

## IS THE HEALTH CARE REVOLUTION FINISHED?—A FOREWORD

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In May 1974, a committee appointed by the newly founded Institute of Medicine (“IOM”) of the National Academy of Sciences published a report on health maintenance organizations (“HMOs”) entitled *HMOs: Toward a Fair Market Test*.<sup>1</sup> That report was notable as an early endorsement, by an organization somewhat representative of the health care establishment, of HMOs as desirable additions to the health care scene. Perhaps more significantly, the report went beyond merely embracing HMOs as promising alternative vehicles for financing and delivering health care, and emphasized the potentially bracing effects that HMO competition might have on the health care system as a whole.<sup>2</sup> The use of the word “market” in the report’s title was another precursor of the new departure that would occur in American health policy in the late 1970s, in the direction of greater reliance on competition and consumer choice. In retrospect, one might see the IOM report, with its suggestive title, as helping to launch a quarter-century-long natural experiment to determine the value not only of HMOs and other forms of managed care<sup>3</sup> but also of free-market principles in caring for people’s health.<sup>4</sup>

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1. INSTITUTE OF MEDICINE, *HMOs: TOWARD A FAIR MARKET TEST* (Policy Statement, 1974). The instant author was a member of the IOM committee, whose report was presented at congressional hearings. See *Hearings on Competition in the Health Services Market before the Subcomm. on Antitrust and Monopoly of the Senate Comm. on the Judiciary*, 93d Cong. 2d Sess. 49-92 (1974) (statement by Paul Ward et al.).

2. INSTITUTE OF MEDICINE, *supra* note 1, at 63 (“Benefits of HMO development would accrue not only to those consumers who chose to enroll in HMOs but to other consumers as well, for the HMO has demonstrated a capacity to stimulate desirable changes and increased efficiency in the entire health care system.”).

3. “Managed care” is a generic term encompassing proactive efforts by health plans to control the cost—and, ideally, to maintain and improve the quality—of health care. Available tools include selecting providers, negotiating with them, monitoring their performance, and imposing and prospectively administering limits on coverage. The management of care for the purpose of cost control is a natural and wholly legitimate response to the problem of moral hazard that prevails whenever insurance (or the equivalent) relieves primary decision-makers of the need to balance costs and benefits.

4. The IOM committee rejected formal experimentation with HMOs, however: “Advocates of further experimentation imply that close governmental control and limitation of HMO development must continue until a scientifically conclusive judgment can be reached about the quality and cost of the service being marketed.” INSTITUTE OF MEDICINE, *supra* note 1, at 7.

## I

## END OF AN EXPERIMENT?

If one were in fact to view the last two and a half decades as an experimental trial of managed care and market mechanisms in the health care sector, the measured results of that “fair market test” would appear moderately encouraging. In the 1990s, when managed care finally became dominant in many health care markets, the rate at which health care costs in the United States rose relative to other costs was, for the first time in modern history, brought into line with the growth of gross domestic product (“GDP”). Thus, from 1993 through 1998, the share of GDP devoted to health care stabilized around 13.6%, after having claimed more than a quarter percent more of GDP, on average, in each of the twenty-eight years since 1965.<sup>5</sup> Although GDP itself grew especially fast in the period from 1993 to 1998 (making it easier to absorb the increases in health costs that did occur),<sup>6</sup> inflation-adjusted health spending was under unprecedented restraint, growing less than 3% each year from 1995 to 1997; premiums for private health coverage rose only 2.8% in 1995, 3.3% in 1996, and 3.5% in 1997, after growing at double-digit rates in most of the 1980s. At the same time that cost increases were seemingly under effective control,<sup>7</sup> studies of industry performance detected no net adverse effects of managed care on the outcomes of health care or on other measures of overall quality.<sup>8</sup> To be sure,

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5. Katharine Levitt et al., *Health Spending in 1998: Signals of Change*, HEALTH AFF., Jan./Feb. 2000, at 124, 125. Health care costs tend to grow naturally each year as a percentage of GDP, as the population ages (partly because of past medical successes) and as new technologies yield new benefits to patients. The unprecedented leveling off of cost increases for six years was thus a remarkable accomplishment.

6. Health care’s reduced demand for additional funds may itself have contributed to that growth by allowing employers and consumers to put their resources to more productive uses. (By the same token, new government policies increasingly restricting efforts by managed care firms to control health costs may adversely affect productivity in the period ahead. See *infra* notes 10-13 and accompanying text.)

7. Cost savings may have other explanations as well. See, e.g., J.D. Kleinke, *The Price of Progress: Prescription Drugs in the Health Care Market*, HEALTH AFF., Sept./Oct. 2001, at 43, 46 (“Added pharmacy costs that offset other medical costs . . . reflect a profound permanent movement . . . away from medical labor and toward medical technology—a belated catching-up of health care with the rest of the ‘new economy.’”); *id.* at 49 (referring to “the classic health insurance underwriting cycle, which hit its low in the 1994-1996 period, when all health insurers were engaged in a pricing war that everybody lost”). But it is hard to deny managed care substantial credit for the temporary leveling off of cost increases in the 1990s. See Stephen Heffler et al., *Health Spending Growth Up in 1999; Faster Growth Expected in the Future*, HEALTH AFF., Mar./Apr. 2001, at 193 (“Cost containment strategies embraced by managed care plans, coupled with increasing enrollment, produced a mostly one-time effect that helped to cut spending growth in the 1990s.”). The latter source’s characterization of managed care’s accomplishment as merely a “one-time effect” is erroneous if the upward trajectory of costs remains permanently below the trajectory that would have been followed but for the six-year relative plateau. On the other hand, if regulation increasingly hampers efforts to manage care, cost increases could easily return to the earlier trajectory, making the savings from managed care one-time savings indeed.

8. See generally R. Adams Dudley et al., *The Impact of Financial Incentives on Quality of Care*, 76 MILBANK MEM. FUND Q. 649, 673 (1998) (finding “little evidence of any consistent difference in clinical quality between [fee-for-service] and [HMOs]”); Joseph Gottfried & Frank A. Sloan, *The Quality of Managed Care: Evidence from the Medical Literature*, 65 LAW & CONTEMP. PROBS. 103 (Autumn 2002); Robert H. Miller & Harold S. Luft, *Does Managed Care Lead to Better or Worse*

one might have expected increasingly hands-on management of the health care enterprise to yield net quality improvements as well as cost control, rather than merely holding the line against deterioration.<sup>9</sup> But the objective evidence at least reassures us that the money saved in the experiment with managed care probably came without a net lowering of quality.

Notwithstanding these promising results from two decades of experimentation with market mechanisms, recent market and policy developments make it seem that managed care flunked its “fair market test.”<sup>10</sup> The role of managed care has been, or is currently being, drastically curtailed as both employers and government take action to limit the tools that managed care firms can use to resist cost increases. On the one hand, some employers, responding to employee perceptions and complaints, have begun to question the methods employed by health plans and to press plans to adopt less restrictive arrangements.<sup>11</sup> On the other hand, the greatest restrictions on health plans are not those imposed voluntarily by the industry’s customers but the mandatory ones increasingly found in state and federal legislation, including pending federal patient protection legislation.<sup>12</sup> The latter bill not only would impose new regulatory requirements at the federal level but would also lift some previous bars to state authority over employer-sponsored managed care plans. Under a combination of federal and state laws and regulations, therefore, health plans

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*Quality of Care?*, HEALTH AFF., Sept./Oct. 1997, at 7, 13–14, 20–22. These sources document some declines in quality under managed care but also some improvements, making it possible to argue that managed care’s cost savings do not come at the expense of overall quality.

9. The health care system as a whole did continue to improve its overall technical performance in the 1990s, finding new treatment modalities and making progress against some important diseases. E.g., David M. Cutler & Mark McClellan, *Is Technological Change in Medicine Worth It?*, HEALTH AFF., Sept./Oct. 2001, at 11 (documenting desirable progress in several areas). While there may be some concerns, there is no evidence that managed care firms unduly inhibited the adoption of cost-effective improvements. See *id.* at 25–26. Managed care has not, however, made a dent in basic quality failings in day-to-day patient care as highlighted in two widely noted IOM reports. INSTITUTE OF MEDICINE, *CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY* (2001); INSTITUTE OF MEDICINE, *TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM* (1999).

10. See James C. Robinson, *The End of Managed Care*, 285 JAMA 2622 (2001) (describing and assessing the sudden reaction against managed care).

11. Jon Gabel et al., *Job-based Health Insurance in 2001: Inflation Hits Double Digits, Managed Care Retreats*, HEALTH AFF., Sept./Oct. 2001, at 180, 186 (“Heavily managed health care appears to be in full retreat, . . . networks are broader, and use of medical management techniques—such as gatekeepers and preadmission review—to control costs has declined.”).

12. Bipartisan Patient Protection Act, S. 1052, 107th Cong. (2001); H.R. 2563, 107th Cong. (2001). This legislation, passed by both houses in 2001 in slightly different forms, was expected to be finally adopted in time for treatment in this symposium. As publication deadlines neared, however, it was still awaiting action by a joint conference committee, and its enactment seemed likely to be delayed and possibly obviated by the Supreme Court’s recent decision in *Rush-Prudential HMO, Inc. v. Moran*, 122 S. Ct. 2151 (2002). In *Moran*, the Court narrowed the preemptive effect of federal law on state HMO regulation, adding to health plans’ regulatory burdens and somewhat lessening the perceived urgency of federal reform. Other reasons why federal legislation may not be forthcoming in 2002 include the recent dramatic upturn in employers’ health care costs, which may diminish Congress’s zeal for new regulatory controls, and election-year politics, which may make compromise less attractive to members than campaigning for another year on a salient issue productive of votes and (more importantly?) campaign contributions. On HMO regulation by the states, see generally Frank A. Sloan & Mark A. Hall, *Market Failures and the Evolution of State Regulation of Managed Care*, 65 LAW & CONTEMP. PROBS. 169 (Autumn 2002).

are losing much of their previous freedom to take such cost-control measures as the following: selecting physicians on the basis of cost considerations; requiring patients to obtain covered care only through a primary care physician or “gatekeeper”; limiting patient use of emergency services for non-emergent needs; placing presumptive limits on the length of patient hospital stays following childbirth or other procedures; and using financial incentives to discourage physicians from ordering tests, referrals to specialists, or hospitalization. In addition, managed care firms increasingly face both new procedural requirements in administering contractual limits on coverage and substantial new exposure to legal risks, including personal injury and punitive damages if a court or jury, exercising hindsight, should decide that the plan improperly denied coverage for a desired service.

Most of the new regulations and new legal exposures of managed care plans may seem reasonable on their face or to affect plan costs only marginally. Their cumulative impact, however, will certainly be to weaken managed care firms’ ability to resist cost increases. Most important, they have been adopted as a result of a strong public and political reaction against managed care based on only anecdotal, not experimental, evidence of its shortcomings. For the moment at least, the managed care experiment—if that is what it was—has been largely suspended on the basis of suspicions that managed care is unsafe. Without demonstrable quality gains, even poorly verified reports of adverse side effects from the administration of managed care have been enough to halt its clinical trial.<sup>13</sup>

## II

### REVOLUTION?

Recent legislative moves significantly reducing the role of managed care in the face of objective evidence of relatively good industry performance suggest that the last quarter-century of health policy in the United States has been something other than a scientific experiment with managed care, competition, and consumer choice. Although it should surprise no one that health policy has been driven by politics and not by findings from health services research, not everyone may appreciate the fundamental nature of the upheavals that began to occur in the health care sector in the late 1970s, first in policy and then in the industry itself. Indeed, as the title of this symposium suggests, American health care has been through something of a revolution. The nature and extent of that revolution—and what has (or may) become of it—are the general subject of the articles collected in these pages.

The revolution in health policy was perhaps first evident in the May 1979 defeat of the Carter Administration’s plan to put regulatory controls on all hos-

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13. The mentality shown here is depressingly consistent with the prevailing general attitude that, when it comes to health care, lower cost (to anyone but one’s self) is no justification for running any apparent or arguable risk. See Clark C. Havighurst, *How the Health Care Revolution Fell Short*, 65 *LAW & CONTEMP. PROBS.* 55, 57 n.8, 68-74 (Autumn 2002).

pital revenue increases.<sup>14</sup> From that date onward, congressional policy began to move in the direction of opening the health care marketplace to competition and widening consumers' options; the Reagan Administration reinforced this policy approach when it came into office in 1981. Such a policy was potentially revolutionary in the truest sense, because it threatened to empower consumers and their agents at the expense of entrenched provider interests that had effectively controlled essential features of the health care system in the earlier era.<sup>15</sup> Although a policy with such radical possibilities was too controversial and too threatening to powerful interests to be adopted through deliberative political processes alone, an exogenous event in 1975 gave it a fortuitous foothold. In that year, the Supreme Court opened the so-called "learned professions" to effective antitrust enforcement (including private lawsuits),<sup>16</sup> thereby supplying a *sine qua non* of a health policy based on competition and freer markets. With competition now at least arguably feasible in the health care sector, a market-oriented health policy became thinkable for the first time as more than an academic idea. The Supreme Court's action was potentially revolutionary because it overturned a long-standing consensus that competition in health care was not only unseemly but would be affirmatively objectionable because it might allow costs and the preferences of consumers to influence decisions better entrusted to professional judgment.

The antitrust campaign following the *Goldfarb* case opened the way for payers and providers to adopt methods of buying and selling health services that had previously been unacceptable to provider cartels. This new freedom produced strong moves toward selective contracting with providers and toward other cost-control innovations constituting what we now know as managed care. Government contributed to the revolution, first, by enabling public programs to become aggressive ("prudent") purchasers of providers' services and, second, by generally ceasing to treat private health care costs as a public regulatory responsibility. As it turned out, newly aggressive purchasing by government, private employers, and private health plans triggered a major transformation of American health care.

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14. Debate on H.R. 2626, 96th Cong., 1st Sess., 125 CONG. REC. 10,089 (daily ed. Nov. 15, 1979). The 96th Congress also manifested its hope that freer markets would control private health care costs by amending a then-popular federal health planning law to explicitly acknowledge competition's potential value. See CLARK C. HAVIGHURST, DEREGULATING THE HEALTH CARE INDUSTRY: PLANNING FOR COMPETITION 142-48 (1982). Both legislative actions reflected new doubts about the efficacy of command-and-control regulation in the economy as a whole and were consistent with the earlier deregulation of the airlines and several other industries. See Clark C. Havighurst, *Health Planning for Deregulation: Implementing the 1979 Amendments*, 44 LAW & CONTEMP. PROBS. 33 (Winter 1981) (symposium on "Managing the Transition to Deregulation").

15. Particularly striking was the potential shift of power directly to consumers without introducing government as an intermediary and controlling force. See generally Clark C. Havighurst, *The Changing Locus of Decision Making in the Health Care Sector*, 11 J. HEALTH POL. POL'Y & LAW 697 (1986) (observing, perhaps too hopefully, "the simultaneous deprofessionalization and depoliticization of important decisions affecting health care, a decentralization and diversification of the system that is opening new possibilities for translating diverse consumer desires into provider performance").

16. *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975).

Though adopted by peaceful means (if antitrust litigation can be so characterized), the new health policy contained the seeds of a revolutionary power shift. Indeed, the potential for converting powers-that-be into powers-that-were was great enough to invite analogy to the political revolutions occurring in the same era in eastern Europe and the Soviet Union. In the same way that *perestroika*, *glasnost*, and other democratic ideas swept away one-party rule by self-appointed elites in other parts of the world, American health policy in the 1980s, especially its antitrust component, significantly undermined the hegemony previously exercised by the organized medical profession in the American health care system.

### III

#### COUNTER-REVOLUTION? (OR DID THE REVOLUTION JUST FIZZLE ON THE GROUND?)

Just as the revolutionary directions taken by health policy in the early 1980s threatened to alter fundamental power relationships, more recent political developments arguably represent a counter-revolution led by forces seeking to recapture power previously lost. The medical profession, which stood to lose the most if the health care revolution succeeded, has led the legislative fight against managed care, arguing persuasively that physicians are better allies of patients than are profit-driven corporate health plans. The profession was aided in its campaign by the media, which found it easy to adopt and popularize the physicians' version of the story. Capitalizing on the resulting populist backlash against managed health care, plaintiffs' lawyers filed class action complaints against the leading HMO companies incorporating allegations drawn not from the findings of health services research but from medical society propaganda and congressional testimony by representatives of organized medicine.<sup>17</sup> Although courts have so far resisted most invitations to pile on the managed care companies,<sup>18</sup> it has been relatively easy for populist coalitions of professional interests, consumer groups, and outraged consumers to persuade legislators to take aggressive action against managed care.

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17. *E.g.*, *In re Humana Managed Care Litig.*, 285 F.3d 971 (11th Cir. 2002) (addressing attempts to compel arbitration of class action claims by providers against HMOs); *In re Managed Care Litigation*, 185 F. Supp. 2d 1310 (S.D. Fla. 2002) (evaluating HMO subscribers' amended class action complaint against HMOs). *See* Clark C. Havighurst, *Consumers versus Managed Care: The New Class Actions*, HEALTH AFF., July/Aug. 2001, at 8.

18. Early courts gave HMOs the benefit of the doubt concerning otherwise questionable business methods because they enjoyed general legislative approval. *E.g.*, *Pulvers v. Kaiser Found. Health Plan, Inc.*, 160 Cal. Rptr. 392, 393 (Cal. Ct. App. 1979). More recently, the Supreme Court has overturned a court of appeals ruling highly critical of HMOs, expressing some respect for HMOs' mission and leaving regulation of their methods to Congress. *Pegram v. Herdrich*, 530 U.S. 211, 234 (2000) ("[T]he Federal Judiciary would be acting contrary to the congressional policy of allowing HMO organizations if it were to entertain an ERISA fiduciary claim portending wholesale attacks on existing HMOs solely because of their structure."). *See also* *Maio v. Aetna Inc.*, 221 F.3d 472, 499 (3d Cir. 2000) ("[W]e must decline appellants' invitation to pass judgment on the social utility of Aetna's particular HMO structure.").

It is understandable that health care providers would want to roll back the managed care revolution and that politicians might accommodate them by reasserting their power to regulate. After all, the hands-off role legislators assumed *vis-à-vis* privately financed health care in the 1980s was a notable departure from their preferred and customary role as dispensers of favors among factions competing for economic advantage by political means. It is less obvious, however, why consumers themselves, rather than clinging to the power they were supposed to enjoy under the revolutionary regime, would as voters yield ground to, and even support, attacks on managed care by revanchist forces in the health care establishment. Although it is easy to see why some employers had second thoughts about certain aspects of managed care, it is less clear why consumer advocates, public opinion, and the majority of consumer/voters fell in so readily with the movement to reverse the revolutionary direction of health policy.<sup>19</sup>

The public's willingness to see managed care plans significantly disabled suggests, to say the least, that health plans never succeeded in establishing themselves as trusted agents of consumers in dealing with providers and controlling costs. Perhaps early "revolutionaries" expected too much when they envisioned that subscribers might perceive their health plans as responsible fiduciary-providers faithfully administering care with their interests (in cost as well as quality) uppermost in mind. In any event, today's health plans never achieved the legitimacy they must have to perform without political, regulatory, and legal interference the sensitive job of curbing demand-increasing moral hazard and rationalizing health care spending on behalf of a covered population.

Because modern health plans—the health care revolution's supposed instruments for empowering consumers—never finally gained public acceptance in their role as organizers and arbiters of medical care, any characterization of the backlash against them as a counter-revolution probably dignifies it too much. In fact, the revolution itself, rather than being overthrown after an initial triumph, may have simply fizzled in the first instance, failing like many other revolutions to produce a new class of decision-makers who could credibly present themselves as reliable executors of citizens' preferences. To be sure, managed care plans originally enjoyed some public enthusiasm as new, consumer-oriented participants in the health care system—even seeming for a time, both to themselves and to others, to be the wave of the future. But, even though they prospered into the 1990s, their early mandate quickly evaporated under physician and media criticism. Consumers, it seems, saw no reason to be loyal to their supposed allies against professional power.

In the last analysis, the health care revolution may have failed to ignite public support because consumers are largely unaware of the cost of their own health care. Insulated from the actual cost of coverage by tax subsidies and by employer policies in structuring their benefit offerings, consumer/voters tend to

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19. See Havighurst, *supra* note 13, at 78-95.

focus only on the benefits of health care and to assume that most of the cost will fall on someone else. Thus, they turned out to have little interest in a revolutionary agenda that contemplated empowering them to act collectively through health plan intermediaries to resist inappropriate demands by providers (and other patients) on pooled resources. Consumers wanted to be empowered, all right—but only to spend other people’s money without restraint.<sup>20</sup> Because the essential logic of the health care revolution never fired the public imagination, the revolution and its agents, the managed care plans themselves, may never have had a reasonable chance of getting very far off the ground.

#### IV

#### THE SYMPOSIUM

This symposium was conceived in part to consider whether the first generation of managed care plans have finally reached a dead end and, if so, to assign causes for their demise and consider whether there is any way to restart the American health care revolution. To judge whether the revolution has a future, one must consider precisely why managed care failed its “fair market test.” To the extent that the revolution failed because the purveyors of managed care went about their business in the wrong way, there may be some basis for hoping that a new generation of managed care plans will succeed where the first one failed. Indeed, a new burst of health care cost increases, coupled with harder economic times and employer policies making costs more visible to employees, could finally inspire real consumer interest in effective cost containment. The managed care industry’s ability to respond to new demand for cost control will depend heavily, however, on the legal and regulatory environment. If it precludes health plans from controlling costs by means that did not deserve to be discredited or exposes health plans to more than reasonable legal liabilities, then little will be achieved unless government alters circumstances once again to give managed-care-like institutions another chance. It is also possible, of course, that too much was expected of health plans in the revolutionized health care system and that the tasks assigned to them were impossible under any realistic circumstances. If the United States cannot make the world safe for efficient private management of the health care enterprise, then it must look for a new approach to health policy. It is apparent that the symposium deals with crucial issues at a crucial time.

The symposium’s title, characterizing the recent history of American health care as a revolutionary struggle, was intended to prompt insights concerning the highly political economy of American health care and to underscore the fundamental values at stake in health policy. The specific question in the symposium’s title is double, even triple-edged. One reading of it asks whether we have now seen all the American health care revolution has to offer or whether

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20. Robinson, *supra* note 10, at 2263 (noting “an iceberg of hostility toward any entity that would substitute its own priorities for those of the individual citizen”).

it still has further to go. Another possible reading, however, is even more despairing of the future, suggesting that the revolution's days are numbered, that it is essentially doomed. Yet another possible reading of the symposium's title suggests the hypothesis that the revolution has come full circle, bringing us back nearly to the point where we began. Posing the question(s) in this provocative form has proved a good way to stimulate our authors' collective effort to explore the overriding issue of what has become, or is likely to become, of the notion, seemingly implicit in health policy trends in the 1980s and 1990s, that competing private entities could be usefully employed in managing American health care.

Our authors—the great majority of them, by design, persons who, in addition to being distinguished figures in their fields, have had Duke University and/or the State of North Carolina as at least a brief stopping point sometime during their careers<sup>21</sup>—describe the origins, accomplishments, and fate of the health care revolution, particularly the managed care movement that it spawned. In varying degrees, the authors seek a better understanding of the total experience in the hope that public policy will not misconstrue what has occurred or overreact to the revolution's perceived shortcomings. Whether it will ever be possible to restart the health care revolution and finally realize its original promise, it is possible that managed care and the related policy of fostering competition in health care financing and delivery can still perform a useful role in governing the American health care enterprise, encouraging it to strive for good quality while also checking its extraordinary propensity to absorb more resources than an efficient economy would devote to curing (or trying to cure) individuals' afflictions.

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21. These connections appear in biographical notes in the respective articles. The symposium was conceived as a project of the newly formed Health Policy Council of Duke University, which provided the principal funding.