# Overview

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This issue focuses on various aspects of change in the health care delivery system in the United States. Unlike most industrialized countries, the United States does not have a single, unified, government-sponsored health care system. Instead, this country relies on the combined efforts of individuals and families, private business, non-profit organizations, and various levels of government to provide health care services to its citizens. The resulting polyglot system of health care delivery has both strengths and weaknesses relative to other systems. On one hand, the U.S. health care system succeeds in providing very high-quality health care—using the latest technology—to most of the country's population. On the other hand, because of the decentralized nature of the system and the resulting gaps in coverage, a significant minority of Americans suffer from a chronic lack of needed care. Another area in which both strengths and weaknesses are evident is in the system's ability to adapt to change. The decentralized U.S. health care system affords its various parts greater flexibility to develop creative responses to changing conditions; however, changes made by one segment of the health care system often adversely impact the operations of other segments in unforseen ways.

Much of the recent change in the U.S. health care system has been in response to the cumulative effect of trends taking place over the last half-century. In the early part of this period, two interrelated themes predominated. First, medical research has produced a steady stream of new knowledge which has transformed the practice of medicine, greatly increasing the capacity of the health care system to treat and prevent disease. In response to the improved effectiveness of health care, demand arose for financing arrangements through which people could gain access to the new technology. These arrangements largely took the form of prepayment for services; i.e., health insurance. Encouraged by favorable tax treatment, employers began offering health insurance to their employees as a fringe benefit. Later, in an effort to improve access to care for those who were excluded from the employer-based system, the government began offering health insurance to selected populations through the Medicare and Medicaid (and other) programs.

As the level of technology and the extent of health insurance coverage increased, however, so did the cost of health care. To a large extent, this reflects the success of the health care system in developing new ways of fighting disease, and in putting new technologies into practice. When the level of expenditure was low, the ability of the health care sector to use resources efficiently was not an important consideration. However, as health care expenditures continued to rise, so did concern about incentives for providers to use resources efficiently. Payers began demanding more accountability for their expenditures. The system responded by adopting health insurance arrangements that provide stronger incentives for efficient resources

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use. Prospective payment systems (such as the Medicare diagnosis-related group system for hospital reimbursement), various managed care arrangements (such as health maintenance organizations) and increased competition among providers and health insurance plans are some of the ways that are being used to encourage greater efficiency. As with the introduction of health insurance, these changes started first in the private, employer-based health insurance sector. More recently, the major public health insurance programs—Medicare and Medicaid—have begun adopting these methods. Although there is some evidence that measures to promote efficiency have had some impact in restraining costs, there also are concerns that the new incentives could at the same time undermine quality of care, and that the increased level of competition could reduce the ability of public and non-profit providers to cross-subsidize care for the remaining uninsured.

This issue of the *Health Care Financing Review* contains four articles that examine various aspects of recent health care system change. Two look at the role of consumer choice in the functioning of the health care system. Some prominent models of health care cost containment, such as the managed competition model, rely on competition among health plans to contain costs and maintain quality of care. In order for these models to be effective, consumers must have the ability to make well-informed choices among competing health plans. One way to help consumers become better informed is to gather information about the quality of the services provided by plans (using plan administrative data or consumer surveys) and distributing the information in the form of a report card. Knutson et al. studied the impact of health plan report cards on the selection of health plans by employees of the State of Minnesota. One group of State employees, employees of the University of Minnesota, faced the same set of health plan choices as other State employees but did not receive report cards, thus providing a natural comparison group for the study. Employees were interviewed before and after the State's open enrollment season. Comparison between the two groups revealed little discernable impact of report cards on recipients' knowledge of health plan attributes or their assessment of plans. The results suggest, at the very least, that further work is needed before report cards fulfill their promise as a means for helping consumers make informed decisions about health plan options.

In the other study focusing on consumer choice, Schur and Berk used data from a five-State survey to look at choice of health plans by low-income persons. Survey respondents included persons covered both by Medicaid and by private insurance. They found that persons who had a choice of health plans and exercised that choice experienced better access to care, and were more satisfied with their care, than those who either had only one plan from which to choose or had a choice but did not exercise it (i.e., were assigned to a plan without making a choice). They also found that cost was the most important determining factor of choice for privately insured individuals, while for Medicaid-insured persons, whether their own doctor was a member of the plan was the most important factor.

The other two articles deal with the impact of health system change on public health care providers and programs. In the first of these, Long and Zuckerman focus on the Los Angeles County, California 1115 Medicaid Demonstration and chronicle the efforts of the Los Angeles County Department of Health Services (LACDHS) to continue meeting the needs of the

County's low-income residents in a changing health care economy. The LACDHS operates the public health care system for a county of 9.4 million people, many of whom live in poverty. In the summer of 1995, DHS faced an operating deficit of $655 million, forcing it to consider closure on many of its hospitals and outpatient facilities. The financial crisis was caused by a number of factors, including changes in State and Federal Medicaid reimbursement policies, and limitations in the ability of the County to raise local tax revenues. In order to avert the shutdown of most of the public health infrastructure in the County, the Federal Government granted an 1115 waiver demonstration to the State that provided fiscal relief to the strapped Los Angeles County public health system. In return, the County was to embark on a program of restructuring, designed to transform the County's costly, hospital-based system into one more reliant on primary care in outpatient settings. The article describes the changes made by the LACDHS under the demonstration and assesses their progress in meeting those goals.

Finally, Fox examines the impact of recent changes in the Medicaid program on Medicaid funding for early intervention services. The Infants and Toddlers with Disabilities Program (ITDP), authorized under the Individuals with Disabilities Act, assists States in establishing statewide systems to provide for the needs of children with disabilities and their families. Since the inception of ITDP, Medicaid has been an important source of funding for early intervention services provided through these programs. Increasingly, however, States are contracting with capitated managed care to provide services to their Medicaid-eligible populations, rather than reimbursing providers directly as in the past. This change in the method for funding Medicaid services may be causing disruptions in the flow of Medicaid funding for early intervention services. Based on interviews with directors of State ITDPs and Medicaid directors, and a review of Medicaid managed care contracts, Fox produces evidence suggesting that Medicaid managed care has, in fact, caused a reduction in Medicaid financing for early intervention services. Implications of these changes are discussed.

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