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Health Care Reform

A free-market proposal

An award-winning essay proposes applying free-market economics to health care in order to maximize consumer welfare.

by Andrew Ferris and Griffin Seiler

The fundamental problems in the health care market are a result of government intervention. This government intervention, under the guise of market correction, has caused market failure. The market clearing price in the health care market, like any other market, is driven by the intersection of supply and demand. Lowering the price and thus, the total amount of expenditure on health care, requires action to decrease demand, increase supply, and reduce transaction costs.

To correct market failure on the demand side, health care benefits must be tied to health care costs. First, recipients of health care must consider the full cost of health care when making health related decisions. Second, "free riders" must pay for the health care they ultimately receive.¹ Third, demand for health care services must be reduced by redefining medical malpractice in a manner that reduces excessive treatment. Finally, demand must be reduced by increasing reliance on preventative health care, self-diagnosis, and self-treatment.

To correct market failure on the supply side, the supply of health care providers must be increased. This can be achieved by loosening state licensing restrictions on health care providers to create a market

for the services of nurses and physician assistants. Additionally, eliminating artificial restrictions on medical school enrollment and the number of residency programs will also help increase the supply of health care providers.² Finally, correcting the failure of the health care market requires addressing its high transaction costs.³ Transaction costs may be reduced in three important ways. First, restrictions must be placed on the amount of government regulation. Second, malpractice costs must be reduced. Third, the costs associated with purchasing and maintaining insurance coverage must be reduced by mandatory disclosure provisions and convertibility requirements.

Two solutions emerge when one accepts that market failure occasioned by government intervention is a cause of the problems in the health care market. One solution is a government takeover of the market, or the socialization of medicine.⁴ An alternative solution is for the government to remove itself entirely from the health care market, participating only in a minimal fashion. Market-minded thinkers since Adam Smith have acknowledged

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that the case for government intervention is strong; however, this strength is only theoretical. This is because, in theory, governments are wise, disinterested, and technically competent. However, in practice, governments rarely measure up to such standards. Thus, as empirically proven in the health care market, government failure has done more harm than the failure of the market.⁵ Accordingly, minimal governmental intervention, rather than socialism, is the preferred method to correct market failure.

This article proposes a free-market health care reform solution aimed towards reducing demand for high cost primary health care services, increasing supply in the health care market, and lowering market transaction costs. This type of market-based reform will maximize welfare by vesting health care choice and responsibility in the consumer.⁶ Fundamental health care reform should include the following components: universal coverage of basic health care;⁷ individual internalization of the costs of health care services received; limited government intervention in the market; and the maintenance of existing antitrust law. This proposal achieves these goals by mandating a minimum level of catastrophic health care insurance⁸ and use of the Medical Savings Account (“MSA”).⁹ All individuals employed in the United States would be required to purchase high deductible catastrophic health insurance for themselves and their families. In addition, all individuals would be required to pay a minimum annual amount into a MSA.¹⁰ This MSA would provide funds for health maintenance expenses, cover insurance deductible amounts, and serve as a funding reserve for future health expenses. The MSA and insurance would be self-funded with pre-tax dollars. In conjunction with these reforms, the federal government’s role as a primary provider and third party payor of medical care would be phased out. All federal employees and entitlement recipients would receive a transfer credit to purchase the health insurance plan of their choice and to establish an MSA.¹¹ These transfer credits would be in the form of a negative income tax.¹²

This plan proposes three specific reforms aimed toward correcting failure in the health care market. First, the supply of health care must be increased. This should be achieved by federal regulation of medical licensing with the goal of increasing the number of non-physician practitioners and the scope of services they provide. Additionally, medical school and residency program enrollment restrictions must be reduced. Second, malpractice

costs must be curtailed. This proposal addresses the malpractice costs problem by eliminating pain and suffering and non-economic loss of consortium damages in ordinary negligence malpractice actions and by establishing interdisciplinary medical malpractice review boards to eliminate frivolous claims.¹³ Third, more restrictions must be placed on insurance carriers. Under this proposal, insurance carriers would be required to make uniform and comprehensive disclosures about the type and extent of coverage their policies provide. These reforms will increase the quality and availability of health care, personal accountability, and choice, while reducing government regulation and health care expenditures.

Health care reform has become a politically divisive issue not because of any special opposition to reform, but rather, because special interest lobbyists and elected officials have engaged in a pork barrel feeding frenzy whenever large scale government projects are proposed.¹⁴ Health care debate should concentrate on the primary issues of funding, coverage, choice, and control with the interests of the average American being the sole concern. Instead, the public has been besieged by a multitude of views on the problems in the health care market. Politicians, providers, insurers, and special interest groups have embraced false problems and put forth unworkable self-serving proposals. Until very recently, the health care debate has focused primarily on special interest politics rather than economic analysis and logical problem solving. This health care reform proposal attempts to cut through the politics of the health care reform debate and addresses the deficiencies inherent in the health care market in an attempt to formulate market-based solutions.

Part I.A. of this paper discusses the competitive market model of health care services that existed historically in the pre-1900 health care market. Part I.B. demonstrates how the health care market evolved from a paradigm of efficiency to a market characterized by major defects. Next, the paper analyzes additional market defects in Part I.C. Thereafter, in Part I.D., the paper analyzes previous government attempts at health care reform. In Part II the paper considers the antitrust constraints on market-based health care reform. Then, in Part III, the paper argues that the Clinton plan fails to correct the inherent problems in the health care market. In Part IV, the paper presents a detailed free market health care solution to correct the identified problems in the health care market. Finally, Part V of the paper briefly discusses funding.

Health care market analysis

A competitive market paradigm. The following section illustrates that prior to large scale government intervention, the health care market was competitive and efficient. This analysis is a starting point for understanding that government intervention in the health care market is the cause of the problem, not the solution. A perfectly competitive market operates to ensure low prices and high quality, and therefore, maximizes consumer welfare. The modern health care market, however, deviates significantly from the perfectly competitive market.¹⁵ Perfect competition, a basic principle of economics under which all humans will act rationally to maximize utility, tends to drive the market towards a welfare-maximizing result. This occurs because rational consumers in a free market will purchase goods and services consistent with their preferences and ability to pay. While most product and service markets deviate from a perfectly competitive market, the pre-1900 health care market came close to the competitive ideal.

Prior to 1900, the American health care market was a model of efficiency.¹⁶ Consumers and providers participated equally in a competitive market. Low demand, high supply, and negligible transaction costs kept health care costs low. The cost of health care services was driven by market forces, free from government participation.

Before 1900, demand for health care services was a product of individual preference and ability to pay.¹⁷ Equally significant, lifestyle played an important role in defining medical care needs.¹⁸ A low-risk lifestyle contributed to lower health costs. Furthermore, individuals and society internalized the cost of high risk behavior and accepted non-treatment as a legitimate health care choice. Finally, fewer high-cost services were available.

From a supply perspective, primary care substitutes were readily available prior to 1900.¹⁹ Both physicians and non-physicians provided primary medical care. Midwives and other alternative practitioners provided competent low cost medical care in both urban and rural areas. In addition, self-treatment was prevalent.

Further, transaction costs were much lower before the turn of the century. The federal government was not involved in the health care market, either as a regulator or as a participant. Malpractice actions were extremely rare,²⁰ and administrative costs and overhead were minimal.

Successful health care reform must emulate the virtues of the pre-1900 free market health care paradigm. Specifically, government involvement must be minimized. Additionally, successful market reform must include these key elements: individual financial accountability; individual choice; limited government involvement; available substitutes for medical care providers; and limited malpractice actions.

Historical development of market defects. As the health care market evolved and government intervention increased, the market was transformed from an efficient to a defective market. It is critical to understand that the problems in the health care market developed over time. The first factor in this transformation was the centralization of health care facilities. Centralization, combined with demand uncertainty, caused increased overhead. This, in turn, led to the development of health insurance plans, which over time restricted the supply of providers, increased demand for services, and added transaction costs. In addition, wage and price controls during World War II, as well as tax policy, combined to tie health insurance to employment.²¹ As a result, competitive market forces were displaced and overall health care costs rose.

The proliferation of hospitals. The genesis of defects in the health care market occurred when the first hospitals were constructed. Around the start of the twentieth century, hospitals became the primary component of the health care delivery system. Hospitals were able to care for a large number of patients in a centralized location, resulting in the more efficient utilization of physicians, nurses and support personnel. Moreover, hospitals created a market for new technology. The benefits of hospital-based medical care resulted in a stunning proliferation of hospitals.²² Further, as the public embraced the convenience and benefits of centralized medical care, demand for health care services increased.²³ Consequently, increased demand caused financing problems for hospitals.²⁴ Because consumer demand for health care services is inherently uncertain,²⁵ hospitals were forced to increase capacity to meet demand fluctuations. Naturally this resulted in an increase in overhead costs. At times when capacity exceeded demand, hospitals had difficulty paying their fixed costs.²⁶

The development of health insurance. To finance these overhead costs, hospital administrators sought to price services by prorating overhead costs over the entire popu-

lation of hospital users. This proration led to the use of insurance to allocate cost on the basis of risk. Insurance allowed hospitals to cover increasing overhead costs in the face of uncertain demand.²⁷ Early insurance plans laid the foundation for the financial and organizational structure central to current health care financing problems. Under a typical plan, a subscriber paid a premium which would cover the expected cost of hospital care of a certain duration.²⁸ For hospitals, this provided the important benefit of being able to pool risks, thereby reducing the costs associated with demand uncertainty in the health care market.

As the number and size of these plans increased, state governments attempted to bring hospitals under the regulatory reach of insurance commissions.²⁹ The American Hospital Association (“AHA”) responded to state governmental pressure by establishing non-profit groups to offer health plans.³⁰ However, AHA and other medical groups persuaded states to exempt these plans from state insurance, tax, and antitrust regulation through lobbying efforts.³¹ As a result, “Blue Cross” plans were born.³² State authorization and hospital cooperation assured that only one “Blue Cross” organization operated in a given area.³³

The benefit and reimbursement structure established by the Blue Cross organizations (“Blues”) provided anti-competitive incentives for health care providers and divorced consumers from the true cost of health care services. These two effects are central to the problems inherent in the modern health care market. Specifically, physicians were paid on the basis of “reasonable and customary” fees in their area. This, in effect, mandated cartel pricing.³⁴ Physicians could charge higher prices if they all agreed. They had no incentive to prescribe less expensive treatments.

Hospitals were reimbursed a percentage of their costs based on the number of plan subscribers using hospital facilities and the amount of capital expenditures made by the hospital.³⁵ Hospital administrators then used this reimbursement scheme to capitalize the cost of new hospitals. Like physicians, hospitals had no incentive to control costs. Because of asymmetric information, the market did not prevent the development of these reimbursement schemes or police abuses in their implementation.

The Blues developed the third-party payment system. Patients received treatment and the insurance plans directly reimbursed providers. As a result, patients were divorced from actual treatment cost and with no incentive to reduce consumption. Market failure was amplified as early market domination by the Blues forced other insurance plans to adopt the same inherently defective benefit and reimbursement structure.

Health care as an employment benefit. The development of the tie between health care and employment further separated the consumer from actual health care costs. In addition, this tie provided a political incentive for government intervention in the market. During the 1940s and 1950s, health insurance gained prominence as an employment benefit. Because of the labor shortage during World War II, the federal government implemented wage and price controls.³⁶ This forced employers to use benefits to compete for the best labor and to attract new entrants to the labor market.³⁷ After the war ended and federal wage

controls were lifted, labor unions continued to successfully demand health insurance in contract negotiations.³⁸ This tie between employment and health insurance was further strengthened when the Internal Revenue Service ruled that health in-

surance costs were deductible to employers and not taxable to employees.³⁹

As health insurance became closely tied to the employment relationship, the worker-recipient of health care services became divorced from direct payment for the services received.⁴⁰ Health care took on the characteristics of an entitlement without direct personal cost. Natural market demand restrictions were severely diminished. The health care recipient had no incentive to reduce usage or seek lower cost treatment.⁴¹ Finally, employer-provided health care granted little incentive for the worker to self-diagnose and treat minor ailments.

Social welfare programs. Health insurance financed through employment benefit packages left many people without coverage. Consequently, political forces induced the federal government to establish social welfare programs to cover these groups.⁴² As a result, the federal government became both a provider and a third-party payor

Patients were divorced from actual costs and left with no incentive to reduce consumption.

of health care. The programs creating Medicaid⁴³ and Medicare⁴⁴ were enacted in 1965. These programs expanded federal and state government intervention in the health care market. As a third-party payor, the government adopted the defective reimbursement financing structure already established by the Blues and commercial health insurers.⁴⁵ Hospitals were reimbursed according to their costs, while physicians were permitted to charge their “reasonable and customary” fees.⁴⁶ This system intensified the market disincentives on the supply side.⁴⁷

From the demand side, the effect on the market was even more profound. Social welfare programs, like insurance plans, served to completely divorce the consumer from the cost of receiving health care.⁴⁸ Medicaid recipients received health care services at no charge to themselves. Medicare recipients paid small premiums which had no relation to use of services. Thus, government intervention meant that for a significant portion of the health care market, demand and supply were no longer price determinants. As a direct result, government expenditures on these entitlement programs exploded.⁴⁹

Additional market defects. As the preceding section illustrated, the proliferation of hospitals, the rise of insurance financing, the tie between health care and employment, and social welfare programs all combined to displace the natural role of supply and demand in the health care market. Over time, the failed market of today developed and additional factors further magnified the problems inherent in the structure of the health care market.

Uninsured free riders. While many Americans receive health insurance through their employer or through state or federal governments, there is a large number of individuals uninsured or underinsured.⁵⁰ This later group is largely composed of individuals who are unemployed, employed part-time, self-employed or uninsurable by reason of a pre-existing medical condition. Often, these individuals are either destitute and cannot afford to purchase health insurance or choose not to purchase health insurance with their available resources. These “free riders”⁵¹ receive health care; however, in most instances they never pay the total cost of the services received.⁵² As a result, the insured population⁵³ finds itself paying higher overall costs to finance the free riders’ benefits.

Supply restrictions. The American Medical Association, the physicians’ lobbying organization, and its state counterparts artificially restrict the supply of primary health care providers under the auspices of maintaining

quality care.⁵⁴ State regulations mandate that only licensed physicians provide primary health care services.⁵⁵ To earn a medical license, a person must attend an accredited medical school and complete postgraduate training in a hospital residency program. Medical school admissions, as well as acceptance into residency programs, are also controlled by physician groups. As a result, non-physician substitutes for health care providers and the total number of physicians are artificially reduced.

High transaction costs characterize the health care market. Compliance with state and federal government regulation is one primary cost. The behavior of every participant in the health care market is regulated. Examples include certificate of need laws, insurance regulations, Medicare and Medicaid payment and reimbursement regulations, licensing regulations, restrictions on the purchase of pharmaceuticals, and antitrust laws. Also, providers are subject to transaction costs resulting from medical malpractice liability. Further, an asymmetry of information related to the purchase of health insurance increases overall consumer costs.

Government attempts at reform. Faced with increasing health care costs caused by the defective market structure just illustrated, Congress and state governments have repeatedly attempted to reform the health care market. However, these reform efforts have failed to address the defects inherent in the health care market. Instead, the focus of this legislation has been ill-conceived industry regulation driven by a blind desire to satisfy special interest constituencies. This kind of government regulation only serves to magnify the structural problems inherent in the health care market.

To illustrate, legislative enactments in the 1970s provided strong incentives for states to establish Certificate of Need (“CON”) programs.⁵⁶ The regulatory philosophy behind CON legislation is that an excess of beds or equipment generates a self-fulfilling demand, and that the most effective way of controlling this demand is to carefully control or reduce supply.⁵⁷ It was not a surprise to economists when CON regulations proved to be a poor substitute for free-market operation.⁵⁸ Despite the fact that Congress repealed the legislation in 1986, the vast majority of states still maintain CON programs.⁵⁹ A CON license essentially grants a geographic monopoly to the holder. After receiving a CON license, a provider may charge monopolistic prices. As a result, providers are induced to spend significant resources to obtain CONs and to prevent their

competitors from obtaining CONS. The result is an overall increase in prices and market transaction costs.

In the period between 1973 and 1988 state governments passed laws mandating that health insurance plans pay for specific medical services, including psychiatric and chiropractic care.⁶⁰ These coverage mandates were the result of aggressive lobbying from health care providers and consumer advocates. Coverage mandates guarantee markets for favored health care providers. As a result, the supply of providers offering the service increases, policyholders increase their use of the service, and the cost of the service rises. The effect of mandated coverage laws is increased health insurance costs discouraging the purchase of health insurance.⁶¹

In 1988, Congress enacted the Employee Retirement Income Security Act ("ERISA") under which the federal government assumed responsibility for regulating employer-provided welfare plans, including health care.⁶² ERISA encouraged employers to avoid state insurance regulations, including coverage requirements, by self-insuring.⁶³ However, only large employers have the cash flow to establish self-insurance programs. Further, because ERISA is a complex statute with significant penalties for noncompliance, it has had the result of increasing transaction costs for those employers who establish plans subject to its restrictions.

The 1983 Social Security Act was another congressional effort at health care cost control. This legislation established the prospective payment system ("PPS") for hospital reimbursement by Medicare. Under PPS, Medicare established a fixed ceiling for hospital service costs.⁶⁴ If a hospital's actual cost for a treatment is less than the fixed fee, the hospital keeps the difference. If the hospital's actual cost is more, the hospital suffers the loss. The objective of the program was to encourage competition among hospitals and create the incentive to reduce costs. PPS has not achieved the desired results. Like all price control systems, PPS creates skewed incentives for providers. Specifically, providers shift costs to services not covered by price controls,⁶⁵ "dump" high cost patients, and reduce the overall quality of care.

Antitrust restraints on health care reform

A free market health reform proposal must operate within the constraints of current antitrust law. Defects in the health care market have resulted in the formation of cartels by both health care providers and purchasers. Physician cartelization efforts fall into two general categories: price fixing and group boycotts. Hospital cartelization efforts typically involve mergers and acquisitions. Cartels foster economic efficiencies and encourage competition; however, they also operate to extract monopoly prices and eliminate market entry. Due to the potential for health care cartels to harm consumer welfare, many cartels have been challenged under antitrust law.

For many years, health care providers avoided antitrust enforcement by utilizing a number of defenses and immunities. However, beginning in 1975, the Supreme Court rejected these defenses one by one.⁶⁶ All doubt regarding the existence of antitrust immunity for the health care industry was removed in *Arizona v. Maricopa County Medical Society*.⁶⁷ Since then, various provider cartelization efforts have been challenged under antitrust statutes. Some of these efforts have been overt attempts at price fixing. For example, in *Maricopa*, the Supreme Court held that by attempt-

ing to establish a minimum fee schedule for insurance payments, a physician joint venture committed a per se violation of the Sherman Act.⁶⁸ Other similar physician efforts to fix prices have been declared illegal.⁶⁹

Physicians have also engaged in group boycotts. In *Michigan State Medical Society*, joint provider efforts to boycott government programs in order to obtain higher fees were struck down.⁷⁰ Additionally, efforts by provider groups to prevent the establishment of managed care groups have been found illegal.⁷¹ Physicians have also utilized group boycotts against other physicians in their attempts to increase market share.⁷² Other group boycott efforts have been more subtle. For example, in *United States v. Halifax Hospital Medical Center*,⁷³ the Federal Trade Commission ("FTC") successfully challenged actions by hospitals and physicians to prevent HMO-employed physicians from utilizing hospitals.⁷⁴ Attempts to prevent non-physician care providers from obtaining hospital staff privileges have also been successfully challenged by the FTC.⁷⁵

Socialized medicine,
like all other socialist
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Hospitals have formed cartels by merging to reduce overall market capacity and take advantage of economies of scale. In many cases, the FTC has successfully challenged these acquisitions under Section VII of the Clayton Act and Section V of the Federal Trade Commission Act.⁷⁶ These hospital merger cases turn on the issues of product and geographic market definition. Furthermore, joint ventures between hospitals and physicians are an increasingly popular provider effort at cartelization that is attracting antitrust scrutiny.⁷⁷

On the demand side of the health care market, the insurance industry operates as a government sanctioned cartel.⁷⁸ Under federal law, those engaged in “the business of insurance” are granted broad antitrust immunity.⁷⁹ From an economic standpoint, this policy is a government sanction of the “theory of the second best.”⁸⁰

Despite antitrust immunity, insurers who exercise their significant market power have been subject to antitrust challenges. Providers, consumers, and even other insurers have challenged insurer contracts with providers. These challenges, however, have not succeeded as courts have recognized the pro-competitive benefits to exclusive dealings.⁸¹ Cartels have emerged on both the supply and demand side of the health care market. The existence of these cartels is positive for consumers in that competition and economies of scale are facilitated. However, antitrust laws must be prudently enforced to prevent these cartels from eliminating competition.

A non-market solution is no solution

Socialized medicine, like all other socialist systems, will reduce consumer welfare, reduce personal autonomy, and result in a redistribution of wealth based on the value judgments of those in power. Specifically, governmental decision-making divorced of market considerations will result in wage and price controls, rationing of services, excessive administration costs, and oppressive government-dictated value judgments.

The Clinton proposal states basic universal health care as a primary goal. However, universal coverage under this plan would also increase the power and influence of the federal government. In order to increase coverage, reduce costs, and eliminate the free-rider problem, the Clinton plan proposes: (1) large purchasing alliances; (2) provider networks; (3) community rated risk pools; and (4) reducing the number of specialist physicians. These proposals,

like previous government intervention efforts, fail to address the fundamental defects inherent in the health care market. Additionally, these proposals will reduce competitive market forces. Furthermore, if current antitrust laws are not enforced, consumer welfare will be reduced.

Purchasing alliances. The first element of the Clinton proposal is the creation of state or regional-based purchasing alliances operated by either state governmental agencies or non-profit corporations. These purchasing alliances would establish various health plans, set fee schedules, negotiate insurance premiums, and contract with providers on behalf of their members.⁸² In essence, these alliances would force all consumers into one or two large health plans with a National Health Board to oversee them. These large scale alliances really amount to large government run and subsidized Blue Cross and Blue Shield plans.⁸³ The idea of alliances creating economies of scale is palatable if they were not government operated. However, cost savings from alliances would more likely occur from government dictated rationing of services,⁸⁴ reduced coverage, and reduced quality of care rather than from administrative and market efficiencies. With government run alliances, providers of health care would not have to convince thousands of consumers about the value of their services. Providers would buy market share by negotiating with government bureaucrats.

The principal benefit of these alliances is cost containment by virtue of purchasing power. However, it is precisely this purchasing power that creates the potential for antitrust problems. Large alliances could potentially possess sufficient market power to dictate prices. As such, the alliances would be subject to a challenge as an illegal joint purchasing arrangement.⁸⁵ Admittedly, cooperative purchasing arrangements typically have pro-competitive effects; however, the potential for anti-competitive behavior exists. First, an alliance could drive prices below marginal cost through the exercise of monopsony power. Second, consumer alliance members could be charged monopoly prices. In either circumstance, the market, and consequently, the consumer, are harmed.

Provider networks. The Clinton proposal also relies on large networks of physicians, hospitals, and third-party payers who would contract with the alliances to provide medical services to members.⁸⁶ In reality, this system is nothing more than government legislation of the “theory of the second best.” Rather than solving the market de-

facts that led to the creation of one monopoly,⁸⁷ the Clinton plan would allow the creation of other non-competitive monopolies or cartels to deal with the first. These provider networks would have an incentive to fix prices and reduce services in order to maximize profits.

Community rated risk pools. In addition to the creation of purchasing alliances and provider networks, the Clinton plan limits the ability of insurance companies to segment the health care market based on risk. This plan will result in healthy consumers subsidizing the health care costs of people making unhealthy lifestyle choices. As a result, the incentive to live a healthy lifestyle and use preventative health care will be eliminated. Short of government lifestyle mandates, community rated risk pools can only result in increased health care expenditures.⁸⁸ Under such a plan, low-risk individuals would be paying a higher rate than otherwise, while high-risk individuals would pay a lower rate. Thus, the low-risk lifestyle is being taxed to subsidize the high-risk lifestyle.⁸⁹

Instead of community rated risk pools, health insurance should be based on actuarially fair rates determined by a competitive market. Competition on cost, including risk, is the essence of capitalism. When free market assumptions are valid, the market clearing price yields a match of consumer demand with consumer desire that maximizes consumer welfare. As such, competition on risk is both just and good for society. Furthermore, prevention of risk competition would run afoul of current antitrust laws.⁹⁰

Reducing the number of specialists. The Clinton plan calls for a reduction in the number of physician specialists. Clinton incorrectly faults specialists for high costs based on a belief that specialists charge more than generalists. While Clinton is correct that specialists cost more than generalists, this analysis of the problem is overly simplistic and the proposed solution ignores free market principles.⁹¹

Specialists are merely following the law of supply and demand. Specialists can charge more because they provide a special service for which people are willing to pay more. Any governmental regulation in the market will displace competitive forces. Any attempt to regulate lower wages for specialists would decrease the number and quality of specialists available. Reducing the number of specialists would only result in an increase in the value of their services, which in a competitive market, go to the highest bidder.

Furthermore, a limited supply of medical specialists has the potential to result in a concentrated market, and thus implicates antitrust concerns. Government agencies would dictate the type and number of specialists, thereby granting specialists monopolies. Absent price controls, specialists will be given the incentive to charge monopolistic prices.

Taken together, Clinton's reform proposals fail to address the defects inherent in the health care market. His plan will result in increased concentration in almost every area of the health care market. Absent effective antitrust enforcement, consumer welfare will suffer.

A free-market reform solution

Historical analysis of the health care market shows the defects inherent in the current health care market. Natural market mechanisms do not operate to control supply and demand and the market suffers from high transaction costs. A solution to these problems must correct these fundamental market defects. Our solution encompasses the following components directed toward creating an efficient market in health care goods and services which will maximize overall social welfare.

Mandatory catastrophic insurance. One fundamental goal of this solution is to provide universal health care coverage. Universal coverage will not occur without a government mandate.⁹² Therefore, in order to achieve this goal, mandatory catastrophic health care insurance is an element of this solution. Mandatory catastrophic insurance is necessary to eliminate the market defect caused by the free rider problem. Government intervention in this area is both necessary and appropriate, reflecting a societal consensus in favor of universal coverage and individual responsibility. Although catastrophic insurance is mandatory, the consumer will maintain the choice of how this insurance fits into her total health care expenditures beyond the mandatory coverage threshold. Specifically, emergency medical care and hospitalization coverage will be mandated. To reduce cost, this insurance policy will have a high deductible which will be self-funded through an MSA or additional insurance coverage.⁹³

All employed individuals will fund the purchase of this insurance with pre-tax dollars. These dollars will be withheld from paychecks and paid directly to the health insurer of the employee's choice. Self-employed individu-

als will have to provide proof of catastrophic insurance with their routine tax disclosures. The federal government will directly pay the cost of this insurance for employees and entitlement recipients through a negative income tax.⁹⁴

Medical savings account. In conjunction with required catastrophic insurance, employed individuals will be required to establish and maintain a medical savings account. This MSA will tie the health care consumer directly to the cost of health care, thus creating the incentive to avoid excessive consumption. Actuarial data shows that apart from catastrophic disease or injury, the average cost of routine health maintenance is between two and three thousand dollars annually. This amount also roughly corresponds with the average cost of participation in a health maintenance organization. Therefore, individuals would be required to establish and maintain MSAs large enough to purchase a standard health maintenance plan and these accounts would be available only to purchase qualified health care or health care insurance.

Similar to the mandatory catastrophic insurance payment plan, the MSA would be funded with pre-tax dollars through payroll deductions. An individual would be allowed to make unlimited contributions to her MSA. At death, an MSA fund could be willed to family members' MSAs, donated to medical charities, or removed and taxed. The federal government would establish MSAs for all federal employees and all federal entitlement recipients.⁹⁵ Social workers would then counsel federal entitlement recipients to use their MSAs to the most personal utility.⁹⁶

In essence, the MSA is the best health plan available. With an MSA program, the government requires people to maintain the ability to purchase a fixed level of health care; however, how a person does this is her choice. With respect to achieving the goals of health care market reform, the MSA is the most effective alternative. The MSA ties consumer demand for health care services directly to the desire for the plan and the ability to pay the price.

With an MSA system, cost savings are achieved because the government's role as a direct provider and third-party payor of health care is eliminated and replaced with

individual choice and responsibility. Furthermore, employers and state and local governments will have the flexibility to offer any type of health insurance they choose in conjunction with, or to supplement, an employee's MSA. Concomitantly, employees will have the choice to purchase the amount and type of health care that maximizes personal welfare through their employer or from any other source. Additionally, the MSA treats everyone similarly situated equally.⁹⁷

A consumer's ability to purchase health care benefits would be limited only by her income and lifestyle as manifested in risk classification. Thus, individuals will be encouraged to earn more, maximize their available health care dollars, and live healthier lifestyles. Providers will have to respond to consumer demands in terms of cost, service, and information. Alliances and cooperatives providing both information and purchasing power will emerge along traditional group lines to the extent such cooperation is beneficial.

Expanding the supply of health care services. Mandatory catastrophic insurance coverage and MSAs solve

the problems associated with the uncontrolled demand for health services. Currently, no substitutes for physician-provided health care exist. The following reforms will increase the supply of health care providers. The American Medical Association and affiliated groups control the

supply of health care providers through state licensing boards and medical school admissions. This solution takes a two-prong approach to expanding the supply of health care providers, thereby reducing the overall cost of health care. First, the federal government must promulgate regulations on licensing non-physician providers. Specifically, restrictive state licensing regulations must be preempted; thereafter consumers and insurers will be available to select non-physician providers for certain therapies. An entirely new provider market will emerge, and as a result, nurse-practitioners, midwives, and other specially trained personnel will provide lower-cost primary care treatment.

Second, the overall number of physicians must be increased. This solution calls for physician numbers to be increased by government regulation that forces an increase

The President's plan fails to address the defects inherent in the health-care market.

in total medical school enrollment. A larger pool of medical school graduates will increase the size of the physician population and allow provider groups to increase the size and number of residency programs. Competition among physicians for employment and patients will increase. Moreover, physicians will be forced to address the cost and quality demands of both patients and provider groups. As in all businesses and professions, talented individuals will rise to the top of the market and receive the benefits that their abilities command.

Reducing transaction costs. Implementation of mandatory catastrophic insurance and MSAs eliminates the government's role as a provider and third-party payor of health care. Thus, federal regulation aimed at cost control will be redundant. Supply and demand will replace government intervention and its accompanying transaction costs. Furthermore, this proposal calls for malpractice reform to reduce the overall transaction cost in the health care market. Specifically, the damage categories of pain and suffering and non-economic loss of consortium will be eliminated in ordinary negligence actions.⁹⁸ As a result, transaction costs will be lowered, the deterrent effect of malpractice will be maintained, and the windfall component of many damage awards will be eliminated. In addition, in order to eliminate frivolous claims, medical malpractice review boards will be established to screen out clearly frivolous claims.⁹⁹ Finally, insurance companies will be required to make mandatory comprehensive disclosures about the type of coverage policies they provide. Such a requirement will allow consumers, employers, and other alliances to compare the relative

value of different insurance policies. This reform will facilitate competition and reduce the current burden of analyzing benefit packages.

Funding

Funding for any health care reform plan must come from one of three sources: employer mandates, borrowing, or taxes. Under the Clinton plan, employers would bear the majority of health care costs for their employees. Although providing a non-governmental funding mechanism, the economic effects of such mandates cannot be ignored. As the cost of labor rises, the demand for labor will decrease. Job loss and reduced overall production will result.¹⁰⁰ Borrowing (a popular method of federal funding) merely passes the cost of current expenditures on to future generations.¹⁰¹ Therefore, health care reform must be funded out of current tax receipts. This will require politicians and special interests groups to establish priorities.¹⁰² By paying for health care reform out of present tax receipts, as contrasted to borrowing, the incentive to act in an economically efficient manner is reinforced.¹⁰³

Conclusion

Those who do not learn from their mistakes are doomed to repeat them. By totally ignoring free market economics, many proposed plans repeat the mistakes of the past. Maximizing consumer welfare in the health care market will only occur if the defects inherent in the market are eliminated, and antitrust laws are prudently applied to noncompetitive market participants.

E N D N O T E S

¹ For a definition of "free rider," see *infra* note 51 and accompanying text.

² Evidence that the American Medical Association and other physician groups restrict the supply of physicians in the United States is found in the fact that international medical graduates make up 21.4% of the total physician population in the United States. AMERICAN MEDICAL ASSOCIATION, PHYSICIAN CHARACTERISTICS AND DISTRIBUTION IN THE U.S. (1990).

³ These transaction costs are in the form of insurance administrative costs, legal costs related to regulatory compliance, and costs associated with medical malpractice.

⁴ Health care expenditures comprise 14% of Gross National Product ("GNP"). Robert Pear, *Health Care Costs Up Again*, N.Y. TIMES, Jan. 5, 1993, at A1. It is estimated that by the year 2000 health care costs will account for 16.4% of GNP. Sally T. Sonnenfeld et al., *Projections of National Health*

Care Expenditures Through 2030, 11 HEALTH CARE FINANCING REV. 1, 1 (1991). Turning this portion of the economy over to government control is tantamount to accepting socialism as our political norm.

⁵ See *infra* Section I.D.

⁶ In this paper, there is a decided attempt to distinguish economically legitimate health care reform from hidden political agendas. Politics as usual is a reality. However, this reality is neither good governance nor intellectually honest.

⁷Universal coverage mandates some type of coverage limitation. This coverage does not include unlimited access to all available medical services without regard to lower cost health care alternatives and preventative care. Universal health care implicitly contemplates widespread public support. As a result, it is limited by who and what the public is willing to support by a redistribution of wealth to finance universal health care coverage. Therefore, like publicly supported food stamp programs, housing, education, and criminal defense, publicly supported health must reflect a two-tier system. Consistent with a capitalist economic system, people of different income levels will receive different levels of health care.

⁸As used in this paper, catastrophic health insurance means coverage for inpatient hospital care.

⁹Our formulation and use of the MSA is different from that used in those health care reform proposals currently under consideration.

¹⁰This minimum amount would correspond to the average cost of yearly health maintenance in the United States. Actuarial data suggests that between \$2,000–3,000 per person would be sufficient.

¹¹MSA funds would be restricted to use on qualified primary health care expenditures. Services such as purely elective cosmetic surgery would not qualify. Social workers would counsel federal entitlement recipients on the best use of their available health care resources, most likely encouraging enrollment in a health maintenance organization (“HMO”).

HMOs are designed to provide certain basic health care services to members at a set fee, regardless of the services actually utilized by a member. Under this type of system, physicians work as employees of the HMO and are paid according to pre-arranged fee schedule. HMOs maximize profits by limiting unnecessary services and encouraging efficiency by the selected physicians.

¹²“Negative income tax” refers to utilizing the Internal Revenue Service (“IRS”) as the transfer and compliance agency for this health care proposal. The IRS would transfer funds to the insurance/MSA program of the recipient’s choice.

¹³These Boards would be composed of physicians, lawyers, businessmen, and insurance executives.

¹⁴One need only read the National Health Security Act for this point to be evident.

¹⁵The perfect competition model is based on four major assumptions. First, homogeneity, i.e., all products are virtually identical in function and quality. Second, the model assumes that all sellers and buyers are price seekers and that no single producer is large enough to effect market price or total market output. Third, entry and exit barriers do not exist in the model. Finally, the competitive model assumes no transaction costs and assumes that all market participants are in possession of perfect information regarding price, output and quality levels.

¹⁶This is noteworthy because at that time no claims of a health care crisis existed.

¹⁷At this point, health care was paid for on a fee-for-service basis. For example, prior to 1930, over 80 percent of Americans covered their own medical costs as the expenses were incurred.

¹⁸Individual accountability was an important virtue of the pre-1900 health care paradigm. Americans were responsible for their own lifestyle choices. Preventive measures were a viable alternative. The medical cost of lifestyle choices was born by the individual without economic externality.

¹⁹See generally STUART M. BUTLER & EDMUND F. HAISLMAIER, A NATIONAL HEALTH SYSTEM FOR AMERICA 4–5 (1989).

²⁰Because malpractice was not a concern among physicians, patients did not receive unnecessary specialized tests nor unneeded visits to specialists that are often used as defensive protective measures by physicians today. For an example of a medical malpractice case that is credited with promoting defensive medical treatment, see *Harris v. Robert C. Groth M.D., Inc.*, 663 P.2d 428 (1983) (glaucoma testing).

²¹Primary among the influential social, political, and economic factors were World Wars I and II and the Depression.

²²In addition to the economic efficiencies, medical developments contributed to the increased utilization of hospitals. For example, one major medical ad-

vance around this time was the development of antiseptics and sterilization procedures. BUTLER & HAISLMAIER, *supra* note 19, at 4. The resulting sudden increase in the number of hospitals was incredible: the number of hospitals grew from a mere 149 in 1873 to almost 7,000 in 1923. *Id.* at 9. These hospitals were located primarily in population centers and were community or charitable in origin. *Id.*

²³*Id.* at 4 (describing the “dramatic... change in public attitudes toward hospitals”). “Americans no longer viewed them as places housing the sick poor, but as ‘medical workshops’—the primary facilities for meeting the health needs of the general population.” *Id.* at 5 (citing PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 145–79 (1982)).

²⁴The economic depression and the resulting unpaid patient medical bills were other factors in hospital financing problems. LAWRENCE D. WEISS, NO BENEFIT: CRISIS IN AMERICA’S HEALTH INSURANCE INDUSTRY 11 (1992).

²⁵Health care is different from other goods because we do not know when, or how much health care we will need. As a result, it is critical that we have excess capacity in the health care market as a whole. This demand for excess capacity is also a characteristic of other industries such as public utilities. When we turn on the faucet we want water to come out. This excess capacity is an often overlooked component of overall health care costs. See generally Kenneth Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941 (1963).

²⁶See BUTLER & HAISLMAIER, *supra* note 19, at 6.

²⁷*Id.*; see also WEISS, *supra* note 24, at 11.

²⁸BUTLER & HAISLMAIER, *supra* note 19, at 7.

²⁹*Id.* at 8. The insurance commissions’ objectives were to “require these new plans to maintain reserve funds — that is, to set aside a portion of their premium revenues to cover unexpectedly large claims.” *Id.* This would have reduced profits.

³⁰*Id.* at 8–9; see also WEISS, *supra* note 24, at 11.

³¹BUTLER & HAISLMAIER, *supra* note 19, at 9.

The special enabling legislation sought by the AHA conferred the

following advantages and privileges on the proposed hospital service corporations: exemption from the general insurance laws of the state; status as a charitable and benevolent organization; exemption from the obligation of maintaining the reserves required of commercial insurers; and tax exemption.

WEISS, *supra* note 24, at 11 (citations omitted).

³²By 1945, Blue Cross plans existed in 35 states and controlled around sixty percent of the hospital insurance market. See WEISS, *supra* note 24, at 12-13. Encouraged by the success of the Blue Cross hospital plans, physicians' groups established similar "Blue Shield" plans to cover other medical expenses. *Id.* at 13.

³³*Id.* at 11. In exchange for the preferential exemptions from state regulation, the Blues were required to provide coverage to all applicants at the same rates. See BUTLER & HAISLMAIER, *supra* note 19, at 9. This, in effect, subsidized medical care and insulated the consumer from the actual costs.

³⁴*Id.* Cartel pricing has long been recognized as a per se violation of the anti-trust laws. See *United States v. Trans-Missouri Freight Ass'n*, 166 U.S. 290 (1897).

³⁵BUTLER & HAISLMAIER, *supra* note 19, at 9.

³⁶*Id.*

³⁷*Id.* Health insurance was an effective means of attracting employees while ostensibly holding wages constant. *Id.* The availability of health care coverage became an important non-cash salary component and served as a hidden wage supplement. *Id.*

³⁸*Id.* at 10; see also WEISS, *supra* note 24, at 14.

³⁹BUTLER & HAISLMAIER, *supra* note 19, at 10. This ruling increased the number of plans and the scope of coverage provided. *Id.*

⁴⁰*Id.* Economists characterize this situation as "moral hazard." HAL R. VARIAN, *MICROECONOMIC ANALYSIS* 239 (1978). Moral hazard occurs when somebody else pays for a good or service. *Id.* In health insurance, the moral hazard problem promotes the excessive consumption of health services. The moral hazard problem is further exac-

erbated by government decision making. Government decision making of ten results in the over-consumption of a public good. See generally Garrett Hardin, *The Tragedy of the Commons*, 162 *SCIENCE* 1243, 1244-45 (1968).

⁴¹Additionally, employer-provided health insurance is "non-portable" and thus restricts movement in the labor market.

⁴²See BUTLER & HAISLMAIER, *supra* note 19, at 15. "Even the American Medical Association and other staunch defenders of private health care agreed that the government should in some way help meet the health care needs of the elderly and the poor." *Id.*

⁴³Medicaid is a social welfare program to fund health care services for the poor, disabled, and other needy individuals. See BUTLER & HAISLMAIER, *supra* note 19, at 16. It is funded with both federal and state government dollars and is operated by state governments. *Id.*

⁴⁴Medicare provided funding for health care services for the elderly. BUTLER & HAISLMAIER, *supra* note 19, at 16. One portion of the program provided general hospital insurance and was available to all elderly persons, regardless of income. The second portion of the program provided additional coverage for physician services and was funded through federal subsidies and recipient premiums. *Id.*

⁴⁵BUTLER & HAISLMAIER, *supra* note 19, at 16.

⁴⁶*Id.*

⁴⁷For a discussion of the market disincentives under this reimbursement financing system, see *supra* notes 25-32 and accompanying text.

⁴⁸See BUTLER & HAISLMAIER, *supra* note 19, at 16. "[B]eneficiaries had virtually no incentive to question costs and every incentive to demand more services." *Id.* "Even the few restraints that still remained in the private sector were completely absent in these new government programs." *Id.* at 17.

⁴⁹For example, government expenditures on Medicare and Medicaid were \$8.94 billion in 1970. WEISS, *supra* note 24, at 19. This expenditures reached \$46.12 billion in 1980, and \$102.56 billion in 1987. *Id.*

⁵⁰The current figure utilized by the Clinton Administration is 37 million uninsured

persons. See Greg Steinmetz, *Shaky Statistic: Number of Uninsured Stirs Much Confusion in Health-Care Debate*, WALL ST. J., June 9, 1993, at A1.

⁵¹Free riders are health care recipients who do not purchase health care insurance or pay for the health care services they receive. Consequently, many of these individuals do not purchase low cost preventative health care and only enter the health care market as the result of a catastrophic disease or injury. Thus, the free rider elects to maximize current consumption by not purchasing the health insurance or preventative care that he can afford. As a result the free rider postpones health care expenditures until forced to use unaffordable high cost emergency care. Further, anyone who does not pay the fair market value for health insurance, or health care received, is a free rider to a certain degree. Thus, through price controls on Medicare, the government is a free rider.

⁵²Federal legislation and medical ethical standards prohibit physicians and hospitals from turning away patients in need of care. For example, in 1985 Congress passed the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). Pub. L. No. 99-272 (1986). Certain provisions of COBRA, known as the Emergency Medical Treatment and Active Labor Act ("EMTALA") prohibit "patient dumping." Under these provisions, a hospital that receives Medicare funding can not turn away a patient with an emergency condition. Rather, the hospital must provide tests and examinations to determine if an emergency condition exists.

⁵³This includes self-insured individuals.

⁵⁴See *Wilk v. AMA*, 719 F.2d 207 (7th Cir. 1983) (holding that AMA regulations that prevented physicians from professionally dealing with chiropractors were a Sherman Act §1 violation).

⁵⁵Primary health care services means diagnostic and specialty treatment procedures. This is in contrast to routine physician-prescribed therapy, which is currently provided by non-physicians.

⁵⁶The National Planning and Resources Development Act was enacted in 1974, to ensure that demand existed before health care facilities were built or expanded. See Pub. L. No. 93-641, 88

- Stat. 225 (1975), later codified at 42 U.S.C. § 300(k-m) (repealed).
- ⁵⁷ See CHAYET & SONNENREICH, P.C., CERTIFICATE OF NEED: AN EXPANDING REGULATORY CONCEPT (1978).
- ⁵⁸ See generally Maxwell J. Mehlman, *Health Care Cost Containment and Medical Technology: A Critique of Waste Theory*, 36 CASE W. RES. L. REV. 778, 843 (1986). Competitive market forces and anti-fraud statutes should have preempted the need for such legislation. See *id.* However, such forces were never allowed to act. See *id.*
- ⁵⁹ The program was repealed by Pub. L. No. 99-660, 100 Stat. 3799 (1986). See also James B. Simpson, *Full Circle: The Return of Certificate of Need Regulation of Health Facilities to State Control*, 19 IND. L. REV. 1025 (1986).
- ⁶⁰ BUTLER & HAISLMAIER, *supra* note 19, at 23. In 1973, there were 93 state mandated benefit laws; by 1988, there were 726 such laws. *Id.*
- ⁶¹ *Id.*
- ⁶² See Pub. L. No. 93-406, 88 Stat. 829 (1974). ERISA was designed to "protect the interstate commerce and the interests of participants in employee benefit plans and their beneficiaries." *Id.* at 833. The law was primarily intended to protect employees from abuses in employer sponsored pension plans.
- ⁶³ BUTLER & HAISLMAIER, *supra* note 19, at 22.
- ⁶⁴ *Id.* at 24. PPS was an effort to curtail costs under Medicare's open-ended reimbursement system. *Id.* Prior to the enactment of PPS hospitals and physicians were induced to charge as much as they could for patient treatment. *Id.* at 25.
- ⁶⁵ *Id.* at 25. For example, while PPS has been effective in reducing the growth of hospital reimbursements, Medicare physician reimbursements (which are not cost controlled) have skyrocketed. *Id.*
- ⁶⁶ For example, in *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975), the Supreme Court rejected the "learned profession" antitrust exemption. A year later, the Court utilized a health industry case to broadly interpret the jurisdictional requirement of an effect on interstate commerce. See *Hospital Building Co. v. Trustees of Rex Hospital*, 425 U.S. 738 (1976); accord *Summit Health Ltd. v. Pinhas*, 500 U.S. 322 (1991). Additionally, the state action exemption was limited. *Cantor v. Detroit Edison*, 428 U.S. 579 (1976) (holding that exempted conduct must be mandated by the state). In 1979, *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979) clarified the McCarron-Ferguson insurance immunity and held that health care providers, merely being reimbursed by an insurance company, were not engaged in the "business of insurance."
- ⁶⁷ 457 U.S. 332 (1982). In holding that the establishment of minimum prices was a per se violation of the Sherman Act, the *Maricopa* Court reasoned that "the claim that the price restraint will make it easier for customers to pay does not distinguish the medical profession from any other provider of goods or services." *Id.* at 349.
- ⁶⁸ See *id.*
- ⁶⁹ See, e.g., *United States v. North Dakota Hosp. Ass'n*, 640 F. Supp. 1028 (D. N.D. 1986); *Ohio v. Greater Cleveland Hosp. Ass'n*, 1983-2 Trade Cas. (CCH) 65, 685 (N.D. Ohio 1983) (consent decree); *United States v. Montana Nursing Home Ass'n*, 1982-2 Trade Cas. (CCH) 64, 852 (D. Mont. 1982) (consent decree); *United States v. South Carolina Healthcare Ass'n, Inc.*, 1980-2 Trade Cas. (CCH) 63, 616 (D. S.C. 1980) (consent decree).
- ⁷⁰ 101 F.T.C. 191 (1983).
- ⁷¹ See, e.g., *FTC v. Indiana Fed'n of Dentists*, 476 U.S. 447 (1986); *Barry v. St. Paul Fire & Marine Ins. Co.*, 438 U.S. 531 (1978).
- ⁷² See, e.g., *In the Matter of Physicians of Meadville*, 109 F.T.C. 61 (1982) (group boycott); *Patrick v. Burgett*, 496 U.S. 94 (1988) (peer review).
- ⁷³ 1981-1 Trade Cas. (CCH) 64, 151 (M.D. Fla. 1981) (consent decree); see also Eugene M. Addison, M.D., 111 F.T.C. 339 (1988) (consent order); *Forbes Health Sys. Medical Staff*, 94 F.T.C. 1042 (1979) (consent order).
- ⁷⁴ For other group boycott staff privileges cases, see *Summit Health, Ltd. v. Pinhas*, 500 U.S. 322 (1991); *Bhan v. NNE Hospitals, Inc.*, 929 F.2d 1404 (9th Cir. 1991) (summary judgment for defendant hospital because of insufficient market share to substantiate nurse anesthetist's challenge of hospital's exclusive use of anesthesiologist).
- The federal government played a major role in the establishment of HMOs. In 1973, Congress enacted the Health Maintenance Organization Act in order to "provide assistance and encouragement for the establishment and expansion of health maintenance organizations" as alternatives to traditional insurance. Pub. L. No. 93-222, 87 Stat. 914, 914 (1973).
- ⁷⁵ See, e.g., *Health Care Mgmt. Corp.*, 107 F.T.C. 285 (1985) (consent order involving podiatrists); *Medical Staff of Mem. Medical Ctr.*, 110 F.T.C. 541 (1988) (consent order involving nurse midwives). In general, however, these provider efforts to reduce non-physician substitutes have been successful.
- Some types of physician agreements that appear to be group boycotts actually serve legitimate economic and patient care purposes. For example, in *Jefferson Parish Hosp. Dist. No. 2 v. Hyde*, 466 U.S. 2 (1984), the Supreme Court upheld an exclusive contract between a hospital and a group of anesthesiologists, finding an insufficient market share to declare the practice a per se tying arrangement. The effect of this case, however, was to limit the hospital staff privileges of other doctors and to require that any hospital patients utilized those doctors. See also *Beard v. Park View Hosp.*, 912 F.2d 138 (6th Cir. 1990); *White v. Rockingham Radiologists, Ltd.*, 820 F.2d 98 (4th Cir. 1987).
- ⁷⁶ *Hospital Corp. of Am. v. FTC*, 807 F.2d 1381 (7th Cir. 1986) cert. denied 481 U.S. 1038 (1987) (divestiture of hospitals acquired in the Chattanooga, Tennessee area ordered); *In the Matter of Amer. Medical Int., Inc.*, 107 F.T.C. 310 (1984) (divestiture of hospital in San Luis Obispo, California ordered).
- ⁷⁷ See generally PHILIP A. PROGER, AN ANTITRUST ANALYSIS OF HEALTH CARE PROVIDER JOINT VENTURES (1992). In evaluating the antitrust implications of a health care joint venture, the inquiry will focus on the resulting market share. *Id.* at 6. A court will examine: "(1) the degree of concentration in the relevant market . . . ; (2) the degree to which there are barriers to entry into the relevant market; and (3) the number of actual and perceived potential entrants into that market." *Id.* at 6-7. A venture's competitive effects will be balanced against any uncompetitive effects. *Id.* at 9.
- ⁷⁸ See Weiss, *supra* note 24, at 72.

⁷⁹See McCarron-Ferguson Act, 15 U.S.C. § 1011-15 (1988). As interpreted by the Supreme Court, this immunity applies so long as the insurance entity is regulated by state law and the challenged conduct does not involve "boycott, coercion, or intimidation." *Hartford Fire Ins. Co. v. California*, ___ U.S. ___, 113 S.Ct. 2891 (1993).

⁸⁰The theory of the second best posits that if a monopoly on one side (supply or demand) is inevitable, then the best way to counter a negative market effect from the monopoly is to allow a monopoly on the opposite side of the market to develop.

⁸¹For example, in *U.S. HealthCare, Inc. v. U.S. HealthSource, Inc.*, a court upheld a contract between an HMO and its physicians which prohibited the physicians from providing services to any other HMO. 1992-1 Trade Cas. (CCH) 69, 697 (D.N.H. 1992). Under rule of reason analysis, the court found a large relevant market, the general health care financing market. *Id.* at 67, 180. Additionally, the court acknowledged the economic efficiencies achieved by such a contract. *Id.* Similarly, a court has upheld an HMO's exclusive contract with certain specialists, finding that no conspiracy existed and that there was not a significant restraint of trade. *Capital Imaging Assocs. v. Mohawk Valley Medical Assocs.*, 791 F. Supp. 956 (N.D.N.Y. 1992).

In *Austin v. Blue Cross and Blue Shield of Alabama*, 903 F.2d, 1385 (11th Cir. 1990), hospital patients not insured by the Blues brought suit to challenge the lower rates charged to Blue Cross members. Under the plaintiff's theory, the hospitals were subsidizing the lower rates by charging higher rates to other patients, *i.e.*, "cost shifting." The court disagreed, finding no antitrust injury because the Blue Cross/hospital agreements were competitive:

[T]he agreements between Blue Cross and the hospitals . . . actually promote competition within the relevant health care market by allowing Blue Cross to charge lower rates to its subscribers resulting from a reduction in the cost of health care services which it purchases from hospitals. To the extent competitors seek to compete successfully with Blue Cross, they will be required to lower

their rates or improve the benefits offered to subscribers.

Id. at 1391. See also *Travelers Ins. Co. v. Blue Cross of W. Pa.*, 481 F.2d 80 (3rd Cir. 1973), *cert. denied*, 414 U.S. 1093 (1973) ("The antitrust laws . . . protect competition, not competitors; and stiff competition is encouraged, not condemned.").

Only one recent case actually condemns insurer attempts at exclusive contracts. In *Reazin v. Blue Cross and Blue Shield of Kansas, Inc.*, 899 F.2d 951 (10th Cir. 1990), *cert. denied*, 110 S.Ct. 3241 (1990), the Tenth Circuit held that Blue Cross committed an antitrust violation by threatening to end relations with a hospital that would not enter into an exclusive contract.

⁸²Specifically, the alliances would cover all employees of companies with fewer than 5,000 employees, all federal employees, and all other individuals except Medicare recipients. Employers with over 5,000 employees would be permitted to establish their own alliances.

⁸³One need only look to Medicare and Medicaid to see that the federal government has already demonstrated its inability to efficiently operate such a system.

⁸⁴Clinton uses the doublespeak term "global budgeting" to refer to rationing.

⁸⁵See *Northwest Wholesale Stationers, Inc. v. Pacific Stationery and Printing Co.*, 472 U.S. 284 (1985).

⁸⁶Strict guidelines have been proposed to regulate these networks and their operations. As Part I.D. of this paper demonstrates, government regulation of the health care market has been ineffective at best and, at worst, resulted in partial market failure.

⁸⁷Or, in this situation, allowing competitive forces to drive the market instead of the government.

⁸⁸Government lifestyle mandates could occur by virtue of banning tobacco and alcohol as well as making high risk recreational behavior illegal.

⁸⁹See generally THOMAS J. PHILIPSON & RICHARD A. POSNER, *PRIVATE CHOICES, PUBLIC HEALTH* (1993).

⁹⁰See *National Collegiate Athletic Ass'n v. Board of Regents of the Univ. of Okla.*, 468 U.S. 85 (1984). In this case, the Supreme Court, per Justice Stevens, rejected an NCAA revenue sharing

plan also designed to diversify televised collegiate football, on the grounds that plaintiffs were denied the ability to pursue their own individual interests in the negotiation of television rights.

⁹¹The only solution to high cost specialists consistent with Clinton's basic formulation of universal coverage is to simply exclude specialist services from government mandated health coverage. Under a two-tiered system, this solution would permit those who want to use specialists to obtain pay for insurance which covers their services. Those who could not afford high cost specialists could appeal to charity, get a job, or do without.

⁹²Some individuals will choose not to purchase health insurance and instead spend their economic resources on other goods.

⁹³The deductible must be set at a level to dissuade the unnecessary use of emergency medical care. Although mandates are disfavored, they are clearly preferable to wholesale government takeover.

⁹⁴This system reflects that collecting money through the Internal Revenue Service is one thing federal and state governments appear to do in a reasonably efficient manner. Government payment will be phased out over income levels in order to allow people to seek employment without the current fear of losing health insurance benefits.

⁹⁵Members of military and foreign service and their dependents are the only exception to this plan. Health care capacity in the military is a component of military readiness. Furthermore, military personnel are often stationed in areas where quality health care is not available. Therefore, in order to serve the health care needs of military personnel and maintain well trained military physicians the current military health system would be maintained. Retired military personnel would be treated the same as any other federal entitlement recipient with an exception for combat-injured veterans.

⁹⁶Entitlement recipients would most likely use their funds to participate in the HMO of their choice. This solution reflects the notion that people will not take charge of their lives unless given a reason. It rejects the paternalistic notion that individuals receiving pub-

lic assistance cannot make choices with respect to money and lifestyle.

⁹⁷Artificial risk lines will not be drawn on the basis of geography as with a regional alliance. Furthermore, an employee will not be placed in a risk pool on the basis of the pool of other employees who work at the same corporation. People who live in areas with high health care costs will not be able to externalize that cost of living over the rest of the population. This concept is no different than New Yorkers paying more for car insurance than people who live in Iowa. Furthermore, the

janitor at the federal building does not receive better health care than the janitor across the street working for a private employer, and the self-employed purchase health care with the same pre-tax dollars as all other employees.

⁹⁸Proven economic loss of consortium damages will be maintained. Furthermore, all existing damages will be available in cases involving gross negligence.

⁹⁹These boards will review claims and issue approvals to proceed with cases in the same manner as other state regulatory bodies.

¹⁰⁰Furthermore, employer mandates are an artificial barrier to market entry and could be a factor in market concentration.

¹⁰¹Borrowing externalizes the cost of care to future individuals who have no say in the current formulation of policy.

¹⁰²Society in general must determine whether angora wool price supports are more important than universal health care coverage.

¹⁰³This economic concept is the same as tying consumer health care use and payment together.

A N N O U N C E M E N T S

Free safety reviews

Many small businesses dread the prospect of a workplace safety inspection. The U.S. Occupational Safety and Health Administration (OSHA) randomly performs OSHA enforcement audits. Small companies may find it difficult and costly to stay abreast of complex safety regulations.

The OSHA Consultation Service, an independent branch of OSHA, sponsors a program designed to help small businesses with 250 or fewer employees. The service offers free workplace safety reviews. If any violations are discovered, the company is allowed to correct the infractions within an agreed-upon time. In addition to avoiding penalties, firms that excel under the program are exempt from random inspections.

More than 397,000 visits have been made since the program began in 1975. Presently, the average wait for a visit is one to two months according to Joe Collier, the program's director. For more information, small businesses should contact their state's labor department.

Smokers feel older

Smoking can make elderly women feel older, according to a recent study. Researchers have found smoking can affect a woman's muscle strength, agility, and balance. The study, published in the *Journal of the American Medical Association*, measured how women over 65 performed basic tasks in 12 categories such as

gripping an object, walking, rising from a chair, and climbing stairs.

Smokers performed more poorly than non-smokers in 11 of the 12 categories, according to Dr. Heidi Nelson, chief author of the report and an assistant professor of internal medicine at Oregon Health Sciences University's School of Medicine.

The results for the smokers were similar to what would have been expected for women years older. "For an older woman, smoking may have the same effect as adding five years to a person's age," Nelson said. "The study adds to the long list of reasons why people should not be smoking."

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