

## CHAPTER 1

# Wars, Strikes, Riots, and Acts of Congress

In 1943, at the height of World War II, a forty-eight-year-old shipyard laborer had a major heart attack, spent a week in the hospital, and was unable to return to work for two months. His wife and teenage son both worked at the same shipyard, and begged the boss for extra pay to help cover the family's medical bills. Though the boss was sympathetic to their situation and wanted to increase their wages, he could not because of a new law freezing wartime pay—a law designed to control inflation during a period of scarce labor and round-the-clock work schedules.

He gazed out his office window, through the sparks and smoke and dust of the bustling shipyard, and spotted the big white hospital on the horizon, a long bus ride away for his workers.

Why not pay the hospital directly myself? he wondered. They get their raise, the guy gets his bills paid, and I'm still right with the law. Better yet, why not bring some of those doctors over here to the shipyard? They can take care of these people in that empty office downstairs. That way, they don't lose so many hours from the yard when they need something checked. How hard can that be? How much can it possibly cost?

There is no U.S. health care system. What we call our health care system is, in daily practice, a hodgepodge of historic legacies, philosophical conflicts, and competing economic schemes. Health care in America combines the tortured, politicized complexity of the U.S. tax code with a cacophony of

intractable political, cultural, and religious debates about personal rights and responsibilities. Every time policymakers, corporate health benefits purchasers, or entrepreneurs try to fix something in our health care system, they run smack into its central reality: the primary producers and consumers of medical care are uniquely, stubbornly self-serving as they chew through vast sums of other people's money. Doctors and hospitals stumble their way through irresolvable conflicts between personal gain and ethical responsibilities; patients struggle with the acrimony and anguish that accompany life-and-death medical decisions; consumers, paying for the most part with everybody's money but their own, demand that the system serve them with the immediacy and flexibility of other industries; and health insurers are trapped in the middle, trying to keep everybody happy. A group of highly imaginative, energetic people armed with the world's largest Mark-n-Wipe board could not purposefully design a more complex, dysfunctional system if they tried. It is a \$1.3 trillion per year fiasco narrated with moral shrillness and played out one competing anecdote after another.

A bustling shipyard may not be the best place to receive our medical care, but in spirit, that is where most of us with commercial insurance get it. Because of a unique and difficult moment in our nation's history, our health care system was slapped on top of our employment system, with the government picking up the enormous slack for most of those who fell outside that system. And so it began. The imposition of the nation's employers, insurance companies, legislators, lawyers, investment bankers, insurance brokers, and countless other corporate and regulatory middlemen into the financing and delivery of medical care is the source of the fundamental structural problems that cripple health care in this country. The endless layering of interloper upon interloper—all ultimately charged with managing the shipyard's or the government's money—dooms the market's ability to fix any of the system's root problems.

The best proof of how impossible it is to rationalize the spending of \$1.3 trillion every year is the twisted set of paradoxes at the heart of the managed care industry. Managed care as we know it consumes an ever

larger share of money earmarked for medical care, in the process replacing the chronic disorganization of American medicine with acute overorganization. Managed care has added more layers of complexity and redundancy to the financing and delivery of medical care, solving none of its underlying economic dilemmas while introducing a new set of political, cultural, and behavioral problems. If managed care provides us with one overriding message, it is this: the U.S. health care system as currently structured is so complicated and rife with economic conflict that every attempt to simplify it actually complicates it further.

### **THE ACCIDENTAL PATIENT**

The U.S. health care system grew out of a series of historical accidents. Today, most commercially insured Americans receive their health care coverage through their jobs or unions. This is a legacy of our metaphorical shipyard boss's attempt to cope with the economic struggles created by World War II. Those who retire from the shipyard, are fired, cannot get hired, or end up permanently disabled all count on a combination of federal and state government agencies for help. The unlucky 44 million Americans caught in the middle—in the no-man's land outside of good jobs, union membership, major disability, old age, or chronic poverty—have no coverage at all, fending for themselves in a system built to accommodate everyone else. Contrary to popular belief, those 44 million uninsured do in fact receive medical care. But they get it only when their medical conditions have deteriorated to the point of crisis, at unnecessarily great expense to themselves, to taxpayers, to those working in the shipyard, and to their own already marginal personal solvency.

During the wage freeze necessitated by the labor shortage of the 1940s' wartime economy, employers across the nation began adding health coverage as a noncash incentive to attract and retain scarce workers. Their successful lobbying of Congress for a tax exemption for this compensation created a permanent cultural expectation that health insurance be not only free, but tax-free. Under employer-based insurance, every time a worker

demands a medical service paid for directly or indirectly by his employer, he is, in effect, giving himself a tax-exempt raise. The economic and behavioral effects of this system are deeply perverse and go a long way in explaining why the United States spends far more per capita on medical care than any other nation in the world. Tax-free, job-based insurance—combined with mushrooming consumer medical information and advertising—induces people to demand more medical care than they would if they were spending their own hard-earned, highly taxed income. It also creates a shadow, regressive tax system, whereby the best compensated employees are encouraged to demand still more health benefits rather than cash to escape marginal taxation on this compensation. In the metaphorical shipyard, the temptation to drop your tools and go see the “free” doctor—at any time, for any reason—is often overwhelming.

Employers have responded to this dysfunctional system by giving freely with one hand while attempting to manage what they give with the other. The dirtiest work associated with managing what is perceived by employees as free has been delegated by employers to health insurers, brokers, consultants, and myriad other third, fourth, fifth, and sixth parties. The cumulative result is mistrust, misunderstanding, bitterness, reactive legislation, and lawsuits; complex gamesmanship throughout the dysfunctional “love triangle” of purchasers, patients, and their doctors; and an ever-growing thicket of paperwork surrounding the whole mess.

The clearly capitalist thrust of job-based—that is, merit-based—health insurance grated on the social architects of the Great Society, who sought to fill the gaps by providing equivalent benefits to the elderly and poor through the creation of Medicare and Medicaid in the 1960s. Because of the historic, ongoing struggle between federalism and states’ rights, those architects decided that the financing of Medicare should be the responsibility of the federal government; the administration of Medicare should be the work of the states; half the financing of Medicaid should be the responsibility of the federal government, with the other half the responsibility of the states; and the administration of Medicaid should be the full responsibility of the states. The resulting schizophrenic provision of what

should be a uniform public benefit has resulted in total confusion over which level of government pays for what medical care and why, a bewildering array of financial transfers and a political cat-and-mouse game between the states and Washington, and a mother lode of bureaucratic complexity.

As if inspired by the inefficiencies and uncertainties created by a combination of state and federal administration of public health care benefits, the government inadvertently extended the benefits of this same system to the nation's employers through another legislative accident. Since the passage of the McCarran-Ferguson Act in 1945, private health insurance plans have been regulated by the states. Under this law, fifty different states were required to build fifty different regulatory systems for overseeing premiums, mandating levels of coverage, and disciplining health insurers—even though most Americans receive their coverage from health insurers who operate across state lines and in many cases across the entire country. Fair enough. Even as small companies grew and merged into large national corporations over the past few decades, with employees scattered across dozens of states, this may have made sense given the uniquely local nature of medical care delivery, economics, and abuses.

But then another legislative earthquake erupted. In 1974, the federal government passed the Employee Retirement Income Security Act (ERISA), designed to protect retirees' pension funds in states without sufficient regulatory oversight. It created provisions under which the boss in the shipyard could self-fund his workers' pension plans, established uniform standards for that self-funding, and strengthened federal insurance protections in case the shipyard went bankrupt and could not pay out those pensions. ERISA also happened to contain a "minor" provision that extended the new law to cover those few, large national employers who chose to self-fund their health benefits as well as their pension plans. Duke University health law professor Clark Havighurst points out that "ERISA was enacted in response to some highly publicized instances of fraud and mismanagement with respect to pension funds and was not perceived by Congress as a health care measure at all" (Havighurst, 2000).

As companies like the shipyard grew in size, added or acquired workers across the country, and chafed at the regulations imposed willy-nilly on their health benefit plans across fifty different states, many of them took advantage of the ERISA exemption. Meanwhile, medium-size employers, in response to the same state-based regulatory burdens, also chose to self-insure under ERISA. As a result, one-third of privately insured people today have health coverage regulated by the federal government, whereas two-thirds have health coverage regulated by their states. Aside from a few seemingly arbitrary mandates imposed by new federal laws—and the passage in 1996 of one long overdue federal law regarding health insurance portability—55 million insured Americans receive whatever specific health benefits their employers choose to cover (Wechsler, 2000). The other 105 million privately insured, employed Americans receive a set of highly defined benefits depending on the state they live in, and their employers are forced to pay for them. Neither system works well, and the combination of the two systems attempting to work in parallel creates an administrative fiasco for health insurers that has drained billions of health insurance dollars otherwise earmarked for medical care.

“How much can it possibly cost?” our shipyard boss wondered, back in 1943. Little did he know that much of what he would end up paying for decades later would have nothing to do with medical care for his shipyard workers, and everything to do with how big the shipyard grew, where it chose to do business, how its workers voted, and how many lawyers set up shop down the street.

## THE ACCIDENTAL PROVIDER

Meanwhile, over the decades, what has happened to the big white hospital across town and the doctor in the office downstairs? They too have expanded what they do and where, in the process coping with their own series of historic and legal accidents.

If the demand side of the health care equation is checkered with a complex series of accidental, often unintelligible variables, the supply side

of the equation is just as complicated. Specific supply-side variables driven by health policy accidents include, but are certainly not limited to, the following:

- Conflicting ownership and management of different kinds of U.S. hospitals, depending on state laws
- Tortured relationships between U.S. hospitals and the physicians who drive their costs and business fortunes
- A series of cynical, poorly thought-out laws on the financial relationships of physicians and hospitals
- Complicated legal relationships among physicians themselves when they attempt to negotiate their own business fortunes with everyone from the metaphorical shipyard to the various middlemen negotiating on its behalf

With the backdrop of these institutionalized economic, cultural, and philosophical conflicts—and the occasionally bizarre public policy or application by the courts of unrelated legal precedent—is it any wonder that even the most earnest entrepreneurial attempts to make a health care business work do not go according to plan?

Attempts throughout the 1990s to “integrate” the delivery of health care—among physician groups and between physician groups and hospitals—have been complicated by a set of laws passed nearly a century ago. The ownership of physician practices is governed by ridiculously antiquated laws still on the books in numerous states (but not all states) against the so-called corporate practice of medicine. This archaic legal doctrine, fashionable in state legislatures in the 1920s, was designed to prevent financial considerations from affecting clinical decision making. (The long view of history frequently allows us a good laugh at the naivete of earlier generations, embodied in so many attempts over the years to legislate away normal human behavior.) If our shipyard operates in a corporate-practice-of-medicine state, then it cannot directly employ the doctor downstairs but it can enter into an exclusive business contract that carries few of the advantages and most of

the drawbacks of direct employment. Across town at the hospital, the same corporate-practice-of-medicine law makes the already complicated task of building an integrated delivery system a legal circus. Because it is technically illegal for hospitals or other corporations to own physician practices outright, the laws have compelled the creation of additional corporate structures on top of existing physician and hospital corporate structures.

The result is a set of health care organizations that resemble Chinese boxes—organizations within organizations within organizations, each with their own legal ownership, governance boards, officers, managers, and financial records. The situation benefits no one, except perhaps the armies of lawyers who happily churn their way through all the resulting paperwork on a billable hourly basis. Health care contracting dollars that flow from a self-insured employer like our shipyard to the actual caregivers in the innermost box pass from that employer through an alphabet soup, including the national TPA (third-party administrator), the local TPA, the MSO (management services organization), the IPA (independent practice association), and finally the PA (professional association or corporation) that actually employs the physicians. Each acronym represents a tollbooth along the way, taking a piece of the care dollar and contributing greatly to the Chaos Factor that employers, consumers, and patients confront when they attempt to navigate the system. Each acronym also adds to the Inertia Factor, which hampers those employers or coalitions of consumers that—when dissatisfied with some dimension of the care process—try to simplify administrative procedures, suggest clinical reform, or introduce a disease prevention or management initiative.

## **IS THERE A DOCTOR IN THE CORPORATION?**

That is the mess we make when we try to integrate physicians and hospitals at the legal and corporate levels. Making it actually work is another story altogether. Lawyers may be deft at creating an ever-expanding number of corporate shells around hospitals and their admitting physicians, but they cannot make the people working inside those shells get along. In health care, the same cultural diversity that makes America such an adaptive, vibrant

nation is a significant impediment to the system's progress. This cultural diversity is manifested in the wide variety of hospital ownership and management patterns across the country, which range from fiercely not-for-profit hospital organizations—both sprawling and small—run by very different religious organizations, to for-profit hospital organizations both large and small run by entrepreneurs with very different goals and philosophies, to large medical centers with rich academic cultures and an exotic mix of foreign-born professionals.

Historically, U.S. hospitals have been “self-ghettoized” by their religious affiliation, or in the absence of any religious affiliation other than fealty to the almighty dollar, by their tax status. As Paul Starr notes in his brilliant, durable book *The Social Transformation of American Medicine*, “Cultural heterogeneity has been one of the chief factors inhibiting consolidation of hospitals in a state-run system. Ethnic and religious groups have wanted to protect their own separate interests” (Starr, 1982, p. 176). This situation is not unique to the U.S. system. Medical sociologist and historian William Glaser noted that around the world, “The greater the number of religions in a society, the more diffused the ownership and management of hospitals and the smaller their average size” (p. 176). As the most heterogeneous of the world's leading nations, the United States suffers from the worst diffusion and complexity of hospital ownership and management. This historic truth about our cultural diversity does much to explain the U.S. health care system's enormous fragmentation when compared with the rest of the world. Attempts since the late 1980s to consolidate different hospitals in a community based on market need have run headlong into inevitable cultural and philosophical conflicts as they try to mix nuns on a mission to serve the poor with corporate managers on a mission to serve their shareholders.

These are the obvious problems to anticipate and manage. More insidious cultural and economic conflicts arise inside the walls of an individual hospital. A principle struggle in hospital management has always been the constant complicating factor of the de facto veto power by a hospital's nonemployees over nearly every aspect of its day-to-day operations. Indeed, physicians drive the bulk of a hospital's costs and exercise control over

nearly all of its actual employees but have no real vested interest in its success. The Medicare system galvanized the historic economic and operational disunion between hospitals and physicians by replicating and expanding what was already an antiquated schism. With the rise of the early “Blues” plans in the 1930s and 1940s, insurance for hospital care and physician services was financed and managed by separate organizations: Blue Cross versus Blue Shield. Thanks to more rational alternatives offered by integrated insurance plans like Kaiser Foundation Health Plan and Group Health of Puget Sound, this system was just starting to wither when Medicare was created. However, the architects of the program enshrined this split when they created Medicare’s own payment system in the 1960s. This split still runs down the middle of the Medicare system today, no matter how silly and counterproductive it appears to even the most casual observer. Because of this fault line between payment systems, hospitals and physicians function at economic cross-purposes. Lump-sum Medicare Part A payment compels hospitals to speed up the discharge of patients, whereas line-item-by-line-item Part B payment compels physician specialists to slow them down. More chaos, more inertia.

The legal and financial disunion between the hospital across town and the admitting colleagues of the physician downstairs in our metaphoric shipyard has always subjected hospitals to the vagaries of physician clinical decision making. This disunion has left them vulnerable—in the worst case scenario—to economic recklessness and substandard clinical practices. Traditionally, however, the disunion between hospitals and physicians did not matter. Before managed care, when all patients wielded blank checks written on the shipyard’s account, sloppy physician practices made more money for the hospital. After all, substandard medical care or surgical technique—when it does not kill patients or entice malpractice attorneys—will almost always result in longer stays, more drugs, longer detours through the ICU, and bigger bills.

Managed care screwed all that up. When our shipyard boss started to discover just how much his vision back in 1943 was costing him by the mid-1980s, he took drastic action. He hired a new kind of third party, a man-

aged care organization (MCO), to keep tabs on exactly what the hospital across town was doing and what it was charging him for it. He also asked the MCO to keep an eye on what the doctor downstairs, whom he could not legally employ or control, was doing and charging for it.

Through the 1990s, the price pressures of consolidating MCOs compelled hospitals to seek closer economic alignment with, and some might say greater business control over, their admitting physicians. This made sense economically *and* clinically, and it was one of the few signs that the economic disciplines of managed care really did hold promise for improving the way medical care was organized and delivered. Throughout the 1990s, consultants went into overdrive working on reimbursement and compensation models that pursued these alignments. Thanks to the Twaddle Echo Factor, everybody became convinced that in a few short years these models would come to redefine the entire medical care landscape, and every freestanding hospital and group of physicians would be happily engaged in a contractual, if not corporate, version of the vertical integration of a Kaiser or Group Health.

But just as managed care was taking hold, the federal government went and screwed *that* up. The historic disunion between hospital services—the highest cost component of health care—and all those physicians driving most of those services has been reinforced by what are commonly known as the Stark laws. In the mid-1990s, Congressman Fortney “Pete” Stark (D-California) championed two incredibly complex Medicare-related payment laws that have foiled all meaningful attempts to integrate what doctors do with what hospitals need them to do. Combined with similar so-called anti-kickback laws passed a few years earlier, the Stark anti-self-referral laws have foiled numerous efforts to integrate doctors and hospitals over the past ten years. These laws have grossly complicated every attempt to align hospitals and physicians economically, most glaringly the gain-sharing arrangements that would have rewarded legally independent physicians for helping hospitals manage inpatient costs more efficiently (“HMOs,” 1999).

Attempts to comply with these laws—which stem from the presumption that most U.S. physicians are thieves who cannot be trusted with the

blank checks handed over by Medicare beneficiaries—have forced hospitals and physician groups to create still more corporate layers for the simple purpose of joint contracting with health plans for insured populations. They have also forced those within the corporate layers to seek “safe harbors” from subsequent prosecution by submitting details of their business plans to the Justice Department. The department reviews the plans for months and then, if it approves them, publishes the details for all to see (with the corporate names removed) as so-called advisory opinions. As a result of this process, if a hospital simply wants to pay a doctor an extra thousand dollars for a good surgical outcome or faster discharge of patients from its ICU, it needs to get what amounts to a proactive legal settlement. Not quite an act of Congress, but the next best thing. Once again, this is a boon for the lawyers, a headache for the busy health care executive, more costs for our metaphorical shipyard to bear, and an economic drag on the entire U.S. health care system. Let us pretend for a moment that these laws did not exist. In their absence, whatever fraud and waste we as taxpayers would endure from truly self-dealing physicians and hospitals could not possibly outweigh the costs of the gross operational inefficiencies associated with economically disenfranchised physicians, not to mention the costs when thousands of hospitals are forced into protracted legal compliance rituals with each attempt at an innovative hospital-physician integration strategy.

Of all the legal accidents that have complicated or even doomed well-meaning attempts by providers to fix the health care delivery system, none is more paradoxical than the antitrust rulings as they relate to physicians. In 1975, the Supreme Court ruled in *Goldfarb v. Virginia State Bar* that the “learned professions” are engaged in “trade or commerce” and therefore are not exempt from antitrust actions when they attempt to band together for the purposes of collective negotiation of their own payment rates. The ruling meant that although consolidating health insurers can impose payment rates on physicians, the physicians cannot stand together to push back. The Twaddle Echo Factor has it—erroneously, judging from physician pricing data from across the country—that the *Goldfarb* ruling galvanized com-

petitive market forces in the fragmented physician community. Many also believe that it paved the way for the consumerism that will prove to be the panacea for what ails the U.S. health care economy.

*Goldfarb* has become the cornerstone of physician antitrust law. Based on this precedent, physicians are free to charge as little or as much as they want, independent of each other, and attempts to do otherwise open them up to possible antitrust actions. But in actual practice, *Goldfarb* makes contract-based integration of fragmented physician practices tortuous and uncertain. After a decade of twaddle about “care integration,” physicians are still forced, even with safe-harbor protections, either to risk prosecution, collude in secret, or go it alone against well-organized health insurers, running the business of their practices the way they always have—in legal, commercial, and clinical isolation.

The doctor practicing downstairs in the shipyard is thus left legally and financially defenseless against the new MCO hired by the boss. It is not a fair fight. Finally, there is a supreme irony in the *Goldfarb* case. Just like ERISA, it had nothing to do with health care—it was an antitrust case against the legal profession.

## **A MEDICAL CHICKEN IN EVERY POT?**

Much of the U.S. health system’s complexity arises from its hybrid private and public funding. *This* is no accident. The shipyard worker’s health care is paid for by the boss, and the worker has very clear and growing expectations of what that means. His retired neighbor, covered by Medicare, has the exact same expectations. Both want to go to the “best” hospital in town, see their own doctor, and have access to the same new medicines. When one falls ill, gets a certain level of medical care, and tells the neighbor about it, the other’s expectations are raised accordingly.

The uneasy coexistence of public and private health insurance systems in this country reflects our deeply rooted cultural conflict about medical care, one that is unique in the industrialized world. Is access to the best medicine a basic human right or an earned privilege? The answer to this

question depends on whom you ask. As a society we are incapable of deciding, so we decide by not deciding. This indecision becomes even more entrenched when we add the issue of specific level and caliber of medicine to which American citizens either have a basic right or must earn the privilege as workers and taxpayers. How else can you explain why the chronically poor, infirm elderly, and prison population often have access to state-of-the-art surgical and drug therapies, while a steadily employed blue-collar worker who cannot afford health insurance has access to nothing except the emergency room?

This is the health care edition of the split Congress, the traditional chocolate versus vanilla politics of American life that forces us into electoral choices that most of us do not want to make. As a culture of ambitious shipyard employees, we are philosophically split between the personal drive to get rich quick and a populist sympathy for the oppressed worker. Yet we are trapped into choosing: between the Democrats' self-serving faith in bureaucracy-expanding "compassion" for the disenfranchised and the Republicans' self-serving fealty to lower taxes and the resulting "opportunity" that lower taxes supposedly create, if only for those already benefiting from opportunities harvested by their parents. Our ambivalence over whether every U.S. citizen is entitled to the best medical care in the world, or should be forced to earn that entitlement, pervades all political debate on the subject and has always precluded the creation of coherent, bipartisan health policies that have any chance of actually working.

In everything but health care, we resolve this conflict with bare-bones solutions and trickles of money per disenfranchisee. Not counting the de facto welfare programs administered by the defense and agriculture departments, our housing, food stamp, school lunch, and other welfare programs provide a thin safety net for only the most marginalized of American people. In health care, by contrast, this safety net has expanded to cover nearly half the population—if you define the safety net as the combination of official government programs for selected groups, with the "system" of cross-subsidies, hospital tax breaks, foundation-funded clinics, medical residency funding, and drug company largesse that provide care for the uninsured (Fronstin and Helman, 2000).

The philosophical impasse over the nature of medical care entitlement in America, propagated in shipyard worker neighborhoods across the United States, serves as yet another fault line, this one running through the center of every one of our health care institutions. It not only affects but often dominates policy debates over everything from the financing of physician education, to the regulation of commercial MCOs, to the amount of charity care provided by hospitals, to the future of the Medicare and Medicaid programs. As of this writing, the public financing of prescription coverage for Medicare beneficiaries is stumbling over precisely this fundamental philosophical impasse. Should seniors have unlimited, publicly funded access to the entire pharmaceutical arsenal? Should they have such access only to those drugs that are critical to saving their lives rather than improving the quality of those lives? Or should they make this decision for themselves, in the marketplace, with a combination of government funding and their own money?

The cultural and philosophical ambivalence about our rights to medical care in this country has turned the financing and management of the Medicare and Medicaid programs into a fifty-one-ring circus. Those in Congress who believe the government can fix everything want to expand these programs to include more segments of American society, one group at a time; those on the other side of the aisle want to go in the opposite direction and fully privatize both programs. As a result, neither side prevails, and these enormous, already complex programs grow by inches into an ever more multidimensional hybrid of expanding government agencies, nonprofit organizations, and for-profit companies. Roughly 15 percent of Medicare beneficiaries have their care administered by private MCOs; the rest have their care administered by a crazy quilt of federal contractors. As a result, who pays a Medicare beneficiary's different medical bills can vary not only within the same community, or even family, but for that same beneficiary, depending on which type of care she received and from whom. The enrollment choice she may have made the previous fall is only one of several variables. Similarly, the Medicaid program in many states is run by the state government, the same program in other states is run by nongovernmental nonprofit agencies, and the same program in still other states has

been handed over to one or more for-profit HMOs. In all three cases, the actual medical care is delivered by both for-profit and nonprofit providers. The Chaos Factor that pervades this system when viewed across the country ensures that the Inertia Factor will preclude any meaningful, systemic reform.

By the mid-1990s, momentum was building for a greater share of these public programs to convert to private programs. The commercial supporters of such privatization, making good use of the Twaddle Echo Factor, argued that consolidating, competing MCOs created economic efficiency and better customer service systems, which in turn presented attractive alternatives to the traditional Medicare and Medicaid programs. Why this turned out to be pure twaddle and never coalesced depends, once again, on whom you ask. The MCOs claim that the government underpaid them, they were never able to make money, and they were thus forced to restrict what they could offer. According to the American Association of Health Plans (AAHP), more than half of all commercial health insurers lost money on Medicare risk contracting because of underpayment (conversation with AAHP spokesperson, June 20, 2001). In contrast, the government claims that the insurers never achieved the efficiencies they claimed they could and thus could not make money on legislated prices that were more than adequate. According to a Justice Department audit, Medicare overpaid managed-care companies by \$1.8 billion in fiscal year 2000 (Taylor, 2000). Here's where the Twaddle Echo Factor gets really interesting. Conservative conspiracy theorists believe the Clinton administration kept those prices artificially low on purpose, setting up the whole privatization movement to fail and leading to a subsequent expansion of government management. Liberals see the Medicare risk-contracting meltdown as sweet vindication, launching into the familiar chorus that there is something evil, or at least unsavory, about trying to profit from the delivery of medical care to sick people—the insurers got what they deserved.

The truth, as in most things involving a struggle for the soul of health care in America, has little to do with these polarized philosophies. All the managed care rhetoric notwithstanding, MCOs are unable to earn profits on fixed price contracts with the government for the simple reason that

more stuff cannot be provided for less money. Under managed-care risk contracting for Medicare beneficiaries, the federal government paid 88 cents on the traditional fee-for-service dollar. For this shrunken benefit dollar, the health plans were expected to provide *more* benefits, cover their added marketing and administrative costs, and make a profit. This is the something-for-nothing accounting that made the Clinton reform plan the laughingstock of the health insurance lobby and those in Congress who helped defeat it. As Chapter Three will explore at length, the fundamental premise of managed care is flawed. Forget the Twaddle Echo Factor about proactive prevention and disease management saving money. The MCOs were doomed from the start when they set out to make money with their more-for-less market offerings to elderly consumers and patients who will always demand more. When the shipyard worker tells his bald neighbor in a Medicare HMO about a great new drug that is helping a bald guy at work, what is the neighbor's obvious response?

If government-dictated prices for Medicare beneficiaries do not work, why do we not have competitive bidding for those beneficiaries by for-profit MCOs, the same way we have supposedly competitive bidding for military work by for-profit defense contractors? We have been trying to move toward exactly this kind of system since the mid-1990s, and it has been a resounding failure. The MCOs argue that the "competitive pricing demonstration" process, attempted for years to no avail, has set them up to fail; the government argues back that the MCOs do not really want to compete; the nation's providers blame everybody for excluding them from the process; and consumer activists think the whole process is evil. And so it goes. An astute summation of the problem can be found in a preface to an edition of *Health Affairs* that included hundreds of pages of research on the failure of Medicare to create a competitive managed care pricing project. "No single culprit is to blame, because every interest involved had a hand in derailing this effort" ("Painful Pursuit," 2000, p. 6).

The numerous irreconcilables that cripple the debate over how much to pay an MCO to take care of the shipyard worker's bald neighbor—a highly demanding beneficiary of a public entitlement program—is one more variation on our broader theme. What should be a simple analysis of

medical cost allocations and normal rates of return for the delivery of a public service has tumbled headlong into the same old muck. Is medical care a market good that is subject to market prices or a special human right that should be sacrosanct?

Our cultural ambivalence over this problem, applied only recently to health insurers, has been a permanent feature of the provider financing landscape for decades. How much to pay hospitals and doctors who treat Medicare and Medicaid beneficiaries is one of the most complicated and costly annual rituals in Washington, as the federal government seeks to legislate a set of prices affecting nearly \$400 billion in annual spending—prices that also end up as reference points for much of the private sector. As a result, the business fortunes of hospitals, physician specialties, and other types of providers rise and fall at the whim of government reimbursement policies. When hospitals make too little money at something, they lobby Congress for payment increases. When they make too much, a Congressional “watchdog” or member of one of several regulatory agencies charged with overseeing health care smells a rat and attacks. The clearest example of this process was the nearly five-year persecution of the once-ambitious hospital company, Columbia-HCA, by the Justice Department for various business, administrative, and accounting practices. Under its founder and former CEO Richard Scott, Columbia was enormously successful at playing by the arbitrary legal and reimbursement rules created by the federal government, and making money. Columbia was seen as a growth stock on Wall Street, a favorite with mainstream and aggressive mutual fund managers alike, which gave the company a fat currency for expanding its unapologetically for-profit health care empire. This resulted in a highly publicized witch-hunt, the ouster of Scott and his lieutenants, the makeover of the company by less aggressive, more conciliatory executives, and a record \$840-million fine (Taylor, 2001). Five years after the dramatic, symbolic raid on Columbia’s first hospital by gun-toting federal agents, the company has shrunk to two-thirds its original size and been renamed “HCA, The Healthcare Company” The message of the Columbia scandal to hospitals is clear: you can make money on the backs of Medicare patients, but God help you if you make too much and brag about it to Wall Street.

## **I'M FROM THE GOVERNMENT, AND I'M HERE TO AUDIT YOU**

In its funding of health care entitlement programs, the government, like employers, gives with one hand and takes away with the other. With government driving nearly half of health care purchasing in the United States, the provider community is vulnerable, year by year, to the whimsy of public policy, which echoes every subtle change in the perennial emotional debate over the essential nature of medical care entitlement. U.S. hospitals spent fifteen years learning to cope with the introduction of lump-sum DRG payments for Medicare inpatients, rationalizing their operations to weed out excess costs and sloppy care patterns built up over the previous decades. Then in 1997, with one stroke of the legislative pen, nearly the entire hospital industry's profitability—built up through this process—was torn down by the Balanced Budget Act. By 1998, the impact of the government's attempts to manage the entire federal budget by starving the nation's hospitals was starting to show (Jaklevic, 2000b).

This reversal of fortune reversed again in 2000, when hospital lobbyists convinced Congress of the damage the Balanced Budget Act had done. The highest monthly increase in hospital revenues since 1995 occurred in October 2000, exactly one month after the rollback (Bellandi, 2000b). And so, although hospitals should be focused on putting their houses in order, they spend the balance of their time and energy coping with how that house measures up to the government standards of the day. These standards change drastically with every new presidential administration; they also change more subtly, every two years, with shifts in the balance of power in Congress.

Although the winds of political change distract and distort the normal functioning of the typical U.S. hospital, the problem is especially ferocious for the hundreds of teaching hospitals across the country, which conduct some of the most important work in the health care system. Under a hybrid private and public health care system, teaching hospitals have conflicted missions. They receive extra public funding to conduct research, train doctors, and care for the uninsured, but they also seek to compete in the commercial marketplace with nonteaching hospitals, despite the economic and

organizational burdens associated with their other noncommercial activities. As a result, hospitals affiliated with academic medical centers carry a 20 to 30 percent surcharge over nonteaching hospitals. Researchers have found that roughly half this surcharge is funded by the federal government and the rest comes from higher prices in the commercial market. “Considerable uncertainty exists about the reliability of [the federal government as] funding source in the future,” those researchers note in *Health Affairs*. “Higher payments from multiple private-sector insurers have been a more reliable source of revenues” (Anderson, Greenberg, and Lisk, 1999, p. 164). For now, this means that the “brand” value of a teaching hospital in its community—and the public’s perception that this brand value translates into better care—is all that sustains that hospital as a business. It is a testament to the business skills of those running these institutions that they are able to convey the value of that brand, while coping with the pricing pressures of managed care and simultaneously dealing with all the politics and economics attendant to a reliance on government funding.

Teaching hospitals are remarkably adept at coping with a central fact about health care in the United States: under hybrid public-private financing of medical care, our system, though driven by common consumer expectations fostered by neighbors sharing their medical experiences, is really three completely different systems, all running in parallel. One system exists for those with a public entitlement, another for those with private insurance, and still another for those with neither. The splintering of the system into three parallel systems has trained providers to cope as best they can, forcing them to choose, independent of actual clinical need, which patients get what care, when, and for how much. Providers charge completely separate sets of prices for patients with identical conditions. They are coerced economically into treating those identical conditions differently, in accordance with completely different types of coverage rules. And then they are held accountable for variations in the care they deliver. The cumulative result of this system is the persistence of distinct patterns of medical technology diffusion and utilization. The demand side of the health care equation, bolstered by neighborhood discussions across the country and a

wealth of health information provided by the media, grows rapidly and rather harmoniously; the supply side does not.

Small wonder that decades of research have shown one stubborn feature about medical care in America: the kind of care you receive in this country has less to do with how sick you are and more to do with the kind of health insurance you carry. If the MCO hired to manage the shipyard's medical costs is especially tightfisted, the worker may have no access to a needed diagnostic procedure, whereas his neighbor covered by Medicare will get the same procedure every year. Throughout the medical literature, we see patterns of care that vary as much by insurance status as by age, sex, and race. Such variations provide the perfect rationale for the government's strategy of "managing" the care it delivers by policing the provider community for compliance with its reimbursement rules. It does not help that such compliance must occur in accordance with a reimbursement rulebook that is forty-five thousand pages long and counting, nor that all the laws against self-referral are so vague that they are useless without extensive, preemptive legal documentation. This rulebook is the manifestation of the Chaos Factor in the health care system, and obsessive attempts to comply with it give rise to much of the system's Inertia Factor—an often insurmountable hurdle for numerous well-meaning attempts at innovation by providers.

The federal government's efforts to root out and penalize providers for failure to comply with these rules, known collectively as acts of fraud and abuse, accomplish two things: they serve as a de facto rebate program for a fraction of the \$400 billion it spends on medical care; they also ape the IRS's strategy of using the fear of reprisal to compel voluntary compliance among providers when seeking government reimbursement. A public flogging in the pages of *Modern Healthcare*, the *Wall Street Journal*, and a provider's hometown newspaper signals to all providers in the community that anything but the most conservative interpretation of the rules contained in those forty-five thousand pages will result in prosecution, professional disgrace, and financial ruin.

Thus providers seeking to make money on delivering health care to those with a public entitlement do so at the risk of being branded criminals

when their navigation of the system slips past a set of invisible tolerances. As Havighurst observes, the “government has found it convenient to characterize provider conduct that exploits the program’s shortcomings as ‘fraud and abuse’ and to criminalize it. The moral spin was necessary to overcome the presumption that all providers are entitled to participate in Medicare and to shift responsibility for the program’s deficiencies away from its designers” (Havighurst, 2000, p. 90). Through the detection and prosecution of this so-called fraud and abuse, the government is in effect admitting that it cannot proactively manage its own purchases. It overpays and then goes after a portion of that overpayment, a bizarre process that seeks a tortuous equilibrium between provider profiteering and insolvency. Such is the endgame of using private organizations to deliver a public good for the one-third of the American citizenry that consumes one-half of all health care costs.

## **BACK ALLEYS AND “INTEGRATED” CARE SYSTEMS**

The many bitter conflicts attendant to delivering a public good through private means grow especially shrill and emotional in the arena of reproductive health care. Because the issue of reproductive freedom will come up throughout this book, let me state my moral and political position on this subject once and for all. Voluntary abortions may be morally repugnant, but they are far less repugnant than the words and actions of those with the audacity to judge, legislate, or otherwise interfere in this most sacred, profound, and personal of human choices. I am not an advocate of abortion. I am, however, an advocate of fully preserving the awesome, terrible responsibility that the Supreme Court has guaranteed American women. And I stand in vehement opposition to anyone who—frustrated by both the Supreme Court’s guarantee and the large majority of Americans who support abortion rights—resorts to acts of domestic terrorism and harassment of patients, physicians, and their families to achieve what their political meddling cannot. Regardless of one’s own personal position on the subject, the impact of this bitter, permanent philosophical debate on the politics of

the U.S. health care system is the same: when we use public money to finance private medical choices, we run into enormous trouble.

Over the past decade, as hospitals around the United States have struggled to integrate their fragmented operations into “systems” of care, our national stalemate over reproductive health almost always rears its ugly head. In many cases, it derails an entire hospital integration effort, even though reproductive health represents a tiny fraction of the total package of services involved. A good example is the protracted legal and political wrangling within the BayCare Health System in Florida, which controls approximately half the hospital beds in the Tampa–St. Petersburg area. The BayCare system includes several Catholic hospitals, which like most (but not all) Catholic hospitals have refused to coordinate their services with other BayCare hospitals that provide the full range of women’s health services, including surgical sterilization and abortion. One of the key hospitals in the system, Bayfront Medical Center, sits on land leased by the local government. Consistent with constitutional law that (generally) guarantees the separation of church and state, the city insisted that Bayfront not acquiesce to its Catholic partners and continue to provide the full range of women’s health services. Making the BayCare system comply with constitutional doctrine would clearly put it into conflict with Catholic doctrine. The system spent nearly \$1 million in legal fees trying to sort through the mess before finally giving up. According to a report in *Modern Healthcare*, members of the eight-hospital system kicked Bayfront Medical out because neither the hospital nor the system could “continue to justify a costly legal battle with the city” (Bellandi, 2000a, p. 24).

This drama plays itself out in communities across the country, often to very different ends. Some systems accommodate their Catholic partners in often bizarre ways; others dig in their heels. How shrill does the screaming over this issue get? When Frances Kissling, president of the lobbying group Catholics for a Free Choice, spoke out against the rollback of reproductive services in hospital alliances between Catholic and non-Catholic hospitals, a “pro-life” group issued a press release calling her an “ex-Catholic” and a “heretic.” Luckily for Kissling, those seeking to follow up on their medieval

condemnation of her would have trouble finding her street address because the group spelled her name incorrectly in the press release (“Outliers,” 2001). The acrimony of this debate and the plurality of its resolution in different communities is a testament to the widespread governance and internal struggles of the Catholic church, the heterogeneity of the U.S. health care system, and to our point, the hazards of mixing public money with private health care systems.

This local drama also plays itself out at the national level in the nearly perennial debate over changes to the financing of Medicaid and Medicare coverage. Antichoice lawmakers use the public funding of private health care choices by the poor and disabled as a way of advancing their broader political agenda. The result is that those women in the United States with the most desperate economic and personal need for access to the full array of reproductive choices have those choices placed in the greatest jeopardy. Like all political struggles over abortion rights, and all struggles over medical care entitlement, the more vulnerable you are, the fewer options you get.

## **CHOCOLATE AND VANILLA POLITICS**

I have no faith that we as a society will ever resolve the abortion rights debate or any other philosophical conflict attendant to the public financing of private health care choices. We remain a nation of Democrats and Republicans, of staunchly pro-choice and antichoice voters, of hardworking taxpayers and needy entitlement beneficiaries who will never agree on the most fundamental of all health care questions: Is access to everything our medical community has to offer a basic human right or a hard-won privilege? The best we can do is acknowledge the implacability of this debate and the plurality it represents. We should create health care reform policies that acknowledge and accommodate this, and leave the rest to be sorted out in the marketplace.

Such an accommodation is a key element of the reform plan outlined in Chapter Eight of this book, the one dedicated to tax parity. Because government pays for nearly half of all medical services in the United States, we

have decided one thing: health care is a social good, and an investment in our collective health status is worthwhile at the most fundamental level. The shipyard boss inadvertently made this determination back in 1943 when he chose to pay for his workers' medical care and bring a doctor into the workplace. Our desire to pay for better medical care with tax-free dollars—and tax dollars themselves—is a central tenet of American public health policy and social beliefs; it provides a rationale for the continued tax deductibility of health insurance premiums and other expenses for those fortunate enough to have job-based health benefits.

The biggest problem arises when the shipyard boss—fed up with high costs and the failure of the MCO he hired to manage those costs—stops paying for his workers' medical care. The shipyard worker is then forced to fend for himself, going without insurance or trying to buy it on the retail market with aftertax dollars. All other pricing matters being equal (and they are not), the same medical coverage and care that cost the shipyard 75 cents will cost the worker on his own a full dollar in pretax income. This is wrong.

If, as a society, we believe that Americans should have unlimited access to all the medical care they need, want, and can afford, then we should remove the tax distortions that give one group of Americans this access while restricting it for another group. Such tax parity will finally help remove the complexity and conflicts created by the imposition of employers into the health care system while accommodating two central beliefs about health care in this country: Americans should be entitled to unlimited access to whatever medical care they can afford and are willing to pay for, and they should do so through the private marketplace.

