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STATE HEALTH-CARE REFORM: A Resource for State Legislators

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I INTRODUCTION

DURING THE TWENTIETH century, U.S. physicians, scientists, and other health-care professionals made rapid progress in curing disease, restoring function, and relieving pain. During this time, essentially all measures of health status improved, and while studies are limited, there are recent data suggesting that for many clinical conditions, U.S. patients have equal or superior outcomes to patients in other advanced countries.¹

On the other hand, there are data suggesting that many Americans have limited access to care,² U.S. health-care expenditures are very large,³ and some Americans receive less than ideal care.⁴ For example, the U.S. Census Bureau estimated that 47 million Americans, approximately 15.8 percent of the population, did not have health insurance in 2006.⁵ The Centers for Medicare and Medicaid Services estimated that Americans spent \$2.106 trillion, approximately 16.0 percent of Gross Domestic Product (GDP), on health care in 2006,⁶ and based on two earlier studies, the Institute of Medicine estimated that in 1997 between 44,000 and 98,000 Americans died in hospitals

at least partially as a result of medical errors.⁷ While these estimates are often disputed and the significance of the first two questioned, they do reflect common concerns, and they suggest that reform may be indicated.

Views vary widely as to why Americans spend 16 percent of their GDP on health care and why almost 16 percent of Americans are uninsured. Some observers emphasize inherent features of modern health care.⁸ For example, because modern medicine requires highly trained professionals using expensive technology, modern medicine is likely to be very expensive. As a result, many people may never be able to pay for care or insurance without public assistance.

Other observers emphasize the increasing role of federal and state governments in providing and regulating both care and insurance.⁹ These observers maintain that federal and state policies are at least partially responsible for large expenditures. Because they result in higher prices for care and insurance, these policies may be partially responsible for the large number of people without health insurance.

1. Because of differences among countries in disease registries and in the ability to detect diseases at early stages, comparison studies must be interpreted with caution. Nevertheless, recent comparison studies suggest that for treatment of various types of cancers, U.S. outcomes are equivalent to and sometimes superior to other advanced countries. See Milena Sant, Claudia Allemani, Franco Berrino, et al., "Breast Carcinoma Survival in Europe and the United States: A Population Based Study," *Cancer* 100 (February 15, 2004): 715; Peter S. Hussey, Gerard F. Anderson, Robin Osborn, et al., "How Does the Quality of Care Compare in Five Countries?" *Health Affairs* 23 (May/June 2004): 89; Arduino Verdecchia, Silvia Francisci, Hermann Brenner, et al., "Recent Cancer Survival in Europe: A 2000–02 Period Analysis of EUROCARE-4 Data," *Lancet Oncology* 8 (2007): 784; June E. O'Neill and Dave M. O'Neill, "Health Status, Health Care and Inequality: Canada vs. the U.S." (NBER Working Paper #13429, September 2007).
2. Access to care may be limited by a lack of insurance, the high cost of care, or other reasons. For a review of the effects that lack of insurance, high costs, and inadequate access have on families, businesses, and federal and state governments, see Timothy Stoltzfus Jost, *Health Care at Risk* (Durham: Duke University Press, 2007), chap. 1.
3. See Centers for Medicare and Medicaid Services, "National Health Expenditures Aggregate, Per Capita Amounts, Percent Distribution, and Average Annual Percent Growth, by Source of Funds: Selected Calendar Years 1960-2006," *NHE Web Tables*, table 1, <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf>.
4. For studies suggesting that Americans frequently do not receive recommended care, see Elizabeth A. McGlynn, et al., "The Quality of Health Care Delivered to Adults in the United States," *New England Journal of Medicine* 348 (2003): 2635; Rita Mangione-Smith et al., "The Quality of Ambulatory Care Delivered to Children in the United States," *New England Journal of Medicine* 357: 1515.
5. Carmen DeNavas-Walt, Bernadette D. Proctor, and Jessica Smith, "Income, Poverty, and Health Insurance Coverage in the United States: 2006" (U.S. Census Bureau Current Population Reports—Consumer Income, August 2007), <http://www.census.gov/prod/2007pubs/p60-233.pdf>.
6. Centers for Medicare and Medicaid Services, "National Health Expenditures."
7. Institute of Medicine, *To Err is Human: Building a Safer Health System* (Washington, DC: National Academy Press, 2000), chap. 2.
8. See David M. Cutler, *Your Money or Your Life* (Oxford: Oxford University Press, 2004), chap. 10; Jost, "Health Care at Risk," ch. 11.
9. See Michael F. Cannon and Michael D. Tanner, "Introduction" in *Healthy Competition*, 2nd ed. (Washington, DC, Cato Institute, 2007); John F. Cogan, R. Glenn Hubbard, and David P. Kessler, *Healthy, Wealthy, and Wise* (Washington, DC: The AEI Press, 2005), chap. 2.

1A. Health-Care Reform

MOST REFORMERS AGREE that increasing access to care, improving the quality of care, and eliminating unnecessary expenditures are worthy goals. However, there are widely varying views as to how best to achieve them. In general, there are two basic approaches, with some reforms combining elements of the two approaches.

Reformers who emphasize the influence of modern health care in causing large expenditures and inadequate access usually recommend that federal or state governments play a greater role.¹⁰ These reformers tend to emphasize the large number of persons without health insurance, often proposing that the federal or a state government provide insurance or require employers or individuals to purchase insurance. In general, these reformers tend to support greater regulation of private insurance.

Reformers who emphasize the influence of public policies in causing large expenditures and inadequate access usually recommend that federal and state governments play a smaller role.¹¹ These reformers tend to emphasize the importance of individuals choosing the care and insurance they desire from competing providers and insurers. In general, these reformers recommend less regulation of private care and private insurance.

In addition to providing and regulating both care and insurance, for at least the past 70 years, both federal and state governments have provided incentives and subsidies to facilitate the private provision of care and insurance. For example, federal and state governments have provided subsidies to hospitals¹² and tax incentives to insurers.¹³ In addition, since 1943, the federal government has provided a tax incentive, sometimes referred to as a tax “subsidy” or tax “expenditure,” for individuals to obtain private insurance through their employer.¹⁴

Because most working Americans take advantage of the tax incentive for employer-provided insurance, and because both incentives and subsidies combine a government role with a private role, either set of reformers may support or oppose incentives or subsidies in certain situations.

1B. Federal and State Reform

BOTH FEDERAL AND state policies have an important influence on U.S. health care. In general, reforms that would alter federal policies require federal reform, and those that would alter state policies require state action. As required by the U.S. Constitution, federal laws take precedence over state laws,¹⁵ though some federal laws specifically prevent states from acting in certain ways.¹⁶ As a result, state reforms often are limited by the federal policies that are in place.

Despite these limitations, there are many reforms states can implement to increase access, improve quality, or decrease unnecessary expenditures. Chapters 6–8 of this policy resource describe a number of options states may consider.

1C. Purpose and Plan of Policy Resource

THE PURPOSE OF this policy resource is to provide state policy makers with a framework for approaching health-care reform at the state level. While there are many factors that contribute to health-care access, quality, and cost,¹⁷ this resource emphasizes the role that federal and state policies have on U.S. health care and the effects that state reforms may have.

10. See Cutler, *Your Money or Your Life*; Jost, “Health Care at Risk,” chap. 11.

11. See Cannon and Tanner, *Healthy Competition*; Cogan, Hubbard, and Kessler, *Healthy, Wealthy, and Wise*.

12. For example, the federal Hill-Burton Act in 1946 provided subsidies to hospitals for facility construction, Public Law 79-725, 79th Cong., 2d sess. (1946).

13. For example, in the 1930s many states declared Blue Cross hospital service plans to be charitable organizations exempt from state taxes. See Paul Starr, *The Social Transformation of American Medicine, Book 2* (New York: Basic Books, 1982), chap. 2.

14. By allowing individuals to exclude employer-provided insurance from gross income, Congress has provided a tax incentive for individuals to obtain health insurance through their employer. See Joint Economic Committee, *How the Tax Exclusion Shaped Today’s Private Health Insurance Market* (Dec. 17, 2003). See also Robert B. Helms, *Tax Reform and Health Insurance*, Health Policy Outlook (Washington, DC: American Enterprise Institute for Public Policy Research, January–February 2005).

15. U.S. Const. art. VI.

16. For example, the Employee Retirement Income Security Act (ERISA) preempts state laws that affect employee welfare benefit plans. Public Law 93-406, *U.S. Statutes at Large* 88 (September 2, 1974): 829.

17. For a discussion of health care access, cost, and quality, see chapter 2.

The first half of this policy resource provides an introduction to federal and state policies and their influence on U.S. health care. **Chapter 2** provides background information concerning U.S. health-care policy. **Chapter 3** describes effects that previous federal and state policies have had on U.S. health care. **Chapter 4** provides examples of state regulations that involve the care provided by physicians, other professionals, and hospitals. **Chapter 5** provides examples of state regulations that involve health insurance underwriting, pricing, and benefits.

The second half of this policy resource describes a number of reforms that are available to the states. The chapters on reform proposals are organized by specific goals of state policy makers. Because reforms often have multiple effects, some reforms are discussed in multiple chapters. **Chapter 6** describes reforms designed to increase access to care and insurance for the general population; **Chapter 7** describes reforms designed to increase access to care and insurance for low-income patients, and **Chapter 8** describes reforms designed to increase access to care and insurance for high-risk patients.

Chapters 6–8 are each divided into four sections. The first section of **Chapters 6–8** provides background information concerning relevant federal policies and the federal environment in which state reform can take place. The next three sections review the major reform options available to the states, organized under three general categories: (1) reforms that involve the state providing or requiring care or insurance, (2) reforms that involve the state providing incentives or subsidies for private care or insurance, and (3) reforms that modify the regulation of care or insurance.

For most reforms included in **Chapters 6–8**, the discussion includes a number of theoretical advantages and disadvantages of the reform. For some reforms, the discussion provides data from selected empirical studies related to the reform and comments concerning the reform's likely effects.

Chapter 9 provides a summary and conclusion.

1D. Additional Reading

1. Michael F. Cannon and Michael D. Tanner, *Healthy Competition*, 2nd ed. (Washington, DC: Cato Institute, 2007).
2. John F. Cogan, R. Glenn Hubbard, and David P. Kessler, *Healthy, Wealthy, and Wise* (Washington, DC: The AEI Press, 2005).
3. David M. Cutler, *Your Money or Your Life* (Oxford: Oxford University Press, 2004).
4. Timothy Stoltzfus Jost, *Health Care at Risk* (Durham: Duke University Press, 2007).



BACKGROUND INFORMATION— HEALTH-CARE POLICY

THIS CHAPTER PROVIDES background information concerning U.S. health-care policy. It is divided into the following sections: (1) patients, (2) access, cost, and quality, (3) public policy and health care, and (4) evaluation of government policies.

2A. Patients

TO UNDERSTAND POLICIES designed to increase access to health care, it is useful to consider three types of patients: patients with average risk and average income (the general population), low-income patients who may have difficulty affording even basic care (low-income patients), and patients with medical conditions making them more likely to require expensive services (high-risk patients).

General Population

WHILE MOST PEOPLE may be able to afford basic health care, some care is likely to be very expensive. For example, because care in an intensive-care unit for severe accident victims requires 24-hour 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, one important goal of public policy may be to increase access for the general population to insurance for large, unexpected expenses, as well as to basic care.¹⁸

Low-Income Patients

FOR MANY CLINICAL conditions, health care is essential for one to maintain normal function, and sometimes it is essential for survival. Low-income individuals may have difficulty paying for either care or insurance. As a result, another important goal of public policy may be to increase access for low-income individuals to both basic care and to insurance for large, unexpected expenses.¹⁹

High-Risk Patients

SOME INDIVIDUALS ARE more likely to require expensive care than the average person. For example, an older person, a person with a genetic abnormality, or a person with a chronic disease has a greater risk of requiring health care than a young, healthy person with no known predisposition to disease. Because they require more care, high-risk patients may be unable to pay for needed care, and they may not be able to obtain insurance to cover large, unexpected expenses. As a result, another goal of public policy may be to increase access for high-risk patients to basic care, to care for their particular condition, and to provide insurance for large, unexpected expenses.²⁰

2B. Access, Cost, and Quality

AS NOTED IN Chapter 1, increasing access to care, improving the quality of care, and decreasing unnecessary expenditures are worthy reform goals. This section provides a brief description of these concepts.

Access to Care—Insurance

BECAUSE HEALTH CARE for major illnesses and injuries may be very expensive, health insurance is an important component of access to care. Also, many studies suggest that persons with health insurance receive more care and have better health outcomes than those who lack insurance.²¹

On the other hand, the presence of health insurance is not synonymous with access to care. For example, an employee's insurance options may be limited to the plans chosen by one's employer, and both private and public insurance plans vary as to the availability of benefits and access to physicians and hospitals. As a result, some insured patients may not have full access to certain types of care.

Conversely, some patients without insurance may have quite good access to care. For example, although paying directly for care is usually very expensive, patients who can afford to pay directly have access to most U.S. phy-

18. Chapter 6 discusses reforms designed to increase access for the general population.

19. Chapter 7 discusses reforms designed to increase access for low-income patients.

20. Chapter 8 discusses reforms designed to increase access for high-risk patients.

21. See Jack Hadley, "Sicker and Poorer—The Consequences of Being Uninsured: A Review of the Research on the Relationship between Health Insurance, Medical Care Use, Health, Work, and Income," *Medical Care Research and Review* 60 (supp., June 2003), 35-75S. See also Helen Levy and David Meltzer, "What Do We Really Know about Whether Health Insurance Affects Health?" in *Health Policy and the Uninsured*, Catherine G. McLaughlin, ed. (2004), chap. 4.

sicians and hospitals. Also, some hospitals, clinics, and physicians provide care to all patients regardless of ability to pay.²²

In addition, there are disadvantages to purchasing health insurance for small or expected expenses. First, there are large administrative costs to involving a third party in two-party transactions. Administrative costs include the value of the time and other resources necessary for an insured individual, a physician, or a hospital to prepare and submit claims, for an insurer to evaluate the appropriateness of claims, and for the insurer to pay the claims.

Also, third-party payment provides incentives that may result in excess resource use. For example, when a third party is paying, there are incentives for both patients and physicians to use resources in which the expected benefits are less than the cost.²³

Finally, since a third-party payer cannot be present during the millions of patient-physician encounters that occur each day, a third party is not in the best position to make informed decisions concerning appropriateness of care or whether payment is justified. As a result, encounters that involve third-party payment are more subject than two-party encounters to disputes concerning the necessity of care or whether fraud has occurred.

For all of these reasons, maintaining insurance for small or expected expenses is likely to be more expensive than paying directly for these expenses.

Access to Care—Expenditures, Costs, and Prices

THE LARGE AND growing percentage of U.S. GDP represented by health care is not necessarily harmful. Since

maintaining one's health is very desirable for most people, one would expect that as people become wealthier, they would spend a larger percentage of their income on health-related items, including health care. In addition, there are data suggesting that at least some of the large growth in U.S. health-care expenditures during the past 50 years is responsible for significant improvements in health and well being.²⁴

However, from the perspective of a patient, employer, or government payer, health-care expenditures represent costs.²⁵ These costs are best thought of as "opportunity costs," i.e., the value of the next-best alternative one has to forgo in order to obtain the item or service. When deciding whether to pay for health care, an individual, employer, or government payer must decide to choose between health care and food, housing, education, wages, savings, or even other health care. Provided they result in equivalent quality and outcome, policies that result in fewer expenditures are desirable because they allow individuals to meet needs other than health care.

In addition, lower prices for care or insurance should lead to greater access. As will be discussed in Chapter 3, one major reason many persons do not buy health insurance is that the expected benefits are less than the cost. Public policies that lead to lower prices for both care and insurance may significantly increase access to care.

Quality of Care

Definition and Measurement

Health-care quality is difficult to both define and measure.²⁶ In general, "high quality" refers to decisions and performance that offers a patient the highest probability of achieving the best clinical outcome.²⁷

22. These hospitals and physicians often discount their charges using a "sliding scale." For example, a patient with an income less than the federal poverty level (FPL) may be required to pay 0 percent of charges, 1.0–1.25 of FPL, 20 percent; 1.25–1.50 of FPL, 40 percent; 1.50–1.75 of FPL, 60 percent; 1.75–2.00 of FPL, 80 percent; and greater than two times FPL, 100 percent.

23. Moral hazard is a term that denotes the tendency for insured individuals to be less careful than they would be if they were financially responsible for the loss themselves. With respect to health insurance, moral hazard also can refer to a tendency for individuals and physicians to use all potentially beneficial measures, even if the expected benefits of the measure are less than the cost.

24. Cutler provides data suggesting that the benefits resulting from additional spending on neonatal care, mental health, and cardiovascular disease have been significantly greater than the costs. See David M. Cutler, *Your Money or Your Life* (Oxford: Oxford University Press, 2004) chap. 3–6.

25. Since employers and government payers pay for most U.S. health care, one can attribute the opportunity cost to employers and government payers. On the other hand, government expenditures represent costs to taxpayers, and most of the cost of employer-provided insurance and care are borne by employees in the form of lower wages, fewer benefits, or fewer workers. For example, see Jonathan Gruber, "The Incidence of Mandated Maternity Benefits", *American Economic Review* 84 (1994): 622.

26. See David Blumenthal, "Part 1: Quality of Care—What Is It?" *New England Journal of Medicine* 335 (1996): 891. See also Federal Trade Commission/Department of Justice, "Overview/Background," in *Improving Health Care: A Dose of Competition* (July 23, 2004), http://www.usdoj.gov/atr/public/health_care/204694.htm

27. See Federal Trade Commission/Department of Justice, "Overview/Background."

One may attempt to measure the quality of a nation's health care in a number of ways. Traditional methods include (1) measures of life-expectancy, mortality, or health status of the population, (2) measures of physician adherence to evidence-based guidelines, (3) determinations of the rate of a particular type of error, e.g., medication errors, and (4) risk-adjusted outcomes for certain conditions, e.g., the five-year survival rate for a particular type of cancer.

However, each of these measures has weaknesses. For example, an individual's life expectancy and health status are the result of many factors, only one of which is the quality of care one receives. Other factors include genetic makeup and lifestyle factors, such as type of work, risk of accidents, diet, exercise, and tobacco use.

Evidence-based guidelines also have weaknesses. Because there are wide variations in the situations physicians face, evidence-based guidelines may not accurately measure quality in many situations. In addition, rapid advances in medical science and technology may render guidelines rapidly out of date.

Probably the best way to compare health-care quality among populations is to use risk-adjusted outcomes of patients with similar conditions. For example, one can determine the five-year survival rate in patients who have various types of cancer. Using this approach, there are data suggesting that U.S. health care is equal or superior to that of most other industrialized countries.²⁸

Competition and Choice

Many factors influence the quality of a product or service. In a competitive marketplace, the two most important factors are the level of competition among producers or providers and the extent to which consumers assign value among competing goods or services. Competition is enhanced when the payment is influenced by the value provided and when producers are free to develop innovative products or services. Ability to assign value is enhanced when individuals own the resources used to

pay for an item or service and when they have information concerning quality and price.

With respect to health care, competition among professionals and hospitals and the ability of patients to assign value often are limited. As a result, states may be able to improve the quality of care by instituting reforms that increase competition among professionals and hospitals and increase a patient's ability to assign value among multiple options.

2C. Public Policies and Health Care *Policies and Laws*

A PUBLIC POLICY usually refers to a course of action by the federal or one of the state governments. Federal and state policies are brought into effect through at least three types of laws—statutes, administrative regulations, and judicial opinions.²⁹

Laws influence behavior in many ways. Some laws prohibit certain types of behavior. For example, a speed limit prohibits one from driving above a specified speed. Violating a speed limit results in a penalty.

Other laws do not prohibit behavior, but provide an incentive for one to behave in a certain way. For example, because U.S. tax laws treat employer-provided health insurance (EPI) more favorably than either individually purchased insurance (IPI) or out-of-pocket expenses, the federal government provides an incentive for Americans to obtain comprehensive health insurance through their employers.³⁰ Although there is no requirement to obtain comprehensive health insurance through one's employer, it is usually in one's best interest to do so.

Types of Public Policies

THERE ARE MANY ways the federal or a state government can influence health care. Either the federal or a state government may provide care or insurance for specific groups of people or for the entire population. Either

28. See chapter 1, note 1 above.

29. Most laws affecting U.S. health care are statutes passed either by Congress or by one of the 50 state legislatures. Administrative regulations are authorized by federal or state statutes and issued by administrative agencies. Judicial opinions result when federal and state courts decide controversies between parties. Their decisions may be based on state common law or on federal or state constitutions, statutes, administrative regulations, or previous judicial decisions.

30. The U.S. tax code allows taxpayers to exclude EPI from gross income when calculating one's income tax, but taxpayers cannot exclude IPI or out-of-pocket expenses. *U.S. Code* 26 (January 2002), § 106(a).

may regulate or tax the private provision of care or insurance, and either may provide incentives or subsidies to the providers of care or insurance. In addition, federal or state governments may require or subsidize employers to pay for care or insurance, or they may require or subsidize individuals to pay for care or insurance.

At this time, the most common types of health care policies used by U.S. federal and state governments are: (1) provision of insurance, e.g., Medicare and Medicaid,³¹ (2) regulation of physician and hospital care, e.g., licensing, scope of practice rules, and certificate-of-need regulations,³² (3) regulation of health insurance, e.g., mandated guaranteed issue, mandated community rating, and mandated benefits,³³ and (4) tax incentives for individuals to purchase insurance, e.g., exclusion of the value of employer-provided insurance from gross income when calculating one's income tax.³⁴

Goals of Reform and Tradeoffs

THE GOAL OF most reform proposals is to increase access, improve the quality of care, or decrease unnecessary expenditures. While some reforms may achieve each of these goals, others make tradeoffs between greater access, higher quality, and fewer expenditures. In addition, for most policies and reforms, the beneficial effects accrue to one or more groups of individuals, while the harmful effects are borne by others.

For example, a state may require an insurer to cover in vitro fertilization or alcoholism treatment in all insurance policies it sells. While these requirements result in greater access to care for those who need these types of treatment, the required benefit results in higher insurance prices, decreasing access for those who do not require these types of care and may be unable to afford the higher insurance price.

2D. Analysis of Policies and Reforms

ASSESSING A POLICY'S benefits and costs is the most common method used to evaluate the effects of public policies. Benefits include the intended and sometimes

unintended benefits. Costs include the cost of the agency responsible for implementing the policy and the cost for individuals and organizations to comply with the policy. Also, there often are difficult-to-quantify costs that result from incentives engendered by the policy.

Following are brief discussions illustrating the benefits and costs of administrative regulations and entitlement programs. These are followed by a discussion of the cost of taxation.

Administrative Regulations

BEFORE INTRODUCING A new drug to the U.S. pharmaceutical market, a company must obtain approval from the U.S. Food and Drug Administration (FDA) by showing that the new drug is both safe and effective for at least one clinical indication.³⁵

To illustrate the benefits of this policy, assume a pharmaceutical company is attempting to gain approval for a potentially life-saving drug that carries a significant risk of harmful effects. One benefit of prohibiting such a drug is that individuals will not be harmed if the drug is not released. Although imprecise, one can attempt to quantify the benefits by estimating the number of patients who may be harmed by a drug and estimating the cost of the injuries that may occur. One additional benefit is that resources will not be wasted in those patients in whom the drug would not have been effective.

Costs of this policy include the FDA's costs in developing and issuing regulations, the cost of monitoring pharmaceutical companies to make sure they are complying with the regulations, and the cost of enforcing the regulations. Costs also include the cost for pharmaceutical companies to comply with the regulations. Dimasi et al. estimated that between 1990 and 2001, pharmaceutical companies incurred over \$800 million in research and development costs for each new drug that was approved.³⁶ While much of these costs was a result of research and development that would have been necessary even without the regulations, a portion of these costs resulted from regulation compliance.

31. See chapters 3 and 7.

32. See chapters 3 and 4.

33. See chapters 3 and 5.

34. See chapter 3.

35. *Drug Amendments of 1962*, Public Law 87-781, *U.S. Statutes at Large* 76 (1962): 780.

36. See Joseph A. Dimasi, Ronald W. Hansen, Henry G. Grabowski, "The Price of Innovation: New Estimates of Drug Development Costs," *Journal of Health Economics* 22 (2003): 151.

In addition, some costs resulting from administrative regulations are more difficult to predict. For the policy requiring new drug approval, these additional costs include the morbidity and even mortality in patients who could have benefited from a drug, but did not, because the drug was not approved, approval was delayed, or regulation-induced higher prices made the drug less affordable.

Finally, two additional costs are associated with administrative regulations. There are the costs of lobbying by those who may benefit and those who may be harmed by the regulation,³⁷ and there are costs associated with the taxation needed to generate the necessary funds.³⁸

Entitlement Programs

ONE ALSO CAN evaluate the benefits and costs of government policies other than administrative regulations. For example, one can evaluate the benefits and costs of entitlement programs such as Social Security, Medicare, and Medicaid. The primary benefit of the Medicaid program is the value of the health insurance for each Medicaid beneficiary.³⁹

In addition to the cost of the entitlement itself, there are costs for both the Center for Medicare and Medicaid Services (CMS) and state Medicaid offices to administer the program. Also, Medicaid beneficiaries have compliance costs, both to apply for the program and to abide by regulations governing the program. Because means-tested programs provide incentives for beneficiaries and potential beneficiaries to earn less income than they otherwise might, there may be costs resulting from less labor input.⁴⁰

As with administrative regulations, there are two additional types of costs: the cost of lobbying by those who support or oppose program expansion and the cost of taxation. With respect to the Medicaid and Medicare programs, both patient advocacy groups and professional groups incur costs when attempting to increase payment rates or to increase the types of services covered

by these programs. Similarly, taxpayer advocacy groups incur costs when attempting to prevent expansion of these programs.

Taxation

TO CREATE THE benefits of either an administrative regulation or an entitlement program, a government must first obtain funds. As noted above, administrative regulations require funds for an administrative agency to develop, monitor, and enforce regulations. Entitlement programs require funds to pay the entitlement and for an administrative agency to administer the program.

In addition to the specific costs of the administrative regulation or entitlement program described above, one should consider the cost to generate the necessary funds. In addition to the cost of the revenue obtained, costs include the cost of an administrative agency to develop, monitor, and enforce the regulations governing taxation as well as the compliance costs of taxpayers. 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.⁴¹

Similar to administrative regulations and entitlement programs, taxation provides incentives that also have costs. Feldstein has described three types of costs resulting from 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 or other 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., larger interest payments on a home mortgage.⁴²

Using IRS data from 2000, Feldstein estimated that the "deadweight loss"⁴³ of these three costs, resulting from a one percent increase in marginal tax rates, would be

37. Lobbying costs are sometimes referred to as "rent-seeking" costs.

38. See the discussion of taxation below.

39. The value of the insurance could also be considered a transfer of funds from taxpayers to Medicaid beneficiaries.

40. See Taxation section below for discussion of loss of labor input.

41. 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 (December 2005).

42. Martin A. Feldstein, "The Effect of Taxes on Efficiency and Growth," *Tax Notes* 679 (May 8, 2006).

43. A deadweight loss, or welfare loss, is the "aggregate loss in well-being of the participants in a market resulting from an inefficient output level." See Browning and Zupan, *Microeconomics: Theory and Applications* (New York: John Wiley & Sons, Inc., 2002), chap. 10.

76 percent of the revenue obtained.⁴⁴ Thus, in addition to IRS agency costs, taxpayer compliance costs, and the taxpayer cost of the actual revenue obtained, there may be additional taxpayer costs of up to \$ 0.76 for every dollar of revenue.

2E. Summary

FROM THE STANDPOINT of public policy, it is useful to consider policies designed to increase access to care for the general population, low-income patients, and high-risk patients.

Federal and state policies are brought into effect through laws. Laws influence behavior by prohibiting certain actions or by providing incentives that make one action more desirable than another. To influence health care, federal or state governments may provide health care or health insurance, tax or regulate the private provision of care or insurance, or facilitate private care or insurance through incentives or subsidies to professionals, hospitals, insurers, or individuals.

One can analyze public policies by evaluating their benefits and costs. Benefits are the intended and sometimes unintended beneficial effects of policies. Costs include the cost of an administrative agency to implement the policy, the compliance costs of those who must abide by the policy, the costs of alternative actions people take to either obtain the benefits or avoid the costs of the policy, and the costs of taxpayers who provide the funds.

2F. Additional Reading

1. David Blumenthal, "Part 1: Quality of Care—What Is It?" *New England Journal of Medicine* 335 (1996): 891.
2. David M. Cutler, *Your Money or Your Life* (Oxford: Oxford University Press, 2004), chap. 3–6.
3. Federal Trade Commission/Department of Justice, *Improving Health Care: A Dose of Competition* (July 23, 2004), Overview/Background.
4. Jack Hadley, "Sicker and Poorer—The Consequences of Being Uninsured: A Review of the Research on the Relationship between Health Insurance, Medical Care Use, Health, Work, and Income" *Medical Care Research and Review* 60 (supp., June 2003): 3S.

44. Feldstein, "The Effect of Taxes."

HISTORICAL EFFECTS OF FEDERAL AND STATE POLICIES ON U.S. HEALTH CARE

PRIOR TO THE twentieth century, the federal government was not actively involved in providing or regulating health care.⁴⁵ Many states and cities built hospitals for low-income patients, but with the exception of physician licensing that began in the latter part of the nineteenth century, state and municipal regulation of physician and hospital care was minimal.⁴⁶ In the twentieth century, both federal and state governments became actively involved in paying for care, the federal government began regulating pharmaceuticals and medical devices, and both federal and state governments began regulating professional care, hospital care, and health insurance.

As noted in Chapter 1, Americans spend approximately 16 percent of U.S. GDP on health care,⁴⁷ and up to 15.8 percent of Americans lack health insurance.⁴⁸ While many factors are responsible for both large expenditures and many uninsured patients,⁴⁹ it is likely that federal and state policies are at least partially responsible. This chapter reviews a number of federal and state policies that have influenced U.S. health care, emphasizing those that may have contributed to the growth in health care expenditures and the large number of uninsured. Chapters 4 and 5 provide a more complete discussion of many of the state regulations mentioned in this chapter.

3A. Health Care Expenditures

WHILE MANY FACTORS have increased U.S. health-care expenditures, from the public policy standpoint, there are three primary factors: (1) For income-tax purposes,

an individual can exclude employer-provided insurance (EPI) from gross income, but not individually purchased insurance (IPI) or out-of-pocket expenses; (2) federal and state governments provide insurance (publicly provided insurance—PPI) for a large percentage of the population; and (3) the federal government regulates the development and sale of pharmaceuticals and medical devices, and the federal and state governments regulate professional and hospital care. The first two of these factors result in a greater demand for care. The third results in a smaller supply of care.

Demand for Care

ONE DOES NOT normally think of the demand for health care in the same way one thinks of the demand for other goods or services. For most individuals, the demand for care is what one's physician recommends, e.g., whether there is a need to see a specialist, have a diagnostic test performed, or take medication.

On the other hand, when considering the factors responsible for large expenditures and many individuals without insurance, it is useful to consider traditional economic concepts such as demand and supply. In addition, one important study described in this chapter suggests that the demand for some forms of health care follows a pattern similar to that for goods and other services.⁵⁰

Finally, greater demand and large expenditures are not necessarily harmful. Both PPI and the exclusion of EPI from gross income have undoubtedly increased access to care for many people. However, even beneficial policies may increase the demand for care and result in either higher prices or more provided services.

45. See Paul Starr, *The Social Transformation of American Medicine*, Book 1 (New York: Basic Books, 1982).

46. Ibid.

47. Centers for Medicare and Medicaid Services, "National Health Expenditures Aggregate, Per Capita Amounts, Percent Distribution, and Average Annual Percent Growth, by Source of Funds: Selected Calendar Years 1960-2006," *NHE Web Tables*, table 1, <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf>

48. Carmen DeNavas-Walt, Bernadette D. Proctor, and Jessica Smith, "Income, Poverty, and Health Insurance Coverage in the United States: 2006," (U.S. Census Bureau Current Population Reports—Consumer Income, August 2007), <http://www.census.gov/prod/2007pubs/p60-233.pdf>.

49. Increased expenditures are partially a result of greater wealth, an aging population, and greater ability to diagnose and treat disease, restore function, and relieve pain. Ideal care often requires the use of costly diagnostic or treatment measures, and it sometimes requires management in an intensive care unit, staffed 24 hours a day by highly trained professionals. As a result, one would expect that Americans would spend a larger percentage of their GDP on health care today than in 1960.

50. See Willard G. Manning, et al., "Health Insurance and the Demand for Health Care: Evidence from a Randomized Experiment," *American Economic Review* 77 (1987): 251.

Differential Tax Treatment of Health Care Expenses

In 1943, the Internal Revenue Service ruled that the value of EPI could be excluded from gross income when calculating one's income tax, and in 1954, Congress enacted a statute incorporating this exclusion.⁵¹ However, the exclusion does not apply to health insurance if an individual purchases it independently (IPI) or to health care expenses if one pays for care directly or out-of-pocket.⁵²

Differential taxation of health care expenses increases demand for health care in at least three ways. First, EPI is less costly for an individual than that person's other living expenses.⁵³ This provides an incentive for an individual to obtain more health insurance than one would otherwise purchase.

Second, EPI is less costly for an individual than if one purchases insurance independently. As a result, Americans have a strong incentive to obtain health insurance through their employer. Because the employee is not paying for insurance directly, these costs are "hidden" from the employee. Because the cost is hidden, an employee is likely to demand more insurance than if the employee paid for insurance directly.

Third, EPI is less costly for the individual than out-of-pocket expenses. As a result, an employee has an incentive to choose a plan that covers all conditions, has minimal cost-sharing, and pays for even minor medical expenses, sometimes called "first-dollar" coverage. Third-party payment for essentially all services limits or even eliminates normal constraints on an insured individual's demand for care.

Each of these factors increases the demand for care, and under most circumstances, a larger demand results in higher prices and more provided services than would otherwise occur.

Public Payment for Care

In 1965, Congress enacted legislation that created Medicare and Medicaid.⁵⁴ Medicare is a federal program that pays for health-care services and products for individuals 65 years of age and older, disabled Americans, and patients with end-stage renal disease.

Medicaid is a combined federal and state program that pays for health care services and products for certain groups of low-income individuals.⁵⁵ Because the 50 states, the District of Columbia, and five U.S. territories have flexibility concerning eligibility criteria, services covered, and payment levels, Medicaid is actually 56 different programs with much variation.

Similar to differential taxation, publicly provided insurance (PPI) sets up incentives that increase the demand for care. Because either the federal or a state government pays for much of a beneficiary's care, health care is less costly for the beneficiary than his/her other living expenses. In addition, because the government pays for the expenses, the cost is hidden from the beneficiary. Finally, similar to first-dollar private coverage, both Medicare and Medicaid pay for minor services. As with comprehensive EPI, each of these factors increases the demand for services, and a larger demand usually results in higher prices and more provided services.

The Rand Health Insurance Experiment

During the 1970s, the U.S. government initiated The Rand Health Insurance Experiment (HIE).⁵⁶ The HIE was a controlled experiment in which individuals in six cities throughout the country were randomly assigned to a prepaid group practice or to one of fourteen fee-for-service health insurance plans.

The investigators found that patients assigned to plans that required large coinsurance payments used significantly fewer medical services than patients with either small or no coinsurance payments.⁵⁷ For example,

51. See Joint Economic Committee, *How the Tax Exclusion Shaped Today's Private Health Insurance Market* (Dec. 17, 2003), http://jec.senate.gov/republicans/public/_files/HealthTaxExclusion.pdf.

52. *Ibid.* U.S. Code 26 (January 2002) § 106(a).

53. Because an employee pays for health insurance using pre-tax dollars, the employee incurs less opportunity cost for health insurance than for expenses paid with post-tax dollars. See discussion of opportunity cost in chapter 2.

54. *Social Security Amendments of 1965*, Public Law 89-97, U.S. Statutes at Large 79 (1965): 286.

55. *Ibid.*

56. See Manning, et al., "Health Insurance."

57. *Ibid.*

patients who paid no coinsurance had annual outpatient expenses 67 percent higher than patients who paid a 95 percent coinsurance rate. These data suggest that third-party payment for most services does increase the demand for services and results in larger expenditures than otherwise would occur.

For the group as a whole, there were no differences in health outcomes between the plans.⁵⁸ However, compared to low-income patients in the HMO or cost-sharing plans, patients in the lowest 20th percentile of income who paid no coinsurance had better outcomes with respect to blood pressure control, vision correction, and teeth and gum health.

Comment—Effects of Differential Taxation and PPI
Both PPI and the tax incentive for EPI have increased access to insurance and care for many Americans. However, even beneficial policies that increase the demand for care may result in higher prices and a greater volume of provided services. Because patients without access to EPI or PPI must pay for care and insurance with after-tax dollars, higher prices are especially costly for these individuals.⁵⁹

Supply of Care

THIS SECTION BRIEFLY describes three categories of federal and state regulation involving the provision of health-care services or products: (1) regulation of professional care, (2) regulation of hospital care, and (3) regulation of pharmaceuticals and medical devices.⁶⁰

Most of these regulations were designed to assure the quality of professionals or the safety and quality of the care they provide. While undoubtedly they have had benefits, they also have had costs.

In general, regulation of any good or service increases the cost of providing the good or service. For example, to comply with a new regulation, a regulated entity may need to hire additional employees, purchase new equipment, alter operating procedures, or provide additional documentation. In a competitive market, a higher cost to provide a good or service results in a smaller supply. In addition, some regulations prevent competitor entry, and barriers to entry also decrease supply. A smaller supply usually results in higher prices.

Regulation of Professional Care

Throughout much of the nineteenth century, there was minimal regulation of physicians and other practitioners.⁶¹ Beginning in the late nineteenth century, states began licensing physicians,⁶² and in the latter half of the twentieth century, states began licensing and developing scope of practice regulations for those entering a number of newly created health-care professions.⁶³

While stringent licensing and scope of practice rules may improve quality under some circumstances, they do increase the cost of providing care and limit the entry of potential competitors. Both mechanisms result in a smaller supply of care and often higher prices.

In addition to administrative regulations, during the latter half of the twentieth century, there was a significant increase in the number and value of medical malpractice lawsuits.⁶⁴ While medical malpractice law is quite different from an administrative regulation, malpractice law does increase the cost of providing care and may limit the supply of care.⁶⁵

Unlike most administrative regulations, malpractice law also may increase the demand for care. To protect themselves against a potential lawsuit, physicians may order more diagnostic or therapeutic procedures than they

58. Ibid.

59. While patients without access to EPI or PPI may pay the same prices for care or insurance, because they pay with after-tax dollars, their opportunity cost is greater.

60. See chapter 4 for a more complete discussion of state regulation involving professional or hospital care.

61. See Starr, *The Social Transformation*.

62. Ibid.

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

64. See Paul C. Weiler, *Medical Malpractice on Trial*, (Cambridge, MA: Harvard University Press, 1991), chap. 1.

65. See chapter 4 for a discussion of medical malpractice.

otherwise would, a practice sometimes called “defensive medicine.”⁶⁶

Regulation of Hospital Care

Both federal and state governments have enacted legislation resulting in state regulation of hospital expansion and major-equipment purchase.⁶⁷ For example, state certificate-of-need (CON) regulations require hospitals and other facilities to obtain approval from a state planning board before expanding facilities or purchasing major equipment.

As with other forms of regulation, CON laws increase the cost of providing care. For example, hospitals incur costs developing their applications and presenting their case for approval. In addition, CON laws specifically limit the entry of competitors. Both higher costs and limited entry decrease the supply of hospital and other facility care and may increase prices.

Regulation of Pharmaceuticals and Medical Devices

During the twentieth century, Congress passed legislation that requires pharmaceutical companies to gain approval from the Food and Drug Administration (FDA) before introducing a new drug to the market.⁶⁸ To gain approval, a pharmaceutical company must demonstrate, based on controlled studies, that a new drug is both safe and effective for at least one clinical indication.

To implement this policy, the FDA has developed regulations that increase the cost of bringing new drugs to the market.⁶⁹ As with other regulations, gaining approval based on safety and efficacy increases the cost of providing pharmaceuticals and likely results in higher prices.

Comment—Effects of Health-Care Regulation

Most of the regulations described in this section were designed to assure the quality of health-care professionals or the care they provide, and many of these regulations have had significant benefits. However, even beneficial regulations increase the cost of providing care, and these higher costs have likely decreased the supply of care and increased prices. Higher prices are partially responsible for the large growth in U.S. health-care expenditures.

3B. Prevalence of Health Insurance

ONE IMPORTANT REASON many Americans lack health insurance is that health insurance is expensive, and for many, the expected benefits are less than the cost.⁷⁰ This section discusses two types of policies that have made health insurance more expensive than it otherwise would be: (1) differential tax treatment of health-care expenses and (2) regulation of insurance underwriting, pricing, and benefits.⁷¹

Differential Tax Treatment of Health-Care Expenses

THE PRIMARY PURPOSE of most insurance is to protect one’s assets against large, unexpected losses. Because of the administrative cost of involving a third party in minor transactions, and the tendency for individuals to use excess resources when a third party is paying, insurance for minor or expected expenses is usually more costly than direct payment of these expenses.

As noted earlier, differential tax treatment of health-care expenses increases the demand for comprehensive, first-dollar insurance, and comprehensive, first-dollar insurance is more expensive than insurance for large,

66. See chapter 4. For studies related to defensive medicine, See David M. Studdert et al., “Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment,” *Journal of the American Medical Association* 293 (2005): 2609; A. Russell Localio et al., “Relationship Between Malpractice Claims and Caesarean Delivery,” *Journal of the American Medical Association* 269 (1993): 366; Laura-Mae Baldwin et al., “Defensive Medicine and Obstetrics,” *Journal of the American Medical Association* 274 (1995): 1606; Lisa Dubay et al., “The Impact of Malpractice Fears on Cesarean Section Rates,” *Journal of Health Economics* 18 (1999): 49; Daniel Kessler and Mark McClellan, “Do Doctors Practice Defensive Medicine?” *Quarterly Journal of Economics* 111 (1996): 353; Daniel Kessler and Mark McClellan, “Malpractice Law and Health Care Reform: Optimal Liability Policy in an Era of Managed Care,” *Journal of Public Economics* 84 (2002): 175.

67. See Patrick John McGinley, “Beyond Health Care Reform: Reconsidering Certificate-of-Need Laws in a Managed Competition System,” *Florida State University Law Review* 23 (1995).

68. Drug Amendments of 1962, Public Law 87-781, U.S. Statutes at Large 76 (1962): 780.

69. As noted earlier, Dimasi et al. estimated that pharmaceutical companies spent over 800 million dollars in research and development costs for each drug approved between 1990 and 2001. See Joseph A. Dimasi, Ronald W. Hansen, and Henry G. Grabowski, “The Price of Innovation: New Estimates of Drug Development Costs,” *Journal of Health Economics* 22 (2003): 151.

70. See Cogan, Hubbard, and Kessler, *Healthy, Wealthy, and Wise*, chap. 1.

71. See chapter 5 for a more complete discussion of state regulation of health insurance.

unexpected expenses. Because differential tax treatment leads to more expensive insurance, it may be partially responsible for the large number of people who lack health insurance.⁷²

Regulation of Underwriting, Pricing, and Benefits

Federal Regulation

During the latter half of the twentieth century, the federal government began regulating private health insurance. To encourage large, multi-state employers to develop employee benefit plans and to assure a uniform regulatory structure for these plans, Congress passed the Employee Retirement Income and Security Act (ERISA) in 1974.⁷³ Because ERISA preempts many state regulations, ERISA has actually had a deregulatory effect on health insurance. In addition, it has encouraged employers to self-insure.⁷⁴

In 1986, Congress passed the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985.⁷⁵ COBRA required employers that provide health insurance for their employees to continue coverage for up to 18 months after the employee leaves employment.

In 1996, Congress passed the Health Insurance Portability and Accountability Act (HIPAA).⁷⁶ HIPAA requires employers and insurers that provide employer group coverage to limit the preexisting condition exclusion period to no more than 12 months and to provide insurance regardless of health status. HIPAA also requires insurers in the individual and small-group markets to guarantee availability and renewability of insurance to certain individuals.

State Regulation

Some states require all insurers who offer a particular type of insurance to make the insurance available to all applicants regardless of health status (guaranteed issue), and some states have required insurers to renew insurance policies when the policy expires (guaranteed renewal).⁷⁷

In addition, a number of states have substituted community rating for risk rating.⁷⁸ Strict community rating refers to a requirement that insurers charge each insured individual the same premium regardless of age, sex, health status, claims experience, or other risk factors. Modified community rating refers to a requirement that allows insurers to vary the premium based on age or another of these factors, but not health status.

Finally, all 50 states require insurers to either offer or include certain benefits in the insurance policies they offer.⁷⁹ For example, some states require an insurer to offer or include benefits for the treatment of alcoholism or benefits for treatment by a chiropractor, regardless of whether an individual desires these features.

Comment—Effects of Insurance Regulation

As with other forms of regulation, even beneficial regulations that affect underwriting, pricing, or benefits increase the cost of providing health insurance. In a competitive market, higher costs result in a smaller supply and often result in higher prices. Higher prices make insurance less desirable to the marginal buyer, and high prices may be a contributing factor to the large number of Americans without health insurance.⁸⁰

72. Since individuals without access to EPI or PPI must pay with pre-tax dollars, high insurance prices represent an especially high opportunity cost for them.

73. *ERISA*, Public Law 93-406, *U.S. Statutes at Large* 88 (September 2, 1974): 829.

74. Richard Briffault and Sherry Glied, "Federalism and the Future of Health Care Reform," in *The Privatization of Health Care Reform* 49, M. Gregg Bloch, ed. (2003).

75. *Consolidated Omnibus Budget Reconciliation Act of 1985*, Public Law 99-272, *U.S. Statutes at Large* 100: 82.

76. Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, 104th Congress (August 21, 1996).

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

78. *Ibid.*

79. See Victoria Craig Bunce, J.P. Wieske, and Vlasta Prikozsky, *Health Insurance Mandates in the States*, 2007 (Alexandria, VA: Council for Affordable Health Insurance, February 2007), http://www.cahi.org/cahi_contents/resources/pdf/MandatesInTheStates2007.pdf.

80. Chapter 5 describes studies suggesting that regulations involving underwriting, pricing, or benefits decrease the prevalence of health insurance among individuals who do not benefit from the regulations.

3C. Summary

PUBLICLY PROVIDED INSURANCE and differential taxation of employer-provided insurance, individually purchased insurance, and out-of-pocket expenses result in greater demand for health care. In addition, federal and state regulation of care results in a smaller supply of care. These policies may be partially responsible for higher prices and large U.S. health-care expenditures.

Similarly, differential taxation increases the demand for comprehensive, first-dollar insurance, a more expensive form of insurance than insurance for large, unexpected expenses. In addition, federal and state regulation of health insurance results in a smaller supply of insurance. Both the greater demand and smaller supply may be partially responsible for high insurance prices, and high prices are likely a contributing factor to the large number of Americans who lack health insurance.

3D. Additional Reading

1. John F. Cogan, R. Glenn Hubbard, and David P. Kessler, *Healthy, Wealthy, and Wise* (Washington, DC: The AEI Press, 2005), chap. 1.
2. Joint Economic Committee, “How the Tax Exclusion Shaped Today’s Private Health Insurance Market” (Dec. 17, 2003), http://jec.senate.gov/republicans/public/_files/HealthTaxExclusion.pdf.
3. Paul Starr, *The Social Transformation of American Medicine*, Book 1 (New York: Basic Books, 1982).
4. Willard G. Manning, et al., “Health Insurance and the Demand for Health Care: Evidence from a Randomized Experiment,” *American Economic Review* 77 (1987): 251.

STATE REGULATION OF HEALTH CARE

IN AN ATTEMPT to assure the quality of care, state governments actively regulate professional and hospital care. Because these regulations have a significant influence on access, this discussion precedes the discussion of specific reform proposals in Chapters 6 through 8.

The chapter begins with background information concerning federal health-care regulation. The next section discusses the effects of two types of state administrative regulation and one type of state common law: (1) limits to facility expansion and equipment purchase, (2) professional licensing and scope of practice rules, and (3) medical malpractice law.

Medical malpractice law is not a form of administrative regulation, and traditionally it was not considered subject to policy considerations. However, medical malpractice lawsuits and awards increased in the late twentieth century,⁸¹ and malpractice law has an important influence on how medicine is practiced.

In addition, judicial opinions in medical-malpractice cases often invoke policy considerations, both proponents and opponents of present malpractice law use policy arguments to justify their positions, and malpractice law continues to be the subject of vigorous policy debates in state legislatures throughout the country. Finally, one can evaluate the benefits and costs of malpractice law similar to the way one evaluates an administrative regulation. For all of these reasons, this chapter discusses medical malpractice law along with administrative regulations involving health care.

4A. Background—Federal Regulation of Health Care

BECAUSE REGULATIONS INVOLVING health and safety are traditionally considered within the domain of a state's

police powers, the federal government did not actively regulate professional care, hospital care, or pharmaceuticals in the nineteenth century.⁸² However, this changed markedly in the twentieth century, beginning with pharmaceuticals and later extending to hospital and physician care.

During the early twentieth century, the federal government began regulating the manufacture and sale of biologics⁸³ and pharmaceuticals.⁸⁴ With passage of the Kefauver-Harris Drug Amendments to the Federal Food, Drugs, and Cosmetic Act in 1962, Congress for the first time required a pharmaceutical manufacturer to gain approval from the U.S. Food and Drug Administration (FDA) before introducing a new drug to the U.S. market.⁸⁵

In 1965, Congress established Medicare, a health insurance program in which the federal government serves as a payer for health care services for Americans age 65 and older.⁸⁶ Because the Center for Medicare and Medicaid Services (CMS) pays for physician and hospital services, the federal government regulates physician and hospital care provided to Medicare beneficiaries in three primary areas—quality control, utilization review, and billing.

In addition, while CMS does not directly regulate most aspects of medical practice, it does determine the physician services for which it will pay and the amount it will pay. As a result, CMS indirectly has a major influence on U.S. medical practice.

In 1996, Congress passed the Health Insurance Portability and Accountability Act (HIPAA).⁸⁷ One component of HIPAA authorized the Department of Health and Human Services to develop regulations governing the privacy and security of personal health information. These regulations were implemented between 2002 and 2005. They apply to physicians, hospitals, third-party payers, and others who come in contact with personal health information.⁸⁸

81. See Paul C. Weiler, *Medical Malpractice on Trial*, (Cambridge, MA: Harvard University Press, 1991), chap. 1.

82. Police power is defined as "the inherent and plenary power of a sovereign to make all laws necessary and proper to preserve the public security, order, health, morality, and justice;" *Black's Law Dictionary*, 2nd pocket ed. (West Group, 2001).

83. *Biologics Control Act*, Public Law 57-244, U.S. Statutes at Large 32 (July 1, 1902): 728.

84. *Food and Drugs Act of 1906*, Public Law 59-384, U.S. Statutes at Large 34 (June 30, 1906): 768.

85. *Drug Amendments of 1962*, Public Law 87-781 U.S. Statutes at Large 76 (October 10, 1962): 780.

86. *Social Security Amendments of 1965*, Public Law 89-97 U.S. Statutes at Large 79 (July 30, 1965): 286.

87. *Health Insurance Portability and Accountability Act*, Public Law. 104-191, 104th Congress (August 21, 1996).

88. *Code of Federal Regulations* 45 §160–64.

4B. State Limits to Facility Expansion and Equipment Purchase

IN THE 1960s and 1970s, a number of states passed laws requiring hospitals and other facilities to obtain a “certificate of need” (CON) before expanding facilities or purchasing major equipment.⁸⁹ In 1974, Congress passed the National Health Planning and Resources Development Act (NHPDA).⁹⁰ One component of NHPDA conditioned federal funds on states establishing CON programs.⁹¹

As a result, most states soon developed state planning boards to investigate state facility needs and review applications for certificates of need.⁹² However, Congress repealed NHPDA in 1986,⁹³ and some states have since repealed their CON laws. As of 2007, 36 states and the District of Columbia continued to maintain CON regulations for at least some types of facility expansion.⁹⁴

The original rationale for CON laws was that approval from a state planning board would lower health-care costs by preventing unnecessary duplication of hospital facilities.⁹⁵ More recently, proponents have argued that CON laws are needed to assure the quality of care.⁹⁶ Their rationale is that CON laws can be used to prevent unqualified facilities and personnel from performing highly specialized procedures, such as cardiac surgery.

However, CON laws have a number of potential costs. These include both the cost of a state planning board that investigates state needs and grants approval and the

compliance costs hospitals incur preparing their applications for approval. In addition, there are likely to be deadweight losses resulting from higher prices.⁹⁷

CON regulations are likely to increase prices for at least two reasons. First, hospitals incur compliance costs developing and supporting their applications for approval. In addition, by requiring prior approval, CON laws specifically restrict the entry of competitors. Both higher costs and limited entry decrease the supply of hospital care, and under most circumstances, a smaller supply results in higher prices and fewer provided services. Finally, CON laws may result in lobbying costs. A requirement for prior approval provides an incentive for hospitals to lobby for or against approval for their allies or competitors.

Review of Selected Studies—Costs

IN THE 1980s, the Federal Trade Commission carried out a series of studies of the effects of CON laws on hospital costs.⁹⁸ Using 1981 Medicare cost reports, Anderson and Kass estimated that CON regulation increased the cost of providing home health services by approximately 2 percent.⁹⁹ Using 1983 and 1984 American Hospital Association survey data, Sherman estimated that if states were to double the capital threshold necessary for prior approval—decreasing the number of projects requiring approval—total hospital costs would decrease by 1.4 percent.¹⁰⁰ He further estimated that for acute-care hospitals, doubling the threshold would decrease total hospital costs by \$1.3 billion per year.

89. Patrick John McGinley, “Beyond Health Care Reform: Reconsidering Certificate-of-Need Laws in a Managed Competition System,” *Florida State University Law Review* 23 (1995).

90. *National Health Planning and Resources Development Act of 1974*, Public Law 93-641.

91. McGinley, “Beyond Health Care Reform.”

92. *Ibid.*

93. *Ibid.*

94. American Health Planning Association, “Certificate of Need,” <http://www.ahpanet.org/copn.html>.

95. See McGinley, “Beyond Health Care Reform.” In a competitive market, a smaller supply of facilities would likely result in higher prices, fewer provided services, or both. However, because third-party payment results in few constraints on demand, prior to managed care, there was very little price competition among hospitals. CON supporters reasoned that limiting the supply of facilities would decrease facility expansion and thus lower hospital costs.

96. American Health Planning Association, *Improving Health Care: A Dose of Competition: AHPA Response Arguments in Favor of Planning and CON Regulation*, <http://www.ahpanet.org/files/AHPAargfavorCON.pdf>.

97. For a definition of deadweight losses, see chapter 2, note 26 above.

98. 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 (January 1986); Daniel Sherman, *The Effect of State Certificate-of-Need Laws on Hospital Costs*, Bureau of Economics Staff Report to the Federal Trade Commission (January 1988); see also Federal Trade Commission/Department of Justice, “Miscellaneous Subjects,” in *Improving Health Care: A Dose of Competition*, chap. 8.

99. Anderson and Kass, *Certificate of Need*.

100. Sherman, *Effect of State*.

In 1998, Conover and Sloan studied the effects of CON regulation on per capita health-care spending.¹⁰¹ They estimated that states with mature CON programs had 5 percent lower per capita acute-care spending, but there was no reduction in total per capita health-care spending. They also estimated that CON laws resulted in a 2 percent reduction in hospital beds and that hospitals in CON states had higher costs per hospital day and higher costs per admission.

Review of Selected Studies—Quality

ONE OF THE first major studies looking at the effects of CON laws on quality of care was conducted by Shortell and Hughes in 1998.¹⁰² Using Medicare data for 16 clinical conditions, they estimated that states with the most stringent CON laws had a 5 to 6 percent higher mortality rate than states with less stringent CON laws. Robinson et al. studied mortality rates resulting from coronary artery bypass graft (CABG) procedures in Pennsylvania before and after CON repeal.¹⁰³ They found no difference in mortality rates before and after repeal.

On the other hand, Vaughan-Sarrazin et al. studied the effects of CON laws on the mortality rate following CABGs¹⁰⁴ and found higher mortality rates in states without CON regulation. DiSesa et al. studied the effects of CON laws on operative mortality for CABG procedures for the years 2000–2003.¹⁰⁵ They found no difference in operative mortality except in the South, where states with CON laws had lower operative mortality. However, after adjusted for region and random state effects, these results were not statistically significant.

Popescu et al. studied the effect of CON laws on the rate of revascularization procedures and the mortality rate following acute myocardial infarction.¹⁰⁶ They found that patients in CON states were less likely to have revascularization in the first two days after admission, but there

were no differences in revascularization rate on days three through thirty. There were no differences in mortality rates between states with and without CON laws.

Comment

THE PRESENTLY AVAILABLE data suggest that certificate-of-need laws do not reduce hospital costs or health-care spending, and some studies suggest that CON laws increase hospital costs. The data concerning the effects of CON laws on quality of care are mixed. There are a few data suggesting that states with CON laws have higher quality in certain areas, but most studies have found either opposite results or no effect. In summary, these data suggest that by eliminating or limiting the effects of their CON regulations, states may be able to lower hospital costs, and potentially prices, without decreasing quality.

4C. State Licensing and Scope-of-Practice Rules

MOST STATES EMPLOY a variety of regulations to govern the practice of health-care professionals.¹⁰⁷ These include: (1) licensing or entry regulations, which set the minimum levels of education and training to practice the profession, (2) scope-of-practice regulations, which limit what the professional is allowed to do, and (3) disciplinary procedures that apply if there is evidence of incompetent or unethical practice.

The primary benefit of stringent entry requirements and scope-of-practice rules is that strict rules may result in higher-quality professionals and higher-quality care. Costs include the cost of the state agency that develops, monitors, and enforces the rules and the compliance costs of professionals to meet the criteria and prepare their applications.

101. C.J. Conover and F.A. Sloan, "Does Removing Certificate-of-Need Regulations Lead to a Surge in Health Care Spending?" *Journal of Health Politics, Policy & Law* 23 (June 1998): 455.

102. S.M. Shortell and E.F. Hughes, "The Effect of Regulation, Competition, and Ownership on Mortality Rates Among Hospital Inpatients," *New England Journal of Medicine* 318 (1998): 1100.

103. J.L. Robinson, D.B. Nash, E. Maxey, et al., "Certificate of Need and the Quality of Cardiac Surgery," *American Journal of Medicine Quality* 16 (2001): 155.

104. 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," *Journal of the American Medical Association* 188 (2002): 1859.

105. Verdi J. DiSesa, Sean M. O'Brien, Karl F. Welke, et al., "Contemporary Impact of State Certificate-of-Need Regulations for Cardiac Surgery: An Analysis Using the Society of Thoracic Surgeons' National Cardiac Surgery Database," *Circulation* 114 (2006): 2122.

106. Iona Popescu, Mary S. Vaughan-Sarrazin, and Gary Rosenthal, "Certificate of Need Regulations and Use of Coronary Revascularization after Acute Myocardial Infarction," *Journal of the American Medical Association* 295 (2006): 2141 (2006).

107. See Barry R. Furrow, et al., *Health Law*, 2nd ed. (St. Paul: West Group, 2000), chap. 3.

As with CON laws, stringent rules increase the cost of providing care as well as limit the entry of potential competitors. Both mechanisms decrease the supply of care and may result in higher prices. In addition, because more stringent rules decrease competition, under some circumstances, they may result in poorer quality.

Review of Selected Studies—Effects on Prices and Income

A NUMBER OF investigators have studied the effects of licensure and practice restrictions on professional fees and salaries. In 1978, Shepard studied the effects of licensing restrictions on prices for dental care.¹⁰⁸ He found that dental prices were 14.9 percent higher in states that did not accept out-of-state dental licenses by reciprocity. Similarly, in 1986, Haas-Wilson studied the effects of practice restrictions on the price and quality of optometry services.¹⁰⁹ She found that practice restrictions increased the price of an eye examination and eyeglasses by 5–13 percent, and there were no differences in quality of exams or accuracy of prescriptions.

In 1978, White studied the effect of licensure requirements on the wages of laboratory personnel.¹¹⁰ He found that for personnel in cities with more stringent licensure laws, wages were 16 percent higher than they were for personnel in cities without stringent requirements. Similarly, Sloan and Steinwald studied the effects of licensure requirements on the wages of nurses and medical technologists.¹¹¹ They found that wages in states with mandatory licensing were 2–3 percent higher for RNs, 5–6 percent higher for LPNs, and up to 13 percent higher for medical technologists.

Review of Selected Studies—Mid-Level Practitioner Care

A NUMBER OF investigators have studied the quality and price of care provided by mid-level practitioners. Rooks

et al. studied outcomes of 11,814 low-risk births in 84 free-standing birth centers, approximately 80 percent of which were attended by certified nurse midwives.¹¹² There was no difference in infant mortality rates or low Apgar scores between these births and low-risk hospital births.¹¹³

Similarly, Durand compared 1,707 pregnancies of women enrolled in a home-birth service run by midwives in rural Tennessee to a sample of hospital births from the 1980 U.S. National Natality/ National Fetal Mortality Survey.¹¹⁴ They found no differences between home births and hospital births with respect to labor-related complications, five-minute Apgar scores, or neonatal death. In addition, there were fewer assisted deliveries and fewer Caesarean sections in the home-birth group.

In 1986, the Office of Technology Assessment reviewed the literature concerning the effectiveness of nurse practitioners.¹¹⁵ They found no differences between nurse practitioners and physicians in the adequacy of care for certain acute problems in the primary-care setting. However, nurse practitioners were less effective than physicians in dealing with situations requiring technical solutions.

Other investigators have estimated savings from increased use of mid-level practitioners. Using data from America's Health Insurance Plans and the Midwives Alliance of North America, Hafner-Eaton and Pierce estimated that in 1993, greater use of midwife-attended births could have saved \$8.5 billion.¹¹⁶ In 1992, Nichols estimated that inefficient use of nurse practitioners resulted in greater U.S. expenditures of from \$6.4 billion to \$8.75 billion per year.¹¹⁷

Comment

ALTHOUGH IT IS difficult to generalize from these and other studies, the studies concerning the effects of pro-

108. Lawrence Shepard, "Licensing Restrictions and the Cost of Dental Care," *Journal of Law & Economics* 21 (1978): 187.

109. Deborah Haas-Wilson, "The Effect of Commercial Practice Restrictions: The Case of Optometry," *Journal of Law & Economics* 29 (1986): 165.

110. William D. White, "The Impact of Occupational Licensure of Clinical Laboratory Personnel," *Journal of Human Resources* 13 (1978): 91.

111. Frank A. Sloan and Bruce Steinwald, *Hospital Labor Markets* (Lexington, MA: D.C. Heath and Company, 1980), chap. 3.

112. Judith Rooks, et al., "Outcomes of Care in Birth Centers: The National Birth Center Study," *New England Journal of Medicine* 321 (1989): 1804.

113. *Ibid.* An Apgar score is a numerical measure of an infant's condition just after birth.

114. A. Mark Durand, "The Safety of Home Birth: The Farm Study," *American Journal of Public Health* 82 (1992): 450.

115. 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, December 1986).

116. Chris Hafner-Eaton and Laurie K. Pierce, "Birth Choices, the Law, and Medicine: Balancing Individual Freedoms and Protection of the Public's Health," *Journal of Health, Politics, Policy, and Law* 19 (1994): 813.

117. Len M. Nichols, "Estimating Costs of Underusing Advanced Practice Nurses," *Nursing Economics* 10 (1992): 343.

professional licensure suggest that more stringent laws result in higher prices. The studies concerning quality of care suggest that mid-level practitioners are able to deliver high-quality care in both primary care and low-risk labor and delivery settings.

Based on these and other studies, states may be able to lower prices and increase access, without sacrificing quality, by liberalizing their licensing laws for health-care professionals. Similarly, states may be able to increase access to primary and low-risk labor and delivery care, without sacrificing quality, by liberalizing their scope of practice rules for mid-level practitioners.

4D. State Medical Malpractice Law

TORT LAW IS the branch of law in which each state gives its residents a right to hold another person or entity accountable for harm caused by that individual or entity. Medical malpractice law, one type of tort law, provides a patient the right to hold a physician accountable for harm caused by that physician.

The number of malpractice claims varied throughout the nineteenth and twentieth centuries, but beginning around 1960, the number of malpractice cases and the value of malpractice awards increased markedly.¹¹⁸ Because of increasing malpractice insurance premiums in the mid-1970s, mid-1980s, and early twenty-first century, state legislatures debated and often changed their malpractice law.¹¹⁹

Under malpractice law, if a patient has suffered harm that resulted from negligent care by the patient's physician, the patient has a right to bring suit against the physician. To hold the physician liable, the patient must show that the physician's care was below either a "customary" or "reasonable" standard of care for other physicians facing similar circumstances.¹²⁰ In addition, the patient must show that the substandard care was the cause of the harm incurred by the patient.

118. See Weiler, *Medical Malpractice*.

119. David M. Studdert, Michelle M. Mello, and Troyen A. Brennan, "Medical Malpractice," *New England Journal of Medicine* 350 (2004): 283.

120. Philip G. Peters, Jr., "The Quiet Demise of Defense to Custom: Malpractice Law at the Millennium," *Washington & Lee Law Review* 57 (2000): 163.

121. See Heidi L. Freeman, "Harm and Money: Against the Insurance Theory of Tort Compensation," *Texas Law Review* 75 (1996-1997) 1567.

122. Towers Perrin, *2007 Update on U.S. Tort Cost Trends*, appendix 2, http://www.towersperrin.com/tp/getwebcachedoc?webc=TILL/USA/2007/200712/tort_2007_1242007.pdf.

123. These and many of the studies described in this section use retrospective, physician hospital record review to determine which adverse events are the result of negligence and which are not. See A. Russell Localio et al., "Relation Between Malpractice Claims and Adverse Events Due to Negligence," *New England Journal of Medicine* 325 (1991): 245; David M. Studdert et al., "Negligent Case and Malpractice Claiming Behavior in Utah and Colorado," *Medical Care* 38 (2000): 250.

If the court finds a physician liable, the physician must pay damages to the patient that approximate the value of the harm caused.¹²¹ Damages may include those losses that can be quantified monetarily, e.g. payment for medical expenses or lost wages. Damages also may include non-pecuniary or non-economic losses, e.g. losses resulting from pain, suffering, and other difficult-to-quantify losses.

There are two potential benefits to medical malpractice law—the value of compensation received by patients who have been negligently injured and the value of injuries deterred or avoided because malpractice law may result in safer care.

Costs include the compliance costs of both patients and physicians in preparing and defending cases. A damage award may be considered a benefit to a patient and a cost to a physician or hospital. Towers-Perrin estimates the costs of medical malpractice law each year. It estimated that in 2006, the cost of damage awards plus physician compliance costs, which include insurance administrative costs, was \$30.25 billion.¹²²

There also may be costs associated with what is sometimes called defensive medicine. Defensive medicine refers to two types of effects on physician behavior. To decrease the risk of a lawsuit, a physician may order tests or procedures the physician would not otherwise order. The cost of excess resource would be considered a cost of malpractice law. Also to decrease the risk of a lawsuit, a physician or other professional may restrict one's practice, e.g., discontinue labor and delivery care. The value of the care not provided also would be considered a cost of malpractice law.

Review of Selected Studies

Relationship of Medical Negligence to Legal Claims

There are two major studies of the relationship between negligent adverse events and legal claims.¹²³ Using physi-

cian chart review to determine whether negligent adverse events had occurred, Localio et al. linked medical records from over 30,000 New York hospital admissions in 1984 to data reported to the New York Office of Professional Conduct.¹²⁴ They found that only 2.86 percent of the 280 patients who suffered negligent adverse events filed claims, and of the forty-seven patients who filed claims, only 17 percent had suffered negligent adverse events.

Using similar methodology in Utah and Colorado, Studdert et al. found that only 2.5 percent of 161 patients suffering negligent adverse events filed claims, and only 22.2 percent of the 18 patients filing claims had suffered negligent adverse events.¹²⁵

Relationship of Medical Negligence to Claim Outcome

Many investigators have studied the relationship between medical negligence and claim outcome. Depending on the methods used, investigators have found that physicians made payments to plaintiffs in 56 percent to 93.1 percent of cases in which negligent adverse events occurred.¹²⁶ In addition, however, in 21 percent to 42 percent of the cases in which physicians made payments to plaintiffs, negligent adverse events had not occurred.

Effects of Malpractice Reform on Medical Care

There are two major studies of the effects of malpractice reform on resource use.¹²⁷ Kessler and McClellan reported that in states that enacted direct reforms, e.g., caps on

non-economic damages that reduced expected damage awards, the growth in hospital expenditures for acute myocardial infarction (AMI) and ischemic heart disease (IHD) was less than in states without these reforms.¹²⁸ In a follow-up study, they found similar results, but they also found that the effects were smaller in states with high managed-care penetration, suggesting that managed care served as a substitute for malpractice reform.¹²⁹

Finally, Kessler, Sage, and Becker studied the relationship between malpractice reform and physician supply.¹³⁰ They found that states that had enacted direct reforms had 3.3 percent greater growth in physician supply after three years than states that had not enacted these reforms.¹³¹

Comment

MOST OF THE studies described above used retrospective physician chart review to determine if adverse events met the legal criteria for negligence. Determining whether the legal criteria for negligence have been met is subject to dispute, whether the determination is made at the time the event occurred, by retrospective review of the medical record, or by a jury. As a result, one should be cautious in interpreting these studies.

However, the best available data suggest that most patients injured by substandard care do not sue and many patients who sue have not been injured by substandard care. The data concerning the relationship between negligence and outcome of a suit are mixed. Most studies suggest a relationship between negligence and outcome,

124. Localio et al., "Relationship Between Malpractice Claims."

125. Studdert et al., "Negligent Case."

126. See F.W. Cheney et al., "Standard of Care and Anesthesia Liability," *Journal of the American Medical Association* 261 (1989): 1599; Henry S. Farber and Michelle J. White, "Medical Malpractice: An Empirical Examination of the Litigation Process," *The RAND Journal of Economics* 22 (1991): 199; Mark I. Taragin et al., "The Influence of Standard Care and Severity of Injury on the Resolution of Medical Malpractice Claims," *Annals of Internal Medicine* 117 (1992): 780; T.A. Brennan et al., "Relation Between Negligent Adverse Events and the Outcome of Medical-Malpractice Litigation," *New England Journal of Medicine* 335 (1996): 1963; Ralph Peeples et al., "The Process of Managing Medical Malpractice Cases: The Role of Standard of Care," *Wake Forest Law Review* 37 (2002): 877; David Studdert et al., "Claims, Errors, and Compensation Payments in Medical Malpractice Litigation," *New England Journal of Medicine* 354 (2006): 2024; Localio et al., "Relationship Between Malpractice Claims."

127. Daniel Kessler and Mark McClellan, "Do Doctors Practice Defensive Medicine?" *Quarterly Journal of Economics* 111 (1996): 353; Daniel Kessler and Mark McClellan, "Malpractice Law and Health Care Reform: Optimal Liability Policy in an Era of Managed Care," *Journal of Public Economics* 84 (2002): 175.

128. Kessler and McClellan, "Do Doctors Practice Defensive Medicine?"

129. Kessler and McClellan, "Malpractice Law and Healthcare Reform."

130. Daniel P. Kessler, William M. Sage, and David J. Becker, "Impact of Malpractice Reforms on the Supply of Physician Services," *Journal of the American Medical Association* 293 (2005): 2618.

131. Ibid. Mello recently reviewed the literature on the effects of malpractice damage caps. Of the five major empirical studies investigating the effects of damage caps on physician supply, two showed that damage caps increased physician supply, two showed mixed results, i.e., there were variable positive effects on physician supply, and one showed no effects. See Michelle M. Mello, "Medical Malpractice: Impact of the Crisis and Effect of State Tort Reforms," *The Synthesis Project Report* 10 (Robert Wood Johnson Foundation, May, 2006) http://www.rwjf.org/pr/synthesis/reports_and_briefs/pdf/no10_researchreport.pdf.

but others do not, and in those that do, the relationship often is not strong.

Based on these studies, it appears that most patients injured by substandard care are not receiving compensation. Also, if there is not a strong correlation between substandard care and outcome of a suit, it is doubtful that malpractice law is having a significant deterrent effect on medical injuries.¹³² Finally, there are data suggesting that malpractice reforms that decrease expected malpractice awards may result in less resource use and may increase physician supply.

A complete discussion of malpractice reform is beyond the scope of this policy resource.¹³³ However, based on the data described above, states may be able to decrease unnecessary expenditures and increase the supply of physicians, without decreasing quality, by placing caps on either total or non-economic damages. A more fundamental reform, which may result in lower costs and greater access, would be for states to allow patients and physicians to contract in advance of care for the type and price of malpractice protection the patient desires.¹³⁴

4E. Summary

A NUMBER OF states have laws that require a hospital to obtain approval from a state planning board before purchasing expensive equipment or expanding certain facilities. Empirical data suggest these laws are not effective in decreasing hospital costs and may in fact increase hospital costs. The data concerning their effects on hospital quality are mixed.

Most states have licensing and scope-of-practice rules for health-care professionals. The data suggest that more

stringent rules increase prices for care. In addition, there are data suggesting that for certain types of primary and low-risk labor and delivery care, mid-level practitioners provide high-quality services at relatively low prices.

Finally, malpractice law provides patients a right to sue a physician if a patient believes that negligent care resulted in injury. Empirical data suggest that most patients who are injured from substandard care do not sue, and many patients who sue are not injured by substandard care. In addition, studies suggest there may not be a strong correlation between substandard care and outcome of a suit. Finally, there are data suggesting that reforms that limit expected malpractice awards may result in less resource use and greater physician supply.

4F. Additional Reading

1. Federal Trade Commission/Department of Justice, "Miscellaneous Subjects," in *Improving Health Care: A Dose of Competition*, (July 23, 2004), ch. 8.
2. Patrick John McGinley, "Beyond Health Care Reform: Reconsidering Certificate of Need Laws in a Managed Competition System," *Florida State University Law Review* 23 (1995).
3. David M. Studdert, Michelle M. Mello, and Troyen A. Brennan, "Medical Malpractice," *New England Journal of Medicine* 350 (2004): 283.
4. 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 (Washington, DC: U.S. Government Printing Office, December 1986).

132. On the other hand, Hyman has pointed out that an increase in malpractice suits against anesthesiologists, and a resulting increase in malpractice premiums, was partially responsible for a successful effort by the American Society of Anesthesiology to significantly reduce anesthesia-related injuries. See David M. Hyman, "The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution?" *Cornell Law Review* 90 (2005): 893.

133. For a review of the issues related to medical malpractice and potential reforms, see Studdert, Mello, and Brennan, "Medical Malpractice."

134. 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* (Cambridge, MA: Harvard University Press, 1985), chap. 12; Richard A. Epstein, "Medical Malpractice: the Case for Contract," *American Bar Foundation Research Journal* 1 (1076): 87; Richard A. Epstein, "Medical Malpractice, Imperfect Information, and the Contractual Foundation for Medical Services," *Law and Contemporary Problems* 49 (Spring 1986) 201; Clark C. Havighurst, "Private Reform of Tort-Law Dogma: Market Opportunities and Legal Obstacles," *Law and Contemporary Problems* 49 (Spring 1986): 143; Michael J. Krauss, *Restoring the Boundary: Tort Law and the Right to Contract*, Policy Analysis no. 347 (Washington, DC: Cato Institute, June 3, 1999); Michelle M. Mello and Troyen A. Brennan, "Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform," *Texas Law Review* 80 (2002): 1595; Jeffrey O'Connell, "Neo-No-Fault Remedies for Medical Injuries: Coordinated Statutory and Contractual Alternatives," *Law and Contemporary Problems* 49 (Spring 1986): 125; Paul H. Rubin, *Tort Reform by Contract* (Washington, DC: The AEI Press, 1993), chap. 2. For a review of this topic, see Don W. King, *Contract as a Means of Medical Malpractice Reform*, Policy Resource No. 3, (Arlington, VA: Mercatus Center at George Mason University, March 2007), http://www.mercatus.org/publications/pubID.4158/pub_detail.asp.



STATE REGULATION OF HEALTH INSURANCE

OVER THE PAST few decades, states have enacted statutes that regulate insurance underwriting, pricing, and benefits. Because these regulations have a significant influence on the price of insurance and on an individual's access to insurance, the discussion in this chapter precedes the discussion of measures to increase access in Chapters 6–8.

Regulations that affect underwriting, pricing, and benefits vary widely among the states. In states with fewer regulations, there are reformers proposing their enactment. In states with extensive regulations, there are reformers proposing to eliminate them or decrease their extent. Similar to the discussion in Chapter 4, reform proposals in some states include implementing a particular regulation, while proposals in other states include repealing the regulation.

This chapter begins with background information concerning federal regulation of health insurance. The background section is followed by a discussion of four types of state health insurance regulation: (1) guaranteed issue and guaranteed renewal, (2) community rating, (3) insurance mandates, and (4) mandated minimum-loss ratios. The first three discussions include a review of the theoretical benefits and costs of the regulation, selected empirical studies, and a brief comment.

5A. Background—Federal Regulation of Health Insurance

AS NOTED IN Chapter 3, both federal and state governments regulate health insurance. To encourage employers to establish employee benefit plans, Congress passed the Employee Retirement and Income Security Act (ERISA) in 1974.¹³⁵ ERISA provided employers with a uniform regulatory structure for employee benefits that allowed multi-state employers to avoid often conflicting state regulations.

For those employers who self-insure, i.e., assume the risk of their employees' illnesses and injuries and pay employee expenses out of their own funds, ERISA preempts plan regulation by the states.¹³⁶ For those employers who do not self-insure, but contract with an insurance company for employee health insurance, state insurance regulations do apply. Because ERISA regulations tend to be less stringent than many state regulations, most large multi-state employers self-insure. In 1974, fewer than 5 percent of individuals covered by employer-provided insurance (EPI) were insured under self-insured plans.¹³⁷ By 1996, 40 percent of those with EPI were insured through self-insured plans.¹³⁸

Because ERISA preempts state regulation of self-insured plans but not EPI or individually purchased insurance (IPI), a state's health-insurance regulations apply to a variable percentage of the insurance issued in that state. Because large employers are more likely than small employers to self-insure, state regulations apply primarily to small group insurance provided by businesses with two to fifty employees and IPI.

Two additional federal statutes influence each state's health-insurance market. To improve coverage for terminating employees, Congress in 1986 passed the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).¹³⁹ COBRA requires employers who have 20 or more employees and who offer group health insurance to make an employee's health insurance available to the employee for up to 18 months after the employee terminates employment. The employee is responsible for paying for the insurance; however, the employer must limit the premium to 102 percent of the cost for a similarly situated employee.

In 1996, Congress passed the Health Insurance Portability and Accountability Act (HIPAA).¹⁴⁰ One provision of HIPAA requires insurers who offer insurance to employers in the small group market to offer the insurance to all employers who apply and to all eligible employees in each employer group. In addition, HIPAA requires insurers in the individual market to offer insurance to certain individuals previously covered by employer-provided group insurance. It also requires insurers to

135. ERISA, Public Law 93-406, *U.S. Statutes at Large* 88 (September 2, 1974).

136. *Ibid.*

137. Richard Briffault and Sherry Glied, "Federalism and the Future of Health Care Reform," in *The Privatization of Health Care Reform*, M. Gregg Bloche, ed. (Oxford: Oxford University Press, 2003), 49.

138. *Ibid.*

139. COBRA, Public Law 99-272, *U.S. Statutes at Large* 100: 82.

140. Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, 104th Congress (August 21, 1996).

guarantee renewal of all policies in the individual and small-group markets.

5B. State-Mandated Guaranteed Issue and Guaranteed Renewal

MANDATED GUARANTEED ISSUE requires insurers who offer a particular type of insurance policy to make the policy available to all otherwise qualified applicants, regardless of an individual's health status or other factors that affect the applicant's risk of incurring medical expenses. As of November 2006, ten states required insurers to offer insurance to all applicants in the individual market.¹⁴¹ Guaranteed issue alone does not require the insurer to offer the policy at a given price (see community rating below).

Guaranteed renewal is an insurance feature in which the insurer guarantees to the policy holder that it will renew the policy when the policy expires. State-mandated guaranteed renewal requires an insurer to include a guaranteed renewal feature in some or all policies within the state.

The primary benefit of mandated guaranteed issue or mandated guaranteed renewal is that either should increase access to health insurance for some individuals who otherwise would not be able to obtain it.

However, there are a number of potential costs. Costs include the cost of an administrative agency to develop, monitor, and enforce the regulations as well as the cost for insurers to comply with the regulations. Other potential costs include deadweight losses resulting from higher prices.¹⁴² Mandating guaranteed issue or guaranteed renewal may result in higher prices for at least three reasons—higher insurer compliance costs, greater claims costs because the rule requires the inclusion of additional high-risk patients, and adverse selection, i.e., the tendency for individuals who know they are high-risk to

purchase insurance, while individuals who know they are low-risk to refrain from purchasing insurance.¹⁴³

Guaranteed issue is especially likely to result in adverse selection. Under guaranteed issue, individuals with large expected expenses are likely to purchase insurance, while healthy individuals, knowing that an insurer is required to offer insurance on request, may wait until they become ill before purchasing it.

Review of Selected Studies

USING DATA FROM the 1989–1994 Current Population Survey, Sloan and Conover studied the effects of state health-insurance reforms on the probability that an individual 18 to 64 years of age would be insured in the individual and small-group markets.¹⁴⁴ They found that guaranteed issue and guaranteed renewal did not affect the probability that a state resident would be insured.

Similarly, Jensen and Morrissey in 1999 studied the effects of state reforms on the likelihood that small employers would offer group insurance to their employees.¹⁴⁵ Using data from the Health Insurance Association of America Annual Employer Health Insurance Survey and a similar survey developed by the investigators, Jensen and Morrissey found that neither guaranteed issue nor guaranteed renewal affected the likelihood that an employer would offer health insurance to its employees.

Finally, in a 1992 paper concerning the potential impact of HIPAA on the individual-insurance market, Pauly estimated that prior to its requirement by HIPAA, up to 80 percent of individuals in the individual market purchased policies that contained guaranteed renewal.¹⁴⁶

Comment

THE PURPOSE OF guaranteed issue is to assure that all individuals have access to health insurance regardless of their health status. Similarly, the purpose of guaran-

141. Merrill Mathews, Victoria Craig Bunce, and J. P. Wieske, *State Health Insurance Index 2006: Methodology* (Alexandria, VA: Council for Affordable Health Insurance, November 2006), http://www.cahi.org/cahi_contents/resources/pdf/StateIndexMethodology.pdf.

142. For a definition of deadweight loss, see chapter 2, note 26 above.

143. Requiring the inclusion of additional high-risk patients would be expected to result in higher claims costs and higher insurance prices. Adverse selection may lead to a further price increase, e.g., because of higher prices, low-risk patients may refrain from purchasing insurance, leading to an insurance pool skewed to high-risk patients.

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

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

146. Mark V. Pauly, "Regulation of Bad Things That Almost Never Happen, but Could: HIPAA and the Individual Insurance Market," *Cato Journal* 22 (2002): 72.

teed renewal is to assure that persons who have insurance do not lose it once they become ill. However, unless mandated guaranteed issue or guaranteed renewal is combined with some form of price limits (see community rating below), the price of the guaranteed insurance may be very high for some high-risk patients. In addition, guaranteed issue provides an incentive for people to avoid the expense of purchasing insurance when they are healthy, knowing that an insurer must offer them insurance when they become ill.

The study by Sloan and Conover suggests that state-mandated guaranteed issue and guaranteed renewal do not alter the overall prevalence of health insurance,¹⁴⁷ and the study by Jensen and Morrissey suggests that mandating these features does not alter the likelihood that employers will provide insurance to their employees.¹⁴⁸ However, mandated guaranteed issue or renewal is likely to increase the price of insurance for individuals who do not desire these features, e.g., individuals who are between jobs and need short-term coverage during a transitional period.

Finally, the report by Pauly suggests that even in an unregulated insurance market, insurers provide guaranteed renewal for those patients who desire it.¹⁴⁹ Plans with voluntary guaranteed renewal almost always include a guarantee to continue renewing the policy at the same premium as others in one's rating class.¹⁵⁰ These features allow an individual to purchase insurance at slightly higher rates when one is young and healthy, and then maintain rates similar to one's rating class when one later becomes ill.¹⁵¹

5C. State-Mandated Community Rating

MANDATED COMMUNITY RATING prevents an insurer from using claims experience or health status in setting premiums. Under strict community rating, insurers must charge the same price regardless of age, gender, or behavioral factors such as smoking. Under modified commu-

nity rating, insurers may vary the premiums based on age or one of the other variables, but not health status.

The potential benefit of community rating is that some patients will be able to purchase insurance at a more affordable rate than they would without community rating. However, if community rating is not combined with guaranteed issue, insurers may exclude some high-risk patients. As a result, states usually combine community rating with guaranteed issue.

Potential costs of guaranteed issue plus community rating include the cost of the state agency that develops, monitors, and enforces the regulations plus insurer compliance costs. Other potential costs include the value of the insurance not purchased because of higher prices. Guaranteed issue plus community rating is likely to result in higher prices because insurers incur compliance costs, the inclusion of high-risk patients increases claims costs, and there is high probability of adverse selection.¹⁵²

Review of Selected Studies

COBRA INSURANCE, DESCRIBED in the background section, is a form of guaranteed renewal combined with a form of community rating. Huth studied the effects of requiring employer continuation coverage at 102 percent of the cost of the average employee.¹⁵³ Using data from Spencer and Associates' tenth annual survey, he found that 1996 claims costs for COBRA beneficiaries were \$5,591 per participant, while claims costs for active employees with the same insurance policy were \$3,332 per participant. These data suggest that guaranteed renewal plus community rating results in adverse selection among terminating employees, i.e., high-risk terminating employees are more likely to choose COBRA continuation coverage than low-risk terminating employees.

In their study of the effects of insurance reforms on the probability of being insured, Sloan and Conover estimated that in states with community rating, the prob-

147. This study did not look at important subgroups of patients, e.g., high-risk patients. See Sloan and Conover, "Effects of State Reforms."

148. Jensen and Morrissey, "Small Group Reform."

149. Pauly, "Regulation of Bad Things."

150. Ibid.

151. See Bradley Herring and Mark Pauly, "Incentive-Compatible Guaranteed Renewable Health Insurance Premiums," *Journal of Health Economics* 25 (2006): 395.

152. See note 9.

153. Stephen A. Huth, "COBRA Costs Continue to be High, Erratic," *Employee Benefit Plan Review* 52 (1997): 36.

ability of being insured in the individual market was 2.5 percent lower than in states without community rating, but these results were not statistically significant.¹⁵⁴ Of the insured patients in community-rated states, the probability of having private insurance was decreased by 3.4 percent, and this finding was statistically significant.

Using 1993–1996 National Health Interview Survey data, Davidoff et al. studied the effects of issue reforms and rating restrictions on access to insurance for high-risk employees in the small-group market.¹⁵⁵ They found that issue and rating reforms increased coverage rates for high-risk employees in small groups, compared to low-risk employees in small groups. However, these same reforms resulted in lower coverage rates for low-risk employees in small firms, compared to low-risk employees in large firms.

Using data from the National Health Interview Survey and the Community Tracking Study—Household Survey, Herring and Pauly compared insurance premiums and insurance prevalence in the individual market in states with and without guaranteed issue plus community rating.¹⁵⁶ They found that in states with guaranteed issue plus community rating, the probability of having insurance was greater for high-risk patients, but lower for low-risk patients. They estimated that the net effect was a decrease in overall insurance prevalence of 6.0–7.4 percent.

Herring and Pauly also found that in states without guaranteed issue or community rating, patients in the individual insurance market who had expected expenses twice that of the average risk, paid premiums only 11.5 to 15 percent higher than average.¹⁵⁷ They concluded that even without these requirements, insurers were pooling up to 85 percent of a two-fold increase in risk.

Comment

AS WITH MANDATED guaranteed issue and guaranteed renewal, mandated community rating improves access to insurance for some persons. However, because it results in higher prices for the general population, it decreases

access for others. Huth's study suggests that combined guaranteed renewal plus community rating is likely to result in adverse selection and thus higher prices for those who do not desire these features.

Similarly, the studies of both Davidoff et al. and Herring and Pauly suggest that issue reforms and rating restrictions increase the prevalence of health insurance among the high-risk population, but decrease the prevalence among the general population. In the individual market, the net effect was an overall decrease in insurance prevalence.¹⁵⁸

Finally, the study by Herring and Pauly suggests that even without guaranteed issue or community rating, the individual health-insurance market may pool up to 85 percent of the risk of insuring a person with expected expenses twice the average. The study did not differentiate between pooling that may have resulted from guaranteed renewal and pooling that may have resulted from insurer willingness to underwrite additional risk. Also, the study did not determine the degree of pooling that occurs in patients who are at greater risk than twice the average.

On the other hand, their data do suggest that many moderately high-risk patients are able to maintain health insurance at affordable prices. By eliminating guaranteed issue and community rating, a state may be able to lower insurance prices, increasing access for most individuals, while increasing prices only slightly for moderately high-risk patients.¹⁵⁹

5D. State Benefit, Provider, and Person Mandates

THE TERM “BENEFIT mandate” refers to a state requirement that insurers include a particular benefit or offer a benefit in a certain type of insurance policy. A “provider mandate” is a requirement that an insurer pay for expenses incurred when a member or beneficiary receives care from a particular type of provider. For example, a

154. Sloan and Conover, “Effects of State Reforms.”

155. Amy Davidoff, Linda Blumberg, and Len Nichols, “State Health Insurance Market Reforms and Access to Insurance for High-Risk Employees,” *Journal of Health Economics* 24 (2005): 725.

156. 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, August 2006).

157. *Ibid.*

158. *Ibid.*

159. Chapter 8 discusses a number of reforms that may increase access for very high-risk patients.

state may require an insurer to pay the expenses incurred when a patient consults a psychologist or a chiropractor. Finally, a “person mandate” is a state requirement that an insurer cover a category of persons within certain types of policies, e.g., children up to 25 years of age.

In the late 1960s, insurance mandates were uncommon.¹⁶⁰ Since that time, states have passed numerous such mandates. As of February 2007, the number of mandates varied from 13 in Idaho to 62 in Minnesota,¹⁶¹ the total in all states exceeding 1,900.¹⁶²

The primary benefit of an insurance mandate is the increased value of the insurance policy for those individuals who benefit from the mandate. Costs of these mandates include the cost of the state administrative structure necessary to monitor and enforce the mandate and the costs incurred by insurance companies to comply.

Costs also include the lost value of insurance for those who do not purchase insurance because of a higher price. Similar to guaranteed issue plus community rating, higher prices result because insurers incur higher compliance costs, additional benefits result in greater claims costs, and there is likely to be adverse selection.

Review of Selected Studies

A NUMBER OF investigators have studied the effects of including certain benefits on the price of health insurance. Using data from the 1981–1984 BLS Employee Benefits Survey, Jensen and Morrissey estimated the effects of non-mandated benefits on monthly insurance premiums.¹⁶³ Most benefits resulted in higher premiums. For example, they estimated that coverage of substance-abuse treatment increased premiums for individual coverage by \$4.37 per month in constant 1983 dollars and \$6.59 per month for dependent coverage. Similarly, they estimated that coverage of psychologist services increased premiums by \$5.74 and \$13.32 per month for individual and dependent coverage respectively.

In their 1998 study of the effects of state policies on the prevalence of health insurance in the individual and small group markets, Sloan and Conover found that state-mandated benefits resulted in a lower probability that an individual in the target group would be insured, each mandate decreasing the probability by 0.4 percent.¹⁶⁴

Others have studied the effects of benefit mandates on employer behavior. In their 1999 study of the effects of state policies on an employer’s likelihood of offering health insurance to its employees, Jensen and Morrissey found that in states with more mandates, there was less likelihood that a firm would offer health insurance to its employees.¹⁶⁵ Each additional mandate decreased the probability by 0.4 percent.

Comment

ALL FIFTY STATES mandate certain benefits. The 1990 Jensen and Morrissey study suggests that most added benefits increase the price of insurance, regardless of whether the benefits are purchased voluntarily or mandated.¹⁶⁶ The study of Sloan and Conover suggests that mandates decrease the probability that a person in the target group will be insured.¹⁶⁷ This is undoubtedly because higher prices make insurance less desirable for those individuals who do not benefit from the mandate.

Sloan and Conover estimated that each individual mandate decreased the probability that a person in the studied group would maintain health insurance by 0.4 percent.¹⁶⁸ This suggests that in a state with 50 mandates, the prevalence of health insurance among the population who are affected by the mandate may be 20 percent less than it otherwise would be.

Based on these data, states may be able to significantly reduce the price and increase the prevalence of health insurance in their state by reducing the number and effect of benefit mandates. In addition, decreasing mandates may allow insurers to develop innovative types of insurance that cover very specific individual needs.

160. Victoria Craig Bunce, J.P. Wieske, and Vlasta Prikazsky, *Health Insurance Mandates in the States* (Alexandria, VA: Council for Affordable Health Insurance, February 2007), http://www.cahi.org/cahi_contents/resources/pdf/MandatesInTheStates2007.pdf.

161. Mathews, Bunce, and Wieske, *State Health Insurance Index*.

162. Bunce, Wieske, and Prikazsky, “Health Insurance Mandates”.

163. Gail A. Jensen and Michael A. Morrissey, “Group Health Insurance: A Hedonic Approach,” *Review of Economic Statistics* 72 (10090): 38.

164. Sloan and Conover, “Effects of State Reforms.”

165. Jensen and Morrissey, “Small Group Reform.”

166. Jensen and Morrissey, “Group Health Insurance.”

167. Sloan and Conover, “Effects of State Reforms.”

168. *Ibid.*

5E. State-Mandated Minimum Loss Ratios

SOME STATES HAVE mandated that each insurer maintain a certain minimum loss ratio, and other states have recently considered enacting this type of requirement.¹⁶⁹ An insurer's loss ratio is the amount of money paid out in claims divided by the amount of money received in premiums. A minimum loss ratio limits the administrative expenses and profits of an insurer to a specified amount. If a mandated minimum loss ratio is set at a level below what the loss ratio would be in an unregulated market, the mandate is likely to have little effect. However, if a mandated minimum loss ratio is set at a level that in effect limits the price the insurer may charge, a mandate may result in insurers either withdrawing from the market or eliminating certain insurance products.¹⁷⁰

During the 1990s, both Kentucky and North Dakota passed reforms mandating high minimum loss ratios.¹⁷¹ Wieske reported that in both states, these reforms resulted in less available insurance in the individual insurance market, and both states subsequently repealed their laws. He also reported that no state had implemented an 85 percent or greater minimum loss ratio with successful results.

5F. Summary

IN AN ATTEMPT to increase access to health insurance or to make insurance more beneficial, some states require insurers to issue a policy to certain individuals or renew a policy for certain types of insurance. The data suggest that neither mandated guaranteed issue nor mandated guaranteed renewal has affected the prevalence of health insurance in a state, and neither requirement has affected the number of employers offering insurance to their employees.

Similarly, some states require insurers to charge all individuals the same price for a type of insurance policy regardless of the individual's risk, a requirement known as community rating. When community rating is combined with guaranteed issue, it increases the prevalence of health insurance among high-risk patients. However, because it results in higher prices, it decreases

the prevalence among average-risk patients. There are data suggesting that in the individual market, community rating results in a net decrease in the prevalence of health insurance.

Finally, all states require insurers to either include or offer certain benefits within the insurance policies they issue. These requirements increase the value of the policy for those individuals who benefit from the mandate, but increase prices for others. There are data suggesting that because mandates result in higher prices, they result in a lower overall insurance prevalence than would exist in their absence.

5G. Additional Reading

1. 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, August 2006).
2. Stephen A. Huth, "COBRA Costs Continue to be High, Erratic," *Employee Benefit Plan Review* 52 (1997): 36.
3. Gail A. Jensen and Michael A. Morrissey, "Group Health Insurance: A Hedonic Approach," *Review of Economic Statistics* 72 (1990): 38.
4. Frank A. Sloan and Christopher J. Conover, "Effects of State Reforms on Health Insurance Coverage of Adults," *Inquiry* 35 (1998): 280.

169. J.P. Wieske, "How High Loss Ratios Undermine Affordable Health Insurance," *CAHI Issues and Answers* no. 141 (Alexandria, VA: Council for Affordable Health Insurance, May 2007), http://www.cahi.org/cahi_contents/resources/pdf/n141lossratio.pdf.

170. In a competitive market, fixed prices may result in a shortage or a surplus of a good or service. If prices are set above what would otherwise be the market rate, there may be a surplus of goods or services provided. If prices are set below the market rate, there may be a shortage of goods or services provided.

171. Wieske, "How High Loss Ratios Undermine Affordable Health Insurance."

REFORMS TO INCREASE ACCESS FOR THE GENERAL POPULATION

STATES CAN ATTEMPT to increase access for the general population in a number of ways. Reformers who emphasize the importance of access to insurance recommend increasing the prevalence of health insurance. Reformers who emphasize the harmful effects of differential taxation recommend equalizing the tax treatment of health-care expenses, and those who emphasize the effects of high prices on access often recommend modifying certain regulations involving care or insurance.

While many reforms will require federal action, states do have the authority to enact others. The first section of this chapter provides background information concerning U.S. tax-code provisions that provide tax incentives related to health-care expenses. The background section is followed by three sections describing state reforms designed to increase access to care: (1) reforms that require the purchase of insurance, (2) reforms that provide incentives for care or insurance, and (3) reforms that modify the regulation of care or insurance.

6A. Background—Federal Tax Law and Health Insurance

IN 1954, CONGRESS amended the tax code to allow an individual to exclude from gross income employer-provided insurance (EPI), but not individually purchased insurance (IPI) or out-of-pocket expenses.¹⁷² Since that time, Congress has provided other tax-preferences for health-care expenses, and some of these preferences partially equalize the tax treatment of EPI, IPI, and out-of-pocket expenses. A number of recent state reforms are based on these other provisions of the U.S. tax code.

Section 125 Plans (Cafeteria Plans)

A SECTION 125 plan is an employee benefit plan that

allows an employee to choose among one or more benefits.¹⁷³ As long as the chosen benefits are “qualified,”¹⁷⁴ the value of the benefit is not considered a part of an employee’s gross income for income-tax purposes.

Section 125 plans offer employees a number of advantages. First, an employee can exclude the employee portion of EPI from gross income.¹⁷⁵ For example, under the general exclusion for EPI, many employers pay a portion of an employee’s health-insurance premium, e.g., 75 percent, requiring the employee to pay the remainder. Section 125 plans allow an employee to pay the 25 percent employee portion of EPI with funds that would otherwise be paid as wages. In addition, an employee can now use Section 125 funds to exclude from gross-income insurance purchased in the individual, non-group health-insurance market.¹⁷⁶

Second, using a health flexible-spending arrangement (FSA), an employee can exclude out-of-pocket medical expenses from gross income.¹⁷⁷ As a result, an employee with a health FSA has less incentive to choose a comprehensive plan with minimal or no cost sharing. By choosing a plan with more cost sharing, an employee can save significantly on insurance premiums.

Finally, both employers and employees can save on the payroll taxes they pay. Since Section 125 funds taken as qualified benefits are excludable from gross income, these funds are not considered wages for determining either Social Security or Medicare payroll taxes.

The primary disadvantage of Section 125 funds for an employee is that one cannot carry funds in FSAs from year to year or from employer to employer.¹⁷⁸ In addition, Section 125 plans are not available to those whose employer does not offer them, and they maintain the preference for obtaining health insurance and health care through one’s employer.

172. *U.S. Code* 26 § 106(a).

173. *U.S. Code* 26 § 125.

174. As defined by IRC Section 125(f), which proscribes the benefits an employer may offer under a cafeteria plan.

175. *Ibid.*; see also Internal Revenue Service, *Employee Benefits—Cafeteria Plans; Proposed Rule, Code of Federal Regulations* 26, part 1, *Federal Register* 72, 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, http://www.cahi.org/cahi_contents/resources/pdf/n149Section125Plans.pdf.

176. See Internal Revenue Service, *Employee Benefits*; Wieske, “Benefiting Cities.”

177. *Ibid.*; see also Roger D. Blackwell and Thomas E. Williams, *Consumer Driven Health Care* (Book Publishing Associates, Inc., 2005), chap. 7.

178. See Wieske, “Benefiting Cities;” Blackwell and Williams, *Consumer Driven Health Care*.

Health-Reimbursement Arrangements

A HEALTH-REIMBURSEMENT ARRANGEMENT (HRA) is an agreement between an employer and employee that allows an employee to exclude from gross income any funds paid by the employer to reimburse the employee for medical expenses.¹⁷⁹ Employers who do not provide group health insurance may use an HRA to provide at least some support for an employee's health care. An employee may use HRA funds for either health insurance or out-of-pocket expenses.

Similar to Section 125 plans, HRAs allow an employee to use pre-tax dollars to pay for health insurance and out-of-pocket medical expenses. Unlike FSAs, an employee can carry unused HRA funds from one year to the next. However, an employee cannot contribute to an HRA, and HRAs maintain the tax preference for employer-provided insurance and care.

Health Savings Accounts (HSAs)

A HEALTH SAVINGS account is a tax-sheltered account, owned by an individual, into which either an individual or employer can place pre-tax dollars. Contributions to an HSA are deductible from gross income for income tax purposes. An individual may pay out-of-pocket expenses from an HSA account without incurring a tax liability.¹⁸⁰ To establish an HSA, an individual must maintain a high deductible health plan (HDHP). In addition, one cannot purchase insurance using HSA funds, and HSA owners are limited in the amount of contribution they can make each year.

HSAs with HDHPs offer a number of potential advantages. Similar to FSAs and HRAs, HSAs allow an employee to pay out-of-pocket expenses with before-tax dollars. Unlike the other tax-advantaged plans, HSAs allow an unemployed person or a person whose employer does not offer benefits to pay out-of-pocket expenses with before-tax dollars. In addition, HSAs are owned by the individual, are portable from employer to employer, can be carried from year to year, and can be left to one's heirs.

179. Internal Revenue Service, *Health Reimbursement Arrangements*, Notice 2002 – 45, 2002 – 28 I.R.B. See also Blackwell and Williams, *Consumer Driven Health Care*; Council for Affordable Health Insurance, "HSAs, FSAs, HRAs, Which Consumer-Driven Health Care Option Should You Choose?" *CAHI Issues and Answers* no. 124 (Updated for 2008 and 2009), http://www.cahi.org/cahi_contents/resources/pdf/n124HSAFSAHRA.pdf.

180. U.S. Code 26 § 223.

181. Porter and Teisberg argue that at present, health care competition occurs primarily at the level of health plans, hospital groups, and networks. They argue that true reform will require competition among professionals and hospitals to provide high quality, cost-effective care for specific clinical conditions. See Michael E. Porter and Elizabeth Olmsted Teisberg, "Redefining Competition in Health Care," *Harvard Business Review* 82, no. 6 (June 2004): 1.

Because HDHPs are less expensive than comprehensive plans, an individual who establishes an HSA plus HDHP can save significantly on one's health insurance premium. As a result, allowing HSAs plus HDHPs may result in a larger percentage of the population purchasing health insurance.

Finally, since HSA owners pay directly for many of their expenses, they have a strong incentive to choose the most cost-effective care for their particular situation. The widespread use of HSAs may lead to more effective competition among physicians and hospitals, potentially resulting in lower prices and greater quality.¹⁸¹

Because high-income patients have higher marginal tax rates than others, HSAs plus HDHPs, EPI, and other tax-advantaged plans provide greater advantage to higher income patients than to average-income patients. Also similar to EPI and other tax-advantaged plans, because HSAs allow one to pay health-care expenses with pre-tax dollars, HSAs plus HDHPs may increase the demand for health care, increasing prices for care. However, the greater demand resulting from HSAs and the other incentives that partially equalize taxation is significantly less than that presently resulting from EPI.

6B. State Reforms that Require the Purchase of Insurance

SINCE THE 1970s, some states have required insurers to make insurance available to all otherwise qualified applicants in the state, regardless of their health status. For example, mandated guaranteed issue is a requirement to make insurance available to otherwise qualified applicants. Chapters 5 and 8 discuss these requirements in more detail.

Reformers have suggested at least two additional types of requirements to increase the prevalence of health insurance: (1) a requirement for employers to provide insurance and (2) a requirement for individuals to purchase insurance.

Require Employers to Purchase Insurance

IN 1974, HAWAII became the first state to require employers to provide health insurance for their employees.¹⁸² Hawaii's statute required employers to provide insurance for all employees who worked at least 20 hours per week. Because the Employee Retirement and Income Security Act (ERISA) preempts state laws that govern employee welfare benefit plans, Hawaii's employer mandate was challenged in federal court. In 1981, the U.S. Supreme Court struck down the mandate, holding that it violated ERISA's preemption clause.¹⁸³ Two years later, Congress granted Hawaii a specific exemption from ERISA, allowing Hawaii to maintain its employer mandate.¹⁸⁴ Congress has not enacted an exemption for any other state.

In 2005, Maryland passed a statute requiring employers with more than 10,000 employees to pay at least 8 percent of their payroll as health benefits or pay a penalty fee equal to the difference between 8 percent and the amount they pay for health care.¹⁸⁵ A statute that gives an employer an option between paying for care or paying a penalty fee is sometimes called "pay or play."

Maryland's pay or play provision was designed to avoid a violation of ERISA, providing employers a choice between paying for health care for their employees or paying a penalty fee.¹⁸⁶ However, in 2007, the Fourth Circuit Court of Appeals held that the Maryland law also violated ERISA.¹⁸⁷

In 2006, Massachusetts also enacted a law that required employers to provide health insurance for their employees or pay a penalty fee to the state.¹⁸⁸ However, since the penalty fee is only \$295 per uncovered employee, employer groups have not challenged this provision. During this past year, a number of other states have considered employer pay-or-play proposals. If passed, they will likely be challenged, and it is not clear if federal courts will uphold them.

The primary advantage of an employer mandate is that a mandate should increase the prevalence of health insurance among workers. To the extent this occurs, there should be additional access to care for some individuals and less cost-shifting between uninsured and insured patients.

However, there are a number of potential costs. A state agency must determine the minimum level of insurance an employer must purchase and the penalty to be applied, monitor each employer within the state, and apply the penalty when appropriate.

More importantly, the cost to employers is likely to be large, especially for small employers that do not offer insurance prior to the mandate. A mandate to provide health insurance represents a large increase in an employer's cost of labor. Consequently, an employer mandate is likely to result in lower wages, fewer employee benefits, fewer workers, or higher prices for a firm's customers. Finally, there is a risk that minimal benefit levels will gradually rise in response to lobbying by patient advocacy or professional groups, leading to very expensive insurance for a state's residents.

Review of Selected Studies

Because Hawaii is the only state that has had an employer mandate in effect for more than a short period of time, there are relatively few studies concerning the effects of an employer mandate.

Using insurance coverage rates of Hawaii's two largest insurers, Dick studied the effects of Hawaii's employer mandate on the rate of private insurance and the number of uninsured.¹⁸⁹ He estimated that Hawaii's mandate resulted in a 1 percent increase in state insurance prevalence and an 8 percent decrease in the percentage of people who are uninsured. Using Current Population Survey data, he concluded that while the prevalence of

182. California HealthCare Foundation, *State Employer Health Insurance Mandates: A Brief History* (March 2004), <http://www.chcf.org/documents/EmployerInsuranceMandates.pdf>.

183. *Standard Oil v. Aghalud*, 633 F. 2d 760 (1980).

184. California HealthCare Foundation, *State Employer Health Insurance Mandates*.

185. James P. Baker, "Can Maryland Make Wal-Mart Pay or Play?" *Benefits Law Journal* 19 (2006): 84.

186. *Ibid.* See also *Retail Ind. Leaders Assoc. v. Fielder*, 475 F. 3d 180 (2007).

187. See *Retail Ind. Leaders Assoc. v. Fielder*, 475 F. 3d 180 (2007).

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

189. Andrew W. Dick, "Update: Will Employer Mandates Really Work? Another Look at Hawaii, DataWatch Update," *Health Affairs* 1 (1994): 343.

insurance from 1985–1987 was higher in Hawaii than in other states, the high prevalence was likely a result of Hawaii’s population characteristics.

Using data from the 1990–1993 Current Population Survey and the 1970 and 1990 U.S. Census, Thurston studied the effects of Hawaii’s employer mandate on insurance coverage, wages, and employment.¹⁹⁰ Between 1969 and 1990, the prevalence of health insurance in Hawaii increased from 88.3 percent to 90 percent. This was in contrast to a decrease from 87.2 percent to 82 percent for the U.S. population as a whole.

Thurston also found that between 1970 and 1990, wages in Hawaii grew at a faster rate than in the rest of the country.¹⁹¹ However, wage increases in the three most affected industries—restaurant, hotel/motel, and retail—grew at a slower rate than the state’s average wage growth. Finally, Thurston found that the proportion of part-time employees grew faster in Hawaii than in the rest of the country, and the percentage of part-time employees was especially large in the three industries most affected by the mandate.

Comment

Because Hawaii is the only state to have an employer mandate over an extended period of time, there are relatively few data concerning the effects of employer mandates on either the prevalence of health insurance or employment. Economic theory and empirical data from benefit mandates suggest that most of the cost of an individual mandate would be borne by employees, in the form of lower wages, fewer benefits, or fewer workers.¹⁹²

Require Individuals to Purchase Insurance

IN ITS 2006 reform law, Massachusetts became the first state to require all residents to maintain health insurance.¹⁹³ All Massachusetts residents who did not have health insurance as of December 31, 2007, were required to pay a penalty. Those whose annual family income is less than 300 percent of the federal poverty level but do

not qualify for publicly provided insurance (PPI) receive a subsidy to purchase private insurance. The funds for these subsidies come partially from funds Massachusetts previously paid to hospitals to offset the cost of providing uncompensated care.

The primary benefit of an individual mandate is the value of health insurance to individuals who otherwise would not have insurance.¹⁹⁴ Unlike an employer mandate, an individual mandate does not directly affect labor markets.

On the other hand, there are a number of potential costs.¹⁹⁵ As with an employer mandate, an individual mandate requires the state to determine a minimum level of insurance benefits and a penalty to be imposed if one does not purchase the minimum level. Enforcement requires an agency to set up some means of monitoring every individual in the state, and when indicated, apply a penalty. Enforcement is most easily accomplished through an income tax system. However, some uninsured residents may not pay income taxes, and some may not file returns.

Depending on the type of insurance required, the cost to individuals also may be large, and for many people, the expected benefits of the mandated insurance may be less than the cost. As noted in Chapter 2, resources used for health insurance are resources that can not be used for other items, including food, housing, other necessities, savings and investment, or paying directly for care.

Finally, there may be pressure from patient-advocacy groups for the state to increase minimum benefit levels.¹⁹⁶ Lobbying may result in continually increasing minimum benefit levels and higher insurance prices for a state’s residents.

Review of Selected Studies

Because Massachusetts’s individual mandate took effect at the end of 2007, no long-term studies of individual health-insurance mandates are available.

190. Norman K. Thurston, “Labor Market Effects of Hawaii’s Mandatory Employer-Provided Health Insurance,” *Industrial & Labor Relations Review* 51 (1997): 117.

191. *Ibid.*

192. As noted previously, there are data suggesting that the cost of mandated benefits is borne primarily by the affected employees. For example, see Jonathan Gruber, “The Incidence of Mandated Maternity Benefits,” *American Economic Review* 84 (1994): 622.

193. See Gruber, “The Massachusetts Health Care Revolution;” Hyman, “The Massachusetts Health Plan.”

194. Even though the value to the person may be less than the cost, the insurance does have some value to the individual.

195. See Michael Tanner, *Individual Mandates for Health Insurance*, Policy Analysis no. 565 (Washington, DC: Cato Institute, Apr. 5, 2006).

196. *Ibid.*

Comment

There are data suggesting that individual requirements for one to maintain automobile liability insurance may not be very effective in increasing insurance coverage rates,¹⁹⁷ and the same may be the case for health insurance. However, individual mandates for health insurance are different from mandates for automobile insurance. Because states provide health insurance for many low-income individuals, the lack of health insurance may not be as concentrated among low-income residents as is the lack of automobile insurance. An individual mandate, enforced through a state's income-tax code, may have a greater chance of increasing the prevalence of health insurance than it does in increasing the prevalence of automobile insurance.

On the other hand, a mandate for a person to spend a significant percentage of one's income on any item is a major infringement on individual freedom. In addition, a mandate to purchase health insurance requires much greater state involvement than an automobile insurance mandate. State officials must determine a minimum level of benefits and must monitor every state resident, whether they drive or not. As with employer mandates, there is a risk that lobbying by advocacy groups will result in continually increasing minimum benefit levels and higher prices.

Finally, individual mandates are likely to require an increase in public funding. Most proposals for individual mandates include subsidies for low-income patients, and most proponents recommend granting subsidies to more low-income individuals than are presently covered by PPI.

6C. State Reforms that Provide Incentives for Care or Insurance

AS NOTED PREVIOUSLY, differential tax treatment of health-care expenses has had more influence on health-care financing for persons less than 65 years of age than any other factor.¹⁹⁸ The increased demand for health care resulting from tax-favored EPI has likely increased prices

for both care and insurance and made care and insurance especially costly for individuals without access to either EPI or PPI. In addition, reliance on EPI may result in loss of insurance when one changes employment.

Supporters of equalizing the tax treatment of health-care expenses make two primary arguments. First, differential tax treatment is unfair or unjust, requiring individuals without access to either EPI or PPI to pay more of their pre-tax income for health care and insurance than do those with EPI. Second, differential tax treatment is inefficient, providing incentives for individuals to purchase more insurance than otherwise would be in their best interest.

Because differential taxation of health-care expenses is a product of the federal tax code, only Congress can eliminate it. However, states do have the authority to enact reforms that would partially equalize the taxation of health-care expenses. For example, states could enact reforms that facilitate the use of federal tax-advantaged plans, such as Section 125 plans, HRAs, or HSAs. In addition, states could provide state tax incentives.

This section discusses three approaches: (1) make state laws compatible with federal tax incentives, (2) provide state tax incentives similar to federal tax incentives, and (3) offer federal tax incentives to state employees.

Make State Laws Compatible with Federal Tax Incentives

THERE ARE TWO types of state laws that prevent residents of some states from taking advantage of HSAs.¹⁹⁹ Some states mandate that insurance plans sold in their states contain benefits that make all of the state's insurance plans incompatible with HDHPs.²⁰⁰ Some states require an HMO deductible that is not compatible with an HDHP. As a result, some states may need to alter their laws to allow their residents to take advantage of the federal tax incentives provided by an HSA.

197. See Greg Kelly, "Can Government Force People to Buy Insurance?" *CAHI Issues and Answers* no. 123, (Alexandria, VA: Council for Affordable Health Insurance, March 2004), <http://www.heartland.org/pdf/14895.pdf>.

198. The exclusion of the value of EPI from gross income is often referred to as either a tax incentive or tax subsidy. By allowing an individual with EPI to pay less in taxes, the federal government provides an incentive, or in effect, a subsidy to an individual whose employer pays for his/her insurance. To differentiate a subsidy from an incentive, this policy resource uses the term subsidy only when referring to an actual transfer of money from the government.

199. See Brian Fraley, "States Target Remaining Impediments to HSA Success," *AHIP Coverage* (March/April 2005), <http://www.ahip.org/content/default.aspx?docid=10788>.

200. An HDHP is defined in *U.S. Code* 26 § 223(c).

Provide State Tax Incentives Similar to Federal Incentives

FORTY-ONE STATES NOW require their residents to pay an income tax.²⁰¹ Most of these states tailor their income tax code to conform to the U.S. code. For example, most states allow an individual to exclude or deduct the same items for state income-tax purposes that the federal code allows. However, a few states do not, and some do not allow a deduction for an HSA.²⁰² As a result, some states may need to alter their tax laws to allow individuals to receive a tax incentive from the state similar to the one they now can obtain from the federal government.

In addition, a state could offer tax incentives not presently offered by the federal government. For example, Georgia recently enacted the following state tax incentives not offered by the federal government: (1) an exemption for Georgia insurers from paying state and local premium taxes on HDHPs associated with HSAs, (2) a tax credit for small businesses up to \$250 for money they spend enrolling employees in HDHPs associated with HSAs, and (3) a deduction from gross income for Georgia residents for the premium they pay for an HDHP associated with an HSA.²⁰³ Similarly, states could provide incentives encouraging the use of Section 125 plans or HRAs.

Offer Federal Tax-Advantaged Plans to State Employees

STATES ALSO COULD make federal tax-advantaged plans, e.g., Section 125 plans, HRAs, or HSAs, available to state and local government employees. Making tax-advantaged plans available to state employees would provide significant advantages to the employees and may decrease state costs.

Comment—Federal and State Tax Incentives

BY ALLOWING RESIDENTS to take advantage of federal and state tax incentives, a state can make health care and insurance less costly for its residents, increasing access for many people. In addition, HSAs with HDHPs offer individuals greater portability when one changes employment and an opportunity to accumulate savings for health-care expenses.

Additional use of tax-advantaged plans does decrease tax revenue for the federal or state government. However, the revenue lost from EPI far exceeds that from these additional tax-advantaged plans, and it does seem unfair to extend tax advantages to individuals with access to EPI, but not individuals who purchase insurance independently or pay out-of-pocket.

6D. State Reforms that Modify the Regulation of Care or Insurance

ONE REASON THAT many individuals lack access to care is that they are unable to afford the prices of either care or insurance. As a result, states may be able to increase access by modifying administrative regulations or common-law rules that result in higher prices. This section briefly discusses two broad categories of regulations, the modification of which may result in lower prices and greater access: (1) those involving professional and hospital care and (2) those involving health insurance. Because these regulations usually have benefits as well as costs, one must consider both benefits and costs to determine if changing them would be desirable.

Liberalize the Regulation of Professional and Hospital Care

AS NOTED IN chapter 4, regulations involving professional and hospital care often increase the cost of providing care, and some provide barriers to the entry of competitors. Both mechanisms may result in a smaller supply of care and higher prices. Also as noted in chapter 4, some of these regulations may provide relatively few benefits.

Liberalizing the rules that govern hospital and facility expansion, professional licensing, and professional scope of practice may result in lower prices and greater access without decreasing quality. Similarly, limiting damage awards or allowing patients to contract for malpractice protection in advance of care may result in less resource use and greater physician supply, both of which may lower prices and increase access.

201. Two additional states require a tax on dividend and interest income; see Federation of Tax Administrators, *State Individual Income Tax Rates—2008* (Jan. 1, 2008), http://www.taxadmin.org/fta/rate/ind_inc.html.

202. See Fraley, "States Target Remaining Impediments."

203. Office of the Governor, State of Georgia, *Governor Perdue Signs Health Care Reform Bills*, May 7, 2008, http://gov.georgia.gov/00/press/detail/0,2668,78006749_78013037_113105367,00.html.

Liberalize the Regulation of Health Insurance

AS NOTED IN chapter 5, regulations involving health insurance underwriting, pricing, and benefits often increase access for some patients. However, because they result in higher prices and prevent insurers from offering low-cost insurance, they decrease access for others. In addition, there are data suggesting they may result in a lower overall prevalence of health insurance.

Liberalizing the rules that govern health insurance underwriting, pricing, or benefits may result in lower insurance prices and greater access for the general population.²⁰⁴ In addition, liberalizing these rules may result in the development of innovative types of insurance that better meet many patients' needs.

6E. Summary

STATES CAN UNDERTAKE many reforms to increase access to care. Employer mandates are likely to increase the prevalence of health insurance, but employer mandates also may decrease wages, other benefits, or total employment. Similarly, individual mandates should increase the prevalence of health insurance, but individual mandates are costly for an individual and may be difficult to enforce.

Equalizing the tax treatment of employer-provided insurance, individually purchased insurance, and out-of-pocket expenses offer a number of potential advantages. These include lower prices for care and insurance, greater portability of insurance, and potentially a higher insurance prevalence. States could partially equalize the tax treatment of health-care expenses by making their insurance laws compatible with federal tax incentives, providing state tax incentives similar to federal incentives, and offering federal tax-advantaged plans to state employees.

Liberalizing the rules governing professional and hospital care may result in lower prices and greater access to care. Similarly, liberalizing the rules that govern insurance underwriting, pricing, and benefits may lower insurance prices and provide greater access to low-cost insurance.

6F. Additional Reading

1. California HealthCare Foundation, "State Employer Health Insurance Mandates: A Brief History" (March 2004), <http://www.chcf.org/documents/EmployerInsuranceMandates.pdf>.

2. Jonathan Gruber, *The Massachusetts Health Care Revolution: A Local Start for Universal Access*, Hastings Center Report 36 (Garrison, NY: The Hastings Center, 2006): 14.

3. David A. Hyman, *The Massachusetts Health Plan: The Good, the Bad, and the Ugly*, Policy Analysis no. 595 (Washington, DC: Cato Institute, June 28, 2007), <http://www.cato.org/pubs/pas/pa-595.pdf>.

4. John F. Cogan, R. Glenn Hubbard, and David P. Kessler, *Healthy, Wealthy, and Wise* (Washington, DC: The AEI Press, 2005), chap. 2.

204. Chapter 8 discusses a number of reform options designed to increase access for high-risk patients.

REFORMS TO INCREASE ACCESS FOR LOW-INCOME PATIENTS

AS NOTED IN Chapter 2, access to care may be limited both by lack of insurance and by high prices for care. Because low-income patients have fewer resources to pay for care or insurance, reforms that decrease prices may be especially important for these patients. In addition, there are many reforms designed specifically to increase access for low-income patients. These include expanding eligibility for publicly provided insurance (PPI), increasing payment levels for PPI, and providing subsidies to providers or directly to low-income patients.

This chapter contains four sections. The first provides background information concerning federal and state programs for low-income patients. The next three sections discuss state reforms under the following three categories: (1) reforms that expand publicly provided care or insurance, (2) reforms that provide subsidies for care or insurance, and (3) reforms that modify the regulation of care or insurance.

7A. Background—Public Insurance for Low-Income Patients

Health Insurance for Medical Care

MEDICAID, ESTABLISHED IN 1965, is a combined federal and state program that pays for health care for low-income Americans.²⁰⁵ Eligibility, benefits, and payment levels vary from state to state.²⁰⁶ The federal government requires state Medicaid programs to include all individuals who earn less than the federal poverty level (FPL) and who also meet one of the following criteria: (1) children,

(2) parents of dependent children, (3) pregnant women, (4) disabled individuals, or (5) persons over 65 years of age. States have the option to include additional persons, e.g., those up to 200 percent of FPL.

The federal government requires states to pay for certain services.²⁰⁷ These include: (1) inpatient and outpatient hospital services, (2) physician or nurse practitioner services, (3) laboratory and x-ray services, (4) both nursing home and home care services for adults, (5) screening, diagnosis, and treatment of children, (6) family planning services, and (7) certain rural health clinic and qualified health-center services. States have the option to pay for additional services, including prescription drugs, dental care, prosthetic devices, and hearing aids.

For individuals who are eligible for both Medicare and Medicaid (dual eligible), a state has the option to pay a beneficiary's Medicare premiums.²⁰⁸ State Medicaid programs also may pay for long-term care and for other services that Medicare does not cover.²⁰⁹ Finally, a state may offer managed care options to Medicaid beneficiaries.²¹⁰ In 2006, combined federal and state spending for the fifty-six Medicaid programs was \$314.5 billion.²¹¹

Section 1115 Waivers

SECTION 1115 WAIVERS permit states to develop demonstration projects in which certain Medicaid requirements are waived.²¹² They are used primarily to expand coverage, control spending, or test new ways of providing care.

State Children's Health Insurance Program

IN THE BALANCED Budget Act of 1997, Congress passed an amendment to the Social Security Act authorizing

205. *Social Security Amendments of 1965*, Public Law 89-97, *U.S. Statutes at Large* 79 (1965): 286.

206. Kaiser Commission on Medicaid and the Uninsured, "The Medicaid Program at a Glance," The Henry J. Kaiser Family Foundation, Medicaid Facts # 7235-02 (March 2007), <http://www.kff.org/medicaid/upload/7235-02.pdf>.

207. *Ibid.*

208. *Ibid.*

209. Kaiser Commission on Medicaid and the Uninsured, "Medicaid and Long-Term Care Services and Supports, Medicaid Facts # 2186-05," The Henry J. Kaiser Family Foundation (December 2007).

210. Centers for Medicare and Medicaid Services, "Technical Summary," Medicaid Program General Information, http://www.cms.hhs.gov/MedicaidGenInfo/03_TechnicalSummary.asp#TopOfPage.

211. Kaiser Commission on Medicaid and the Uninsured, "Medicaid Enrollment and Spending Trends, Medicaid Facts # 7523-02," The Henry J. Kaiser Family Foundation (October 2007), <http://www.kff.org/medicaid/upload/7523.pdf>.

212. Kaiser Commission on Medicaid and the Uninsured, "Medicaid Section 1115 Waivers: Current Issues, Key Facts # 7234," The Henry J. Kaiser Family Foundation (January 2005) <http://www.kff.org/medicaid/upload/Section-1115-Waivers-in-Medicaid-and-the-State-Children-s-Health-Insurance-Program-An-Overview.pdf>.

the creation of the State Children's Health Insurance Program (S-CHIP).²¹³ S-CHIP was designed to provide insurance coverage for children who were uninsured but not eligible for Medicaid. As of July 2006, the S-CHIP program covered children above 200 percent of the FPL in 16 states plus the District of Columbia, between 100 and 200 percent of the FPL in 24 states, and at some level less than 100 percent of the FPL in 10 states.

7B. State Reforms that Expand Publicly Provided Care or Insurance

TO INCREASE ACCESS for low-income patients, states could consider funding additional public hospitals or clinics, or they could consider expanding PPI. This section discusses two proposals for expanding PPI.

Expand Eligibility for Publicly Provided Insurance

THE MOST COMMONLY recommended reform for increasing access for low-income persons is to expand eligibility for Medicaid or S-CHIP. Expanding eligibility should increase access to care for some individuals who otherwise would not have access. Potential disadvantages include the possibility of limited access for PPI beneficiaries, "crowd-out" of private insurance, and the need for additional public funding.

Review of Selected Studies—Access

Currie and Gruber studied the effects of Medicaid eligibility expansion between 1984 and 1992.²¹⁴ They found that among the newly eligible population, the probability of being insured increased by 23 percentage points. Since 32 percent of the newly eligible persons were uninsured prior to the expansion, the upper limit of the take-up rate for the uninsured portion of the target population was 71 percent.²¹⁵

213. Kaiser Commission on Medicaid and the Uninsured, "State Children's Health Insurance Program (S-CHIP) at a Glance, Key Facts # 7610," The Henry J. Kaiser Family Foundation (January 2007), <http://www.kff.org/medicaid/upload/7610.pdf>.

214. Janet Currie and Jonathan Gruber, "Health Insurance Eligibility, Utilization of Medical Care, and Child Health," *Quarterly Journal of Economics* 111 (1996): 431 (1996).

215. *Ibid.* The take-up rate is the percentage of newly eligible individuals who enroll. Because some percentage of the newly eligible uninsured may have gained private insurance, the Medicaid take-up rate of the otherwise uninsured may have been smaller.

216. *Ibid.*

217. Laurence C. Baker and Anne Beeson Royalty, "Medicaid Policy, Physician Behavior, and Health Care for the Low-Income Population," *Journal of Human Resources* 35 (2000): 480.

218. David M. Cutler and Jonathan Gruber, "Does Public Insurance Crowd-Out Private Insurance?" *Quarterly Journal of Economics* 111 (1996): 391.

219. Lara Shore-Sheppard, Thomas C. Buchmueller, and Gail A. Jensen, "Medicaid and Crowding Out of Private Insurance: A Re-examination Using Firm Level Data," *Journal of Health Economics* 19 (2000): 61.

220. Anthony T. LoSasso, Thomas C. Buchmueller, "The Effect of State Children's Health Insurance Program on Health Insurance Coverage" (NBER Working Paper 9405, December 2002).

Currie and Gruber also found that among the newly eligible population, the probability of seeing a physician in the previous year increased by 9.6 percentage points and the probability that a newly eligible person would consult a physician in the previous two weeks increased by 5.1 percentage points.²¹⁶ In addition, there was a decrease in child mortality rate in the newly eligible population.

Baker and Royalty studied the effects of Medicaid eligibility expansion on access for pregnant women in the 1980s and 1990s.²¹⁷ They found that expanding Medicaid eligibility by 10 percent resulted in a 0.8 percent increase in the percentage of low-income patients seen by physicians, but the increase was present only for public physicians. They did not provide data on health outcomes.

Review of Selected Studies—Crowd-Out

Cutler and Gruber studied the effects of Medicaid expansion to pregnant women and children between 1987 and 1992 on the probability that an eligible individual would maintain private health insurance.²¹⁸ They estimated that for every 100 newly eligible individuals who enrolled in Medicaid, there was a decrease in private coverage of almost 50 percent.

Sheppard, Buchmueller, and Jensen studied the effects of Medicaid expansion on employer and worker behavior.²¹⁹ Medicaid expansion did not affect the likelihood that an employer would offer insurance, but it did decrease the likelihood that an employer would offer dependent coverage, and it decreased the likelihood that an employee would accept employer-provided insurance.

LoSasso and Buchmueller studied the effects of S-CHIP on private insurance coverage.²²⁰ They found that for every 100 newly eligible children who enrolled in S-CHIP, private coverage decreased from fifty to eighteen children.

In 2006, Gruber and Simon studied the effects of public-insurance expansion on the prevalence of private insurance. They estimated that for every 100 individuals who enrolled in public coverage, there was a decrease in private coverage of approximately sixty individuals.²²¹

Comment

The presently available data suggest that expanding eligibility for PPI is partially successful in increasing access for low-income patients. Currie and Gruber's study suggests that when individuals become eligible for Medicaid, they increase their use of health-care services, and there may be positive health outcomes including a lower infant-mortality rate.

On the other hand, there are data showing that many eligible patients do not enroll in PPI. This may be because enrollment in Medicaid does not increase the available options for many patients. For example, some patients who enroll in PPI may not gain access to private physicians and continue to receive care at public hospitals and clinics.

The data also suggest that expanding PPI eligibility has a relatively large crowd-out effect. Those patients who had private insurance prior to enrolling in Medicaid may actually have less access to care after switching to public insurance. Finally, expanding eligibility criteria does require additional public funding.

Increase Payment Levels for Publicly Provided Insurance

TO ENCOURAGE PRIVATE physicians to accept Medicaid and S-CHIP patients, some states have increased payment levels to physicians and hospitals for beneficiaries of PPI. Recently, Governor Schwarzenegger proposed that California's Medicaid and S-CHIP programs increase the payment rates for physicians and hospitals.²²²

POTENTIAL ADVANTAGES OF increasing payment levels include more access to care by increasing the number of

physicians from which Medicaid and S-CHIP beneficiaries may choose. The primary disadvantage is that higher payment levels require additional public funding.

Review of Selected Studies

In the same study referred to above, Baker and Royalty found that an increase of 10 percent in PPI fees paid to physicians increased the percentage of low-income patients seen by private physicians by 3.4 percent, but decreased the percentage of low-income patients seen by public physicians by 3.0 percent.²²³

Cunningham and Nichols studied the effects of Medicaid fee levels on Medicaid acceptance rates. They found that a 20 percent increase in the ratio of Medicaid to Medicare fees increased the Medicaid acceptance rate among physicians from 62.1 percent to 72.7 percent.²²⁴

Comment

The primary goal of increasing payment rates is to increase access to care for PPI beneficiaries, especially access to private physicians. These studies suggest that increasing payment levels does increase the number of private physicians who will accept Medicaid patients, and this should increase access for some Medicaid beneficiaries. However, increasing payment levels does require additional public funding.

7C .State Reforms that Provide Subsidies for Care or Insurance

BECAUSE LOW-INCOME PATIENTS have lower marginal tax rates than the general population, equalizing the tax treatment of health-care expenses is not as advantageous for low-income patients as it is for others. On the other hand, refundable tax credits may be very helpful for increasing access for low-income patients.²²⁵

In addition to providing tax credits, states may attempt

221. Jonathan Gruber and Kosali Simon, "Crowd-out Ten Years Later: Have Recent Public Insurance Expansions Crowded Out Private Health Insurance?," (NBER Working Paper 12858, January 2007), <http://ideas.repec.org/p/nbr/nberwo/12858.html>.

222. Governor Schwarzenegger's Health Care Team, *Governor's Health Care Proposal*, <http://gov.ca.gov/index.php?/fact-sheet/governor-schwarzeneggers-health-care-proposal/>.

223. Baker and Royalty, "Medicaid Policy", 480.

224. Peter J. Cunningham and Len M. Nichols, "The Effects of Medical Reimbursement on the Access to Care of Medicaid Enrollees: A Community Perspective," *Medical Care Research and Review* 62 (2005): 676.

225. Most proposals for refundable tax credits have been federal proposals. However, it would be possible for a state to provide a refundable tax credit for low-income individuals. See Mark Pauly and Bradley Herring, "Expanding Coverage via Tax Credits: Trade-Offs and Outcomes," *Health Affairs* 20 (2001): 9.

to increase access for low-income patients using the following types of subsidies: (1) subsidies to hospitals, (2) subsidies to individuals to pay for care, or (3) subsidies to individuals to purchase insurance.

Provide Subsidies to Hospitals

STATES COULD PROVIDE hospitals or even professional groups with additional funds to provide care for low-income patients. When Congress passed the Hill-Burton Act in 1946, it conditioned receipt of funds for hospital construction on the hospital providing care for low-income patients.²²⁶ Similarly, through the “disproportionate share” (DSH) program, each state provides supplemental funds to hospitals that serve a large number of low-income patients.²²⁷

Subsidies to hospitals or physicians for the care of low-income patients should decrease the cost of providing care and increase the supply of care. On the other hand, subsidies directly to hospitals may subsidize services not desired or needed by low-income patients, it may be costly for a state to verify that a hospital is using the money to provide low-income patient care, and hospital subsidies require public funding.

Provide Subsidies to Patients to Pay for Care

WHILE TAX INCENTIVES are of less value to low-income patients than they are to the general population, direct subsidies for care may be very helpful. A number of states have obtained Medicaid waivers that allow them to provide Medicaid beneficiaries with subsidies to pay directly for certain types of care. Through one such program, known as “cash and counseling,” a state may provide patients with funds that allow the beneficiary to pay for disability-related services from whomever they choose.²²⁸

Foster et al. conducted a randomized controlled study of the Medicaid cash-and-counseling program in Arkansas.²²⁹ They found that patients in the cash-and-counseling program had greater patient satisfaction and fewer unmet needs than patients in agency-directed care. There were no differences in health or safety outcomes.

In addition, as a part of the Deficit Reduction Act of 2005, Congress authorized states to make health opportunity accounts (HOAs) available to Medicaid beneficiaries.²³⁰ HOAs are accounts similar to health savings accounts (HSAs), into which a state Medicaid office deposits funds and from which a Medicaid beneficiary withdraws funds to pay for care. Similar to HSAs, Medicaid beneficiaries control their HOAs, and HOA funds can be carried from year to year to be used for health-care expenses in future years.

Provide Subsidies to Patients to Purchase Insurance

IN 2001, THE Department of Health and Human Services developed the Health Insurance Flexibility and Accountability Initiative (HIFA).²³¹ One component of HIFA gave states greater flexibility to develop premium-assistance programs for Medicaid beneficiaries. Under premium assistance, a state provides a subsidy directly to a Medicaid beneficiary, allowing the beneficiary to take advantage of employer-sponsored insurance.

Similarly, one of the key goals of the 2006 Massachusetts reform plan was to provide assistance to low-income individuals to purchase private insurance.²³² Under the Massachusetts plan, subsidies to purchase private insurance are made available to those earning up to 300 percent of FPL.²³³

226. Hill-Burton Act, Public Law 79-725, 79th Cong., 2d sess. (1946).

227. David Rousseau and Andy Schneider, “Current Issues in Medicaid Financing—An Overview of IGTs, UPLs, and DSH,” (Issue Paper, The Henry J. Kaiser Family Foundation April 2004).

228. Leslie Foster, Randall Brown, Barbara Phillips, et al., “Improving the Quality of Medicaid Personal Assistance Through Consumer Direction,” *Health Affairs* 22 (March 26, 2003): W3-162.

229. *Ibid.*

230. Public Law 109-171. For a more complete discussion of Health Opportunity Accounts, see Nina Owcharenko, “Options and Opportunities for State Medicaid Reform,” in *What States Can do to Reform Health Care: A Free-Market Primer*, John R. Graham, ed. (San Francisco: Pacific Research Institute, 2006), chap. 1.

231. Gretchen Engquist and Peter Burns, *Health Insurance Flexibility and Accountability Initiative: Opportunities and Issues for States, State Coverage Initiatives*, Issue Brief, (Princeton, NJ: The Robert Wood Johnson Foundation, August 2002).

232. Jonathan Gruber, *The Massachusetts Health Care Revolution: A Local Start for Universal Access*, Hastings Center Report 36 (2006): 14.

233. *Ibid.* Cutler also has proposed that states provide subsidies for low-income patients to purchase health insurance. See David M. Cutler, *Your Money or Your Life* (Oxford: Oxford University Press, 2004), chap. 10.

Comment—Patient Subsidies

THERE ARE A number of potential advantages to patient subsidies over PPI. Subsidies to pay for care allow a beneficiary to choose one's physician, hospital, and services based on quality and price. Subsidies to pay for insurance allow a beneficiary to choose the type of insurance best suited to that patient's needs and eliminates the crowd-out effect that PPI has on private insurance.

The primary disadvantage of patient subsidies is that they require public funding. The recent Massachusetts plan extends these subsidies to individuals who earn up to 300 percent of the FPL, significantly above the previous eligibility threshold for PPI.²³⁴ However, a state could limit the subsidies it provides to individuals eligible for traditional PPI. In addition, unlike PPI, a subsidy for either care or insurance allows the state to control its costs by making a defined contribution.

7D. State Reforms that Modify the Regulation of Care or Insurance

AS NOTED IN Chapter 6, liberalizing regulations governing professional care, hospital care, and health insurance may increase access by lowering prices for care or insurance. Reforms that decrease prices would be especially important for low-income patients.

While each measure that decreases the cost of care or insurance may increase access for low-income patients, two measures may be especially helpful: (1) decreasing restrictions on mid-level practitioner care and (2) decreasing restrictions on underwriting, pricing, and benefits.

Decrease Restrictions on Mid-Level Practitioner Care

WHILE ACCESS TO all types of care is important for low-income patients, access to primary care and to low-risk labor and delivery care is especially important. For many low-income patients, primary care is the major point of access to health promotion, disease prevention, and spe-

cialty care. As noted in Chapter 4, there are data suggesting that nurse practitioners often provide high-quality care in a primary care setting, and nurse midwives often provide high-quality low-risk labor and delivery care. States vary widely as to the oversight requirements, practice authority, and prescription authority of mid-level practitioners.²³⁵ More restrictive states may require physician presence at the time of encounter, written protocols for practice, or physician review of all medical charts involving a medication prescription.²³⁶

Decreasing these restrictions should increase the supply of primary care, potentially decreasing prices and increasing access for low-income patients. Similarly, decreasing restrictions for care provided by nurse midwives may increase access to low-risk labor and delivery care without decreasing quality.

Decrease Restrictions on Underwriting and Benefits

ONE OF THE primary reasons individuals do not purchase health insurance is that the expected benefits are less than the cost. For low-income individuals who are relatively healthy, the expected benefits of comprehensive, first-dollar coverage may be much less than the cost.

States vary widely as to the availability of low-cost insurance. Required guaranteed issue plus community rating prevents an insurer from offering insurance to young, healthy individuals at prices adjusted to their risk. Similarly, mandating added benefits prevents an insurer from offering flexible, low-cost insurance to individuals who do not desire the added benefits.

Decreasing restrictions on underwriting, pricing, and the allowable benefit package would allow insurers to offer low-cost insurance to those who desire it, and lower prices should be especially helpful for low-income patients.²³⁷ It is possible that decreasing these requirements would increase the percentage of low-income patients who maintain private health insurance.

234. See Gruber, *The Massachusetts Health Care Revolution*.

235. See Sharon Christian, Catherine Dower, and Edward O'Neill, *Chart Overview of Nurse Practitioner Scopes of Practice in the United States*, (San Francisco: Center for the Health Professions, UCSF, 2007), http://www.futurehealth.ucsf.edu/pdf_files/Chart%20of%20NP%20Scopes%20Fall%202007.pdf; Sharon Christian, Catherine Dower, and Edward O'Neill, *Overview of Nurse Practitioner Scopes of Practice in the United States—Discussion*, (San Francisco: Center for the Health Professions, UCSF, 2007), http://www.futurehealth.ucsf.edu/pdf_files/NP%20Scopes%20discussion%20Fall%202007%20121807.pdf. See also Richard A. Cooper, Tim Henderson, and Craig L. Dietrich, "Roles of Nonphysician Clinicians as Autonomous Providers of Patient Care," *Journal of the American Medical Association* 280 (1998): 795.

236. See Christian, Dower, and O'Neill, *Overview of Nurse Practitioner Scopes of Practice*.

237. Chapter 8 discusses reforms designed to increase access for high-risk patients, some of whom are also low-income.

7E. Summary

STATES HAVE A number of options for increasing access for low-income patients. States could expand eligibility for publicly provided insurance or increase PPI payment levels to physicians and hospitals. While these measures should increase access for some, they may decrease access for those who substitute PPI for private insurance. In addition, expansion of PPI requires additional public funding.

To ensure access for low-income patients, states could provide subsidies directly to patients that would allow them to obtain the care or purchase the insurance of their choice. Potential advantages include more options for care or insurance and more competition among professionals, hospitals, and insurers to serve low-income patients.

Finally, states may be able to increase access for low-income patients by reforming regulations that increase the cost of providing care or insurance. Reforms that may be especially important for low-income patients include decreasing restrictions on mid-level practitioner care and allowing individuals to purchase insurance free of restrictions on underwriting, pricing, and benefit package.

7F. Additional Reading

1. Richard A. Cooper, Tim Henderson, and Craig L. Dietrich, "Roles of Nonphysician Clinicians as Autonomous Providers of Patient Care," *Journal of the American Medical Association* 280 (1998): 795.
2. Janet Currie and Jonathan Gruber, "Health Insurance Eligibility, Utilization of Medical Care, and Child Health," *Quarterly Journal of Economics* 111 (1996): 431.
3. Jonathan Gruber and Kosali Simon, "Crowd-out Ten Years Later: Have Recent Public Insurance Expansions Crowded Out Private Health Insurance?" (NBER Working Paper 12858, January 2007), <http://ideas.repec.org/p/nbr/nberwo/12858.html>.
4. Centers for Medicare and Medicaid Services, "Technical Summary, Medicaid Program General Information," http://www.cms.hhs.gov/MedicaidGenInfo/03_TechnicalSummary.asp.

REFORMS TO INCREASE ACCESS FOR HIGH-RISK PATIENTS

FOR THIS POLICY resource, a high-risk patient is a person who, because of age, a genetic condition, or a chronic disease, has a greater probability of requiring health care than the average person. Because high-risk patients require more care, they may be unable to afford the care they need, and they may be unable to obtain health insurance.

This chapter begins with brief background information concerning federal efforts to increase access for certain high-risk patients. The background section is followed by potential state reforms discussed under three categories: (1) reforms that require insurers to cover high-risk patients, (2) reforms that provide incentives or subsidies for private care or insurance, and (3) reforms that modify the regulation of care or insurance.

8A. Background—Federal Legislation and High-Risk Patients

ESTABLISHED IN 1965, Medicare is a form of health insurance for one large group of high-risk individuals—Americans 65 years of age and older.²³⁸ In 1972, Medicare was extended to cover two additional groups of high-risk patients regardless of age—patients with chronic disabilities and patients with end-stage renal disease.²³⁹ At this time, disabled patients and patients with end-stage renal disease are the only two groups of high-risk patients under age 65 who are eligible to participate in Medicare.

In addition, Medicare specifically subsidizes the care of high-risk patients who choose to participate in Medicare Part C, now known as Medicare Advantage. Medicare Advantage allows patients who are eligible for Medicare to substitute a private health plan for traditional fee-for-service Medicare. Under Medicare Advantage, the Centers for Medicare and Medicaid Services (CMS) pays a private health plan a fixed amount each month to provide care for a Medicare beneficiary.²⁴⁰

Because some persons are expected to require more care than others, CMS varies its payment based on the health status or risk of the beneficiary. By adjusting its payments based on the beneficiary's risk, CMS in effect provides a subsidy to insurers to encourage them to provide insurance for high-risk patients. As of 2007, 8.7 million Medicare beneficiaries were participating in Medicare Advantage.²⁴¹

8B. State Reforms that Require Insurers to Provide Insurance

TO INCREASE ACCESS for high-risk patients, states could require insurers to provide insurance at affordable rates by requiring guaranteed issue plus community rating.

Require Guaranteed Issue at Community-Rated Prices

AS NOTED IN chapter 5, mandated guaranteed issue requires an insurer to offer insurance to all otherwise qualified applicants, regardless of risk. However, because high-risk patients are expected to require more care than a patient of average risk, unless guaranteed issue is combined with community rating, the insurance may be unaffordable for some high-risk patients.

Mandated community rating requires an insurer to charge all of the insured the same price for similar coverage, regardless of the risk of incurring medical expenses. In effect, guaranteed issue at community-rated prices is one way a state can require an insurer to provide insurance for high-risk patients at more affordable prices.

The primary benefit of guaranteed issue at community-rated prices is that health insurance is made more available for high-risk patients than it otherwise would be. However, there are a number of potential costs. Costs include the cost of a state agency to develop, monitor, and enforce the requirements as well as the costs incurred by insurers to comply with the regulations.

Also, there are likely to be deadweight losses because guaranteed issue plus community rating would likely

238. *Social Security Amendments of 1965*, Public Law 89-97, *U.S. Statutes at Large* 79 (1965): 286.

239. Centers for Medicare and Medicaid Services, "Key Milestones in CMS Programs—History," <http://www.cms.hhs.gov/History/Downloads/CMSProgramKeyMilestones.pdf>.

240. *Ibid.*

241. The Henry J. Kaiser Family Foundation, "Medicare Advantage, Fact Sheet #2052-10," (The Henry J. Kaiser Family Foundation, June 2007), <http://www.kff.org/medicare/upload/2052-10.pdf>.

result in higher prices for those who are not high-risk.²⁴² Higher prices may occur for at least three reasons—higher insurer compliance costs, larger claims costs because more high-risk patients are included in the pool, and a high probability of adverse selection.²⁴³ As noted in chapter 5, guaranteed issue is especially likely to result in adverse selection, because guaranteed issue provides an incentive for healthy individuals to refrain from purchasing insurance until they have need of it.

Review of Selected Studies

Following is a brief summary of studies described in chapter 5 involving guaranteed issue, guaranteed renewability, and community rating.²⁴⁴

Sloan and Conover found that state requirements for guaranteed issue and guaranteed renewability did not increase the probability that a state resident would be insured.²⁴⁵

Davidoff et al. found that issue and rating reforms, e.g., guaranteed issue and community rating, resulted in greater coverage rates for high-risk employees in small firms compared to low-risk employees in small firms.²⁴⁶ In addition, these reforms resulted in lower coverage rates for low-risk workers in small firms as compared to low-risk workers in large firms.

Herring and Pauly found that in the individual-insurance market, community rating increased the prevalence of health insurance among high-risk patients, but decreased the prevalence among average-risk patients.²⁴⁷ The net effect was an overall decrease in health-insurance prevalence within the individual-insurance market.

These same investigators found that in states without community rating, individual-insurance markets pooled up to 85 percent of the additional risk of a patient who is expected to require twice the expense of the average person in that market.²⁴⁸

Finally, Pauly estimated that prior to its requirement by HIPAA, up to 80 percent of persons in the individual-insurance market had guaranteed renewability as a feature of their policy.²⁴⁹

Comment

Some states have used guaranteed issue plus community rating to increase the affordability of health insurance for their high-risk population. The studies by Davidoff et al. and by Herring and Pauly suggest that guaranteed issue plus community rating results in a higher prevalence of health insurance for high-risk patients, but a lower prevalence for average-risk patients. Herring and Pauly's study suggests that in the individual market, overall health insurance prevalence may decline.

The data also suggest that unregulated markets may provide access to health insurance for at least some high-risk patients. For example, Pauly's report suggests that most individuals who are young and healthy are able to obtain guaranteed renewability, even without a state requirement. Voluntary or optional guaranteed renewability allows a policyholder to pay a slightly higher premium when one is healthy in return for rates similar to others in the same rating class if the policyholder later becomes high-risk.²⁵⁰

In addition, Herring and Pauly's study suggests that unregulated insurance markets may pool the risk of mod-

242. See chapter 2, note 26 above for a definition of deadweight losses.

243. While the inclusion of additional high-risk patients results in higher claims costs and higher prices, adverse selection increases prices further by leading to an insurance pool skewed to high-risk patients.

244. See chapter 5 for a more complete description of these studies.

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

246. Amy Davidoff et al., "State Health Insurance Market Reforms and Access to Insurance for High-Risk Employees," *Journal of Health Economics* 24 (2005): 725.

247. 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, August 2006).

248. *Ibid.*

249. Mark V. Pauly, "Regulation of Bad Things That Almost Never Happen, But Could: HIPAA and the Individual Insurance Market," *Cato Journal* 22 (2002): 72.

250. Recently, Herring and Pauly have described a model of guaranteed renewability in which the incentives for individuals and insurers are properly aligned. See Bradley Herring and Mark V. Pauly, "Incentive-Compatible Guaranteed Renewable Health Insurance Premiums" *Journal of Health Economics* 25 (2006): 395.

erately high-risk patients at only slightly higher prices than those charged average-risk patients.²⁵¹ Since the study did not differentiate between the insured high-risk patients who had guaranteed renewability and those who purchased insurance after becoming high-risk, one can not be certain how many uninsured high-risk patients would be able to purchase affordable insurance in an unregulated market.

Based on the above data, states may be able to increase access for at least some moderately high-risk patients by allowing insurers to offer insurance policies free of requirements for guaranteed issue or community rating. For those high-risk patients who cannot obtain insurance in an unregulated market, states have additional options, described in the following two sections.

8C. State Reforms that Provide Subsidies for Care or Insurance

BECAUSE BOTH CARE and insurance are likely to be expensive for high-risk patients, the federal and state tax incentives described in chapter 6 may be quite helpful for these patients.²⁵² As with the general population, states can facilitate the use of these incentives by making sure their laws are compatible with federal incentives, providing state tax incentives similar to federal incentives, and offering federal tax incentives to state employees.

In addition, states may be able to facilitate access for high-risk patients by subsidizing their care or insurance. This section describes two ways states may subsidize insurance for high-risk individuals: (1) provide subsidies to a state-created high-risk pool and (2) provide a subsidy to an insurer or an individual.

Provide a Subsidy to a State-Created High-Risk Pool

BEGINNING WITH CONNECTICUT and Minnesota in 1976, a number of states have created high-risk pools for individuals who are unable to obtain affordable insurance in the standard individual-insurance market.²⁵³ As of 2006, 33 states had functioning high-risk pools that covered 190,361 members.²⁵⁴

State-created high-risk pools vary as to eligibility criteria.²⁵⁵ Most states limit these pools to two groups of patients—those who have preexisting illnesses and as a result have difficulty qualifying for coverage at affordable rates, and those who qualify for guaranteed issue through the Health Insurance Portability and Accountability Act (HIPAA). Some pools accept only individuals who have been turned down by an insurer.

State high-risk pools also vary as to the types of plans provided.²⁵⁶ Some states allow the pool to offer only a single type of plan, usually a comprehensive plan, while others allow multiple types of plans, including plans with high deductibles and coinsurance.

Patients who qualify for a high-risk pool must pay premiums.²⁵⁷ Most states limit the premium to between 125 and 200 percent of the average premium in that state for the type of plan selected by the high-risk patient. Because high-risk patients may require more care than covered by the price-controlled premiums, states provide subsidies to reimburse the pool for expenses in excess of premiums collected.²⁵⁸ States use various sources of funding to reimburse these pools. Some states place a tax or surcharge on health insurers. Some states use general revenues, and some states use multiple sources of funding.

251. See Herring and Pauly, "State Community Rating Regulations".

252. Tax incentives include Section 125 plans, health reimbursement arrangements, and health savings accounts.

253. For detailed discussions of high-risk pools, see Lori Achman and Deborah Chollet, *Insuring the Uninsurable: An Overview of State High-Risk Pools* (New York: The Commonwealth Fund, August 2001), 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), <http://gateway.nlm.nih.gov/MeetingAbstracts/102273697.html>; Families USA, *High-Risk Health Insurance Pools*, Issue Brief (May 2006), <http://www.familiesusa.org/assets/pdfs/High-Risk-Pools-May-2006.pdf>.

254. National Association of State Comprehensive Health Insurance Plans, *Comprehensive Health Insurance for High-Risk Individuals, A State by State Analysis*, 21st ed., 2007/2008 (Denver: NASCHIP 2007), 27.

255. See Achman and Chollet, *Insuring the Uninsurable*; Frakt, Pizer, and Wrobel, "Insuring the Uninsurable;" and Families USA, *High-Risk Health Insurance Pools*.

256. *Ibid.*

257. *Ibid.*

258. *Ibid.*

Provide a Subsidy to Insurers or Patients

WHILE MOST STATES that provide subsidies for high-risk care have established a high-risk pool, segregation of patients into high-risk pools is not essential. States could provide a subsidy to an insurer for covering a high-risk patient within the open insurance market. Similarly, a state could provide a subsidy directly to a high-risk individual to pay for either care or insurance. The subsidy could be either an expense-determined subsidy, i.e. a subsidy that would cover expenses incurred over a specified amount, or a risk-adjusted subsidy in advance of care.

Risk-adjustment is a mechanism which allows a payer to adjust the payment rate based on the risk profile of the patient.²⁵⁹ As noted earlier, for Medicare beneficiaries who choose Medicare Advantage, CMS does not pay physicians and hospitals directly for the care provided. Instead, it pays a private health plan a fixed premium to pay for the care of the beneficiary. CMS bases the premium it pays on the beneficiary's risk-profile.

States could adopt a similar approach for the state's high-risk population. Instead of reimbursing an insurer for incurred expenses above a threshold, a state could pay the insurer a risk-adjusted premium in advance of care. Similarly, a state could provide a risk-adjusted subsidy directly to an individual.

Comment—Subsidies for High-Risk Insurance

SUBSIDIES TO FACILITATE health insurance for high-risk patients offer a number of advantages. The major advantage of a subsidy over guaranteed issue plus community rating is that a subsidy results in a much smaller increase in health insurance prices for the general population than does community rating.²⁶⁰ As a result, there is less likelihood that a subsidy would result in a lower prevalence of insurance among the general population. The major disadvantage of a subsidy is that it requires public funding.

The primary advantage of a risk-adjusted subsidy over an expense-determined subsidy is that unlike an expense-determined subsidy, a risk-adjusted subsidy provides an

incentive for an insurer, or potentially an individual, to minimize expenses.

On the other hand, measuring risk, predicting future expense, and adjusting payment rates is not easy.²⁶¹ Costs include the cost for an administrative agency to determine the risk for various categories of patients, determine their expected medical expenses, and set payment rates for each patient category. In addition, there are costs for an agency to monitor the patient data on which each risk-adjusted payment is based. Finally, risk-adjustment provides an incentive for an insurer or other subsidy recipient to exaggerate the risk of an enrollee so that payments will be greater.

As noted above, Pauly's report suggests that most patients who are not high-risk are able to purchase guaranteed renewability as a feature of their plans,²⁶² and the study of Herring and Pauly suggests that unregulated individual insurance markets may pool some of the risk faced by moderately high-risk patients.²⁶³ As a result, some high-risk patients may be able to maintain affordable health insurance even without state subsidies. For those who cannot obtain insurance in an unregulated market, a subsidy to a high-risk pool, to an insurer, or directly to an individual appears to be a more satisfactory way to provide insurance than guaranteed issue plus community rating.

8D. State Reforms that Modify the Regulation of Care or Insurance

AS WITH THE general population and low-income patients, lower prices should provide greater access for many high-risk patients. Two measures may be especially helpful: (1) eliminate or decrease restrictions on new facilities and equipment, and (2) decrease restrictions on underwriting, pricing, and benefits.

Decrease Restrictions on New Facilities and Equipment

THERE ARE DATA suggesting that patients who receive care from high-volume hospitals or high-volume physi-

259. See Robert Kuttner, "The Risk-Adjustment Debate," *New England Journal of Medicine* 339 (1998): 1952.

260. By increasing the demand for insurance and care, subsidies may indirectly increase prices for insurance.

261. See David M. Cutler, *Your Money or Your Life*, (Oxford: Oxford University Press, 2004), chap. 9.

262. Pauly, "Regulation of Bad Things."

263. Herring and Pauly, "The Effect of State Community Rating Regulations."

cians have better outcomes than those who receive care from low-volume hospitals or physicians.²⁶⁴ In addition, because specialized, high-volume programs, sometimes referred to as “centers of excellence” focus on one type of care, they may be able to provide care at lower cost. One example of high quality, specialized care at low cost is Duke University’s congestive heart failure program.²⁶⁵

Many high-risk patients require care from specialists, and often these patients require care from specialized centers similar to Duke’s congestive heart failure program. Because regulations that limit facility expansion and equipment purchase, e.g., CON laws, may inhibit the development of specialized facilities, eliminating or at least liberalizing these rules may lower prices for care and improve access for high-risk patients.

Decrease Restrictions on Underwriting and Benefits

FOR MANY PATIENTS with chronic conditions, the risk for large, unexpected medical expenses is no greater than that of the general population. As with other patients, it may be in their interest to purchase low-cost insurance for large, unexpected expenses instead of purchasing comprehensive insurance with first-dollar coverage.

As discussed in chapter 5, decreasing restrictions on underwriting, pricing, and benefits should decrease the cost of providing insurance for large, unexpected expenses and result in lower insurance prices. In addition, removing these restrictions may allow insurers to develop innovative insurance products tailored to patients with specific high-risk conditions.

By combining more affordable specialized care with less expensive insurance for large, unexpected expenses or insurance for specific clinical conditions, a high-risk patient may be better able to afford care than under the present situation in which most hospitals provide a full array of similar services, and most insurers offer similar comprehensive insurance to all patients.

8E. Summary

STATES HAVE MANY options for increasing access for high-risk patients. States could require insurers to pro-

vide insurance to all high-risk applicants at the same price they charge the general population. However, guaranteed issue plus community rating results in higher prices for patients who are not high risk and may decrease the overall prevalence of health insurance.

States could subsidize insurance for high-risk patients in a number of ways. Many states have established high-risk pools through which a state reimburses the pool for incurred expenses above some specified amount. States also could provide subsidies to insurers who cover high-risk patients or provide subsidies directly to individuals to pay for care or insurance. States could base the payment rate on the expense incurred or on a patient’s actuarial risk in advance of care.

Finally, states may be able to increase access for high-risk patients by decreasing restrictions on facility expansion and equipment purchase. Decreasing these restrictions may encourage the development of specialized centers that provide low-cost, high-quality care for patients with chronic conditions. Decreasing restrictions on insurance underwriting, pricing, and benefits may lower insurance prices and allow insurers to design insurance products for specific types of high-risk patients.

8F. Additional Reading

1. Lori Achman and Deborah Chollet, *Insuring the Uninsurable: An Overview of State High-Risk Pools* (The Commonwealth Fund, August 2001).
2. 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, August 2006).
3. Robert Kuttner, “The Risk-Adjustment Debate,” *New England Journal of Medicine* 339 (1998): 1952.
4. National Association of State Comprehensive Health Insurance Plans, *Comprehensive Health Insurance for High-Risk Individuals, A State by State Analysis*, 21st ed., 2007/2008, (Denver: NASCHIP 2007), 27.

264. 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,” *Annals of Internal Medicine* 137 (2002): 511. See also John D. Birkmeyer, Therese A. Stukel, Andrea E. Siewers, et al., “Surgeon Volume and Operative Mortality in the United States,” *New England Journal of Medicine* 349 (2003): 2117.

265. David J. Whellan, Laura Gauden, and Wendy Gattis, et al., “The Benefit of Implementing a Heart Failure Disease Management Program,” *Archives of Internal Medicine* 151 (2001): 2223.

DESPITE MARKED ADVANCES in the ability to cure disease, restore function, and relieve pain, problems continue to plague U.S. health care. Access to care is limited both by lack of insurance and high prices for care. Despite the fact that most Americans receive excellent care, there are data suggesting that some patients receive substandard care.

While there are many reasons that both care and insurance are expensive, federal and state policies may be important factors. The federal government provides a tax incentive for individuals to purchase health insurance through their employer, but not to purchase insurance independently, and until recently, there were few tax incentives to pay for care out-of-pocket. Also, both federal and state governments provide health insurance for a large percentage of the U.S. population.

Both public insurance and the tax preference for employer-provided insurance have increased access to care for many individuals. However, both have resulted in greater third-party payment for care and have decreased normal constraints on the demand for care. The larger demand has contributed to high prices for both care and insurance, and high prices result in less access for individuals without access to either employer-provided insurance or public insurance.

In addition, both federal and state governments extensively regulate both care and insurance. While regulations often have important benefits, even beneficial regulations increase the cost of providing care, and sometimes they restrict the entry of competitors. High costs and restricted entry decrease the supply of care and insurance, and a smaller supply usually results in higher prices. High prices are likely one reason many Americans do not purchase health insurance.

9A. Increasing Access for the General Population

TO INCREASE ACCESS for the general population, state governments could require employers to provide insurance or require individuals to purchase insurance. However, employer mandates are likely to result in harmful effects on employment, and individual mandates require many individuals to purchase insurance in which their expected benefits are less than the cost.

Equalizing the tax treatment of health care expenses should improve access for individuals not now eligible for employer-provided insurance. While completely equalizing the tax treatment of health care expenses will require federal action, a state could partially equalize tax treatment by structuring its laws so that its residents can take advantage of federal tax incentives, by providing state tax incentives similar to federal incentives, and by offering federal or state incentives to state employees.

Finally, states may be able to lower prices and increase access by liberalizing their regulations governing professional care, hospital care, and health insurance.

9B. Increasing Access for Low-Income Patients

TO INCREASE ACCESS for low-income patients, states could expand eligibility or increase payment levels for its Medicaid and S-CHIP programs. Both eligibility expansion and higher payments should increase access for some patients. However, expanding publicly provided insurance may provide only limited access and may crowd out private insurance. Expansion of public insurance also requires public funding.

States also may be able to increase access for low-income patients by providing PPI beneficiaries with direct subsidies to pay for care or purchase insurance. Patient subsidies would allow beneficiaries to choose the care and insurance they desire, and subsidies may provide greater access than PPI. Subsidies do require public funding.

Finally, states may be able to increase access for low-income individuals by reforming their regulations governing professional care, hospital care, and health insurance. Liberalizing scope-of-practice rules for mid-level practitioners and decreasing requirements that prevent insurers from offering low-cost insurance may be especially helpful for low-income patients.

9C. Increasing Access for High-Risk Patients

TO INCREASE ACCESS for high-risk patients, states could require insurers to provide insurance to all applicants at rates similar to those charged the general population. However, requiring insurers to provide insurance at community-rated prices increases prices for the general

population and may decrease the overall prevalence of health insurance.

States also may be able to increase access for high-risk patients by providing subsidies to state-created high-risk pools, to private insurers, or directly to high-risk individuals. For high-risk patients who are not able to obtain insurance in an unregulated market, subsidies appear to be a more satisfactory way of assuring insurance than guaranteed issue plus community rating.

Finally, states may be able to increase access for high-risk patients by reforming their regulations governing professional care, hospital care, and health insurance. Decreasing restrictions on equipment purchase and facility expansion may result in greater access to specialty care for patients with chronic illnesses. Similarly, decreasing restrictions on insurance underwriting, pricing, and benefits may result in lower insurance prices and may encourage insurers to develop innovative insurance products designed for patients with specific chronic conditions.



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