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**U.S. Health Care Reform:
Universal Insurance or Affordable Care?**

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U.S. Health Care Reform: Universal Insurance or Affordable Care

Executive Summary

The U.S. leads the world in medical innovation and likely leads the world in quality of care. However, U.S. health insurance and medical care are very expensive, and some people cannot afford to pay for either. In addition, Americans may be spending more on health care than is necessary to achieve the highest quality.

While there are many reasons that insurance and care are expensive, federal and state policies appear to be important factors. In 1943, the IRS, and later Congress, created a tax incentive that favors employer-sponsored insurance over individually-purchased insurance and direct payment for care. In 1965, Congress created Medicare and Medicaid, public programs that pay for medical care for many Americans. Beginning in the 1970s, Congress and state legislators enacted extensive regulations involving health insurance, professional care, and medical facility care; and in 1962, Congress required pharmaceutical companies to gain approval before introducing a new drug to the U.S. market. Finally, beginning around 1960, the number and monetary value of malpractice lawsuits increased. Together, these policies have contributed to high prices for health insurance and medical care and to large health care expenditures.

One approach to health care reform emphasizes the importance of all persons having some form of comprehensive, third-party coverage to pay for the majority of their medical expenses. Using this approach, Congress recently passed legislation that requires most persons to maintain health insurance or pay a penalty, provides a subsidy to low and middle-income persons to purchase insurance, requires large employers to pay an assessment if an employee receives a subsidy, and expands eligibility for Medicaid. However, economic theory and many data suggest these measures will lead to higher prices, larger expenditures, and potentially less access to care.

This paper recommends an alternative approach, one that emphasizes the importance of each individual owning the funds used for his or her health care and choosing both insurance and care from many available options. To increase both individual ownership and available options, Congress should consider equalizing the tax treatment of funds used to pay for health care; Congress and state legislators should consider replacing public programs that pay for medical care with public subsidies and private support, decreasing restrictions on health insurance, and decreasing restrictions on professional and medical facility care; Congress should consider decreasing restrictions on access to new pharmaceuticals; and states should consider enacting malpractice reform.

By providing more appropriate incentives and making care more affordable, greater individual ownership and more options should lead to fewer excess expenditures and to greater access to care for most people. In addition, greater individual ownership and more options may be more effective than universal comprehensive insurance at providing access to care for low-income, high-risk, and older Americans.

Introduction

The U.S. leads the world in scientific discovery and medical innovation,¹ and recent studies suggest that for many clinical conditions, U.S. patients have outcomes superior to or equivalent to those in other industrialized countries.² However, U.S. health insurance and medical care are very expensive,³ and Americans may be spending more on health care than is necessary to achieve the highest quality.⁴ While there are undoubtedly many reasons that insurance and care are expensive, present federal and state policies appear to be important factors.

Reformers agree that improving access to care⁵ and decreasing unnecessary expenditures are worthy goals. However, there are widely varying approaches to achieving these goals. One approach emphasizes the importance of “health insurance”⁶ as a means to assure access to care.⁷

¹ For a summary of data suggesting that the U.S. leads the world in scientific discovery and medical innovation, *see* Economic Report of the President, together with the Annual Report of the Council of Economic Advisors, U.S. Government Printing Office, Washington (Feb., 2004), accessed at http://www.gpoaccess.gov/usbudget/fy05/pdf/2004_erp.pdf.

² Because of differences among countries in disease registries and in early disease detection, comparison studies must be interpreted with caution. Nevertheless, recent comparison studies suggest that for many types of cancers, U.S. outcomes are superior to or equivalent to outcomes in other advanced countries. For example, *see* Milena Sant, Claudia Allemani, Franco Berrino, et al., Breast Carcinoma Survival in Europe and the United States: A Population Based Study, 100 *Cancer* 715 (Feb. 15, 2004); Arduino Verdecchia, Silvia Francisci, Hermann Brenner, et al., Recent Cancer Survival in Europe: a 2000-02 Period Analysis of EURO CARE-4 Data, 8 *Lancet Oncology* 784 (2007); June E. O’Neill and Dave M. O’Neill, Health Status, Health Care and Inequality: Canada vs. the U.S., NBER Working Paper # 13429 (Sept., 2007).

³ *See* Gerard F. Anderson, Uwe E. Reinhardt, Peter S. Hussey, et al., It’s the Prices Stupid: Why the United States Is So Different from Other Countries, 22(3) *Health Affairs* 89 (May/June 2003). Between 1960 and 2008, prices for medical care increased at a significantly greater rate than the Consumer Price Index (CPI). *See* Bureau of Labor Statistics, Databases, Tables, and Calculators by Subject, All Urban Consumers (Current Series), accessed at <http://www.bls.gov/data/>. Similarly, between 1988 and 2007, premiums for employer-sponsored insurance increased at a significantly greater rate than the CPI. *See* The Kaiser Family Foundation and Health Research and Educational Trust, Cost of Health Insurance, EMPLOYER HEALTH BENEFITS: 2007 ANNUAL SURVEY, SECTION 1, accessed at <http://www.kff.org/insurance/7672/upload/76723.pdf>.

⁴ For example, *see* Jonathan Skinner, Elliott S. Fisher, and John E. Wennberg, The Efficiency of Medicare, NBER Working Paper No. 8395 (July, 2001); Elliott S. Fisher et al., The Implications of Regional Variations in Medicare Spending, Part 2: Health Outcomes and Satisfaction with Care, 138 *Ann. Intern. Med.* 288 (Feb. 18, 2003). *See also* Willard G. Manning, et al., Health Insurance and the Demand for Health Care: Evidence from a Randomized Experiment, 77 *Am. Econ. Rev.* 251 (1987).

⁵ There is not a standard definition for access to care. For the purpose of this paper, access to care is the ability of an individual to obtain the care one needs at a price one can afford in a convenient and timely manner. Using this definition, access may include care paid by a third party payer, care paid directly by an individual using one’s own funds or donated funds, or care provided at no charge or at a discounted rate.

⁶ For health insurance to efficiently spread the risk of loss, the loss must be uncertain, measurable, and large. In addition, one’s insurance premium must be based on one’s risk, and the risk pool must consist of a large number of insured. *See* John A. Boni, et al., THE HEALTH INSURANCE PRIMER: AN INTRODUCTION TO HOW HEALTH INSURANCE WORKS (The Health Insurance Association of America, 2000). Today, most U.S. health insurance plans contain a component of true insurance, as well as a large component of “prepaid benefits” that cover small and expected expenses. Also, instead of indemnifying individuals for their loss, most plans now pay physicians and hospitals directly and to some extent, “manage” care, e.g., a few plans employ physicians and operate facilities, while many plans contract with physicians and hospitals concerning methods of payment, payment rates, and other items. For a discussion of these arrangements, *see* Paul Starr, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE, Book 2, Chap. 2, (Basic Books, 1982); Charles E. Phelps, HEALTH ECONOMICS, 3RD ED., CHAP. 11 (Addison Wesley, 2003); Thomas Rice, Financial Incentives as a Cost-Control Mechanism in Managed Care, in THE PRIVATIZATION OF

Under this approach, legislation is designed to assure that all persons have some form of comprehensive, third-party coverage to pay for the majority of their medical expenses. Since a third party pays for most care, cost control is achieved primarily by the third party, e.g., by providing incentives for patients, professionals, or facilities to use fewer resources or by negotiating lower payment rates with physicians or hospitals.

A second approach emphasizes the importance of each individual owning the funds used for one's health care and choosing both insurance and care from many available options.⁸ Under this approach, legislation is designed to repeal or neutralize laws that favor one form of paying for care over others and to repeal or decrease the stringency of many of the regulations presently governing health insurance and medical care. Since individuals would choose their insurance and care from many options, individuals, often in consultation with their physician, would be primarily responsible for cost control.

Since World War II, Congress and state legislators have taken the first approach, attempting to increase access to care by increasing the prevalence of some form of comprehensive, third-party coverage.⁹ The bills recently passed by Congress take this same approach.¹⁰ However, for many years, real prices for insurance and care have increased,¹¹ and both private and public expenditures as a percentage of GDP have increased.¹² In addition, it is not clear that access to care has improved.

Proponents of universal, comprehensive insurance envision universal access to high-quality care, a very worthy goal. However, economic theory and many data suggest that legislative attempts to achieve universal insurance will have major unintended consequences. These include higher prices for insurance and care, larger expenditures, and potentially less access to care.

In contrast, by making insurance and care more affordable, greater individual ownership and more options should result in better access to care for most people. In addition, these reforms

HEALTH CARE REFORM, CHAP. 5 (M. Gregg Bloche, ed., 2003). Finally, self-insured employee benefit plans and public programs pay for medical care for many Americans. In this paper, "health insurance" refers to the various forms of payment for medical care that include a component of true insurance.

⁷ For example, *see* David M. Cutler, *YOUR MONEY OR YOUR LIFE*, CHAP. 10 (Oxford University Press, 2004); Timothy Stolfus Jost, *HEALTH CARE AT RISK*, CHAP. 11 (Durham, Duke University Press, 2007).

⁸ For example, *see* John F. Cogan, R. Glenn Hubbard, and David P. Kessler, *HEALTHY, WEALTHY, AND WISE*, CHAP. 2 (Washington, D.C., The AEI Press, 2005); Michael F. Cannon and Michael D. Tanner, *HEALTHY COMPETITION*, SECOND EDITION, INTRODUCTION (Washington, D.C., Cato Institute, 2007).

⁹ Both federal and state governments have attempted to increase access to care by providing tax incentives for employer-sponsored insurance, by providing public insurance for a growing number of Americans, by requiring insurers to offer insurance to all applicants, and by requiring insurers to include certain benefits in the policies they offer. These measures are discussed in Part 1.

¹⁰ Congress recently passed The Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act of 2010 (Reconciliation Act). *See* Pub. L. 111-148 and Pub. L. 111-152. These statutes, discussed in Part 2, extend comprehensive, third-party coverage to more Americans.

¹¹ *See* discussion and references *supra* note 3.

¹² *See* Centers for Medicare and Medicaid Services, Table I, National Health Expenditures Aggregate, Per Capita Amounts, Percent Distribution, and Average Annual Percent Growth, by Source of Funds: Selected Calendar Years 1960-2008, NHE Web Tables, Historical, National Health Expenditure Data, accessed at <http://www.cms.gov/NationalHealthExpendData/downloads/tables.pdf>.

should lead to fewer excess expenditures, greater innovation, and potentially higher quality. Finally, greater individual ownership and more options may be more effective than universal insurance at providing access to care for low-income, high-risk,¹³ and older Americans.

This paper is divided into four parts. Part 1 provides an overview of present federal and state policies and their effects on U.S. health care. Part 2 summarizes the likely effects of recent legislation designed to increase third-party coverage. Part 3 recommends a number of ways Congress and state legislators could increase individual ownership of the funds used for health care and increase people's options for insurance and care. Part 4 describes the likely effects these latter reforms would have on specific populations who may need assistance. There is a brief conclusion.

Part 1 - Effects of Federal and State Policies on U.S. Health Care

Part 1 reviews the effects that present policies have on U.S. health care under six categories: (1) tax incentives for health insurance and medical care, (2) public programs that pay for medical care (public insurance), (3) administrative regulation of private health insurance, (4) administrative regulation of professional and medical facility care, (5) administrative regulation of pharmaceuticals and devices, and (6) medical malpractice law.¹⁴ Each subpart provides a description of major policies, a brief discussion of their advantages and disadvantages, and a brief review of selected data.

The policies described in Part 1 represent only a small portion of the statutes, administrative regulations, and case law governing health care. Arguably, they do represent the most important federal and state policies that influence prices, expenditures, prevalence of health insurance, and access to care.

Tax Incentives for Health Insurance and Medical Care

Exclusion of Employer-Sponsored Insurance (ESI)

In 1943, the Internal Revenue Service (IRS) ruled that employees could exclude the value of employer-sponsored insurance (ESI) from gross income when calculating their income tax; and in 1954, Congress incorporated this exclusion into the tax code.¹⁵ However, the exclusion does not apply if an individual purchases insurance independently (ISI) or if an individual pays for medical expenses directly or "out-of pocket." As a result there is a strong incentive for individuals to obtain health insurance through their employer and a strong incentive to obtain comprehensive insurance with minimal cost sharing.

¹³ For the purpose of this paper, a high-risk individual is one who because of a genetic variation, chronic disease, or other condition is more likely to incur large medical expenses than the general population.

¹⁴ During the latter half of the twentieth century, the number and monetary value of medical malpractice lawsuits increased. As a result, medical malpractice law now has an important effect on health care prices, health care expenditures, and access to care. For a description of the increase in malpractice lawsuits since 1960, *see* Paul C. Weiler, *MEDICAL MALPRACTICE ON TRIAL*, CHAP. 1 (Harv. Univ. Press 1991).

¹⁵ *See* Tom Miller, Joint Economic Committee, *How the Tax Exclusion Shaped Today's Private Health Insurance Market* (Dec. 17, 2003), accessed at http://www.aei.org/docLib/20070222_Millerarticle.pdf.

By allowing individuals to pay for much of their care with pre-tax dollars, the exclusion of ESI from gross income increases access to both insurance and care for many people. In addition, ESI has advantages over ISI independent of tax advantages.¹⁶ For example, employment may be a good means for pooling risk, and employers may be able to decrease employee transaction costs, e.g., the cost for employees to search and bargain for insurance and the cost of claims administration.¹⁷ On the other hand, an employer may offer insurance that does not meet the employee's needs, and ESI is usually not portable from one employer to another.

In addition, the disparate tax treatment of ESI, ISI, and out-of-pocket expenses increases prices for both insurance and care. Because the exclusion for ESI allows employees to pay for insurance with pre-tax dollars, health insurance is less "costly" for an employee than the employee's other expenses.¹⁸ Because an employer is paying for an employee's insurance, the costs are "hidden" from the employee, i.e., the employee is often unaware of the actual cost of the insurance. Finally, the differential nature of the tax exclusion makes insurance less costly to an employee than out-of-pocket expenses. Each of these factors increases the demand for both insurance and care, and greater demand usually results in higher prices and larger expenditures. While higher prices are costly for all, they are especially costly for individuals without ESI, who must pay for insurance and care with after-tax dollars.

Comprehensive health plans with minimal cost sharing have other disadvantages. Since individuals do not own the funds that pay for their care, they have less flexibility to choose the care that best meets the needs of their particular situation. For example, one's health plan may cover care an individual does not need, but not cover care one does need.

Finally, third-party payment for most care affects the physicians and medical facilities that provide care. When a third party is paying, both physicians and medical facilities in a sense serve two masters, a patient and a third-party payer. While essentially all physicians and facilities attempt to provide the best possible care for an individual patient, third-party payment decreases both the incentive and flexibility of physicians and medical facilities to develop innovative ways to provide more cost-effective care.

In 2007, 177.4 million people, 59.3 percent of the population, were covered by employment-based insurance.¹⁹ Between 1988 and 2007, the price of employer-sponsored insurance increased at a greater rate than the consumer price index.²⁰ In 2009, the average price of single coverage ESI was \$4,824 per year, and the average price of family coverage ESI was \$13,375 per year.²¹ The Centers for Medicare and Medicaid Services estimated that in 2008, Americans spent \$2.34 trillion on health care, approximately 16.2 percent of GDP.²²

¹⁶ For example, see David A. Hyman and Mark Hall, Two Cheers for Employment-Based Health Insurance, 2 Yale J. Health Policy L. Ethics 23 (2001).

¹⁷ *Id.*

¹⁸ One who pays for health insurance with pre-tax dollars incurs less opportunity cost than one who pays the same price with post-tax dollars.

¹⁹ See Carmen DeNavas-Walt, Bernadette D. Proctor, and Jessica C. Smith, Income, Poverty, and Health Insurance Coverage in the United States: 2007, Current Population Reports: Consumer Income, PGO - 235, U.S. Census Bureau (Aug., 2008), accessed at <http://www.census.gov/prod/2008pubs/p60-235.pdf>.

²⁰ See The Kaiser Family Foundation and Health Research and Educational Trust, *supra* note 3.

²¹ See The Kaiser Family Foundation and Health Research and Educational Trust, Cost of Health Insurance, EMPLOYER HEALTH BENEFITS: 2009 ANNUAL SURVEY 14, accessed at

Additional Tax Preferences

Since enacting the exclusion of ESI from gross income, Congress and the IRS have created additional incentives that partially equalize the disparate tax treatment of ESI, ISI, and out-of-pocket expenses. For example, flexible spending accounts (FSAs)²³ and health reimbursement arrangements (HRAs)²⁴ allow some employees to purchase individual insurance and pay out-of-pocket expenses with pre-tax dollars. In addition, health savings accounts (HSAs) allow persons who meet certain criteria to pay out-of-pocket expenses with pre-tax dollars.²⁵

An HSA is an account, established with a financial institution, into which an individual can place pre-tax dollars and later withdraw these funds tax free to pay directly for medical expenses.²⁶ HSA funds can be invested, carried from year to year to pay for future expenses, and left to one's heirs. However, there are annual limits to HSA contributions, one cannot purchase health insurance with HSA funds, and to establish an HSA, one must maintain a high-deductible health plan (HDHP) and no other health plan.

The primary advantage of an HSA is that it allows either employed or unemployed individuals to use pre-tax dollars to pay for out-of-pocket expenses. Because an HSA owner pays directly for much of his/her care, there is a greater incentive to choose care based on quality and price. Similar to the tax preference for ESI, the use of an HSA provides a larger benefit for a high-income person than for a low-income person and decreases federal tax revenue. However, the lost revenue is small compared to the lost revenue associated with the exclusion from gross income of ESI.

As of January, 2009, 8.0 million Americans were covered by an HDHP associated with an HSA.²⁷ One study found that premiums for HSA-qualified HDHPs were 10 to 40 percent less than premiums for other plans.²⁸

Public Programs That Pay for Medical Care (Public Insurance)

In 1965, Congress created Medicare and Medicaid.²⁹ Medicare is a federal program that pays for medical services and products for Americans 65 years of age and older.³⁰ Medicaid,

<http://ehbs.kff.org/?CFID=5435011&CFTOKEN=26417390&jsessionid=60307c63c88d1bf4ef22142b4a5c31341c58>.

²² See Centers for Medicare and Medicaid Services, *supra* note 12.

²³ 26 U.S.C. § 125; *see also* Internal Revenue Service, Employee Benefits – Cafeteria Plans; Proposed Rule, 26 CFR Part 1, 72 Fed. Reg. No. 150, 43938 (Aug. 6, 2007); J.P. Wieske, *Benefiting Cities: How Cafeteria Plans Enhance City Benefits While Saving Taxpayers Money*, CAHI Issues and Answers No. 149, Council for Affordable Health Insurance (July, 2008), accessed at http://www.cahi.org/cahi_contents/resources/pdf/n149Section125Plans.pdf.

²⁴ See Internal Revenue Service, *Health Reimbursement Arrangements*, Notice 2002 – 45, 2002 – 28 I.R.B.

²⁵ 26 U.S.C. § 223.

²⁶ *Id.*

²⁷ AHIP Center for Policy and Research, *January 2009 Census Shows 8 Million People Covered by HSA/High-Deductible Health Plans*, *America's Health Insurance Plans* (May, 2009), accessed at <http://www.ahipresearch.org/pdfs/2009hsacensus.pdf>.

²⁸ See Benjamin Zycher, *HSA Health-Insurance Plans After Four Years: What Have We Learned?* Medical Progress Report No. 8, Manhattan Institute for Policy Research (Feb., 2009). Since HSA plans have higher deductibles, total health care expenses may be greater for some HSA owners.

²⁹ Pub. L. 89-97.

jointly funded by the federal and state governments, pays for medical services and products for low-income persons who meet certain criteria.³¹ In 1997, Congress created the State Children's Health Insurance Program (S-CHIP).³² S-CHIP pays for medical services and products for certain low-income children who are not eligible for Medicaid.

As with the tax exclusion for ESI, the primary advantage of public insurance is that it increases access to care for some persons who otherwise may not have access. In addition, providing public insurance should decrease the amount of care for which there is no compensation,³³ decrease cost-shifting between uninsured and insured patients,³⁴ and potentially decrease inappropriate use of emergency departments.³⁵ On the other hand, because of low payment rates and other factors, some physicians may not accept public insurance beneficiaries, and public insurance may "crowd out" private insurance. Because these public programs sometimes provide less than ideal access to care, individuals who replace private insurance with public insurance may have less access to care than they had prior to enrolling.

There are other disadvantages. Public programs are inherently subject to political influence. Types of care covered, payment rates, and other items are determined by Congress, a state legislature, or an administrative body, all of which are subject to political influence. Also, similar to the tax preference for ESI, public insurance increases the demand for care, and greater demand usually results in higher prices. High prices are especially a problem for low-income and high-risk individuals who do not have access to ESI and do not qualify for public insurance.

Finally, public insurance requires government funding, and the taxation necessary to support public insurance entails a number of costs in addition to the cost of the funds collected. For example, taxation costs include the federal or state agency cost to collect taxes,³⁶ taxpayer costs to comply with the tax code,³⁷ and less visible costs resulting from incentives engendered

³⁰ See The Henry J. Kaiser Family Foundation, Medicare: A Primer (Jan., 2009), accessed at <http://www.kff.org/medicare/upload/7615-02.pdf>.

³¹ See The Kaiser Commission on Medicaid and the Uninsured, Medicaid: A Primer (Jan., 2009), accessed at <http://www.kff.org/medicaid/upload/7334-03.pdf>.

³² See Kaiser Commission on Medicaid and the Uninsured, State Children's Health Insurance Program (SCHIP) at a Glance, Key Facts # 7610, The Henry J. Kaiser Family Foundation (Jan. 2007), accessed at <http://www.kff.org/medicaid/upload/7610.pdf>.

³³ Hadley et al. estimated that total U.S. uncompensated care in 2008 was \$54.3 billion, 2.2 percent of total health care spending. See Jack Hadley, et al., Covering the Uninsured in 2008: A Detailed Examination of Current Costs and Sources of Payment, and Incremental Costs of Expanding Coverage, Kaiser Commission on Medicaid and the Uninsured (Aug., 2008), accessed at <http://www.kff.org/uninsured/upload/7809.pdf>.

³⁴ Hadley et al. estimated that the amount of cost shifting from uninsured patients to privately insured patients in 2008 was less than 1 percent of total private health insurer costs. See Hadley et al., supra note 33.

³⁵ In a recent review of the existing literature, Newton et al. found that uninsured individuals were being seen in emergency departments more than in the past, but the rate of increase was similar to that of insured persons. See Newton et al., 300(16) JAMA 1914 (2008).

³⁶ One can estimate the percentage of agency costs attributable to a federal program funded by income taxes by multiplying the cost of the Internal Revenue Service (IRS) by the percentage of the federal budget the program represents.

³⁷ Moody et al. estimated that Americans would spend \$265.1 billion complying with the income tax code in 2005, \$148 billion for businesses, \$111 billion for individuals, and \$7 billion for non-profit organizations. See J. Scott Moody, Andy P. Warcholik, and Scott A Hodge, The Rising Cost of Complying with the Federal Income Tax, Tax Foundation Special Report No. 138 (Dec., 2005).

by the tax code.³⁸ Also, because these public programs represent a large and growing portion of federal and state budgets, they may not be sustainable.

Data suggest that becoming eligible for Medicaid increases the likelihood that a newly eligible beneficiary will see a physician,³⁹ and some data suggest that becoming eligible for Medicaid improves health.⁴⁰ On the other hand, less than 60 percent of U.S. physicians accept all new Medicaid patients.⁴¹ While most data suggest that physician acceptance rate for Medicare beneficiaries is equivalent to that of privately insured individuals,⁴² in some locations, Medicare beneficiaries also may have difficulty finding a physician.⁴³

Studies have shown that the crowd-out rate for Medicaid and S-CHIP is large.⁴⁴ One study found that for every 100 newly eligible individuals who enrolled in public insurance after eligibility expansion, 60 fewer persons were enrolled in private insurance.⁴⁵

In 2007, Medicare Part A covered almost 44 million beneficiaries, and Medicaid covered more than 56 million beneficiaries.⁴⁶ Total federal expenditures for Medicare were \$431.5 billion

³⁸ Feldstein described three types of costs resulting from incentives produced by increasing the U.S. tax rate on labor income: (1) the loss of labor input resulting from less incentive to invest in education, training, or longer hours of work, (2) the loss of value to an employee who takes compensation in a form the employee would not otherwise choose, e.g., health insurance benefits, and (3) the loss of value to an employee who spends income on tax-deductible items the employee would not otherwise choose, e.g., interest payments on a home mortgage. Using IRS data from 2000, Feldstein estimated that the “deadweight loss” of these three costs, resulting from a one percent increase in marginal income tax rates, would be 76 percent of the revenue obtained. Thus, in addition to IRS agency costs, taxpayer compliance costs, and the cost to taxpayers of the revenue obtained, there may be additional costs of up to \$ 0.76 for every additional dollar of revenue. *See* Martin A Feldstein, *The Effect of Taxes on Efficiency and Growth*, Tax Notes 679 (May 8, 2006).

³⁹ Janet Currie and Jonathan Gruber, *Health Insurance Eligibility, Utilization of Medical Care, and Child Health*, 111 *Quart. J. of Econ.* 431 (1996); Laurence C. Baker and Anne Beeson Royalty, 35 *J. Human Res.* 480 (2000).

⁴⁰ *See* Currie and Gruber, *supra* note 39. *See also* Helen Levy and David Meltzer, *The Impact of Health Insurance on Health*, 29 *Ann. Rev. of Pub. Health* (2008).

⁴¹ *See* Peter Cunningham and Jessica May, *Medicaid Patients Increasingly Concentrated Among Physicians*, Tracking Report No. 16, Center for Studying Health System Change (Aug., 2006), accessed at <http://www.hschange.com/CONTENT/866/866.pdf>.

⁴² For example, *see* Peter Cunningham, Andrea Staiti, and Paul B. Ginsburg, *Physician Acceptance of New Medicare Patients Stabilizes in 2004-05*, Tracking Report No. 12, Center for Studying Health System Change (Jan., 2006), accessed at <http://www.hschange.com/CONTENT/811/811.pdf>.

⁴³ For example, *see* Rosylind Frazier and Mark Foster, *How Hard Is It for Alaska’s Medicare Patients to Find Family Doctors?* UA Research Summary No. 14, Institute of Social and Economic Research, University of Alaska Anchorage (Mar., 2009), accessed at http://www.iser.uaa.alaska.edu/Publications/researchsumm/UA_RS14.pdf.

⁴⁴ *See* David M. Cutler and Jonathan Gruber, *Does Public Insurance Crowd Out Private Insurance?*, 111 *Quart. J. Econ.* 391 (1996); Lara Shore-Sheppard, Thomas C. Buchmueller, and Gail A. Jensen, *Medicaid and Crowding Out of Private Insurance: A Re-examination Using Firm Level Data*, 19 *J. Health Econ* 61 (2000); Anthony T. LoSasso, Thomas C. Buchmueller, *The Effect of State Children’s Health Insurance Program on Health Insurance Coverage*, NBER Working Paper 9405 (Dec., 2002); Jonathan Gruber and Kosali Simon, *Crowd-out Ten Years Later: Have Recent Public Insurance Expansions Crowded Out Private Health Insurance?*, NBER Working Paper No. 12858 (Jan., 2007).

⁴⁵ *See* Gruber and Simon, *supra* note 44.

⁴⁶ *See* Erik Dirk Hoffman, Barbara S. Klees, and Catherine A. Curtis, Office of the Actuary, Centers for Medicare and Medicaid Services, *Brief Summaries of Medicare and Medicaid* (Nov. 1, 2008), accessed at <http://www.cms.gov/MedicareProgramRatesStats/downloads/MedicareMedicaidSummaries2008.pdf>.

(3.2 percent of GDP), total federal and state expenditures for Medicaid were \$335.8 billion, and total federal and state expenditures for S-CHIP were \$8.8 billion.⁴⁷

The Medicare Boards of Trustees estimate that if Medicare benefits remain the same as those to which present beneficiaries are now entitled, by 2083, Medicare expenditures will represent 11.4 percent of GDP.⁴⁸ The Centers for Medicare and Medicaid Services estimate that by 2013, Medicaid expenditures will increase to \$523 billion.⁴⁹ These estimates do not include the additional cost to society of the taxation necessary to generate the funds (see above).

Administrative Regulation of Private Health Insurance

During the latter half of the twentieth century, both federal and state governments enacted a number of laws that affect private health insurance. In 1974, Congress passed the Employee Retirement Income Security Act (ERISA).⁵⁰ ERISA provides a uniform regulatory structure for multi-state companies that provide welfare benefit plans for their employees. Under ERISA, if an employer self-insures for health care, i.e., assumes the risk and pays directly for care, the employer's plan is governed by ERISA instead of by a state's insurance regulations. Because ERISA's regulatory structure is less stringent than that of many states, many large employers self insure.⁵¹

In 1986, Congress enacted the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985.⁵² COBRA requires employers to offer a terminating employee continuation coverage at 102 percent of the cost of coverage for a similarly-situated continuing employee. In 1996, Congress enacted the Health Insurance Portability and Accountability Act (HIPAA).⁵³ HIPAA contains a number of health insurance provisions prohibiting discrimination based on health status and requiring individual and small group insurers to make insurance available to certain populations.

States regulate private health insurance if it is not governed by ERISA. Some states restrict insurer underwriting, i.e., the process of determining the risk of an applicant, whether to offer insurance, and the premium to be charged. For example, some states require insurers to issue health insurance to applicants regardless of health status, a requirement known as *guaranteed issue*;⁵⁴ some states require insurers to renew an insurance policy when the policy expires, a requirement known as *guaranteed renewal*; and some states require insurers to charge

⁴⁷ *Id.*

⁴⁸ See The Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, The 2009 Annual Report 4 (May 12, 2009), accessed at <http://www.cms.hhs.gov/reportstrustfunds/downloads/tr2009.pdf>.

⁴⁹ See Hoffman, Klees, and Curtis, *supra* note 46.

⁵⁰ Pub. L. 93-406.

⁵¹ See Richard Briffault and Sherry Glied, Federalism and the Future of Health Care Reform, in *THE PRIVATIZATION OF HEALTH CARE REFORM*, 49 (M. Gregg Bloche, ed., 2003).

⁵² Pub. L. 99-272.

⁵³ Pub. L. 104-191.

⁵⁴ In 2006, ten states required some form of guaranteed issue in the individual insurance market. See Merrill Mathews, Victoria Craig Bunce, and J. P. Wieske, *State Health Insurance Index 2006: Methodology* (Alexandria, VA: Council for Affordable Health Insurance, Nov., 2006), accessed at http://www.cahi.org/cahi_contents/resources/pdf/StateIndexMethodology.pdf.

all insured individuals the same price regardless of their risk of incurring medical expenses, a requirement known as *community rating*.⁵⁵ In addition, all states require insurers to either offer or include certain benefits in the policies they sell.⁵⁶ For example, states may require insurers to offer or include reimbursement for in vitro fertilization, the treatment of alcoholism, or the treatment of drug abuse.

Underwriting Restrictions

Because community rating without guaranteed issue may result in the exclusion of high-risk persons, states that require community rating usually require guaranteed issue as well. The primary advantage of requiring both guaranteed issue and community rating is that high-risk persons are more able to obtain health insurance at an affordable price. The primary disadvantage is that guaranteed issue plus community rating increases prices for others.

Guaranteed issue, combined with community rating, increases prices for average-risk persons for several reasons. First, insurers may incur additional compliance costs. More importantly, because high-risk persons are likely to incur more medical expenses, claims costs increase. Third, because greater claims costs increase insurance prices, low-risk persons may not purchase insurance until they become sick. As a result, guaranteed issue plus community rating may lead to a risk pool skewed to high-risk persons, further increasing prices.

Studies show that guaranteed issue at community-rated prices increases the prevalence of health insurance among the high-risk population, but decreases prevalence among the general population.⁵⁷ In one study, investigators estimated that within the individual health insurance market, the net effect was a lower overall prevalence of 6.0 to 7.4 percent.⁵⁸

In a 2004 study, one investigator estimated the benefits and costs of insurance market reforms that included guaranteed issue and community rating. He estimated that the annual expected benefits were \$3.1 billion, and the expected costs were \$5.4 billion.⁵⁹

Benefit Mandates

The primary advantage of benefit mandates is that they increase access to care for persons who need the care for which payment is mandated. However, because mandates result in higher insurance prices, they decrease access for those who do not need the specified care.

⁵⁵ Under pure community rating, insurers may not vary premiums. Under modified community rating, insurers may vary premiums based on factors such as age, but not on health status. In 2006, seven states required some form of community rating in the individual insurance market. *See* Mathews, Bunce, and Wieske, *supra* note 54.

⁵⁶ *See* Victoria Craig Bunce, J.P. Wieske, and Vlasta Prikazsky, Health Insurance Mandates in the States 2007, Council for Affordable Health Insurance, (Feb., 2007), accessed at http://www.cahi.org/cahi_contents/resources/pdf/MandatesInTheStates2007.pdf.

⁵⁷ For example, *see* Amy Davidoff, Linda Blumberg, and Len Nichols, State Health Insurance Market Reforms and Access to Insurance for High-Risk Employees, 24 *J. Health Econ.* 725 (2005); Bradley Herring and Mark V. Pauly, The Effect of State Community Rating Regulations on Premiums and Coverage in the Individual Health Insurance Market, NBER Working Paper 12504 (Aug., 2006).

⁵⁸ *See* Herring and Pauly, *supra* note 57.

⁵⁹ *See* Christopher J. Conover, Health Care Regulation: A \$169 Billion Hidden Tax, Policy Analysis No. 527, Cato Institute (Oct. 4, 2004).

Benefit mandates increase prices for several reasons. First, insurers may incur compliance costs. More importantly, because insurers must include additional benefits, claims costs increase. Third, similar to guaranteed issue plus community rating, individuals who do not benefit from the mandate are more likely to forgo purchasing insurance, potentially skewing the risk pool toward patients who require the specified care. Finally, mandates increase the amount of care paid by a third party, increasing the risk that patients will be less careful concerning their health,⁶⁰ and increasing the incentive for patients and physicians to use resources even if the potential benefit is less than the cost.

Studies show that most additional benefits increase insurance prices.⁶¹ In addition, data suggest that mandated benefits decrease the prevalence of insurance in the individual insurance market⁶² and decrease the probability that an employer will provide insurance for employees.⁶³ One study found that mandated benefits decrease the overall prevalence of health insurance, each mandate decreasing the probability of being insured by 0.4 percent.⁶⁴ Finally, one investigator estimated in 2004 that the annual expected benefits of benefit mandates were \$17.1 billion, while the expected costs were \$30.6 billion.⁶⁵

Administrative Regulation of Professional and Facility Care

During the latter half of the nineteenth century, states began licensing physicians,⁶⁶ and in the latter half of the twentieth century, states began licensing and developing scope of practice rules for a number of newly-created health professions.⁶⁷ Today, states regulate professional care in three primary areas: (1) licensing requirements that establish the minimal qualifications for one to practice a profession, (2) scope of practice rules that establish what a professional is allowed to do, and (3) disciplinary rules for professionals who violate either ethical or competence standards.⁶⁸

Following the establishment of Medicare in 1965, Congress began actively regulating hospitals and other medical facilities. For example, to receive payment for treatment of Medicare beneficiaries, hospitals and other facilities must meet certain “Conditions of Participation” and sign provider agreements, both of which entail extensive facility regulation.⁶⁹ During the 1980s,

⁶⁰ For example, *see* Jonathan Klick and Thomas Stratmann, *Subsidizing Addiction: Do State Health Insurance Mandates Increase Alcohol Consumption?* 35 *J. Leg. Studies* 175 (Jan. 2006); Jonathan Klick and Thomas Stratmann, *Diabetes Treatments and Moral Hazard*, 50 *J. Law and Econ.* 519 (Aug., 2007).

⁶¹ For example, *see* Gail A. Jensen and Michael A. Morrissey, *Group Health Insurance: A Hedonic Price Approach*, 72 *Rev. Econ. and Statistics* 38 (1990).

⁶² *See* Frank A. Sloan and Christopher J. Conover, *Effects of State Reforms on Health Insurance Coverage of Adults*, 35 *Inquiry* 280 (1998).

⁶³ *See* Gail A. Jensen and Michael A. Morrissey, *Small Group Reform and Insurance Provision by Small Firms*, 36 *Inquiry* 176 (1999).

⁶⁴ *See* Sloan and Conover, *supra* note 62.

⁶⁵ *See* Conover, *supra* note 59.

⁶⁶ *See* Starr, *BOOK 1, CHAP. 3*, *supra* note 6.

⁶⁷ *See* Richard A. Cooper, Tim Henderson, and Craig L. Dietrich, *Roles of Nonphysician Clinicians as Autonomous Providers of Patient Care*, 280 *JAMA* 795 (1998); Gary L. Gaumer, *Regulating Health Professionals: A Review of the Empirical Literature*, 62 *The Milbank Memorial Fund Quarterly, Health and Society*, 380 (1984).

⁶⁸ *See* Barry R. Furrow, et al., *HEALTH LAW, SEC. ED., CHAP. 3* (St. Paul, West Group, 2000).

⁶⁹ 42 U.S.C. § 1395cc; *See also* Furrow, et al., *CHAPS. 1 and 11*, *supra* note 68.

Congress enacted legislation authorizing comprehensive regulation of skilled nursing facilities⁷⁰ and clinical laboratories.⁷¹

In the late 1960s and early 1970s, states began requiring hospitals and other facilities to obtain a certificate of need (CON) before expanding facilities or purchasing major equipment.⁷² In 1974, Congress passed the National Health Planning and Resources Development Act (NHPDA), conditioning federal funds on the establishment of CON programs.⁷³ Congress repealed the NHPDA in 1986; however, 36 states and the District of Columbia continue to maintain CON programs for certain types of facility expansion.⁷⁴

Finally, in 1996, Congress passed the Health Insurance Portability and Accountability Act (HIPAA). One component of HIPAA authorized the Department of Health and Human Services (HHS) to issue regulations concerning the security and privacy of personal health information.⁷⁵ Compliance with the Privacy Rule was required in April, 2003.⁷⁶

Most administrative regulations involving professional and facility care were designed to improve the quality of professionals or the quality of care they provide. Their primary benefit is that they may result in higher quality care, e.g., fewer injuries from substandard care. A few regulations were designed to control costs, e.g., CON rules and Medicare's utilization review requirements. A potential benefit of these regulations is that professionals and facilities may use fewer unnecessary resources. Finally, the primary benefit of the Privacy Rule is that there may be fewer infringements on the confidentiality of patient health information.

However, there are costs to each of these regulations. Compliance with most regulations increases the cost of providing a good or service. For example, preparing CON applications requires significant personnel time and sometimes legal assistance, and compliance with the Privacy Rule may require additional computer equipment or a change in billing operations.

In addition, some administrative regulations specifically decrease the entry of competitors. For example, stringent licensing and scope of practice rules may prevent qualified personnel from providing certain types of care, and CON rules may prevent qualified facilities from obtaining the equipment they need to provide certain types of care. Similar to higher costs, limited competitor entry results in a smaller supply of care, and a smaller supply usually results in higher prices.

⁷⁰ Pub. L. No. 100-203.

⁷¹ Pub. L. No. 100-578.

⁷² See Patrick John McGinley, Beyond Health Care Reform: Reconsidering Certificate of Need Laws in a Managed Competition System, 23 Fl. St. L. Rev. (1995).

⁷³ Pub. L. No. 93-641.

⁷⁴ American Health Planning Association, Certificate of Need, accessed at <http://www.ahpanet.org/copn.html>.

⁷⁵ Pub. L. No. 104-191.

⁷⁶ See Don W. King, FEDERAL HEALTH CARE REGULATION, CHAP. 9, Policy Resource No. 2, Mercatus Center (Mar., 2006), accessed at http://www.mercatus.org/uploadedFiles/Mercatus/Publications/20060511_Federal_Health_Care_Regulation_King_April_2006_Final_as_Posted.pdf.

A number of empirical studies have shown that strict licensing and strict scope of practice rules increase prices for professional care.⁷⁷ Other studies suggest that nurse practitioners are able to provide high quality care in both primary care and low-risk labor and delivery settings.⁷⁸

During the 1980s, the Federal Trade Commission conducted a series of studies of CON programs. These studies showed that CON rules do not decrease hospital costs, but in some cases increase them.⁷⁹ Studies of the effects of CON laws on quality of care are mixed. Most studies suggest they have no effect on quality.⁸⁰ However, some studies suggest they improve quality,⁸¹ and others suggest they decrease quality.⁸²

One investigator estimated in 2004 that the annual expected benefits of professional quality regulation were \$5.7 billion, while the expected costs were \$7.7 billion.⁸³ In the same study, he estimated that the annual expected benefits of medical facility quality regulation were \$4.0 billion, while the expected costs were \$21.8 billion.

Administrative Regulation of Pharmaceuticals and Devices

In the early twentieth century, Congress began regulating pharmaceuticals, first with the Biologics Act in 1902,⁸⁴ followed by the Pure Food and Drugs Act of 1906.⁸⁵ In 1962, Congress amended the Federal Food, Drug, and Cosmetics Act (FFDCA), for the first time requiring pharmaceutical companies to obtain approval from the Federal Food and Drug Administration (FDA) before releasing a new drug to the U.S. market.⁸⁶ To gain approval, a pharmaceutical

⁷⁷ See Lawrence Shepard, Licensing Restrictions and the Cost of Dental Care, 21 J.L. & Econ. 187 (1986); Deborah Haas-Wilson, The Effect of Commercial Practice Restrictions: The Case of Optometry, 29 J.L. & Econ. 165 (1986); William D. White, The Impact of Occupational Licensure of Clinical Laboratory Personnel, 13 J. Hum. Res. 91 (1978); Frank A. Sloan and Bruce Steinwald, HOSPITAL LABOR MARKETS, CH. 3 (Lexington, MA, D.C. Heath and Company, 1980).

⁷⁸ See Judith Rooks, et al., Outcomes of Care in Birth Centers: The National Birth Center Study, 321 New Engl. J. Med. 1804 (1989); A. Mark Durand, The Safety of Home Birth: The Farm Study, 82 Am. J. Pub. Health 450 (1992); U.S. Congress, Office of Technology Assessment, Nurse Practitioners, Physician Assistants, and Certified Nurse-Midwives: A Policy Analysis (Health Technology Case Study 37), OTA-HCS-37 (Dec. 1986).

⁷⁹ See Keith B. Anderson and David J. Kass, Certificate of Need Regulation of Entry into Home Health Care, Bureau of Economics Staff Report to the Federal Trade Commission (Jan. 1986); Daniel Sherman, The Effect of State Certificate-of-Need Laws on Hospital Costs, Bureau of Economics Staff Report to the Fed. Trade Commission (Jan. 1988); C.J. Conover and F.A. Sloan, Does Removing Certificate-of-Need Regulations Lead to a Surge in Health Care Spending? 23 J. Health Politics, Policy & Law 455 (June, 1998). See also Federal Trade Commission/Department of Justice, Miscellaneous Subjects, in IMPROVING HEALTH CARE: A DOSE OF COMPETITION, Ch. 8 (July 23, 2004).

⁸⁰ For example, see J.L. Robinson, D.B. Nash, E. Maxey, et.al., Certificate of Need and the Quality of Cardiac Surgery, 16 Am. J. Med. Qual. 155 (2001); Iona Popescu, Mary S. Vaughan-Sarrazin, and Gary Rosenthal, Certificate of Need Regulations and Use of Coronary Revascularization after Acute Myocardial Infarction, 295 JAMA 2141 (2006).

⁸¹ For example, see Mary S. Vaughan-Sarrazin et al., Mortality in Medicare Beneficiaries Following Coronary Artery Bypass Graft Surgery in States with and without Certificate of Need Regulation, 288 JAMA 1859 (2002).

⁸² For example, see S.M. Shortell and E.F. Hughes, The Effect of Regulation, Competition, and Ownership on Mortality Rates Among Hospital Inpatients, 318 New Engl. J. Med. 1100 (1988).

⁸³ See Conover, *supra* note 59.

⁸⁴ Pub. L. No. 57 - 244.

⁸⁵ Pub. L. No. 59 - 384.

⁸⁶ The FFDCA was enacted in 1938; see Pub. L. No.75 - 717. Prior approval was not required until 1962. Pub. L. No. 87 - 781.

company must demonstrate, based on controlled studies, that a new drug is both safe and effective for at least one clinical indication. Subsequently, the FDA developed detailed regulations governing all aspects of new drug development.⁸⁷

The primary benefit of requiring pharmaceutical companies to obtain approval prior to marketing a new drug is that there may be fewer injuries caused by medications. In addition, by avoiding the use of drugs that would not have been effective, there may be fewer unnecessary expenditures.

Potential costs include the cost for the FDA to develop regulations governing the requirement, to evaluate applications for approval, and to determine for or against approval. More importantly, there are large costs for a pharmaceutical company to comply with the requirement.

In addition, there may be costs that are difficult to quantify. For example, under the requirement for prior approval, a safe and effective drug may not be approved, it may be delayed, or it may be less affordable because large compliance costs resulted in higher prices. If requiring prior approval prevents the use of a drug in a patient in whom it would have been safe and effective, there may be greater morbidity or even mortality.

In one study, investigators estimated that for each new drug approved between 1990 and 2001, pharmaceutical companies had an expected research and development cost of \$802 million.⁸⁸ Other investigators estimated that the expected cost of approval for a new drug entering human trials between 1989 and 2002 was \$868 million.⁸⁹ While the research and development necessary to bring a new drug to the market is costly even without the requirement for prior approval, regulatory compliance is likely an important component of total cost.⁹⁰ Finally, one investigator estimated in 2004 that the annual expected benefits of pharmaceutical and medical device regulation were \$7.1 billion, while the expected costs were \$49.0 billion.⁹¹

Medical Malpractice Law

Medical malpractice law is the branch of law that allows a patient who has suffered an injury caused by a physician or other professional to recover damages from the one or more professionals who caused the injury. Because most diagnostic and therapeutic actions taken by physicians carry a risk of injury, malpractice law holds physicians liable only if the physician's actions were below a customary or "reasonable" standard of care.⁹²

⁸⁷ See King, CHAP. 6, supra note 76.

⁸⁸ See Joseph A. Dimasi, Ronald W. Hansen, and Henry G. Grabowski, The Price of Innovation: New Estimates of Drug Development Costs, 22 J. Health Econ. 151 (2003).

⁸⁹ See Christopher P. Adams and Van V. Brantner, Estimating the Cost of New Drug Development: Is It Really \$802 million?

⁹⁰ Many of the new drugs used to treat HIV infection had lower pre-approval costs. Lower costs were likely a result of less stringent regulatory requirements. See Adams and Brantner, supra note 89.

⁹¹ See Conover, supra note 59.

⁹² See Philip G. Peters, Jr., The Quiet Demise of Deference to Custom: Malpractice Law at the Millennium, 57 Wash. & Lee L. Rev. 163 (2000).

Throughout American history, the number of medical malpractice cases has varied.⁹³ However, beginning around 1960, the number and monetary value of malpractice cases and damage awards increased,⁹⁴ especially during the mid-1970s, the mid-1980s, and the first decade of the twenty-first century.⁹⁵ Primarily because of increasing malpractice insurance premiums, many states have made changes to their malpractice law.⁹⁶

The benefits of malpractice law include the value of damage awards received by patients injured by substandard care and the value of injuries deterred by malpractice law's incentives for safer care. Costs include the cost for both patients and physicians to prepare and defend cases and the cost to physicians of damage awards to patients.

In addition, there likely are costs resulting from other incentives engendered by malpractice law. Defensive medicine refers to two types of physician actions. To avoid a lawsuit, physicians may use resources they otherwise would not use, e.g., they may order additional diagnostic tests or perform additional procedures. Also to avoid a lawsuit, physicians may limit their practice, e.g., discontinue labor and delivery care.

There have been numerous empirical studies of medical malpractice law. The best available data suggest that most patients who suffer injuries resulting from substandard care do not sue, and many patients who sue have not been injured by substandard care.⁹⁷ For example, in two large studies, less than 3 percent of patients injured by substandard care brought suit, and less than 25 percent of patients who brought suit had been injured by substandard care.⁹⁸

In addition, many data suggest that of those cases in which a lawsuit is filed, there is not a strong correlation between substandard care and outcome of the suit.⁹⁹ For example, in six studies of patients who brought suit, physicians made payments to patients in 56 to 96 percent of cases that involved substandard care, but also in 21 to 42 percent of patients when substandard care had not occurred.¹⁰⁰ Finally, some data suggest that reforms which decrease the expected

⁹³ See Kenneth Allen Deville, *Medical Malpractice in Nineteenth-Century America*, CHAPS. 1, 2, AND 8 (New York, New York University Press); see also Weiler, supra note 14.

⁹⁴ See Weiler, supra note 14.

⁹⁵ See David M. Studdert, Michelle M. Mello, and Troyen A. Brennan, *Medical Malpractice*, 350 *N. Engl. J. Med.* 283 (2004).

⁹⁶ *Id.*

⁹⁷ These studies used retrospective physician chart review to determine which adverse events were caused by substandard care and which were not. Determining whether adverse events are the result of substandard care is subject to dispute and error, whether determination is made by physician chart review or by a jury. As a result, one must use caution in interpreting these studies. See A. Russell Localio et al., *Relation Between Malpractice Claims and Adverse Events Due to Negligence*, 325 *N. Engl. J. Med.* 245 (1991); David M. Studdert et al., *Negligent Case and Malpractice Claiming Behavior in Utah and Colorado*, 38 *Med. Care* 250 (2000).

⁹⁸ See discussion and references, F.N. No. 97.

⁹⁹ See F.W. Cheney et al., *Standard of Care and Anesthesia Liability*, 261 *JAMA* 1599 (1989); Henry S. Farber and Michelle J. White, *Medical Malpractice: An Empirical Examination of the Litigation Process*, 22 *The RAND J. Econ.* 199 (1991); Mark I. Taragin et al., *The Influence of Standard Care and Severity of Injury on the Resolution of Medical Malpractice Claims*, 117 *Ann. Int. Med.* 780 (1992); T.A. Brennan et al., *Relation Between Negligent Adverse Events and the Outcome of Medical-Malpractice Litigation*, 335 *N. Engl. J. Med.* 1963 (1996); Ralph Peeples, et al, *The Process of Managing Medical Malpractice Cases: The Role of Standard of Care*, 37 *Wake Forest L. Rev.*, 877 (2002); David Studdert et al., *Claims, Errors, and Compensation Payments in Medical Malpractice Litigation*, 354 *N. Engl. J. Med.* 2024 (2006).

¹⁰⁰ See references, F.N. No. 99.

payout of damage awards, e.g., caps on either total or non-economic damages, result in less resource use¹⁰¹ and greater physician supply.¹⁰²

Each year, Towers Perrin estimates the cost of malpractice awards, physician compliance costs, and malpractice insurance costs, but not the cost of defensive medicine. In 2007, Towers Perrin estimated these costs to be \$30.4 billion.¹⁰³ One investigator estimated in 2004 that the total annual expected benefits of state medical tort law were \$33.0 billion while the expected costs, including the cost of defensive medicine, were \$113.7 billion.¹⁰⁴

Discussion – Effects of Present Policies on U.S. Health Care

This subpart discusses the effects of present policies under three categories: (1) demand, supply, expenditures, and medical care, (2) effects of present policies on prices for private health insurance, and (3) effects of present policies on prices for medical services and products.

Demand, Supply, Expenditures, and Medical Care

The demand for a good or service is the quantity of the good or service a person or group of persons is willing to purchase at a given price. Factors that influence demand include the number of people who want to purchase the item, the tastes and preferences of purchasers, the income or wealth of purchasers, and the number and price of substitutes or alternatives to the good or service.

The supply of a good or service is the quantity of the good or service a person or group of persons is willing to sell or provide at a given price. Factors that influence supply include the number of people offering the item or service, the state of technology needed to produce the good or service, the cost of providing the good or service, and the number and price of available substitutes or alternatives.

With respect to medical care, however, there are several additional factors that influence demand and supply. For example, the demand for care is usually not based on one's tastes and preferences, but instead on one's medical condition, the severity of that condition, and on what one's physician recommends, e.g., whether to have a diagnostic test performed or whether to take a medication. Also, the demand for care is influenced by the extent to which third parties pay for care (see below).

Similarly, the supply of care is influenced by professional ethical considerations. For example, many physicians provide care for persons who are unable to pay at either no charge or a discounted fee. Despite the fact that different factors influence demand and supply, data

¹⁰¹ See Daniel Kessler and Mark McClellan, Do Doctors Practice Defensive Medicine? 111 Quarterly J. Econ. 353 (1996); Daniel Kessler and Mark McClellan, Malpractice Law and Health Care Reform: Optimal Liability Policy in an Era of Managed Care, 84 J. Pub. Econ. 175 (2002).

¹⁰² See Daniel P. Kessler, William M. Sage, and David J. Becker, Impact of Malpractice Reforms on the Supply of Physician Services, 293 JAMA 2618 (2005).

¹⁰³ See Towers Perrin, 2008 Update on U.S. Tort Cost Trends, Appendix 2, accessed at http://www.towersperrin.com/tp/getwebcachedoc?webc=USA/2008/200811/2008_tort_costs_trends.pdf.

¹⁰⁴ See Conover, *supra* note 59.

suggest that medical care does follow basic economic principles, including the law of demand and the law of supply.¹⁰⁵

Finally, greater demand and large health care spending are not necessarily problems. Because maintaining one's health is very important to most people, one would expect that as people become wealthier, they would spend a larger percentage of their income on health-related items.¹⁰⁶ In addition, data suggest that much of the growth in U.S. expenditures over the past 50 years is responsible for improvements in health and well being.¹⁰⁷

On the other hand, data also suggest that some portion of health care spending may have little effect on health outcomes.¹⁰⁸ When third parties pay for most care, there are few constraints on the demand for care, and the excess demand may lead to expenditures that have relatively few benefits. Since large expenditures decrease the resources available for other items, e.g., food, housing, education, or retirement savings, policies that result in fewer expenditures are desirable, provided they lead to either superior or equivalent health outcomes.

Effects on Prices for Private Health Insurance

There are two primary ways that present federal and state policies increase prices for private health insurance. Some policies increase the demand for insurance, and other policies decrease the supply.

The tax preference for ESI increases access to private health insurance for many people. However, the tax preference for ESI increases the demand for insurance, specifically increasing the demand for comprehensive insurance with minimal cost sharing. Greater demand usually results in higher prices and larger expenditures. In addition, because most Americans do not own the funds that pay for their health insurance, they are less able to choose insurance specific to their needs.

Underwriting restrictions and required benefits increase access to private insurance for some individuals. However, these requirements increase insurer claims costs and decrease the insurance options from which individuals may choose. Higher costs and fewer options result in a smaller supply of insurance, and a smaller supply usually leads to higher prices. In addition, underwriting restrictions and required benefits prevent insurers from developing less expensive

¹⁰⁵ For example, one randomized, controlled experimental study suggests that the extent of third-party payment influences the demand for care. In this study, individuals who were assigned to health plans with large co-insurance payments had significantly fewer outpatient expenses than persons assigned to plans with small or no co-insurance payments. There were no differences in health outcomes for persons with mean characteristics. However, for low-income persons who had high blood pressure or visual impairment, those who had no co-insurance payments had better outcomes with respect to blood pressure control and vision correction than those who had co-insurance payments. *See* Manning, et al. *supra* note 4. This latter finding will be noted again in Part 4.

¹⁰⁶ For a discussion of the effects of income on health care expenditures, see Uwe E. Reinhardt, Peter S. Hussey, and Gerard F. Anderson, Cross-National Comparisons of Health Systems Using OECD Data, 21(3) *Health Affairs* 169 (May/June 2002).

¹⁰⁷ For example, *see* David M. Cutler and Mark McClellan, Is Technological Change Worth It? 20(5) *Health Affairs* 11 (Sept. / Oct. 2001). *See also* Frank R. Lichtenberg, Sources of U.S. Longevity Increase, 1960-1997, NBER Working Paper 8755 (Feb., 2002).

¹⁰⁸ For example, *see* Skinner, Fisher, and Wennberg, *supra* note 4; Fisher et al., *supra* note 4; Manning, et al., *supra* note 4.

forms of insurance for persons who desire them and innovative types of insurance such as insurance for persons with specific chronic diseases.

Effects on Prices for Medical Services and Products

Similarly, there are two primary ways that federal and state policies increase prices for medical services and products. Some policies increase the demand for medical services and products, while others decrease the supply.

Both public insurance and the tax preference for ESI increase access to care for many people. However, both policies increase the amount of care paid by a third party, and greater third-party payment increases the demand for medical services and products. Greater demand usually results in higher prices and larger expenditures. In addition, because most patients do not own the funds that pay for their care, they have less ability to use the funds in a way best suited to their situation.

Most administrative regulations involving professional care, facility care, and pharmaceuticals have benefits. However, even beneficial regulations increase costs, and some decrease the entry of competitors. Similarly, the potential of a malpractice lawsuit increases the cost of providing care and may cause physicians to restrict their practices. Both higher costs and restricted entry decrease the supply of care, and a smaller supply usually leads to higher prices. In addition, restrictions on professional care, facility care, and pharmaceuticals decrease the process of competition and discovery that leads to greater innovation and higher quality.¹⁰⁹

Part 2 – Recent Legislation to Increase Third-Party Coverage

Congress recently passed the Patient Protection and Affordable Care Act (PPACA), which it later amended with the Health Care and Education Reconciliation Act of 2010.¹¹⁰ PPACA contains a number of provisions designed to extend comprehensive, third-party coverage to a larger percentage of the population. This section discusses these provisions under the following categories: (1) additional regulations involving health insurance, (2) mandate and tax credit for individuals to purchase private insurance, (3) assessment on large employers if an employee receives a credit to purchase private insurance, and (4) expansion of eligibility for Medicaid.

Additional Regulations Involving Health Insurance

PPACA creates a number of new restrictions on insurance underwriting.¹¹¹ It prohibits insurers in the small group (2 to 50 employees) and individual markets from basing premiums on health status; it prohibits insurers in the group and individual markets from rejecting an applicant for health insurance and from refusing to renew coverage for employers or individuals who want to renew; and it prohibits group health plans and insurers in both the group and individual

¹⁰⁹ See Friedrich A. Hayek, *Competition as a Discovery Procedure*, 5 *Quart. J. Austrian Econ.* 9 (Fall, 2002). This article is an English translation of a lecture delivered in German by Professor Hayek in 1968.

¹¹⁰ Pub. L. 111-148; Pub. L. 111-152.

¹¹¹ Pub. L. 111-148, Sec. 1201.

markets from imposing preexisting condition exclusions and from establishing rules for individual eligibility based on health status.

PPACA also requires that insurers in the small group and individual markets cover an “essential health benefits package” equal to the scope of benefits in a typical employer plan, authorizes the Secretary of Health and Human Services (HHS) to specify what is required in an essential benefits package, and limits cost sharing.¹¹²

As noted in Part 1, the primary advantage of underwriting restrictions is that they allow high-risk individuals to obtain insurance at lower prices than they otherwise would. However, these requirements increase prices and decrease insurance prevalence among low and average-risk persons.¹¹³ Investigators in one study estimated that absent a mandate to purchase insurance (see below), guaranteed issue plus community rating may decrease overall insurance prevalence in the individual market by 6.0 to 7.4 percent.¹¹⁴

Similarly, while a requirement for insurers to cover a specific package of benefits increases the value of insurance for those who need the types of care the package covers, required benefits increase insurance prices,¹¹⁵ and they prevent individuals from purchasing less expensive alternatives. Investigators in one study estimated that absent a mandate, required benefits would decrease overall insurance prevalence by 0.4 percent per required benefit.¹¹⁶

Mandate and Tax Credit for Individuals to Purchase Insurance

PPACA requires most Americans, beginning in January, 2014, to maintain health insurance or pay a penalty.¹¹⁷ Individuals who would be required to pay more than 8 percent of household income for insurance are exempt. In 2016, the penalty amount will be the larger of two and one half percent of household income or \$695 per year.¹¹⁸ After 2016, the amount will be adjusted for inflation. This requirement is similar to a 2016 Massachusetts law that requires most Massachusetts residents to purchase health insurance or pay a penalty.¹¹⁹

To make the required insurance more affordable, PPACA provides a refundable tax credit, a form of subsidy, to individuals whose household income is between 100 and 400 percent of the federal poverty line.¹²⁰ In 2009, 400 percent of federal poverty guidelines for a family of four in the 48 contiguous states was \$88,200.¹²¹

¹¹² *Id.*; Pub. L. 111-148, Sec. 1302.

¹¹³ See Davidoff, Blumberg, and Nichols, *supra* note 57; Herring and Pauly, *supra* note 57.

¹¹⁴ See Herring and Pauly, *supra* note 57.

¹¹⁵ See Jensen and Morrissey, *supra* note 61.

¹¹⁶ See Sloan and Conover, *supra* note 62.

¹¹⁷ Pub. L. 111-148, Sec. 1501.

¹¹⁸ *Id.*; Pub. L. 111-148, Sec. 10106; Pub. L. 111-152, Sec. 1002.

¹¹⁹ See Jonathan Gruber, *The Massachusetts Health Care Revolution: A Local Start for Universal Access*, 36 *Hastings Center Report* 14 (2006); David A. Hyman, *The Massachusetts Health Plan: The Good, the Bad, and the Ugly*, Policy Analysis No. 595, Cato Institute (June 28, 2007), accessed at <http://www.cato.org/pubs/pas/pa-595.pdf>

¹²⁰ Pub. L. 111-148, Sec. 1401; Pub. L. 111-152, Sec. 1001.

¹²¹ Department of Health and Human Services, *Annual Update of HHS Poverty Guidelines*, 74 Fed. Reg. 4199 (Jan. 23, 2009).

Potential advantages of requiring all individuals to purchase health insurance include a higher prevalence of health insurance and a larger percentage of the population over which to spread risk. The primary advantage of a public subsidy over public insurance is that it allows a recipient to choose among more varied insurance options. As a result, a subsidy may provide better access to care than does public insurance.

On the other hand, there are several disadvantages. A mandate that prevents an individual from refusing to purchase insurance will increase the demand for insurance, and a greater demand will likely lead to higher prices. In addition, because the federal government will determine the type and amount of insurance each person must maintain, advocacy groups, professional organizations, or facility organizations may lobby Congress or HHS to increase minimum benefit levels, further restrict underwriting, or further restrict cost sharing. Additional insurance requirements would likely lead to even higher prices.

More importantly, an individual mandate represents a significant infringement on individual freedom. Given health insurance prices in the U.S., an individual mandate will require many individuals to purchase an item, the expected benefits of which are much less than the cost.¹²² An individual mandate also may be unconstitutional.¹²³

Finally, a subsidy extended to such a large percentage of the population will require large public funding. The additional taxation necessary to fund the subsidies will have economic costs in addition to the cost of the funds collected,¹²⁴ and these subsidies will increase the unfunded liability for health care presently faced by both the federal and state governments.¹²⁵

Because the Massachusetts' reform was enacted in 2006 and consisted of many components, there are few data concerning the specific effects of an individual mandate.¹²⁶ Since enacting reform, health insurance prevalence in Massachusetts has increased,¹²⁷ and the increase

¹²² A mandate requiring an individual to purchase insurance made more expensive by guaranteed issue plus community rating seems especially unfair to young, healthy individuals. At present, young, healthy taxpayers are required to pay federal payroll taxes to support Medicare, federal income taxes to support Medicare, Medicaid, and S-CHIP, and state income or sales taxes to support Medicaid and S-CHIP. Under PPACA and the Reconciliation Act, this same person will be required to support federally-subsidized private insurance for middle-class people and to purchase health insurance, the expected benefits of which may be much less than its cost.

¹²³ See Randy Barnett, Nathaniel Stewart, and Todd Gaziano, Why the Personal Mandate to Buy Health Insurance is Unprecedented and Unconstitutional, Legal Memorandum No. 49, The Heritage Foundation (Dec. 9, 2009), accessed at <http://www.heritage.org/Research/Reports/2009/12/Why-the-Personal-Mandate-to-Buy-Health-Insurance-Is-Unprecedented-and-Unconstitutional>.

¹²⁴ See discussion and references, supra notes 36-38.

¹²⁵ See The Boards of Trustees, supra note 48.

¹²⁶ Prior to reform, Massachusetts required guaranteed issue plus community rating. The 2006 reform expanded eligibility criteria for Medicaid, created an insurance exchange for private health insurance, required employers to provide insurance or pay a small penalty fee, required individuals to maintain insurance or pay a large penalty fee, and provided direct subsidies to purchase private insurance to individuals who earn up to 300 percent of the federal poverty level. See Gruber, supra note 119; Hyman 119.

¹²⁷ See Sharon K. Long, On the Road to Universal Coverage: Impacts of Reform in Massachusetts at One Year, 27(4) Health Affairs w270 (June 3, 2008); John Holohan and Linda Blumberg, Massachusetts Health Reform: Solving the Long-Run Cost Problem, Urban Institute (Jan., 2009); Rachel Nardin, David Himmelstein, and Stephanie Woolhandler, Massachusetts' Plan: A Failed Model for Health Care Reform, Physicians for a National Health Program and Public Citizen (Feb. 18, 2009); Michael Tanner, Massachusetts Miracle or Massachusetts Miserable: What the Massachusetts Model Tells Us about Health Care Reform, Cato Briefing Papers No. 112 (June 09, 2009).

has occurred among private group insurance, private individual insurance, publicly-subsidized private insurance, and Medicaid.¹²⁸ However, since reform was enacted, insurance prices, which were the highest in the nation prior to reform,¹²⁹ have increased at a greater rate than the national average.¹³⁰ The CBO estimated that PPACA will increase insurance premiums in the individual market in 2016 by 10 to 13 percent over what they otherwise would be.¹³¹

Since enactment of the Massachusetts reform, access to care has improved for some individuals, but may be worse for others. One study found that more low-income residents reported seeing a physician in 2007, as compared to 2006, and more reported having a place they could go for medical care.¹³² On the other hand, more residents reported difficulty obtaining a physician appointment.¹³³

A 2009 survey found that average physician appointment wait times among five specialties was 49.6 days in Boston, compared to 27.0 days in Philadelphia (the second longest), and an average of 20.5 days in the 15 major metropolitan areas surveyed.¹³⁴ While wait times had decreased in most metropolitan areas compared to 2004, they had increased in Boston in three of the four specialties with comparison data.

Massachusetts expenditures for subsidies to purchase insurance have been larger than originally anticipated.¹³⁵ The Centers for Medicare and Medicaid Services (CMS) Office of the Actuary estimated that PPACA-authorized federal spending for individual premium and cost-sharing subsidies will be \$506.5 billion in years 2014 through 2019.¹³⁶

Assessment on Employers if an Employee Receives a Credit

PPACA does not mandate that employers provide employee health insurance. However, beginning in January, 2014, employers with 50 or more employees who do not provide insurance must pay an assessment, if one of their employees who works at least 30 hours per week receives a credit to purchase insurance.¹³⁷ The amount of the assessment is \$2000 multiplied by the number of employees who work at least 30 hours per week.¹³⁸ Since most individuals will be required to purchase insurance, employers with 50 or more employees will in effect be required

¹²⁸ See Holohan and Blumberg, supra note 127; Nardin, Himmelstein, and Woolhandler, supra note 127.

¹²⁹ See America's Health Insurance Plans, Individual Health Insurance 2006-2007: A Comprehensive Survey of Premiums, Availability, and Benefits (Dec., 2007), accessed at http://www.ahipresearch.org/pdfs/Individual_Market_Survey_December_2007.pdf.

¹³⁰ See Tanner, supra note 127.

¹³¹ See Douglas W. Elmendorf, Director, Letter to Honorable Evan Bayh, Congressional Budget Office, U.S. Congress (Nov. 30, 2009), accessed at <http://www.cbo.gov/ftpdocs/107xx/doc10781/11-30-Premiums.pdf>.

¹³² See Long, supra note 127.

¹³³ *Id.*

¹³⁴ Merritt Hawkins and Associates, 2009 Survey of Physician Appointment Wait Times, accessed at <http://www.merrithawkins.com/pdf/mha2009waittimesurvey.pdf>.

¹³⁵ See Holohan and Blumberg, supra note 127.

¹³⁶ Under PPACA, subsidies to purchase private insurance will begin in 2014, increase annually from 2014 through 2019, and continue to increase annually after 2019. See Richard S. Foster, Estimated Financial Effects of the "Patient Protection and Affordable Care Act," CMS Office of the Actuary 5, Table 1 (Apr. 22, 2010), accessed at http://www.cms.gov/ActuarialStudies/Downloads/PPACA_2010-04-22.pdf.

¹³⁷ Pub. L. 111-148, Sec. 1513.

¹³⁸ *Id.*; Pub. L. 111-152, Sec. 1003.

to either provide insurance or pay the assessment. Since 1974, Hawaii has required employers to provide health insurance to employees who work more than 20 hours per week,¹³⁹ and beginning in 2007, Massachusetts required employers with 11 or more employees to provide health insurance or pay a penalty of \$295.00.¹⁴⁰

Similar to an individual mandate, the employer assessment will likely increase the prevalence of health insurance and assure some level of care for employees of large companies.

However, there are many disadvantages. The employer assessment will increase the demand for insurance, and a greater demand will likely result in higher insurance prices. As with an individual mandate, advocacy, professional, or facility groups may lobby for larger benefit levels, and larger benefit levels would lead to higher prices. More importantly, requiring an employer to either provide insurance or pay an assessment will affect an employer's cost of labor. In a competitive market, an employer cannot absorb higher costs without decreasing other costs. As a result, higher health benefit costs will likely be offset by lower wages, fewer benefits other than health insurance, or fewer employees.

Because Hawaii's employer mandate has a number of exemptions and excludes dependents from required coverage, it has had relatively little effect on the prevalence of health insurance or employment.¹⁴¹ Following implementation of the mandate, Hawaii had an increase in health insurance prevalence compared to the rest of the country, but the increase was small.¹⁴² In addition, Hawaii had a larger increase in wages than the rest of the country, but the increase was smaller in the industries most affected by the mandate.¹⁴³ Finally, compared to other states, Hawaii had an increase in workers who worked less than 20 hours per week.¹⁴⁴

In 2007, Baicker and Levy estimated that 1.4 percent of full time uninsured workers would lose their jobs if the federal government adopted an employer mandate.¹⁴⁵

Expansion of Eligibility for Medicaid

PPACA extends Medicaid benefits to all individuals whose household income does not exceed 133 percent of the federal poverty level.¹⁴⁶ The primary advantage of expanding Medicaid eligibility is that some additional individuals may gain access to care they otherwise would not have.¹⁴⁷ In addition, extending coverage to a larger percentage of the low-income

¹³⁹ California HealthCare Foundation, State Employer Health Insurance Mandates: A Brief History (Mar., 2004), accessed at [http://www.eric.org/forms/uploadFiles/61CF00000097.filename.CHCF - Employer_Insurance_Mandates.pdf](http://www.eric.org/forms/uploadFiles/61CF00000097.filename.CHCF_Employer_Insurance_Mandates.pdf).

¹⁴⁰ See Gruber, supra note 119; Hyman, supra note 119.

¹⁴¹ See Andrew W. Dick, Update: Will Employer Mandates Really Work? Another Look at Hawaii, Data Watch Update, 1 Health Affairs 343 (1994).

¹⁴² *Id.*; See also Norman K. Thurston, Labor Market Effects of Hawaii's Mandatory Employer-Provided Health Insurance, 51 Indus. & Lab. Rel. Rev. 117 (1997).

¹⁴³ See Thurston, supra note 142.

¹⁴⁴ *Id.*

¹⁴⁵ See Katherine Baicker and Helen Levy, Employer Health Insurance Mandates and the Risk of Unemployment, NBER Working Paper No. 13528 (Oct., 2007).

¹⁴⁶ Pub. L. 111-148, Sec. 2001.

¹⁴⁷ For example, see Currie and Gruber, supra note 39; Baker and Royalty, supra note 39.

population may decrease the inappropriate use of emergency departments¹⁴⁸ and decrease cost shifting between uninsured and insured patients.¹⁴⁹

On the other hand, Medicaid often provides less than ideal access to care,¹⁵⁰ and following an expansion of eligibility, there may be a significant crowd out of private insurance.¹⁵¹ In addition, Medicaid is subject to both political influence and fraud.¹⁵²

Finally, expanding Medicaid will require additional public funding, and the taxation required to fund the expansion will have economic costs in addition to the cost of the funds collected.¹⁵³ Both federal and state governments presently spend a large percentage of their revenue to pay for medical care,¹⁵⁴ and both Medicare and Medicaid may not be sustainable in their present form. Expanding eligibility for Medicaid will make public insurance even less sustainable.

The CMS Office of the Actuary estimated that PPACA will increase federal spending for Medicaid and S-CHIP by \$410.3 billion during years 2014 through 2019.¹⁵⁵ These estimates do not include the cost of taxation to generate the funds or the additional costs that states will incur as a result of Medicaid and S-CHIP expansion.

Discussion – Effects of Recent Legislation to Increase Coverage

This subpart discusses the likely effects of PPACA under three categories: (1) health insurance and third-party payment for care, (2) effects on prices for private health insurance, and (3) effects on prices for medical services and products.

¹⁴⁸ See Newton, et al., supra note 35.

¹⁴⁹ See Hadley, et al., supra note 33.

¹⁵⁰ See Cunningham and May, supra note 41.

¹⁵¹ See Cutler and Jonathan Gruber, supra note 44; Shore-Sheppard, Buchmueller, and Jensen, supra note 44; LoSasso and Buchmueller, supra note 44; Gruber and Simon, supra note 44.

¹⁵² One federal investigator recently testified, “approximately 65,000 Medicaid beneficiaries in the five states investigated visited six or more doctors to acquire prescriptions for the same type of controlled substances during fiscal years 2006 and 2007. These individuals incurred approximately \$63 million in Medicaid costs for these drugs ...” See Gregory D. Kutz, Medicaid Fraud and Abuse Related to Controlled Substances Identified in Selected States, Testimony before the Subcommittee on Federal Financial Management, Government Information, Federal Services, and International Security, Committee on Homeland Security and Governmental Affairs, U.S. Senate, United States Government Accountability Office (Sept., 30, 2009), accessed at <http://www.gao.gov/new.items/d09957.pdf>. While all insurers are subject to fraud, public insurers may be more so than private insurers. In general, private insurers use resources to investigate and determine whether claims are valid prior to paying them. In contrast, for most beneficiaries, public insurers pay claims when received, investigating after the fact if there is a suspicion of fraud or abuse. See Merrill Mathews, Medicare’s Hidden Administrative Costs: A Comparison of Medicare and the Private Sector, The Council for Affordable Health Insurance (Jan. 10, 2006, accessed at http://www.cahi.org/cahi_contents/resources/pdf/CAHI_Medicare_Admin_Final_Publication.pdf).

¹⁵³ See discussion and references, supra notes 36-38.

¹⁵⁴ Federal spending on Medicare, Medicaid, and S-CHIP is expected to be 20 percent of federal spending in 2009. See The Henry J. Kaiser Family Foundation, supra note 30. States spend up to 17 percent of their general revenue on Medicaid. See The Kaiser Commission on Medicaid and the Uninsured, supra note 31.

¹⁵⁵ Under PPACA, expenditures for Medicaid and S-CHIP expansion will begin in 2014, increase annually through 2019, and continue to increase annually after 2019. See Foster, supra note 136.

Health Insurance and Third-Party Payment for Care

Medical care for some types of conditions is likely to be very expensive. For example, care in an intensive care unit following severe trauma requires 24 hour a day management by highly trained professionals. All but very wealthy individuals need to pool the risk that they will require this type of care. As a result, insurance for large, unexpected expenses is an important component of access to care.

However, third party-payment for small or expected expenses is usually more costly than paying for these expenses directly.¹⁵⁶ First, there are administrative costs for either patients or physicians to submit claims and for payers to determine eligibility, investigate claims, and pay claims. Because a third party cannot be present during the millions of patient-physician interactions that occur each day, third-party payment is more subject than two-party transactions to costly disputes concerning whether a service is covered or whether the service was necessary for the particular condition. For the same reason, third-party payment is more subject than two-party transactions to fraud.

Third-party payment also leads to excess resource use. When a third party is paying, individuals may be less careful concerning their health than they otherwise would be, and both patients and physicians may use resources, even though the expected benefits are small. Finally, individuals who have a chronic condition and know they are likely to incur expenses are more likely to purchase insurance than persons who are unlikely to incur expenses. As a result, the risk pool may be come skewed to high-risk persons, further increasing prices.

There also are disadvantages to third-party payment unrelated to financial cost. When a third party pays for expenses, individuals do not own the funds that pay for their care. As a result, an individual may not be able to use the funds in the way one desires or in a way best suited for the particular situation. Finally, health information is personal, confidential information, and third-party payment requires informing a third party concerning often very personal health information.

Effects on Prices for Private Health Insurance

There are two primary ways PPACA will likely increase prices for private health insurance. Some features will increase the demand for insurance, and others will decrease the supply.

The individual mandate to purchase private insurance, the tax credit to purchase private insurance, and the employer assessment will increase the prevalence of private insurance and should increase access to care for some people. However, each of these features will increase the demand for insurance, and greater demand will likely lead to higher prices and larger expenditures.

¹⁵⁶ As noted earlier, most U.S. health plans now pay for small and expected expenses as well as for large, unexpected expenses. Also, most plans have contractual arrangements with physicians and hospitals, under which they pay physicians and hospitals a negotiated amount. *See* discussion and references, *supra* note 6.

Restricted underwriting, required comprehensive benefits, and restricted cost sharing will increase access to insurance for some people. However, these features will increase claims costs and decrease the insurance options from which individuals may choose. Higher costs and fewer options decrease the supply of insurance, and a smaller supply will likely lead to higher prices. Also, these requirements will prevent insurers from developing less expensive and more innovative types of insurance that may better meet most persons' needs.

Effects on Prices for Medical Services and Products

The individual mandate, tax credit, employer assessment, and Medicaid expansion will increase the prevalence of comprehensive coverage and likely increase access to care for some people. However, each of these features will increase the amount of care paid by a third party, and the greater demand will likely lead to higher prices and larger expenditures. In addition, greater third-party payment will decrease each person's flexibility to use the funds to meet the needs of each particular situation and decrease both the incentive and flexibility of physicians and facilities to develop better ways to provide cost-effective care.

Part 3 - Recommended Reforms

As described in Part 1, some federal and state policies favor certain forms of paying for care over others, and other policies in effect limit one's options for insurance or care. These policies contribute to high prices, large expenditures, and many persons without health insurance. As described in Part 2, PPACA expands incentives for third-party payment over paying directly for care and further restricts insurance options. While these provisions will increase the prevalence of comprehensive third-party coverage, they will likely lead to higher prices and larger expenditures.

In contrast, reforms that increase individual ownership of the funds used for care and reforms that increase the available options should lead to lower prices and fewer excess expenditures. To increase individual ownership and to increase the available options, Congress and state legislators will need to repeal those features of PPACA that lead to third-party payment for most care, repeal or neutralize previous laws that favor one form of paying for care over others, and repeal or decrease many of the regulations that presently govern health insurance, medical and facility care, and pharmaceuticals.

These reforms can be organized under seven categories, the last six of which are similar to the categories used to describe the effects of present policies: (1) repeal provisions of PPACA and the Reconciliation Act that increase third-party payment for care, (2) equalize the tax treatment of funds used to pay for medical care, (3) replace public insurance with public subsidies and private, voluntary support, (4) decrease restrictions on insurance underwriting, benefit design, and cost sharing, (5) decrease restrictions on professional and medical facility care, (6) decrease restrictions on access to pharmaceuticals, and (7) cap non-economic damage awards and enforce pre-care contracts for protection against medical malpractice.

Repeal Provisions of PPACA and the Reconciliation Act

As noted in Part 2, provisions of PPACA, as amended by the Reconciliation Act, restrict insurance underwriting, require a standard set of benefits, and restrict cost sharing.¹⁵⁷ In addition, PPACA requires most individuals to maintain comprehensive insurance, provides a tax credit for insurance to persons with income between one and four times FPL, requires large employers to pay an assessment if an employee receives a tax credit, and expands Medicaid to all persons whose income is not greater than 133 percent of FPL. While these reforms will increase access to care for some individuals, because they lead to higher prices, they will decrease access for others, and they will increase both total and public expenditures.

To decrease both prices and excess expenditures, Congress should consider repealing each of these provisions. Repeal of the individual mandate, tax credit, employer assessment, and insurance regulations would decrease the probability of a large increase in insurance prices. Repeal of the individual mandate, tax credit, employer assessment, and Medicaid expansion would decrease the probability of a large increase in prices for medical services and products. Repeal of the new insurance regulations would allow insurers who can now do so to continue offering less expensive options, and repeal of each of the provisions listed above will be necessary for many of the reforms described below to be effective.

Equalize Tax Treatment of Funds Used for Medical Care

Federal law allows individuals who maintain employer-sponsored insurance (ESI) to exclude the value of their insurance from gross income for federal income tax purposes.¹⁵⁸ However, the exclusion does not apply if one purchases insurance independent of an employer, and it does not apply if one pays for care directly. As a result, there is a strong incentive for individuals to obtain health insurance through their employer and to purchase comprehensive plans with minimal cost-sharing. The disparate tax treatment of ESI, ISI, and out-of-pocket expenses is one important reason both insurance and care are expensive and one reason many people do not purchase health insurance.¹⁵⁹

To decrease prices for both insurance and care, Congress should consider equalizing the tax treatment of funds used to pay for health care. Equalization would allow individuals to choose the balance between “self-insuring” for small expenses and purchasing insurance to cover potentially larger expenses, free of the tax code’s influence. Some people would continue to choose comprehensive plans with minimal cost sharing. Others would choose less expensive insurance with fewer benefits and more cost sharing. Over time, there likely would be a shift to more direct payment for care, and such a shift should result in lower prices and fewer expenditures.¹⁶⁰ It is also possible that as more individuals take responsibility for paying for their health care, health habits and health may improve.

¹⁵⁷ Pub. L. 111-148; Pub. L. 111-152.

¹⁵⁸ See Joint Economic Committee, *supra* note 15.

¹⁵⁹ See Cogan, R. Hubbard, and Kessler, *supra* note 8.

¹⁶⁰ Many data suggest that direct payment for care would lead to lower prices and fewer expenditures. For example, most people pay directly for cosmetic surgery and LASIK surgery. While inflation-adjusted prices for general medical care have increased during the past ten to fifteen years, inflation-adjusted prices for both cosmetic surgery and LASIK surgery have decreased. See Devon M. Herrick, *Health Care Entrepreneurs: The Changing Nature of*

Because most working Americans are dependent on the tax preference for ESI, eliminating this preference without other changes may be disruptive to care for some people. As a result, Congress should consider partially equalizing the tax treatment of health care expenses in one or more of the following ways.¹⁶¹

Provide a Standard Tax Credit for Health Insurance

Congress should consider enacting a standard tax credit for health insurance.¹⁶² Because a credit would be a specified annual amount, regardless of who purchased the insurance or the type of insurance purchased, there would be less incentive to choose ESI over ISI and less incentive to choose a comprehensive plan over less expensive insurance. Over time, more persons would likely purchase insurance independent of their employer, and more individuals would choose insurance with fewer benefits or more cost sharing.

Unlike the exclusion for ESI, a standard tax credit would provide an equal benefit for all taxpayers, regardless of one's marginal income tax rate. If Congress made the credit refundable, the credit would serve as a direct subsidy for low-income individuals (see below) and should significantly increase the prevalence of health insurance.

Provide a Standard Deduction for Health Insurance

Congress also should consider allowing taxpayers to deduct from gross income a standard amount for health insurance.¹⁶³ Similar to a standard tax credit, a standard deduction would

Providers, Policy Report No. 318, National Center of Policy Analysis (Dec., 2008). In addition, centers that cater to individuals who pay directly, e.g., “medical tourist” destinations in both foreign countries and in the United States, charge considerably less for the same care than do most U.S. medical centers. *Id.* See also Deloitte Center for Health Solutions, Medical Tourism: Consumers in Search of Value, Deloitte (2008), accessed at http://www.deloitte.com/assets/Dcom-UnitedStates/Local%20Assets/Documents/us_chs_MedicalTourismStudy%283%29.pdf. Finally, most Singaporeans own the funds used to pay for their care and pay directly for most care. See Rob Taylor and Simon Blair, Financing Health Care: Singapore's Innovative Approach, Note No. 261, The World Bank Group (May, 2003), accessed at http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2003/07/28/000090341_20030728113711/Rend/ered/PDF/264050PAPER0Vp0no10261.pdf. In 2005, health care expenditures in Singapore were \$944 dollars per capita (3.5 percent of GDP), much lower than in any other advanced country. While there are few data comparing quality of care for specific conditions, neonatal mortality and life expectancy rates in Singapore are among the best in the world. See World Health Organization, WORLD HEALTH STATISTICS 2008 36, 76, accessed at http://www.who.int/whosis/whostat/EN_WHS08_Full.pdf.

¹⁶¹ When enacting a tax credit or a standard deduction, Congress could replace the present preference for ESI with the reform or allow an individual to choose between present law and the recommended reform. From the standpoint of economic efficiency, replacing present law may be preferable. However, repealing present law may be disruptive to care for many people, and it may not be politically possible. As a result, this section discusses these two reforms as though the law would allow an individual to choose between employer-provided tax preferences and the reform. Since these two reforms would not allow an individual to exclude health care expenses from gross income for payroll tax purposes, these reforms do not completely equalize the tax treatment of health care expenses.

¹⁶² For example, see Mark Pauly and Bradley Herring, Expanding Coverage Via Tax Credits: Trade-Offs and Outcomes, 20(1) Health Affairs 9 (Jan/Feb., 2001).

¹⁶³ For example, see Office of the Press Secretary, The White House, George W. Bush, Fact Sheet: Making Private Health Insurance More Affordable for Low-Income Americans (Feb. 23, 2007), accessed at <http://georgewbush-whitehouse.archives.gov/news/releases/2007/02/20070223-4.html>.

provide less incentive for an employee to choose ESI over ISI and less incentive to choose a comprehensive plan with minimal cost sharing. As more people begin to choose less expensive insurance, insurance prices should decline, and as less care is paid by a third party, prices for care should decline. Unlike a tax credit, but similar to the exclusion for ESI, a standard deduction would provide more benefit for a high-income than for a low-income individual.

Decrease Restrictions on Health Savings Accounts

Congress also should consider decreasing restrictions on health savings accounts (HSAs).¹⁶⁴ For example, Congress could increase the annual contribution limit, allow an HSA owner to purchase health insurance with HSA funds, or allow a person to establish an HSA regardless of whether one purchases an HDHP, another type of insurance, or no insurance.

Similar to a standard tax credit or standard deduction, fewer HSA restrictions would decrease one's incentive to choose comprehensive ESI with minimal cost sharing. In addition, fewer HSA restrictions would increase each person's incentive to save for future health care expenses, and less restrictive HSAs should result in a larger prevalence of health insurance.¹⁶⁵ Finally, if individuals owned the funds used to pay for their care, professionals and medical facilities would have more incentive and more flexibility to develop innovative ways to provide cost-effective care. As more patients begin choosing care based on quality and price, prices should decline, and quality may improve.

Decreasing restrictions on HSAs would result in less federal revenue. However, the lost revenue that results from fewer HSA restrictions would be small compared to the lost revenue that presently results from the tax preference for ESI.

Replace Public Insurance with Subsidies and Private Support

As noted above, both federal and state governments pay for medical care for many Americans, and public payment for care increases access to care for many people. However, public insurance sometimes provides relatively limited access to care,¹⁶⁶ and public insurance may crowd out private insurance.¹⁶⁷ The taxation necessary to support public insurance has economic costs in addition to the cost of the funds collected,¹⁶⁸ and public insurance may be unsustainable over the long term.¹⁶⁹

¹⁶⁴ For a discussion of health savings accounts with fewer restrictions, *see* Michael F. Cannon, Large Health Savings Accounts: A Step Toward Tax Neutrality for Health Care, 11(2) Forum for Health Economics & Policy, Article 3 (2008).¹⁶⁴

¹⁶⁵ In 2007, AHIP reported that 27 percent of new enrollees in HSA/HDHP plans in the individual market were previously uninsured. *See* AHIP, January 2007 Census Shows 4.5 Million People Covered by HSA/High-Deductible Health Plans, America's Health Insurance Plans, accessed at http://www.ahipresearch.org/pdfs/final%20ahip_hsareport.pdf. Decreasing restrictions on HSAs should make HSAs even more attractive to uninsured persons.

¹⁶⁶ *See* Cunningham and May, *supra* note 41.

¹⁶⁷ *See* Cutler and Gruber, *supra* note 44; Shore-Sheppard, Buchmueller, and Jensen, *supra* note 44; LoSasso and Buchmueller, *supra* note 44; Gruber and Simon, *supra* note 44.

¹⁶⁸ *See* discussion and references, *supra* notes 36-38.

¹⁶⁹ *See* The Boards of Trustees, *supra* note 48.

To increase access to care and to better control public expenditures, Congress and the states should consider replacing public insurance with a public subsidy or private support.¹⁷⁰ A public subsidy could be a defined amount in advance of care, allowing an individual to purchase insurance or pay directly for care.¹⁷¹ The amount of the subsidy could be based on one's income, could be based on one's risk of incurring medical expenses,¹⁷² or both. A subsidy also could be provided at the time care is provided.¹⁷³

Private support could take the form of an individual paying directly for another's care, contributing to organizations that support the care of those who need assistance, or contributing to professionals and medical facilities that provide care at either no charge or a discounted rate.¹⁷⁴ Finally, private support could take the form of in-kind contributions by professionals and medical facilities that provide care at either no charge or a discounted rate.¹⁷⁵

A public subsidy offers a number of advantages over public insurance. A subsidy in advance of care would allow a beneficiary to choose the insurance and care best suited to the beneficiary's needs. Since some physicians do not accept public insurance beneficiaries, a subsidy that allows one to purchase private insurance or pay directly should increase access to care for many beneficiaries. Also, since a beneficiary would own the subsidy funds, a subsidy may provide an incentive for insurers to develop less expensive forms of insurance and for professionals and facilities to develop innovative ways to provide less expensive care.

¹⁷⁰ While providing subsidies for all persons who earn up to 4 times FPL will significantly increase public spending, replacing public insurance for present beneficiaries with a subsidy of a defined amount should decrease public spending.

¹⁷¹ As noted above, a tax credit in effect is a direct subsidy to a person who qualifies for the credit.

¹⁷² See Robert Kuttner, *The Risk-Adjustment Debate*, 339 *New Engl. J. Med.* 1952 (1998).

¹⁷³ Instead of providing a defined amount in advance of care, Congress or state legislators could authorize an agency to evaluate subsidy applicants at the time they receive care to determine if they are eligible for a subsidy. For example, see Taylor and Blair, *supra* note 160.

¹⁷⁴ There are a number of ways present federal or state laws may inhibit private, philanthropic support for medical care. Public provision of social services may crowd out private contributions to social services. For example, see Daniel M. Hungerman, *Are Church and State Substitutes? Evidence from the 1996 Welfare Reform*, 89 *J. Pub. Econ.* 2245 (2005); Jonathan Gruber and Daniel M. Hungerman, *Faith-Based Charity and Crowd-Out During the Great Depression*, 91 *J. Pub. Econ.* 1043 (2007); Daniel M. Hungerman, *Crowd-Out and Diversity*, 93 *J. Pub. Econ.* 729 (2009). The threat of a malpractice lawsuit may prevent some physicians from providing discounted care to low-income persons. Finally, high tax rates decrease the amount of wealth that individuals could use to contribute to those who need assistance. As a result, decreasing public assistance, reforming medical malpractice law (see below), and decreasing marginal income tax rates may significantly increase private support.

¹⁷⁵ The National Association of Free Clinics estimates that free clinics provide up to \$3 billion of care annually for low-income patients. See Bonnie A. Beavers, Executive Director, Letter to the Citizens Health Care Working Group, National Association of Free Clinics (Aug. 28, 2006), accessed at <http://govinfo.library.unt.edu/chc/recommendations/orgs/nafc.pdf>. See also K. Kellerher, *Free Clinics: A Solution That Can Work Now*, 266 *JAMA* 838 (1991); Stephanie Geller, Buck M. Taylor, and H. Denman Scott, *Free Clinics Helping to Patch the Safety Net*, 15 *J. Health Care for the Poor and Underserved* 42 (2004); Mohan M. Nadkarni and John T. Philbrick, *Free Clinics: A National Survey*, 330(1) *Am. J. Med. Sciences* 25 (2005). Free clinics often have arrangements with physicians and local hospitals to provide specialist care, laboratory and imaging studies, and hospital care at either no charge or at a discounted rate. Also, many professionals and some hospitals that are not associated with free clinics provide care for low-income patients at either no charge or at a discounted rate.

A potential disadvantage of a subsidy in advance of care is that some low-income persons may not seek the care they need.¹⁷⁶ As a result, for some recipients, it may be better to require a recipient to maintain a comprehensive plan with minimal cost-sharing or provide a subsidy at the point of care.¹⁷⁷ In addition, a public subsidy does require government funding. However, by replacing public insurance with a subsidy of a defined amount, the federal or state government should be better able to control its expenditures.

Private subsidies and other forms of private support offer additional advantages. Since private support is usually made at the local level and is not legally required, private support tends to be more flexible than a public subsidy and more adaptable to the specific needs of each individual. Also, private support is less subject to costly disputes, fraud, and political influence. Finally, because private support is voluntary and does not entail taxation costs, private support is less costly to society than public insurance or a public subsidy.¹⁷⁸ It is possible that over time, private support could replace public subsidies.¹⁷⁹

Decrease Underwriting Restrictions and Mandated Benefits

As noted previously, both Congress and all states have required insurers to offer certain benefits, and some states have restricted health insurance underwriting. These requirements increase access to care for some individuals. However, because they result in higher prices, they decrease access for others. In effect, these requirements prevent individuals from choosing less expensive insurance that may be better for their particular situation, and data suggest these requirements decrease insurance prevalence in some markets.¹⁸⁰

To increase access for most persons, Congress and the states should consider decreasing present restrictions on insurance underwriting. For example, to decrease the price of ESI, Congress could eliminate the requirement for COBRA continuation coverage,¹⁸¹ and to lower the price of individual and small group insurance, Congress could eliminate HIPAA's requirements

¹⁷⁶ In the study described in F.N. No. 105, low-income individuals with high blood pressure or visual problems, who also had high co-insurance rates, experienced poorer health outcomes than those who had no co-insurance payments. *See* Manning et al., *supra* note 4.

¹⁷⁷ *See* discussion and reference, *supra* notes 105 and 176.

¹⁷⁸ Taxation costs include the agency cost to collect taxes, taxpayer compliance costs, and the cost of incentives engendered by the tax code. *See* discussion and references, *supra* notes 36-38.

¹⁷⁹ Studies suggest that public spending for social services has a crowd-out effect on philanthropic spending for social services. *See* Hungerman (2005), *supra* note 174; Gruber and Hungerman, *supra* note 174; Hungerman (2009), *supra* note 174. Also, one study suggests that as involuntary transfers increase, the crowd-out effect on voluntary transfers is larger. *See* Kenneth S. Chan, Rod Godby, and Stuart Mestelman, et al., *Crowding-Out Voluntary Contributions to Public Goods*, 48 *J. Econ. Behavior and Organization* 305 (2002). Finally, by decreasing prices for insurance and care and by increasing patient and donor income, over time the recommended reforms may decrease the need for public spending on health care.

¹⁸⁰ For the effects of guaranteed issue plus community rating, *see* Davidoff, Blumberg, and Nichols, *supra* note 57; Herring and Pauly, *supra* note 57. For the effects of mandated benefits, *see* Sloan and Conover, *supra* note 62.

¹⁸¹ Pub. L. 99-272. In effect, COBRA continuation coverage is a form of guaranteed renewal plus community rating. Data suggest that terminating employees who incur more medical expenses are more likely to choose COBRA continuation coverage than terminating employees who have fewer expenses. *See* Stephen A. Huth, *COBRA Costs Continue to be High, Erratic*, 52 *Employee Plan Benefit Rev.* 36 (Sept., 1997). A skewed risk pool of terminating employees likely results in higher prices for continuing employees.

for guaranteed issue and guaranteed renewal.¹⁸² For individuals who live in states that have enacted guaranteed issue plus community rating, the state could eliminate or decrease the stringency of these requirements.¹⁸³

Similarly, Congress and the states should consider eliminating or decreasing the number of mandated benefits. For example, Congress could repeal the requirement that group health plans cover at least 48 hours of hospital care following childbirth¹⁸⁴ or the requirement that insurers provide the same annual and lifetime limits for mental health benefits as for medical/surgical benefits.¹⁸⁵ States could eliminate requirements for insurers to pay for the treatment of alcoholism or for the treatment provided by a particular type of professional.¹⁸⁶ Fewer mandates should result in lower insurance prices, and lower prices should increase both insurance prevalence and access to care.

Finally, using its constitutional authority to regulate interstate commerce, Congress should consider exempting insurers regulated by one state from underwriting restrictions and mandated benefits imposed by a purchaser's state.¹⁸⁷ By bypassing the requirements imposed by one's own state, many individuals would be able to purchase less expensive insurance that may better meet their needs. In addition, allowing individuals to purchase insurance across state lines may encourage states to develop more flexible regulatory policies and encourage insurers to develop more innovative types of insurance.

Disadvantages of these reforms include higher insurance prices for persons who would benefit from the requirements and more difficulty obtaining insurance for some high-risk individuals. However, as discussed below, there are other ways the federal or a state government can increase access to care for high-risk individuals that do not significantly increase insurance prices for others.¹⁸⁸

Decrease Restrictions on Professional and Facility Care

Both federal and state governments regulate professional and facility care. For example, state licensing rules define the minimal qualifications for one to practice a profession, and state scope of practice rules define the types of activity a professional may engage in.¹⁸⁹ State certificate of need laws require facilities to gain approval before expanding or purchasing major

¹⁸² Pub. L. 104-191.

¹⁸³ Two investigators estimated that repeal of New York's guaranteed issue and community rating laws would decrease the price of individual health insurance by 42 percent and encourage up to 37 percent of the uninsured to purchase insurance. *See* Stephen T. Parente and Tarren Bragdon, *Healthier Choice: An Examination of Market-Based Reforms for New York's Uninsured*, Medical Progress Report No. 10, Manhattan Institute for Policy Research (Sept., 2009), accessed at http://www.manhattan-institute.org/pdf/mpr_10.pdf.

¹⁸⁴ 29 U.S.C. § 1185(a).

¹⁸⁵ 29 U.S.C. § 1185a(a).

¹⁸⁶ *See* Bunce, Wieske, and Prikazsky, *supra* note 56.

¹⁸⁷ *See* Health Care Choice Act of 2007, H.R. 4460, Sec. 1-4, 110th Cong. (2007-2008). Two investigators estimated that allowing New York residents to purchase insurance from insurers in Pennsylvania and Connecticut may decrease New York's uninsured rate by 17 percent. *See* Parente and Bragdon, *supra* note 183.

¹⁸⁸ These reforms will be discussed in Part 4 - Application of Reforms to Specific Populations.

¹⁸⁹ *See* Furrow, et al., *supra* note 68.

equipment,¹⁹⁰ and the federal Privacy Rule requires physicians and medical facilities to follow standardized procedures to protect patient confidentiality.¹⁹¹ While many of these regulations have benefits, all have significant costs, and some restrict the entry of competitors. Both higher costs and restricted entry decrease the supply of care, and a smaller supply usually results in higher prices.

To increase access to care without decreasing quality, Congress and the states should consider decreasing restrictions on professional and facility care. For example, states could decrease the stringency of their professional licensing and scope of practice rules for mid-level practitioners. Allowing qualified professionals to practice to the full extent of their training should increase the supply of care and may decrease prices. States also could eliminate or decrease the stringency of their CON rules. Allowing qualified facilities to expand without gaining prior approval should increase the supply of medical facilities, potentially decreasing prices without sacrificing quality.

Similarly, Congress should consider eliminating or decreasing the stringency of the Privacy Rule. Eliminating or decreasing the stringency of this rule should decrease professional and facility costs and would likely lead to lower prices. Less stringent rules also may encourage patients, professionals, and medical facilities to develop a contractual method in advance of care that would more effectively protect patient privacy.

Potential disadvantages of these reforms include less quality, higher costs, or less confidentiality of personal health information. However, data suggest that stringent rules governing licensing,¹⁹² scope of practice,¹⁹³ and facility expansion¹⁹⁴ do not improve quality, but increase both costs and prices. By increasing the process of discovery that occurs under free competition,¹⁹⁵ fewer restrictions also may lead to greater innovation. An assessment of benefits and costs can help determine if a regulation should be retained, decreased, or repealed.

Decrease Restrictions on Access to Pharmaceuticals

As noted previously, Congress requires pharmaceutical companies to gain approval from the FDA before releasing a new drug to the U.S. market. While requiring prior approval has benefits, it increases the cost of developing new drugs¹⁹⁶ and increases drug prices. High pharmaceutical prices are especially harmful for low-income patients and for patients who require many medications. In addition, the expectation of large development costs may prevent pharmaceutical companies from investigating promising new drugs.

¹⁹⁰ See McGinley, *supra* note 72.

¹⁹¹ 45 C.F.R. 164.

¹⁹² For example, *see* Shepard, *supra* note 77; Haas-Wilson, *supra* note 77; White, *supra* note 77; Sloan and Steinwald, *supra* note 77.

¹⁹³ For example, *see* Rooks, et al., *supra* note 78; Durand, *supra* note 78; U.S. Congress, Office of Technology Assessment, *supra* note 78.

¹⁹⁴ For example, *see* Anderson and Kass, *supra* note 79; Sherman, *supra* note 79; Conover and Sloan, *supra* note 79. *See also* Federal Trade Commission, *supra* note 79.

¹⁹⁵ *See* Hayek, *supra* note 109.

¹⁹⁶ Dimasi et al. estimated that for each new drug approved between 1990 and 2001, pharmaceutical companies spent over \$800 million dollars on research and development. *See* Dimasi, Hansen, and Grabowski, *supra* note 88.

To increase access to beneficial drugs, Congress should consider reforming the new drug approval process. This section discusses four possible ways. First, Congress should consider allowing private drug certifying bodies to perform many of the functions presently carried out by the FDA.¹⁹⁷ This approach has been used successfully for medical devices in Europe and as a pilot program in the U.S.¹⁹⁸ Competing private entities may be able to discover more effective and less costly ways to assure safety and efficacy.

Second, Congress should consider creating a dual track approval process that would allow a patient and experimental drug sponsor to contract for the purchase of an unapproved drug that has completed Phase I safety trials, provided the patient and patient's physician are informed concerning the drug's safety and efficacy data.¹⁹⁹ This reform would allow informed individuals to gain access to drugs while the drug is still undergoing Phase II and Phase III clinical trials. It would be especially helpful for patients with serious, life-threatening illnesses, for which there are few approved options.

Third, Congress should consider maintaining the requirement for safety and efficacy, but eliminating the requirement for prior approval. A regulatory or law-enforcement agency can enforce risk-reducing regulations in two primary ways – by serving in a policing capacity, i.e., monitoring products in the marketplace and removing those products that do not meet the regulatory standard, or by serving in a gatekeeper capacity, i.e., requiring the sponsor of a product to gain approval before releasing a new product to the market.²⁰⁰ Monitoring and removal is less costly for a product sponsor,²⁰¹ and this method of enforcement was used successfully by the FDA prior to the 1962 requirement for prior approval.²⁰²

Fourth, Congress should consider maintaining the requirement for safety, but eliminating the requirement that pharmaceutical manufacturers demonstrate efficacy before releasing a new drug.²⁰³ At present, physicians are allowed to prescribe approved drugs for conditions other than the one for which the drug was initially approved, a practice sometimes called “off-label” use. In effect, the FDA is now allowing use of drugs for conditions in which they have not been demonstrated to be effective. Removing the requirement for efficacy may allow safe and effective drugs to reach the market sooner and at less expense.²⁰⁴ Ineffective drugs would rapidly lose favor with patients and physicians, as do ineffective drugs used off-label today.

The primary advantage of each of these reforms is that patients would have greater access to pharmaceuticals at lower prices, and greater access may decrease morbidity and mortality. In addition, liberalizing the prior approval process may allow pharmaceutical companies to develop

¹⁹⁷ For example, Congress could maintain the FDA's authority for final approval, but allow drug certifying bodies to evaluate a pharmaceutical company's research data and recommend for or against approval. See Henry I. Miller, TO AMERICA'S HEALTH: A PROPOSAL TO REFORM THE FOOD AND DRUG ADMINISTRATION, CHAP. 5 (2000).

¹⁹⁸ *Id.*

¹⁹⁹ See Bartley J. Madden, A Dual Track System To Give More-Rapid Access to New Drugs: Applying a Systems Mindset to the U.S. Food and Drug Administration (FDA), 72 Medical Hypotheses 116 (2009).

²⁰⁰ See Peter Huber, Exorcists vs. Gatekeepers in Risk Regulation, Regulation 23 (Nov./ Dec., 1983).

²⁰¹ *Id.*

²⁰² See Miller, CHAP. 1, supra note 197.

²⁰³ See Daniel B. Klein and Alexander Tabarrok, Who Certifies Off-label? 27 Regulation 60 (2004).

²⁰⁴ Even without a requirement for efficacy, a safety standard could be adjusted based on intended use and expected benefits.

safe and effective drugs that cannot be cost-effectively developed under the present regulatory framework. The primary disadvantage is that patients may incur more injuries from unsafe drugs. However, each of these reforms maintains a safety requirement that could be made more stringent if necessary.

Cap Non-Economic Damages and Enforce Pre-Care Contracts

State medical malpractice law allows an injured patient to recover damages from a physician, if the patient can prove to the satisfaction of the court that the physician provided substandard care and the substandard care caused the injury. While present malpractice law provides compensation for some negligently injured patients, data suggest that most such patients are not receiving compensation.²⁰⁵ In addition, data suggest there is not a strong correlation between substandard care and outcome of a lawsuit.²⁰⁶ If this is the case, malpractice law is unlikely to be having a major deterrent effect.²⁰⁷ Finally, malpractice law is administratively costly,²⁰⁸ and the threat of liability may increase the use of unnecessary resources²⁰⁹ and decrease the availability of physician care.²¹⁰

To increase access to care, states should consider reforming malpractice law. This section discusses two possible ways.²¹¹ For situations in which a contract has not been formed in advance of care, states should consider placing a cap on non-economic damages.²¹² Non-economic damages are inherently subjective, and capping them would not alter the fundamental right of redress that individuals have against one who injures them. Because economic damages are not inherently subjective and may be necessary to assure that an injured patient receives both medical care and income replacement, capping only non-economic damages seems more desirable than capping total damages.

²⁰⁵ See discussion and references, *supra* note 97.

²⁰⁶ See discussion and references, *supra* note 99.

²⁰⁷ The Harvard Medical Practice Study attempted to determine whether state malpractice law was having a deterrent effect on medical injuries. There was a trend suggesting that patients cared for by physicians who faced greater malpractice risk had fewer injuries from substandard care, but the results were not statistically significant. See Paul C. Weiler, et al., *A MEASURE OF MALPRACTICE*, CHAP. 6 (1993). On the other hand, Hyman pointed out that malpractice lawsuits and increasing malpractice premiums were one reason the American Society of Anesthesiology initiated a safety program that resulted in a decrease in anesthesia-related injuries. See David M. Hyman, *The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability a Part of the Problem or a Part of the Solution?* 90 *Cornell L. Rev.* 893 (2005).

²⁰⁸ See Towers Perrin, *supra* note 103.

²⁰⁹ See Kessler and McClellan (1996), *supra* note 101; Kessler and McClellan (2002), *supra* note 101.

²¹⁰ See Kessler, Sage, and Becker, *supra* note 102.

²¹¹ While common-law solutions are usually more flexible than legislative solutions, Hayek points out that the common law sometimes evolves in an undesirable direction that is not easily corrected by means of additional case law. Under these circumstances, corrective legislation may be necessary. See F.A. Hayek, *LAW, LEGISLATION AND LIBERTY*, VOL. 1, RULES AND ORDER, CHAP 4, 88 (The University of Chicago Press, 1973). For a review of proposals to reform state malpractice law, see Studdert, Mello, and Brennan, *supra* note 95. Most federal proposals for substantive reform of malpractice law are likely unconstitutional and are not recommended. See Michael I. Krauss and Robert A. Levy, *Can Tort Reform and Federalism Coexist?* Policy Analysis No. 514, Cato Institute (Apr., 14, 2004).

²¹² See Cogan, Hubbard, and Kessler, CHAP. 2, *supra* note 8. For a review of the effects that damage caps have on costs and physician supply, see Michelle M. Mello, *Medical Malpractice: Impact of the Crisis and Effect of State Tort Reforms*, The Synthesis Project Report No. 10, Robert Wood Johnson Foundation, May, 2006, accessed at http://www.rwjf.org/pr/synthesis/reports_and_briefs/pdf/no10_researchreport.pdf.

States also should consider enforcing contracts for malpractice protection made between patients and physicians in advance of care.²¹³ Contracting in advance of care would allow patients and physicians to choose the type of protection that best meets the needs of each particular situation.

Both types of malpractice reform should decrease the cost of providing care and increase physician willingness to provide care. A larger supply of care should result in lower prices and greater access. In addition, allowing patients and physicians to choose the best method of malpractice protection for each situation may lead to both safer care and better compensation of injured patients.

Potential disadvantages include the possibility that fewer injured patients would receive compensation, patients may not be sufficiently compensated, and decreasing the threat of a malpractice suit may lead to more medical injuries. However, the presently available data suggest that a large majority of patients injured by substandard care are not presently being compensated and that malpractice law is having little, if any, deterrent effect.

Discussion – Effects of Recommended Reforms

This subpart discusses the potential effects of the recommended reforms under three categories: (1) effects on prices for private health insurance, (2) effects on prices for medical services and products, and (3) effects on one’s ability to pay for insurance and care.

Effects on Prices for Private Health Insurance

The recommended reforms would likely decrease private insurance prices in two primary ways. Some reforms would decrease the demand for insurance, while others would increase the supply.

Equalizing the tax treatment of funds used for health care would decrease the incentive for employees to choose ESI over ISI and decrease the incentive to choose comprehensive plans with minimal cost sharing. As more people use their own funds to choose insurance targeted to their specific needs, insurance prices and excess expenditures should decline. In addition,

²¹³ Several scholars have proposed allowing patients and physicians to contract in advance of care for malpractice protection; *see* Patricia M. Danzon, *MEDICAL MALPRACTICE: THEORY, EVIDENCE, AND PUBLIC POLICY*, CHAP. 12 (Cambridge, Harvard University Press 1985); Richard A. Epstein, *Medical Malpractice: the Case for Contract*, 1 *Am. B. Found. Res. J.* 87 (1976); Richard A. Epstein, *Medical Malpractice, Imperfect Information, and the Contractual Foundation for Medical Services*, 49 *L. and Contemp. Probs.* 201 (Spring, 1986); Clark C. Havighurst, *Private Reform of Tort-Law Dogma: Market Opportunities and Legal Obstacles*, 49 *L. and Contemp. Probs.* 143 (Spring, 1986); Michael J. Krauss, *Restoring the Boundary: Tort Law and the Right to Contract*, *Policy Analysis No.* 347, *Cato Institute* (June 3, 1999); Michelle M. Mello and Troyen A Brennan, *Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform*, 80 *Tex. L. Rev.* 1595 (2002); Jeffrey O’Connell, *Neo-No-Fault Remedies for Medical Injuries: Coordinated Statutory and Contractual Alternatives*, 49 *L. and Contemp. Probs.* 125 (Spring, 1986); Paul H. Rubin, *TORT REFORM BY CONTRACT*, CHAP. 2 (Washington, D.C., The AEI Press 1993). For a review of this topic, *see* Don W. King, *Contract as a Means of Medical Malpractice Reform*, *Policy Resource No. 3*, *Mercatus Center at George Mason University* (Mar., 2007), accessed at http://mercatus.org/sites/default/files/publication/20071015_King_-_Contract_as_a_Means_of_Med_Mal_Reform.pdf.

replacing public insurance with a public subsidy would allow public insurance beneficiaries to choose from the same insurance options now available to non-beneficiaries.²¹⁴

Decreasing underwriting restrictions and benefit mandates should lead to lower claims costs and additional insurance options. A larger insurance supply, including a larger supply of low-cost alternatives, should lead to lower prices. In addition, fewer restrictions and fewer mandates would allow insurers to offer more innovative types of insurance than exist today.

Effects on Prices for Medical Services and Products

Similarly, the recommended reforms would likely decrease prices for medical services and products in two primary ways. Some reforms would decrease the demand for care, and others would increase the supply.

Equalizing the tax treatment of funds used to pay for care and replacing public insurance with public subsidies or private support would decrease the demand for care by decreasing the incentive for individuals to pay for medical care through health plans instead of paying directly. As more individuals choose to pay for care with their own funds, prices for care and excess expenditures should decline. Also, because more individuals would own the funds used for their care, individuals would have greater flexibility to choose care specific to their needs.

Decreasing restrictions on professional care, facility care, and pharmaceuticals would increase the supply of care by decreasing the cost of providing care and by increasing the available options. Similarly, medical malpractice reform would decrease professional and facility costs and may increase physician willingness to provide care. A larger supply would likely lead to lower prices. Also, fewer restrictions may allow professionals and medical facilities to develop better ways to provide cost-effective care and pharmaceutical companies to develop promising new drugs that cannot be cost-effectively developed under the present regulatory framework.

Effects on One's Ability to Pay for Insurance and Care

There are two primary ways the federal or a state government could make insurance and care more affordable - by enacting policies that lead to lower prices or by enacting policies that increase each individual's ability to pay. As discussed above, each of the recommended reforms should result in lower prices for either insurance or care. In addition, some reforms would increase the ability of many persons to pay.

Decreasing restrictions on HSAs would allow individuals to pay for more of their care with pre-tax funds. Allowing a standard tax credit or standard deduction for health insurance, decreasing restrictions on HSAs, and replacing public insurance with a public subsidy would increase the personal income of millions of Americans. More payment with pre-tax dollars and more personal income would allow more individuals to pay for their own care and more persons

²¹⁴ While replacing public insurance with a subsidy to purchase private insurance would increase the demand for private insurance, the effect would be small compared to the excess demand resulting from the tax preference for ESI. Also, unlike the recent legislation, Congress or state legislators could limit public subsidies to individuals who are presently covered by public insurance.

to contribute to the care of those who need assistance. Finally, a private subsidy or other form of voluntary support would provide access to care for many persons who are unable to pay with their own funds.

Part 4 - Application of Reforms to Specific Populations

While greater individual ownership and more options should increase access to care for most people, low-income and high-risk individuals may not be able to pay for either insurance or care, and high-risk individuals may not be able to obtain insurance at an affordable price. Part 4 discusses application of these reforms to low-income and high-risk persons. Because Medicare pays for care for most individuals 65 and older, Part 4 also discusses the application of these reforms to Medicare beneficiaries.

Application to Low-Income Persons

Prior to the mid-twentieth century, much of the care received by low-income Americans was provided privately. Philanthropic and religious organizations built hospitals that provided care for low-income Americans,²¹⁵ fraternal organizations built hospitals and hired physicians to care for their members and families,²¹⁶ and some employers and unions hired physicians to provide care for their employees, members, and families.²¹⁷ Also, many physicians and hospitals provided care for low-income patients at either no charge or a discounted rate,²¹⁸ and some continue to do so. Finally, during the last 30 years, philanthropic and religious groups have established “free clinics,” most of which serve uninsured patients at no or minimal charge.²¹⁹

During the nineteenth and early twentieth centuries, cities and counties built dispensaries, clinics, and hospitals for low-income persons,²²⁰ and during the latter half of the twentieth century, the federal and state governments established public programs to pay for low-income care. Since the creation of Medicaid, Congress and state legislators have attempted to increase low-income access primarily by expanding eligibility for public programs.²²¹ Expanding eligibility does increase access for some individuals.²²² However, public insurance may provide limited access to care,²²³ may crowd out private insurance,²²⁴ and requires public funding.

As described in Part 3, each of the six types of recommended reform should result in lower prices for insurance, medical care, or both. Lower prices would be especially helpful for low-income persons. While allowing a standard deduction for health insurance or decreasing restrictions on HSAs would provide less direct benefit for low-income individuals, both would

²¹⁵ See Paul Starr, BOOK 1, CHAP. 4, supra note 6.

²¹⁶ See David T. Beito, *From Mutual Aid to the Welfare State: Fraternal Societies and Social Services, 1890-1967*, Chaps. 6, 9, and 10 (2000).

²¹⁷ See Starr, Book 1, CHAP. 6, supra note 6.

²¹⁸ See Starr, Book 1, CHAP. 4, supra note 6.

²¹⁹ See Beavers, supra note 175. See also Kellerher, supra note 175; Geller, Taylor, and Scott, supra note 175; Nadkarni and Philbrick, supra note 175.

²²⁰ See Starr, BOOK 1, CHAPS. 4 AND 5, supra note 6.

²²¹ See Hoffman, Jr., Klees, and Curtis, supra note 46.

²²² See Currie and Gruber, supra note 39; Baker and Royalty, supra note 39.

²²³ See Cunningham and May, supra note 41; Cunningham, Staiti, and Ginsburg, supra note 42.

²²⁴ See Gruber and Simon, supra note 44.

increase the personal income of many Americans. Greater personal income would allow low-income persons on the margin to better afford both insurance and care and allow high-income persons to better support low-income care.

Two types of reform may be especially helpful for low-income persons. First, Congress and state legislators should consider decreasing both underwriting restrictions and mandated benefits. While both types of requirements increase access for some individuals, they prevent a low-income person from choosing relatively inexpensive insurance to cover large, unexpected expenses. Allowing low-income persons to purchase less expensive insurance should increase their access to care and increase insurance prevalence among the low-income population.

Second, states should consider decreasing restrictions on nurse practitioner care. For many low-income individuals, primary care is the point of entry to preventive care, treatment of many conditions, and referral to specialists. Some states have fairly restrictive scope of practice rules, e.g., some states require nurse practitioners to have on-site supervision, and some require physician review for each prescription.²²⁵ Allowing nurse practitioners to provide care to the full extent of their training should make primary care more available to low-income persons. Similarly, decreasing restrictions on nurse-midwife care may result in greater access to low-risk labor and delivery care.

For low-income individuals who continue to need assistance, replacing public insurance with a public subsidy would allow them to choose from the same insurance and care available to average-income persons. Also, because a subsidy would entail fewer administrative costs and because a subsidy in advance of care could be a defined amount, a public subsidy should be less costly for the federal and state governments than maintaining Medicaid as a separate payment system. Finally, because private support is more flexible and more adaptable to specific needs than either public insurance or a public subsidy, and because there are no taxation costs, private support offers the possibility of even greater access to care at less cost to society.

Application to High-Risk Persons

Since the 1970s, some states have attempted to increase high-risk access by establishing a high-risk pool, a state-created entity that provides health insurance for high-risk individuals.²²⁶

²²⁵ See Sharon Christian, Catherine Dower, and Edward O'Neill, Chart Overview of Nurse Practitioner Scopes of Practice in the United States, Center for the Health Professions, University of California, San Francisco (2007), accessed at http://futurehealth.ucsf.edu/Content/29/2007-12_Overview_of_Nurse_Practitioner_Scopes_of_Practice_In_the_United_States_Chart.pdf; Sharon Christian, Catherine Dower, and Ed O'Neill, Overview of Nurse Practitioner Scopes of Practice in the United States – Discussion, Center for the Health Professions, University of California, San Francisco (2007), accessed at http://futurehealth.ucsf.edu/Content/29/2007-12_Overview_of_Nurse_Practitioner_Scopes_of_Practice_In_the_United_States_Discussion.pdf. See also Cooper, Henderson, and Dietrich, *supra* note 67.

²²⁶ See Lori Achman and Deborah Chollet, Insuring the Uninsurable: An Overview of State High-Risk Pools, The Commonwealth Fund (Aug., 2001), accessed at http://www.commonwealthfund.org/usr_doc/achman_uninsurable_472.pdf?section=4039; Austin Frakt, Steve Pizer, and Marian Wrobel, Insuring the Uninsurable: The Growth in High-Risk Pools, HSRE Working Paper 12 (May 15, 2002), accessed at <http://www.abtassociates.com/reports/HSRE-W12-highrisk.pdf>; Families USA, High-Risk Health Insurance Pools, Issue Brief (May 2006), accessed at <http://www.familiesusa.org/assets/pdfs/High-Risk-Pools-May-2006.pdf>.

Participants are required to pay premiums, but premiums are limited to between 125 and 200 percent of the premium required of average-risk persons. To keep premiums within the required range, states subsidize these pools. The primary advantage of a high-risk pool over guaranteed issue plus community rating is that a high-risk pool does not increase insurance prices for low and average-risk persons. The primary disadvantage is that subsidies require public funding.

Other states have attempted to assure high-risk access by requiring insurers to offer insurance to all qualified applicants at community-rated prices. While guaranteed issue plus community rating increases insurance prevalence among the high-risk population, because it results in higher insurance prices, it decreases prevalence among the average and low-risk populations,²²⁷ and it may result in a net decrease in overall insurance prevalence.²²⁸

Each of the recommended reforms should result in lower prices for either insurance or care. Because high-risk persons often require more care, lower prices would be especially helpful for them. In addition, high-risk individuals are not necessarily low-income. As a result, equalizing the tax treatment of funds that pay for care would directly increase the ability of some high-risk persons to pay for both insurance and care. These measures also would increase the ability of middle and high-income individuals to contribute to the care of high-risk individuals who need assistance.

Two types of reform may be especially helpful. First, Congress and states should consider decreasing the number of mandated benefits. Many high-risk individuals do not benefit from these mandates, and eliminating or decreasing them should result in lower insurance prices. Fewer mandates also may lead to the development of more innovative types of insurance designed for persons with specific chronic disorders.

States also should consider decreasing restrictions on facility expansion and equipment purchase. Many high-risk patients require care from specialized centers that treat large numbers of patients with related disorders. Data suggest that patients who obtain care from physicians and hospitals that treat a large number of patients with the same condition have better outcomes than those who obtain care from low-volume physicians and hospitals.²²⁹ In addition, some of these centers are able to provide care at very low cost.²³⁰

Repealing or decreasing the stringency of CON laws should decrease the cost of developing specialized centers, potentially lowering prices for specialized care. By paying directly for care at low-cost centers and purchasing insurance to cover large, unexpected expenses, some high-risk persons may be able to better afford care than by purchasing comprehensive health plans and obtaining care from traditional full-service facilities.

²²⁷ See Davidoff, Blumberg, and Nichols, *supra* note 57; Herring and Pauly, *supra* note 57.

²²⁸ See Herring and Pauly, *supra* note 57.

²²⁹ See Ethan A. Halm, Clara Lee, and Mark R. Chassin, Is Volume Related to Outcome in Health Care? A Systematic Review and Methodologic Critique of the Literature, 137 *Ann. Intern. Med.* 511 (2002). See also John D. Birkmeyer, Therese A. Stukel, Andrea E. Siewers, et al., Surgeon Volume and Operative Mortality in the United States, 349 *N. Engl. J. Med.* 2117 (2003).

²³⁰ For example, Duke University's congestive heart failure program is a specialized program that produces excellent outcomes at low cost. See David J. Whellan, Laura Gaudin, and Wendy Gattis, et al., The Benefit of Implementing a Heart Failure Disease Management Program, 161 *Arch. Intern. Med.* 2223 (2001).

There also are reasons to think that some high-risk persons may be able to obtain affordable insurance in an unregulated market. For example, most people are able to obtain guaranteed renewal as a feature of their insurance policy.²³¹ Voluntary guaranteed renewal allows one to pay extra when one is young and healthy in return for guaranteed renewal at a rate similar to one's rating class if one later becomes ill. Similarly, health-status insurance would allow a low-risk person to purchase insurance to cover the cost of future premiums if one later becomes high risk.²³² Finally, most individuals who are moderately high risk are able to obtain insurance at rates only slightly higher than average-risk persons.²³³ As a result, it may not be necessary to subsidize all patients who are high risk.

For severely high-risk persons who are unable to obtain insurance in an unregulated market, a public subsidy or private support should be more satisfactory than requiring guaranteed issue plus community rating. A public subsidy could be a subsidy to a high-risk pool, a risk-adjusted subsidy to an insurer, or a risk-adjusted subsidy directly to an individual to purchase insurance in the open market. As with low-income patients, private support for high-risk care offers the possibility of even greater access to care at less cost to society.

Application to Medicare Beneficiaries

Since Medicare's inception in 1965, Congress has attempted to increase access for Medicare beneficiaries primarily by increasing Medicare payment rates to physicians and medical facilities.²³⁴ Higher payment rates do help maintain beneficiary access to care. However, Medicare payment rates are in effect a form of fixed prices, and fixed payment rates cannot adjust to the rapid changes in supply and demand for specific types of care. As a result, Medicare payment rates may result in either surpluses or shortages of some types of care. Also, in its present form, Medicare appears to be financially unsustainable.

Each of the six types of recommended reform should result in lower prices for insurance or care. Because Medicare beneficiaries tend to require more care, and because Medicare contains a number of cost-sharing features, reforms that result in lower prices would be very helpful for most beneficiaries.

In addition, Congress should consider replacing traditional Medicare with a public subsidy that the beneficiary could use to purchase private insurance or pay directly for care. The amount could be income based, risk adjusted, both, or neither. A subsidy would allow each beneficiary to choose the insurance and care best suited to the beneficiary's needs. If beneficiaries owned the funds that pay for their insurance and care, insurers would have more incentive and flexibility to develop innovative types of insurance for seniors, and professionals and medical facilities would have more incentive and flexibility to develop cost-effective ways

²³¹ Pauly reported that prior to HIPAA's requirement for guaranteed renewal for certain types of insurance, up to 80 percent of individuals had voluntary guaranteed renewal as a feature of their insurance policy. *See* Mark Pauly, Regulation of Bad Things That Almost Never Happen, But Could: HIPAA and the Individual Insurance Market, 22 *Cato J.* 72 (2002).

²³² Cochrane has recently described health status insurance. *See* John H. Cochrane, Health-Status Insurance: How Markets Can Provide Health Security, Policy Analysis No. 633 (Feb. 18, 2009).

²³³ *See* Herring and Pauly, *supra* note 57.

²³⁴ In most years, Congress increases payment rates for physician care.

to provide senior care. Also, replacing Medicare insurance with a subsidy of a defined amount would allow the federal government to better control both its present expenditures and long term liabilities.

Finally, Congress should consider allowing younger Americans to opt out of Medicare, placing their Medicare payroll taxes and other contributions into personal accounts to pay for retirement medical expenses.²³⁵ By converting Medicare payroll taxes into savings for health care, it is possible that over time, both Medicare as a separate payment system and public subsidies could be eliminated.²³⁶ Low-income and high-risk seniors could be eligible for the same public subsidies and private support described earlier for other low-income and high-risk individuals.

Conclusion

During the twentieth century, both Congress and state legislators enacted laws that favor certain forms of paying for care over others and laws authorizing extensive regulation of private health insurance, professional care, and medical facility care. In addition, Congress required pharmaceutical companies to gain approval before releasing a new drug to the U.S. market, and state malpractice lawsuits increased. While each of these developments has had benefits, together they have contributed to high prices for insurance and care and to large health care expenditures.

Congress recently passed legislation designed to extend comprehensive third-party coverage to most Americans. While this legislation will provide benefits for some individuals, it will likely lead to even higher prices for insurance and care, larger expenditures, and potentially less access to care.

In contrast, reforms that increase individual ownership of the funds used for one's health care and reforms that increase one's options for insurance and care should lead to lower prices and greater access to care for most people. In addition, these reforms should lead to fewer excess expenditures and greater innovation. Finally, greater individual ownership and more options may be more effective than universal insurance at increasing access to care for low-income, high-risk, and older Americans.

²³⁵ See Martin Feldstein, Prefunding Medicare, NBER Working Paper No. 6917 (Jan., 1999).

²³⁶ Since 1984, Singapore has required individuals to save 6 to 8 percent of their wages to pay for health care, and most Singaporeans now pay directly for much of their care. See Taylor and Blair, *supra* note 160.