>
<th>Large public policy role</th>
<th>Comprehensive reform</th>
<th>Medicaid purchasing</th>
<th>Public employee purchasing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boston, MA</td>
<td>1988, passed</td>
<td>1915(b) waiver, mandatory managed care; 1115 waiver, legislative approval pending</td>
<td>State employees, participating in employer coalition (data and premium “challenges”)</td>
</tr>
<tr>
<td></td>
<td>1991, revised</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1995, revised</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minneapolis/St. Paul, MN</td>
<td>1993, passed</td>
<td>1115 waiver implemented in 1995</td>
<td>State employees, managed competition</td>
</tr>
<tr>
<td></td>
<td>1994, revised</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Portland, OR/Vancouver, WA</td>
<td>1989 (OR), passed</td>
<td>1115 waiver (OR), mandatory managed care</td>
<td>State employees (WA), managed competition</td>
</tr>
<tr>
<td></td>
<td>1995 (OR), revised</td>
<td>1915(b) waiver (WA), mandatory managed care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1993 (WA), passed</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1995 (WA), revised</td>
<td></td>
<td></td>
</tr>
<tr>
<td>South FL</td>
<td>1992, passed</td>
<td>Voluntary HMO enrollment; 1115 waiver, mandatory managed care, denied by legislature</td>
<td>State and Dade County employees, aggressive HMO contracting</td>
</tr>
</tbody>
</table>

Source: The Robert Wood Johnson Foundation Community Snapshots study, authors’ analyses.

Note: HMO is health maintenance organization.

Employee health benefits—the California Public Employees Retirement System (CalPERS). These two initiatives are speeding up the private-sector trend toward managed care in San Diego and Orange County. New Mexico’s promise to enroll most Medicaid recipients in managed care by 1997 has pushed providers and health plans in Albuquerque to prepare for full-risk contracts. Two Medicaid initiatives in Delaware are having a similar catalyst effect. Medicaid eligibility was expanded in 1993 to include all poor children under age eighteen, through a partnership between the state and a private foundation. The partnership provides pediatric care through a new managed care network of clinics, three of which are in Wilmington. In addition, an approved 1115 waiver program will begin operations in 1996.

**Large public policy role.** All five states (Massachusetts, Minnesota, Oregon, Washington, and Florida) in this category have not only debated but enacted comprehensive reform laws. These bold initiatives were, in each case, consistent with long histories of activism in social and health policy, and with long experiences with public- and private-sector managed care.

Each of these states has since repealed, delayed, or significantly revised major provisions of these laws. These actions reflect either the failure of Congress to amend the federal Employee Retirement Income Security Act...
(ERISA), new political leadership whose policy agendas no longer support the original reforms, or retrenchment from financial commitments to public programs. Despite these changes, persons interviewed in each site noted that the reform debate and some remaining provisions had hastened market consolidation and managed care expansion. Mandatory Medicaid managed care initiatives also have speeded up market transformation in each of these four markets, except in Boston (the Massachusetts legislature is considering optional strategies to implement a new 1115 waiver program in 1996). However, as noted below, Boston’s market was greatly influenced by a different type of public policy: deregulation of hospital rates.

Use And Effect Of Policy Tools

Governments at all levels in the United States have five types of public policy tools to influence how health care is financed and provided: regulation, taxation, funding of public programs, purchase of services, and collection and provision of information. These tools have been used to address a wide range of policy issues, including the two key issues of the past two decades: escalating costs and eroding access to care.

Throughout the 1980s governmental jurisdictions most often used one or more types of policy tools in isolation, frequently through separate agencies that had quite different missions. Strategies usually were aimed at very specific, narrowly defined problems in the health care market, instead of being coordinated to address a complex set of interrelated issues. At times these disparate strategies resulted in contradictory policies. For example, it was not unusual for a county health department to promote fee-for-service payment for its primary care clinics (to maximize revenue), while the county’s human resources department required capitation contracts with HMOs for its employee health plan (to minimize expenditures).

Regulation. Every state involved in the Community Snapshots project has enacted insurance market reforms, primarily rules for individual or small-group coverage that limit the use of preexisting condition exclusions, guarantee issue and renewability, or require modified community rating. Few persons interviewed in any community identified these rules as playing a major role in either promoting or hindering the market changes taking place; this finding is consistent with recent research.

State lawmakers in Minnesota have gone beyond these insurance reforms and focused on increasing competition by opening up market entry. The 1992 HealthRight legislation (later renamed MinnesotaCare) essentially required all health plans to become integrated service networks (ISNs). This facilitated the extensive consolidation that evolved in Minneapolis/St. Paul, which left the market dominated by three major health plans.
Spurred by fear that such consolidation would reduce competition and consumer choice, lawmakers adopted new rules in 1995 to loosen the reform structure by authorizing new community ISNs for rural areas, with lower reserve requirements; repealing the all-payer rules for non-ISN providers, making it easier for preferred provider organizations (PPOs) to continue; and authorizing new provider-led groups to contract directly with self-funded employers.

Another type of state insurance regulation, just becoming evident during the site visits in mid-1995, may have notable effects on future market changes. Many states have reacted to the perceived or actual strictures of managed care with new laws that are intended to temper the power of such plans. For example, by 1995 nine of the Snapshot states had enacted some form of “any-willing-provider” law, requiring that health plans contract with or offer contracts to any provider willing to comply with contract provisions. During 1996 legislative sessions six of the fifteen study states were expected to consider bills that would require insurers to cover minimum hospital stays after childbirth. Massachusetts is among four states that passed such laws in 1995, in reaction to public outcry over “drive-through deliveries”—postpartum discharges of one day or less. This apparent backlash against the growth of managed care plans may represent an attempt by providers and consumers to create a regulatory counterbalance to a marketplace that they fear gives insurers too much power to decide what is provided and by whom—an interesting response given the recent defeat of comprehensive reform because of fears of too much government control.

Long-standing delivery system regulations were notably absent from interviewees’ assessments of factors affecting market change, with one exception. Nine Snapshot markets are in states that still have certificate-of-need (CON) review, but persons interviewed during the site visits did not identify these requirements as being significant factors in market change (although CON approval was granted, in a reportedly highly political process, to reopen a small St. Louis community hospital that had been previously closed because it was deemed unnecessary). On the other hand, many persons interviewed in Boston noted that the repeal of hospital rate control in 1991 opened the gate for the current frenzy of negotiations among hospitals and health plans. The decline in perceived importance of CON and rate regulations symbolizes the growth of purchaser and other market forces in shaping local health care systems and, in states such as Massachusetts, a dramatic change from a strong regulatory history.

A final area of noteworthy health regulation concerns federal, state, and local government granting of not-for-profit tax status. Certain health care organizations receive exemptions from taxes and in return are expected to provide certain “community benefits,” including charity care, health pro-
fessional training, and medical research. Most Snapshot markets have been dominated by not-for-profit hospitals and HMOs whose tax-exempt status carried these expectations. As competition has heated up, the behavior of not-for-profits has raised some concern about community benefits. Among Snapshot states, Florida, Indiana, Texas, and California have laws that define certain community benefit requirements for hospitals (from submitting community benefit plans to providing a specified amount of charity care), but they have not yet become major factors in how or how fast markets in these states are changing.

In two Snapshot markets some persons interviewed reported that state policy concerning community benefit was influencing market change. Massachusetts is well known for its efforts to maintain the dominance of not-for-profit health care organizations. The continuing trend of community hospital closures in Massachusetts led the state’s attorney general to issue voluntary community benefit guidelines for nonprofit hospitals in 1994. He used these guidelines to publicly scrutinize the recently announced acquisition by Nashville-based Columbia/HCA of a nonprofit medical center in suburban Boston before allowing it to go forward. In early 1996 the attorney general announced similar guidelines for HMOs; he had earlier obtained a commitment from the merging Harvard Community Health Plan and Pilgrim Health Care to spend $3.25 million for education on acquired immunodeficiency syndrome (AIDS), health care for the homeless, and violence prevention.

Minnesota has long-standing policies that require HMOs to be not-for-profit and to abide by certain rules. Not only does the state require these health plans to maintain minimum reserves, it also caps reserves to keep premiums as low as possible. In addition, Minnesota requires HMOs to file plans to promote community health and added a provision in 1994 for the health plans to collaborate with public health and community agencies in health promotion efforts. Although the outcomes of these accountability rules are as yet unknown, collaborative projects have been implemented in the Minneapolis/St. Paul market (for example, on family violence prevention and bicycle helmet use).

Taxation. The 1994 elections brought to power many politicians committed to downsizing government. In Congress and state legislatures, budget discussions turned not only to cutting public spending but also to cutting taxes. So, at a time when market consolidation and competition are threatening the financial viability of safety-net providers, new public policy is expected to restrict the financial resources available to publicly funded health care programs.

Nonetheless, some Community Snapshot states continue to levy special taxes to finance health care. Minnesota and Washington have enacted
provider taxes to underwrite state-subsidized programs for low-income, otherwise uninsured persons: MinnesotaCare and the Basic Health Plan, respectively. California voters passed a cigarette tax increase of twenty-five cents in 1988 to pay for care and insurance for low-income persons, to finance a high-risk pool, and to finance anti-tobacco education. Oregon also uses a cigarette tax to finance its Medicaid eligibility expansions. Various local jurisdictions levy property and other special taxes for public health and public hospitals. For example, local citizens provide significant support to Wishard Hospital in Indianapolis in the form of property tax revenues, and special taxes are levied for similar purposes in south Florida’s Dade and Broward Counties.

Public programs. The major effects of public programs on market changes (other than the effects of purchasing strategies, as described below) involve retrenchment in some states from planned expansions of Medicaid and other programs and fear everywhere concerning future state and federal cutbacks. Most states involved in the Community Snapshots study enacted significant expansions of their Medicaid programs in the late 1980s and early 1990s. As noted earlier, a few states such as Washington and Minnesota also created publicly subsidized insurance programs for low-income people who are not Medicaid-eligible. Some local governments invested heavily in safety-net providers, such as public or quasi-public hospitals (for example, Indianapolis and St. Louis) and community clinics (for example, Boston). However, these public investments and expansions occurred prior to the market changes observed in summer 1995.

While no Snapshot state has yet reduced eligibility for public programs such as Medicaid, Minnesota and Florida have scaled back plans to expand enrollment that had been part of their reform strategies. In Florida delay in expansion was attributed to doubts that greater managed care enrollment would derive sufficient savings to fund increased eligibility and to Republican legislators’ opposition to Gov. Lawton Chiles’s policies. In Minnesota inadequate state funds and fears about Medicare and Medicaid cuts led to the rollback. This same fear-often voiced as concern about the viability of safety-net providers or the ability of hospitals and academic health centers to continue to train health professionals-was expressed in all fifteen markets. Many interviewees across the sites also questioned the future of disproportionate-share hospital funding, which has been an important source of support for the safety net.

Purchasing. Aggressive health care purchasing by public agencies is the single most significant and prevalent policy tool currently used in the Snapshot sites. In these markets Medicaid often represented one of the largest pools of insured persons, so a shift of this program to managed care could have profound effects. For example, the bidding for managed care
contracts in St. Louis’s new mandatory program—a pool of 150,000 persons—drew Humana into the state as an insurer for the first time, acted as a catalyst for an HMO joint venture between the “poor people’s hospital” and a for-profit company, and led to a new HMO formed by community health centers. The Oregon Health Plan, with its expanded Medicaid coverage, enabled an HMO joint venture between a local health department, an academic health center, and community clinics and provided impetus for Portland’s three largest primary care physician groups to come together to accept capitation payments. In Boston and Albuquerque Medicaid managed care led some health plans to actively seek contracts with community health centers, because they are attractive primary care sites and know how to serve the Medicaid population. Finally, statewide Medicaid managed care programs are stimulating new managed care capacity in rural communities in Washington, Oregon, Florida, and Minnesota.

Federal 1115 waiver programs are up and running in five markets, 1915(b) programs operate in four markets, and submitted—but-not-yet-approved waivers would involve four more markets. Only the Columbia, South Carolina, market might remain largely unaffected by Medicaid managed care in the near future; South Carolina has chosen not to implement an 1115 waiver approved in 1994 but is expected to introduce voluntary managed care enrollment in Medicaid in 1996.

Movement of Medicare beneficiaries into managed care has affected market change less dramatically, because it has not yet been made mandatory by the federal government. Nonetheless, “risk contracts” have been one factor in the development and expansion of managed care organizations. For example, Medicare capitation payments in California and Florida are so generous that HMOs in those markets view Medicare enrollees as their most profitable customers. In Portland, with the country’s highest rate of Medicare HMO enrollment (about 60 percent of all beneficiaries), Medicare was an important force in getting both public and private employers to accept and choose managed care.

Aggressive purchasing on behalf of public employees can also stimulate managed care capacity and consolidation. For example, in 1992 Minnesota implemented a managed competition model in which state employees pay higher premiums for plans that are priced higher than the lowest-cost plan in each region. Interviewees in that state reported that this program helped to reduce HMO premiums. The Minnesota public employees program also has recently joined an aggressive purchaser coalition to increase its influence over the market.

CalPERS also has been successful in changing market pricing in California and, according to some reports, stimulated greater service integration, backed by the power of the $1.5 billion it pays out in premiums for its one
million enrollees. Public employers in Albuquerque, that market’s largest employers, have used contract negotiations to expand the range of plan types and provider choices. Massachusetts’s Medicaid and state employees health programs are members of an employer coalition that has issued public “premium challenges” to managed care plans. These challenges may have helped to hold down premium rates in recent years. Interviewees also noted similar market effects by public employee health programs in south Florida, Portland/Vancouver, and (potentially) St. Louis.

**Information.** Public agencies in many of the Snapshot markets are beginning to develop useful information for consumers, purchasers, and health plans, often in collaboration with the private sector and often in support of aggressive public-sector purchasing strategies. For instance, Minnesota has created a Health Data Institute, supported by public and private funds, which conducts consumer satisfaction surveys, facilitates electronic data exchange, develops health outcome measures, and publishes a scorecard for public employees. These data have been assembled into a brochure used by people to choose among health plans.

State agencies in Massachusetts are members of an employer group that is working to develop a report card based on the Health Plan Employer Data and Information Set (HEDIS) to inform purchasing decisions by purchasers and enrollees. The Indiana Department of Public Health also has worked with an employer coalition and the state hospital association to assemble and disseminate hospital-specific charges and lengths-of-stay for certain diagnoses. Policymakers in Iowa, with the private sector, helped to set up a Community Health Management Information System to inform continuous quality improvement processes. The effects of these new information initiatives are as yet unknown.

Missouri is attempting to use information as a policy tool in a unique way. The state’s health department director successfully inserted a provision in Medicaid managed care contracts that requires health plans’ participation in a community data project. The director hopes to use this vehicle to help the plans understand and address the health problems of the communities they serve, extending their efforts beyond the bounds of their own enrollee populations.

**Prospects For Public Policy**

Interviewees across the fifteen markets expect little leadership in the next few years from public policymakers as health care systems become more competitive and consolidated. These observers seem to accept that comprehensive strategies designed to concurrently moderate costs and improve access are “off the table.” The extent to which the observed market
transformations control costs and assure access will influence whether and how public policy plays a role in the future.

**Near-term prospects.** Evidence from the Community Snapshots study suggests that purchasing for public employee and Medicaid benefits—and possibly Medicare benefits as well—will be the primary public policy tool to influence markets in the near future. Many state governments, such as in Missouri, Iowa, and California, are planning or have implemented more aggressive purchasing strategies to increase managed care enrollment or to create financial incentives for enrollees to choose lower-cost plans.

Traditional regulatory tools are not, and are not expected to be, important factors in market change. Other public policy tools, however, may be applied to attempt to guide market changes, such as the community benefits oversight being exercised in Massachusetts and Minnesota and the insurance reforms implemented in all Snapshot states. The recent U.S. Supreme Court decision allowing states to levy provider taxes—which had been challenged as a violation of ERISA—may give states some ability to expand public programs for low-income and other vulnerable groups.

We found some evidence that public policymakers are or will be reacting to market consolidation, competition, and managed care with new or revamped strategies. As noted earlier, Minnesota lawmakers have loosened entry requirements for the managed care market because of fear that the three large consolidated systems may not offer sufficient choice or promote competition. However, opening the market to nontraditional insurers raises issues about who is—and who is capable of—bearing financial risk. State insurance commissioners historically have set reserve and bonding requirements to protect policyholders, but these powers have not yet been applied extensively to provider networks that accept capitation or other risk-based payment from health plans. The National Association of Insurance Commissioners is beginning to examine how best to regulate risk-bearing, provider-sponsored organizations.¹⁵

We also expect legislative backlashes against managed care to continue in the near future, especially in markets where enrollment in managed care plans is growing rapidly or where consolidation is resulting in fewer, larger health plans. New regulatory targets may include additional benefit mandates (such as minimum postpartum hospital stays or bone marrow transplants), mandated point-of-service options, or disclosure of information (also known as “anti-gag” provisions).¹⁶

**Longer-term prospects.** The prospects for public policy roles beyond the next year are difficult to predict. We offer two scenarios that serve to illustrate possible future roles for public policy.

**Scenario 1:** Costs remain under control; access worsens or does not improve. In this scenario, market consolidation and expanded managed care,
as well as continuation of aggressive purchasing strategies, serve to control health care costs. This situation is arguably “simpler” for public policymakers, since they must address only one “mega-issue,” not both, as was the case during the most recent comprehensive reform deliberations. With the cost issue “taken care of,” public policy could focus on the following types of strategies to enhance access and to promote continued market competition.

Public policymakers might be able once again to expand public programs to reduce access barriers, by extending subsidized insurance coverage to uninsured persons, enhancing financial support for safety-net providers to provide direct services to vulnerable populations, or providing or expanding tax incentives for insurance purchase. Policymakers also could focus initiatives on improving or promoting high-quality care.

If Congress substantially cuts Medicare and Medicaid and increases state flexibility (through block grants), states might become more aggressive in expanding Medicaid managed care enrollment. They also might seek to merge Medicaid with other public programs to increase market clout and attain administrative efficiencies (both of which could be accentuated if long-term care—which makes up 50-60 percent of Medicaid spending in many states—is included in the block grants). If health plans continue efforts to avoid risk, either by increasing rates for certain products or through selective marketing and underwriting, insurance commissioners could become more active in regulating health plans. They could, for example, strengthen regulations concerning risk selection behavior or provide closer scrutiny of insurance rates. If consolidation evolves to the point at which choice and competition suffer, state and federal attorneys general could become more aggressive in enforcing antitrust rules. In addition, states could lessen requirements for new market entrants, such as lower reserve requirements or an expanded definition of managed care. If proprietary organizations continue to gain a greater portion of the market, federal and state governments might create or refine rules that require health care providers or plans to provide community benefits or might reduce or eliminate such rules to create a level playing field for nonprofits and for-profits.

Scenario 2: Costs do not remain under control; access worsens or does not improve. This scenario assumes that costs escalate despite market changes, renewing interest in public policy initiatives to control costs, as well as to improve access. Policymakers could respond by employing the types of individual policy tools discussed under Scenario 1, as well as other traditional approaches (for example, CON and price controls).

Policymakers could instead return to the comprehensive reform proposals of the early 1990s, including employment-based approaches such as those enacted in Minnesota, Oregon, Washington, and Hawaii. The policy “toolbox” also could expand to include comprehensive approaches that are
not based on employment status, such as single-payer models.

**Conclusion**

Even though market forces seem dominant in the transformation of the American health care system, public policy remains an important factor in many markets. The focus on comprehensive reform at the state and national levels and aggressive public purchasing strategies have intensified pressures on insurers and providers to compete. Their responses have created a whirlwind of mergers and a rapid expansion of managed care, both of which have raised new fears that the balance of market power has shifted too far in favor of large health plans and provider networks and away from consumers and individual clinicians. To counter this shift, policymakers are seeking new or refashioned tools to promote consumer choice, access, and quality, largely leaving cost to the dynamics of the marketplace.

What role public policy will play in future health system changes depends on three factors. First, the need for health policy initiatives will be determined in large part by whether the new market forces satisfy the needs of consumers and their agents—health professionals—for accessible, affordable, and high-quality health care services. Second, the ability to respond will depend on whether policymakers have useful tools to mitigate or prevent failures of the new health care market. The Community Snapshots study reveals a fast-changing environment in which many of the old policy tools are out of fashion or of questionable relevance and the development of new tools must await much better information than is now available. Even with a clear need and the best tools, the future role of public policy tools will depend heavily on policymakers’ willingness to use them.

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NOTES

1. The fifteen communities were Albuquerque, New Mexico; Boston, Massachusetts; Columbia, South Carolina; Des Moines, Iowa; Fargo, North Dakota/west central Minnesota; Houston, Texas; Indianapolis, Indiana; Minneapolis/St. Paul, Minnesota; north central Florida; Orange County, California; Portland, Oregon/Vancouver, Washington; St. Louis, Missouri; San Diego, California; south Florida; and Wilmington, Delaware.


3. See, for example, papers in the special section on state models, Health Affairs (Summer 1993): 27-88.


6. Despite the few instances when comprehensive reform of the U.S. health care system has been considered, the history of U.S. health policy is typified by targeted rather than comprehensive approaches. See P. Starr, The Social Transformation of American Medicine (New York: Basic Books, 1982), 395.


12. Interestingly, this concern is being voiced by consumer groups, which fear the loss of charity care and other community benefits, and proprietary hospital companies, which argue that tax exemptions give not-for-profits an unfair competitive advantage and that, in any case, proprietaries provide at least as many community benefits.


14. The purchasing role is distinct from the role of public funder, in that the latter relates whether certain segments of the public should be aided by government programs, while the former concerns the strategies used to buy services in the marketplace (perhaps for such programs). The purchasing role is also distinct from that of regulator, because regulations directly affect all players in the market being regulated, while purchasing strategies directly affect only suppliers or contractors doing business with government.
