Lessons for the Health Care Industry from America's Experience with Public Utilities

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THE American health care system is in the midst of profound and often bewildering transformations as it aggregates into larger networks dominated by considerations of capital. The currently fashionable image of health care is that of the competitive free market.

Many are uncomfortable with this metaphor. We propose that because of the nature of the health care "product," the structure of the health care industry, and the role which health care plays in the advancement of human well-being, the health care industry should be considered *an industry affected with the public interest* (1,2).

The popular view of public utilities has been as entities requiring regulation because they have been local monopolies. But, in legal doctrine, their regulation has stemmed as much from their being determined to be "industries affected with a public interest" (3). Though never regulated as explicitly or coherently as the public utilities, and never as obviously organized as local monopolies, the health care industry is being subjected to evolutionary pressures strikingly parallel to the telecommunications and power industries. All are being deregulated to permit increased price competition in the belief that this will lower costs, especially to large payers (4).

The body of public utility law and regulation that has evolved over the last century can be best understood as a triangle of public interests: public accountability, universal access, and quality of service (5). As the health care, power and telecommunications industries become increasingly competitive, the heritage of this triangle remains a valuable touchstone to create public policy (6). Even Adam Smith recognized that unconstrained competition creates winners and losers, not

just among producers, but among consumers as well. The triangle of public interests is a framework through which to advance the public interest. In particular, it points to solutions to the most shameful deficiency in American health care—the lack of universal coverage.

THE RATIONALES FOR REGULATION

Regulation is as old as the fundamental democratic precepts which underlie this nation (7). It is traceable to medieval Europe, when government first declared that prices charged for particular "public" products such as tollways and inns must be "just and reasonable" (8).

No single set of circumstances adequately explains every instance of economic regulation. Three factors are widely cited: the presence of concentrated economic power; the grant of public perquisites; the potential for public harm (9).

Concentrations of Economic Power. The presence of monopoly, or at least dominant economic power, serves as the first basis for public regulation (10). In a "natural" monopoly, a single firm can provide the least-cost service over the entire range of demand (11). Early twentieth century telecommunications and electric power technology aptly illustrated this phenomenon. When natural monopoly has existed, states sanctioned their monopoly status but imposed regulation to prevent consumer abuse (12).

Monopoly power alone, however, is neither necessary nor sufficient to justify public regulation. Not even in *Munn v. Illinois* (13), the case in which economic regulation in the United States was first judicially approved, did the Supreme Court specially predicate the power to regulate on the monopoly by the affected industry. In words still applicable today, the Court held instead that it was the public interest, not the monopolistic character, of the grain industry, that justified regulation. Whether or not an industry should be regulated, in other words, does not depend on whether it is "competitive" (14).

Public Perquisites. The grant of special privileges to a private corporation is a second basis for imposing obligations enforceable through public regulation (9). Public utilities have been granted the right of eminent domain for their facilities (15). Since, under the U.S. Constitution, private land cannot be involuntarily taken for private use, the public has a right to ensure that the industry so supported is

not operated strictly for private gain, with the public good flowing only as an incident therefrom (16).

Other public perquisites also justify public oversight, including the grant of certain tax benefits (17), of antitrust immunities, and of public funds (16). These amenities constitute a sufficient basis to conclude that the benefited company owes an enforceable duty to the community.

Public Harm. The sheer magnitude of public harm should particular industries not be subject to governmental oversight has justified economic regulation (18). The potential to impose significant harm on the public may arise because of the number of people affected, the magnitude of the payments made by the public to an industry, or the life-sustaining necessity of its products (19).

In short, three core characteristics mark the industries which are considered to be "industries affected with the public interest." First, they involve essential services. Second, they have been granted substantial public perquisites, including tax revenue. Third, because their interruption or abuse might cause substantial public disruption, society cannot afford to allow them to fail, to be mismanaged, or to be marked by consumer abuses. Clearly, health care fits this description.

THE EVOLUTION OF INDUSTRIES AFFECTED WITH A PUBLIC INTEREST

Health care, power, and telecommunications have all been pushed by strong ideological and political forces away from regulation in the direction of "pure" competition (20).

Health Care. The importance of regulation in health care has generally been underappreciated, particularly by its managers and professionals. A brief historical view is warranted.

Conservative ideology and the political strength of the medical profession prevented the social insurance programs of the New Deal from including health insurance. Consequently, in the 1930s, a private insurance model took root. The initial private insurer, Blue Cross, was not a "natural" monopoly but was granted administrative monopoly status. In each state, its special charters gave it a quasi-public role, requiring it to provide policies to all who could pay at regulated (community) rates (21).

The wage freeze of World War II led to the rapid expansion of health insurance as a fringe benefit, leading to more companies entering the field. Through "experience rating," commercial insurers offered firms with healthy workers lower rates. But no insurer did more than token oversight of the "medical necessity" of the care for which they paid.

In 1966, to avoid explosive political confrontations, Medicare used public dollars to reinforce this private insurance model (22). While the payment mechanisms used by the government have evolved and grown more sophisticated over the decades, from UCR (usual, customary and reasonable) to DRGs (diagnosis-related groups) and RBRVS (resource-based relative value scale), all have been, at heart, regulated, not competitive prices. During the quarter century after the enactment of Medicare and Medicaid, as consequences of both advances in health care and the incentives inherent in a regulated fee-for-service model, substantial excess capacity has developed in the health care industry.

Health care reform emerged as a major public policy issue in the early 1990s as a consequence of medical inflation, especially for the corporate sector, and declines in employer-provided health insurance, leading to growing numbers of uninsured. President Clinton's health security proposal sought to accomplish the twin goals of controlling costs and moving towards universal coverage (23).

The imperative to control costs survived the 1993–94 health care reform debacle, but the push towards universal coverage did not. The tool chosen by private and public policy-makers to control costs was the replacement of the regulated prices of fee-for-service by competitive managed care—i.e. transferring risk for cost overruns from the payer to both providers and individual consumers. The transformation of the central incentive in health care from inflating costs to limiting costs has let loose an entrepreneurial flood of new managed care and hospital corporations, companies which ideologically and financially oppose seeing themselves as having any special responsibilities to the public (24).

Public Utilities. In the early decades of telecommunications, signals could be transmitted only over wires, leading AT&T to be granted a state-sanctioned monopoly status. However, microwave transmission of telephone conversations, beginning in the 1970s, subsequently

joined with satellite transmission, permitted much telephone service to be provided without resort to AT&T's wires and poles (25). As a consequence, the 1984 break-up of AT&T eliminated artificial economic barriers to the use of new carriers and ushered in a new era of long distance competition. Continuing rapid advances in microelectronics led to the Telecommunications Act of 1996, which, while best known for further expanding telecommunications competition, primarily codifies industry standards (26).

In its infancy, the electric industry was subject to consumer abuse, price gouging, and the powerful but unstable holding company structures of persons such as Samuel Insull (27). Anger at abuses combined with the prevalent view of electricity generation as a natural monopoly led to strict economic regulation at the beginning of the twentieth century (10). In the past few years, new technology has allowed small-scale power generation to be constructed at costs competitive with existing power plants (28). Electric companies with substantial excess capacity, especially large nuclear facilities, began feeling competitive pressures (29). The convergence of technological advances and excess capacity led to federal regulatory changes in 1996 which force major utilities to allow equal access to their transmission lines to other electricity suppliers (30).

THE TRIANGLE OF PUBLIC INTERESTS AND ITS APPLICATION TO THE CLASSIC PUBLIC UTILITIES

All industries are subject to several types of regulation: consumer protection (e.g., airline and automobile safety regulations), worker health and safety, and environmental protection. In addition, products affected with a public interest have been regulated through what we will call a "public utility model of regulation," which has at its heart the pursuit of three interdependent interests, ensuring: 1. universal access; 2. public accountability; 3. quality service.

Universal Access. Universal access is a measure of the geographic, economic and cultural availability of goods and/or services. Universal service in the public utility industry has at its core a legally enforceable obligation to serve, which requires the nondiscriminatory provision of service to all who request it, promise to pay for it, and agree to abide by the reasonable regulations of the company providing service (31). In addition, universal access has an affordability component, pursued through price structures as well as through explicit financial subsidies (32).

Despite the evolution of telecommunications toward more price competition, the points of the public interest triangle have not been left to the vagaries of a purely market-driven system. The Telecommunications Act of 1996 explicitly expresses a national purpose of promoting universal telephone service (26). To that end, it mandates low access fees. Its Link-Up program helps customers connect to the system and a Lifeline program helps maintain their connection. A nationwide Universal Service Fund partially offsets the high costs of serving remote rural areas, and high rural costs are often "averaged" with lower urban costs to maintain overall price affordability.

In the electric industry, many state regulatory commissions have adopted income-sensitive rates, including PIPPs (percentage of income payment plans), to provide assistance to the poor (33). As the electric industry moves towards multiple producers and price competition, prices are being "unbundled"—separate charges for power generation and transmission. To help fund efforts to maintain universal service, states are discussing imposing a "wires charge," a fee in every consumer's bill to cross-subsidize the indigent (34).

Public Accountability. As a business affected with the public interest, the utility industry has been accountable to more than simply investors. Instead, the industry is subject to a public review and control of company finances. The traditional role of regulation has been through "rate of return regulation," a mechanism that limits net income to an amount which regulators find to be necessary to attract equity investors (11). Even as utilities become more competitive, those markets which face concentrations of economic power are subject to a menu of price controls, ranging from continued rate-of-return regulation to price-cap regulation to performance-based regulation (where profits over a certain level are split between ratepayers and investors).

In addition, the public financial scrutiny of utilities still involves regulatory control over the disposition of assets, mergers and acquisitions, and affiliated transactions (35). Regulation sharply controls the types of holding company structures that utilities may maintain, and the types of non-utility businesses in which they may engage (27).

Quality of Service. Quality of service involves public accountability in both the type and manner of service provision; it has technological and nontechnological components. Technological components include availability of service (when the phone is picked up there should be a dial tone); adequate facilities to serve demand (frequent brown-outs demonstrate lack of service quality); and appropriateness of service (industrial customers have an enforceable right to higher voltage power) (36).

Non-technological quality of service issues include the customer's need to contact the company to make payments, inquire about bills, or negotiate deferred payment arrangements for arrears (37). Promptness in the installation of service is an aspect of quality, as is fundamental procedural fairness in the denial or termination of services (6). Despite the advent of price competition by public utilities, continuing regulation will seek to assure continuing quality of service in each of these areas (38).

THE APPLICATION OF THE PUBLIC INTEREST TRIANGLE TO THE EVOLVING HEALTH CARE SYSTEM

The one unarguable trend in the health care industry is increasing concentration. The rapidly growing HMO market is dominated by a handful of nationally marketed firms. Stand-alone hospitals are an endangered species; most hospitals are in one or another type of network. While health care remains a personal service, relying on the trust embodied in personal relationships, the economics of health care is increasingly mediated through large organizations. In an industry so clearly affected with the public interest, the application of the "public utility model of regulation" becomes all the more compelling.

Quality of Service. There is a new industry: studying and reporting on quality issues in health care. Larger-scale organizations permit the collection of more reliable data. In part, the rise of this industry reflects computer technology and the business orientation of health care executives. More significantly, as Angell and Kassirer contend, it is a defensive response to the widely recognized perverse incentives of capitated managed care (39).

Public Accountability. Reconfigurations and changes of ownership

among for-profit hospitals occurred quietly in the early 1990s. However, the current wave of merger and acquisition activity by investor-owned hospitals directed towards non-profit and public institutions has encountered unanticipated resistance by both community groups and elected officials, particularly state attorneys general (40). This resistance has focused primarily on issues of fair valuation, executive compensation, and the creation of nonprofit trusts from the sales of assets.

Larger issues emerge. There has been a vigorous debate in the medical and popular literature as to whether health care corporations should be for-profit or not-for-profit (24,41). The more important axis is whether they are solely private corporations, with closed books and "trade secrets," accountable only to private investors, or public service corporations, accountable to all their stakeholders—their owners, employees, customers, and the public at large. When corporations are recognized as being affected with the public interest, they become subject to public oversight and enforcement of public responsibilities.

State public utility commissions have traditionally required much greater financial disclosure from public utilities than has been expected from other corporations. Health care regulators need to do likewise. HCFA has in piecemeal fashion promulgated rules that prevent excess profiteering on Medicare patients (42) and that regulate the percentage of physicians' income that can be placed at risk by managed care companies (43). HCFA and state regulators should work with their utility peers to create comprehensive disclosure and enforcement provisions.

Universal Access. To achieve universal service, there has to be cross-subsidization of those who can afford only part of the cost. Utility regulators have handled this through rate structures.

In health care, cross-subsidization took place at the level of the physicians' office in the twenties and thirties, and at the level of the insurer, particularly Blue Cross and Medicare, in the fifties through eighties. Over the past decade, cross-subsidization has become more difficult. Corporations which self-insure have avoided participation through the "pre-emption clause" of the 1974 federal ERISA statute. Managed care corporations which bargain strenuously for low rates leave little margin for care-giving institutions to apply towards "uncompensated care" (44). The newest cross-subsidization effort,

Medicaid's Disproportionate Share Hospital (DSH) program, currently provides valuable support, but is limited by its focus on episodic acute care.

Politically, recent efforts to attain universal coverage through explicit tax-based subsidies—whether single payer, pay or play, or Clinton's Health Security Program—have run aground on the shoals of tax resistance. The Supreme Court's unanimous 1995 decision in *New York State Conference of Blue Cross and Blue Shield Plans v Travelers Insurance*, however, opens the door to the direct taxation of the entire health care industry, including managed care plans, to finance care for the uninsured (45).

Assessments on health care corporations are unlikely to run into the same level of political resistance generated by broad taxation programs. In fact, the backlash against HMOs (46), currently focused primarily on quality issues, could easily expand to the area of corporate financial responsibility. Assessments on corporations do not undermine competition; they regulate it in order to level the playing field (20). State legislators and regulators are already grappling with fairness issues in allocating costs among new and old players in the telecommunications and electric power industries (47). The level of redistributive taxation need not be high. A widely quoted 1994 study estimates the resource cost of universal coverage at 2% of current expenditures (48), in the same range as the market inefficiencies of our current nonuniversal system (20).

Medical advances in the twentieth century have allowed us to improve people's lives, to defer and prevent catastrophic illness. We need to start the twenty-first century by applying the standards of corporate responsibility, first engineered at the beginning of this century for the public utilities, to health care—the industry most clearly affected with a public interest.

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ABSTRACT

In the United States, the traditional public utilities, power and telecommunications, along with health care, are being deregulated and becoming increasingly competitive, especially on price. Regulation of the public utilities has occurred for the past century not simply because they have been monopolies, but, more importantly, because they are "industries affected with the public interest," that is industries which: 1. provide an essential service, 2. benefit from public perquisites, and 3. would cause great public harm if mismanaged. Consequently, the presence of competition in these industries does not negate the need for regulation. Regulation of these industries is best understood as being along the three sides of a "triangle of public interests"—quality, public accountability, and universal service. Examples are provided of these types of regulaton in power and telecommunications, even in current "deregulatory" legislation. Health care reform activists in the United States have lately paid attention mostly to the first two legs of the triangle; they are encouraged to focus creatively on the third leg—universal health care.