Testimony of

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Before the Joint Economic Committee
United States Congress
Hearing on *Health Care Costs and the Uninsured*
10:00 a.m., May 13, 2004

Mr. Chairman and Members of the Committee:

How much of the phenomenally high level of health costs in the U.S. can be attributed to health services regulation? And how many uninsured might be covered were we to reduce this sizable regulatory burden? My remarks today will provide some tentative answers to both questions based on the preliminary results of more than two years of research conducted in part under contract to the Department of Health and Human Services. My comments this morning are my own and not intended to represent the views of either the Department or Duke University.

## Research on the Benefits and Costs of Health Services Regulation

*Overview*

I have conducted previous empirical work on a number of domains of health services regulation, including certificate-of-need, hospital conversions, hospital community service requirements (e..g., Hill-Burton), professional credentialing, Blue Cross and Blue Shield plan conversions, state health insurance reforms, managed care regulation and medical tort reform. But my remarks today are based principally on research conducted under contract to the Agency for Healthcare Research and Quality with funding from the Assistant Secretary of Planning and Evaluation, Office of Disability, Aging, and Long-Term Care Policy. This work began in the spring of 2002 and has continued through the present. A second phase of this

work is expected to begin shortly and would entail further empirical work, collection of additional data and publication of a large literature synthesis.

There is a sizable literature on the benefits and costs of regulation in the U.S. economy, with the first efforts to estimate the overall impact dating back to the mid-1970's.[1] From this work we know that regulations impose a considerable burden on U.S. business and that the impact of regulation on the overall economy may be approaching 1 trillion dollars a year. In contrast, however, no one before had even attempted to compile a comprehensive estimate of the overall benefits and costs of health services regulation. With health expenditures projected to absorb one-sixth of the economy in less than a decade,[2] it made sense to focus on this void in our understanding of the impact of regulation. Therefore, the objective of the first phase of our research was to develop a preliminary synthesis of the literature on the benefits and costs

[1] Previous efforts to synthesize the overall burden of regulation in the U.S. include Weidenbaum, M., and R. DeFina. 1978. "The cost of federal regulation of economic activity." American Enterprise Institute, Washington, DC.; Litan, R., and W. Nordhaus. 1983. Reforming federal regulation. New Haven: Yale University Press; Hahn, Robert W., and John A. Hird. 1990. The Costs and Benefits of Regulation: Review and Synthesis. *Yale Journal on Reguation* 8: 233-278; Hopkins, Thomas D. 1992. Costs of Federal Regulation. *Journal of Regulation and Social Costs* 2, no. 1: 5-31; Hopkins, Thomas D. 1995. *Profiles of Regulatory Costs*, Rochester Institute of Technology, Rochester, NY.; Hopkins, Thomas D. 1996. *Regulatory Costs in Profile*, Policy Study No. 132. Center for the Study of American Business, Rochester, NY; Crain, Mark W., and Thomas D. Hopkins. *The impact of regulatory costs on small firms*, RFP No. SBAHQ-00-R-0027. The Office of Advocacy, U.S. Small Business Administration. http://aspe.hhs.gov/health/reports/hipabase/toc.htm; and Dudley, Susan, and Melinda Warren. 2002. *Regulatory Response: An Analysis of the Shifting Priorities of the U.S. Budget for Fiscal Years 2002 and 2003*, Regulatory Budge Report 24. Mercatus Center, George Mason University and Murray Weidenbaum Center on the Economy, Government, and Public Policy, Arlington, VA, and St. Louis, MO., the latter representing the 24th in a series of annual reports issued by the Weidenbaum Center on the Economy, Government, and Public Policy (formerly the Center for the Study of Business) at Washington University in St. Louis (this latest report is a joint effort with the Mercatus Center at George Mason University). Most of these syntheses focus on federal regulation, as does an annual report required of Office of Management and Budget since 1997 that outlines the costs and benefits of all federal regulations. See OMB, Office of Information and Regulatory Affairs. 1997. *Report to Congress on the costs and benefits of federal regulations*; OMB. 1999. *Report to Congress on the costs and benefits of federal regulations*; OMB. 2000. *Report to Congress on the costs and benefits of federal regulations*. OMB. *Making sense of regulation: 2001 report to Congress on the costs and benefits of regulations and unfunded mandates on state, local and tribal entities*; OMB. 2002. Draft Report to Congress on the Costs and Benfitrs of Federal Regulations; Notice. *Federal Register* 67, no. 60: 15014-45. A comprehensive review and synthesis of the cost of workplace regulations whose scope and style are the inspiration for our synthesis is provided by ). Johnson, Joseph M. 2001. A Review and Synthesis of the Cost of Workplace Regulations. Mercatus Center, George Mason University.

[2] Heffler, Stephen, Sheila Smith, Sean Keehan, M. Kent Clemens, Greg Won, and Mark Zezza. 2003. Health spending projections for 2002-2012: Spending on hospital services and prescription drugs continues to drive health care's share of the economy upward. *Health Affairs* Web Exculsive: 54-65.

of health services regulations, culminating in a research plan to do further work to help fill important gaps in our current knowledge identified in the first phase.

*Expert Panel*

This work was completed by researchers at the Center for Health Policy, Law and Management with expert guidance from an advisory panel of 20 knowledgeable experts whose collective expertise included health facilities regulation, health professionals regulation, health insurance regulation and the medical tort system. Apart from providing guidance on the scope and content of this literature synthesis, and feedback throughout the process, most of these experts convened for a 1-day conference at Duke in February 2003. These experts included noted legal scholars such as:

- Clark Havighurst, JD, the William Neal Reynolds Professor Emeritus of Law at Duke University;
- Mark A. Hall, JD, Professor of Law and Public Health at Wake Forest University School of Law and School of Medicine; and
- David Hyman, who also is testifying today.

We also included experienced health economists such as:

- Joseph Antos, PhD, a Resident Scholar at the American Enterprise Institute;
- H.E. Frech III, PhD, Professor at the University of California, Santa Barbara;
- Robert B. Helms, PhD, a resident scholar and director of Health Policy Studies at the American Enterprise Institute;
- Michael Morrisey, PhD, a professor in the Department of Health Care Organization and Policy at the University of Alabama at Birmingham (UAB) and Director of the Lister Hill Center for Health Policy at UAB;
- Mark V. Pauly, PhD, the Bendheim Professor of Health Care Systems, Business and Public Policy, Insurance and Risk Management, and Economics as well as Chairperson of Health Care Systems Department at the Wharton School, University of Pennsylvania; and

- Frank Sloan, the J. Alex McMahon Professor of Health Policy and Management and Director, Center for Health Policy, Law and Management, and a professor of economics at Duke University.

We also included several individuals with expertise dealing with health regulations "in the trenches" so to speak, including:

- Dan Mulholland, who also is testifying today;
- Christy Gudaitis, JD, Assistant University Counsel for Duke University and Duke University Health System, and
- Duncan Yaggy, PhD is Adjunct Professor of Public Policy Studies and Director and Chief Planning Officer, Duke University Health Systems.

Finally, we included individuals with general expertise in the area of measurement of regulatory costs or experts with unique training or perspectives on the issues being discussed such as:

- Lesley Curtis, PhD, Assistant Research Professor, General Internal Medicine, Duke University Medical Center
- Walton J. Francis, independent health consultant;
- Randall Lutter, PhD, Resident Scholar with AEI;
- Kevin Schulman, MD, MBA, Professor, Department of Medicine, Duke University Medical Center and Faculty Director, Health Sector Management Program, Fuqua School of Business at Duke University.

*Scope of Regulations Reviewed*

All told, our literature synthesis included a broad range of health-related regulations, covering the gamut from health facilities regulation, health professionals regulation, health insurance regulation, FDA regulation and the medical tort system. We are confident that no major domain of health services regulation was excluded from this review. We purposely excluded domains of regulation that cut across all industries, such as employment regulations (e.g., worker health and safety, employment discrimination restrictions) even though these too might have the effect of elevating health expenditures. We considered whether to include

antitrust regulation. The argument against inclusion was that, despite its particular influence on the healthcare industry, antitrust is broadly applicable across other types of industries, and thus would not qualify as a unique "health service" regulation. Moreover, one could not include costs without also somehow including benefits that may be difficult to measure. We ultimately decided *not* to include general antitrust regulation of facilities, professionals or insurance, but did elect to include state action statutes that provide exemptions from antitrust laws on grounds that equivalent exemptions are not provided in other industries and these exemptions may result in identifiable costs." Moreover, it is worth noting that our cost estimates do not include the costs imposed on health providers from continual changes in public payment policies. In that regard, our estimates should be viewed as a conservative assessment of the size of the regulatory cost burden in health care.

Table 1 shows all the topics included in the area of health facilities regulation, broken down by whether these regulations principally were aimed at improving access, cost or quality of care. We recognize that some of these categorizations might be viewed as arbitrary. Certificate of need laws, for example, were originally justified predominantly on the basis of controlling costs, but in recent years, as questions have been raised about the efficacy of such programs in controlling costs, the justifications have tended to focus more on CON's purported ability to improve access and/or quality. Some of the most important areas of facilities regulation in terms of net costs (i.e., benefits minus costs) include accreditation and licensure for hospitals and nursing homes, hospital uncompensated care pools and regulation of clinical laboratories.

**Table 1**
**Health Facilities Regulation**

| Regulation | Locus |
|---|---|
| **Access** | |
| EMTALA | F |
| Hospital uncompensated care pools | S |
| Hospital community service requirements | |
| Hill-Burton | F |
| State community service requirements | S |
| State indigent care mandates | S |
| Hospital conversion regulations | S |
| Limited English Proficiency requirements | F |
| **Costs** | |
| Fraud and abuse | |
| False Claims Act of 1863 | F |
| MedicareMedicaid fraud and abuse statute | F |
| Civil Monetary Penalties Law (CMPL) | F |
| Self-referral prohibitions (Stark I and II) | F |
| HIPAA fraud and abuse provisions (1996) | F |
| BBA fraud and abuse provisions (1997) | F |
| State fraud and abuse requirements | S |
| Medical records (includes privacy) | |
| HIPAA Privacy Rule | S |
| State privacy regulations | F |
| Organ transplant regulation | F |
| Hospital provision of transplant-related data | F |
| Organ transplant sales ban | F |
| Certificate of need | S |
| Hospital rate-setting | S |
| Pharmaceutical price regulation | |
| Medicaid Average Wholesale Price | F |
| State pharmaceutical price regulation | S |
| Other cost-related facilities regulations | S |
| Hospital discharge data systems | S |
| Patient Self-Determination Act of 1990 | F |
| **Quality** | |
| Hospital accreditation and licensure | |
| Medicare conditions of participation | F |
| State accreditation and licensure | S |
| Nursing home accreditation and licensure | F |
| Medicare conditions of participation | F |
| Nursing Home Reform Act (OBRA '97) | F |
| State accreditation and licensure | |
| Other facilities accreditation and licensure | F |
| Medicare conditions of participation | F |
| Ambulatory Surgical Centers | F |
| Diagnostic Imaging Centers | F |
| Home Health Agencies | F |
| Renal Dialysis Centers | F |
| Pharmacies | F |
| Ambulances | F |
| State accreditation and licensure | S |
| Peer Review | |
| Quality Improvement Organizations (QIOs) | F |
| Health Care Quality Improvement Act (1986) | F |
| Clinical Laboratory Improvement Act of 1967 | F |
| Other quality-related facilities regulations | |
| Regulation of blood banks (FDA) | F |
| Blood-borne pathogen requirements (OSHA) | F |
| Health outcomes reporting systems | S |

Table 2 shows topics included in the area of health professionals regulation, most of which are focused on either costs or quality. Again, in terms of overall net cost impact, the most important areas of health professionals regulation include Medicare GME payments, professional accreditation and licensure and Medicare assignment rules.

**Table 2**
**Health Professionals Regulation**

| Regulation | Locus |
|---|---|
| **Access** | |
| Medicare assignment rules | F |
| **Costs** | |
| Fraud and abuse | |
| False Claims Act | F |
| MedicareMedicaid fraud and abuse statute | F |
| Self-referral prohibitions (Stark I and II) | F |
| HIPAA fraud and abuse provisions (1996) | F |
| BBA fraud and abuse provisions (1997) | F |
| State fraud and abuse | S |
| Medical records (includes privacy) | |
| HIPAA Privacy Rule | F |
| State privacy regulations | S |
| Medicare GME payments | F |
| **Quality** | |
| Medicare conditions of participation | F |
| National Practitioner Databank | F |
| Professional accreditation/licensure | S |
| Commercial limits on practice of medicine | |
| Corporate practice of medicine | S |
| Advertising restrictions | |
| FTC | F |
| State advertising restrictions | S |
| Resident duty hours limitations | S |

Table 3 shows the many different federal and state regulations affecting health insurance that were included in our analysis. The areas having the largest net cost impact include mandated health coverage, managed care patient protections and general health insurance/HMO regulation.

**Table 3**
**Health Insurance Regulation**

| Regulation | Locus | Health Insurance | | | Managed Care | | | Integrated Delivery Systems | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Blue Cross/ Blue Shield | Com-mercial Insurance Companies | Self-insured Health Plans | HMOs | IPAs | PPOs | PHOs | MSOs | PSOs |
| **Access** | | | | | | | | | | |
| HMO Act of 1973 | F | | | | x | x | | | | |
| Anti-discrimination restrictions | F | | | | | | | | | |
| Rehabilitation Act of 1973 | F | x | x | x | x | x | x | | | |
| Pregnancy Discrimination Act of 1978 | F | x | x | x | x | x | x | | | |
| Americans with Disabilities Act | F | x | x | x | x | x | x | | | |
| Child Abuse Prevention and Treatment Act | F | x | x | x | x | x | x | | | |
| Mandated health coverage | | | | | | | | | | |
| Employer mandates | S | x | x | x | x | x | x | | | |
| Continuation of coverage | | | | | | | | | | |
| State requirements | S | | | | | | | | | |
| COBRA (1985) | F | x | x | x | x | x | x | | | |
| Mandated health benefits | | | | | | | | | | |
| Mandated standards of care | S | | | | x | x | x | | | |
| Other mandated health benefits | S | x | x | | x | x | x | | | |
| Mental Health Parity Act (1996) | F | x | x | x | x | x | x | | | |
| Newborns' and Mothers' Protection Health Act | F | x | x | x | x | x | x | | | |
| Women's Health and Cancer Rights Act (1998) | F | x | x | x | x | x | x | | | |
| Mandated providers | S | x | x | | x | x | x | | | |
| Person mandates | S | x | x | | x | x | x | | | |
| Insurance Market Reforms | | | | | | | | | | |
| Small-group insurance reforms | S | x | x | | x | x | x | | | |
| Individual market insurance reforms | S | x | x | | x | x | x | | | |
| Community rating | S | x | x | | x | x | x | | | |
| Health alliances (voluntary & mandatory) | S | x | x | | x | x | x | | | |
| HIPAA (1996) | F | x | x | | x | x | x | | | |
| Health plan conversion regulations | S | x | | | x | | | | | |
| High risk pools | S | x | x | | x | x | x | | | |
| **Costs** | | | | | | | | | | |
| ERISA (1974) | F | | | x | | | | | | |
| HIPAA (1996) administrative simplification | F | x | x | x | x | x | x | x | x | x |
| Privacy regulation | | | | | | | | | | |
| State requirements | S | x | x | x | x | x | x | x | x | x |
| HIPAA (1996) | F | x | x | x | x | x | x | x | x | x |
| Medicare as secondary payer (1980) | F | x | x | x | x | x | x | | | |
| Medigap minimum standards (1990) | F | x | x | | x | x | x | | | |
| General Insurance/HMO Regulation | | | | | | | | | | |
| General insurance regulation (solvency/rates) | S | x | x | | | | | | | |
| General HMO regulation (solvency/rates) | S | | | | x | x | x | | | |
| Premium taxes | S | x | x | | x | x | x | | | |
| **Quality** | | | | | | | | | | |
| Medicare + Choice conditions of participation | F | x | x | x | x | x | x | x | x | x |
| Managed care regulation | | | | | | | | | | |
| Professional rights | | | | | | | | | | |
| All products statutes | S | | | | x | x | x | | | |
| Anti-gag rules | S | | | | x | x | x | | | |
| Due process protections | S | | | | x | x | x | | | |
| Prompt payments statutes | S | | | | x | x | x | | | |
| Patient protections | | | | | | | | | | |
| Any-willing-provider statutes | S | | | | x | x | x | | | |
| Continuity-of-care requirements | S | | | | x | x | x | | | |
| External review statutes | S | | | | x | x | x | | | |
| Drug formularies | S | | | | x | x | x | | | |
| Limits on financial incentives | S | | | | x | x | x | | | |
| Patient bill of rights | S | | | | x | x | x | | | |
| Bipartisan Patient Protection Act (2001) | F | | | | x | x | | | | |

## The Burden of Health Services Regulation in the U.S.

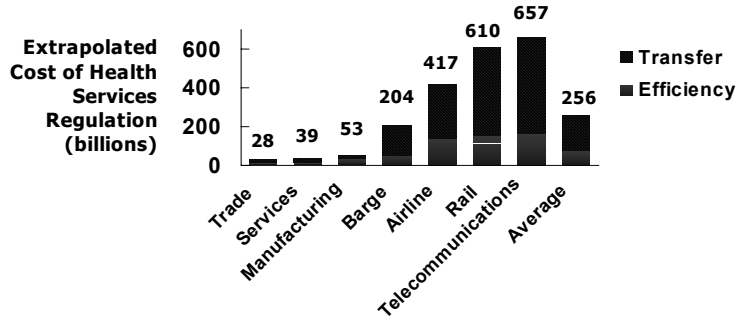
We used two approaches to determining the net impact of regulation. The first was a "top down" approach that relied on extrapolations from other industries. The second was a "bottoms up" approach that systematically examined the evidence.

In the "top down" approach, we looked at the costs of regulation in other industries such as airlines, railroads, telecommunications and other sectors that have long been studied by economists and calculated the percent of gross economic activity in those industries that various studies have attributed to regulatory costs. Some of these figures, dating to 1988, admittedly are somewhat dated cost estimates for industries that in some cases subsequently have seen considerable deregulation; nevertheless, unless one believes that the health industry has undergone a similar form of deregulation, the figures represent plausible impacts for a "typical" regulated industry. Moreover, these industry figures may be underestimates insofar as ex post estimates of the savings that resulted from deregulation of the airlines, railroads and trucking industries have tended to be significantly greater than ex ante estimates (Hahn and Hird 1990).

Thus, one may either view these 1988 estimates as being similarly flawed or as having benefited from the lessons learned from ex post calculations. By applying these percentages to the health sector, we arrive at very rough back-of-the-envelope estimates of upper and lower bounds on the plausible magnitude of the burden. As shown in Fig. 1, this so-called "top-down" approach suggests that in 2002, health regulation could have imposed an annual cost of at least $28 billion to as much as $657 billion. (See Figure 1).[3]

[3] See Appendix A for details of these calculations.

## Fig. 1. "Top Down" Estimate of Health Regulation Costs, 2002 (billions)




The sizable difference between the minimum and maximum cost estimate illustrates neatly the limitations of this approach, which inevitably leaves us with a great deal of uncertainty about where the truth lies. But a further limitation is that it is easily possible that the regulatory burden in health care is even higher than a simple extrapolation from other industries might suggest. After all, according to University of Rochester health economist Charles Phelps, "the U.S. health care system, while among the most "market oriented" in the industrialized world, remains the most intensively regulated sector of the U.S. economy."[4]

This is why it was worth investing effort in the much more fine-grained "bottoms up" approach. As noted above, we examined the literature for nearly 50 different kinds of federal and state health services regulations, including regulation of health facilities, health professionals, health insurance, pharmaceuticals and medical devices and the medical tort system. These various regulations covered the gamut from mandated health benefits to state certificate of need requirements for hospitals and nursing homes. We systematically tallied both the benefits and costs associated with such regulations[5] and found that the expected costs

[4] Charles E. Phelps. *Health Economics*, 2nd edition. Addison-Wesley Publishing Co. 1997: 539.

[5] In many cases, the national dollar impact of a particular form of regulation never has been estimated per se, e.g., state certificate of need regulation of hospitals and nursing homes. In these cases, we synthesized the literature on the percent change in health costs associated with that form of regulated and then calculated the aggregate national impact by applying these estimated effects to aggregate health expenditure estimates for the states that still maintain such regulations. In some cases, our estimates also included mortality gains and losses reported in the literature. In these cases, we monetized such losses using conventional assumptions about the willingness-to-pay value of a human life. We used a standard value of a statistical life that amounted to $4.4

of regulation in health care amounted to $340 billion in 2002. As shown at the bottom of Fig. 2, our estimate of benefits was $212 billion, leaving a net cost of $128 billion. Three areas account for the lion's share of this net burden: the medical tort system, including litigation costs, court expenses and defensive medicine, totals $81 billion, FDA regulation adds another $42 billion, and health facilities regulation adds $29 billion. This suggests that the states and federal government both have important roles to play in findings way to trim regulatory excess.

## Fig. 2. "Bottoms Up" Estimate of Health Regulation Costs, 2002 (billions)

| Type of Regulation | Benefits | Costs | Net |
|---|---|---|---|
| Facilities | 18.3 | 47.7 | 29.4 |
| Professionals | 22.4 | 29.5 | 7.1 |
| Insurance | 131.6 | 100.1 | (31.5) |
| Pharmacy/Devices | 7.1 | 49.0 | 41.9 |
| Medical Tort System* | 32.5 | 113.7 | 81.2 |
| TOTAL | 212.0 | 340.0 | 128.1 |

*Includes costs of medical professional liability insurance, courts and defensive medicine. Claimants' costs not compensated through awards are excluded.

With the caveat that our findings are still preliminary, to date we have found that in the domain of health facilities regulation, of the 16 separate areas of regulation we studied, only 2 produced benefits that exceeded costs. Similarly, benefits exceeded costs for only 3 of 8 health professional regulations we studied and 7 of 19 areas of health insurance regulation. This is not equivalent to saying that we believe 31 areas of health regulation should be discarded entirely since in at least some cases, it is possible that regulatory reform could produce a better alignment of benefits with costs. The medical tort system is a good example of this. This system clearly produces some benefits, including compensation to patients and deterrence of medical errors. However, if there were a way to achieve the same or greater benefits less expensively—whether this be through caps on damages, alternative dispute resolution—this would be an improvement over the status quo.

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million for our average estimates, with $1.6 million and $6.6 million as lower and upper bounds. See Mrozek, James R. and Laura O. Taylor. "What Determines the Value of Life? A Meta-Analysis." *Journal of Policy Analysis and Management* 21, No. 2 (Spring 2002): 253-270 for a detailed justification of these values.

In the context of seeing that most domains of health regulation cost more than the benefits they produce, it may be surprising to see that the reverse apparently is true for health insurance regulation, where benefits exceed costs by $31.5 billion a year. But it is important to note that this arises predominantly due to ERISA which alone provides a net savings of $46 billion. Recall that the benefits of ERISA are the protection it affords self-insured plans from otherwise having to comply with state benefit mandates, premium taxes and other insurance regulation costs. Given that ERISA plans cover 124 million Americans,[6] the cumulative savings from avoiding these regulatory costs is sizable. Thus, without ERISA, the total cost of insurance regulation would be more than 40 percent larger than we have estimated here and the total benefits would be one quarter larger. In that case, costs would exceed benefits by more than $14 billion. In short, ERISA is a peculiar form of regulation whose benefits arise chiefly by exempting certain health plans from even more onerous regulation. Had we left it out, our estimate of the net cost of regulation would have risen by more than one third to nearly $175 billion (Figure 3).

Fig. 3. "Bottoms Up" Estimate of Health Regulation Costs (w/o ERISA), 2002 (billions)

| Type of Regulation | Benefits | Costs | Net |
|---|---|---|---|
| Facilities | 18.3 | 47.7 | 29.4 |
| Professionals | 22.4 | 29.5 | 7.1 |
| Insurance (w/o ERISA) | 84.9 | 99.3 | 14.4 |
| Pharmacy/Devices | 7.1 | 49.0 | 41.9 |
| Medical Tort System* | 32.5 | 113.7 | 81.2 |
| TOTAL | 165.3 | 339.2 | 173.9 |

*Includes costs of medical professional liability insurance, courts and defensive medicine. Claimants' costs not compensated through awards are excluded.

[6] Copeland, Craig, and Bill Pierron. 1998. *Implications of ERISA for health benefits and the number of self-funded ERISA plans*.

It was not the purpose of our study to make recommendations on specific regulatory reforms to be pursued, either in medical torts or any other domain of health regulation. Instead, we were trying to provide something that has never been achieved previously: a "big picture" view of the overall impact of health services regulation with the intent of identifying areas where regulation might be excessive. For each of the areas so identified, one would have to rely on further study or experts in that domain to sort through the best approach to reform. In all likelihood, only in some of these cases would experts judge that we should dispense entirely with regulation.

While sizable, health care regulatory costs should be put into context. For example, this analysis has ignored entirely tax policy as it relates to health care. Yet, federal and state tax subsidies for employer health benefit contributions in 2004 will amount to $209.9 billion[7]—an amount that would effectively more than double our estimate of the cost of health services regulation had it been included. On a smaller scale, a recent study of Medicare found that $26 billion of Medicare expenditures in 1996 (equivalent to $34 billion in 2002) is wasted, i.e., "appears to provide no benefit in terms of survival, nor is it likely that this extra spending improves the quality of life.[8]" Thus there are areas apart from health services regulatory costs where Americans could get more bang for the buck.

Finally, more than a decade ago, some pioneers in estimating regulatory costs stated "We believe that improving and disseminating better information is likely to induce decision-makers to scrutinize the costs and benefits of regulation more carefully. We hope that this increased care will lead to more efficient decisions."[9] The estimates in our synthesis, as uncertain and incomplete as they may be, have been assembled with the same motivation.

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[7] Sheils, John, and Randall Haught. 2004. The cost of tax-exempt health benefits in 2004. *Health Affairs* Web Exclusive, no. W4: W4-106-W4-112.

[8] Skinner, Jonathan, Elliott S. Fisher, and John E. Wennberg. 2001. The efficiency of Medicare. NBER Working Paper Series #8395Cambridge, MA: National Bureau of Economic Research.

[9] Hahn, Robert W., and John A. Hird. 1990. The Costs and Benefits of Regulation: Review and Synthesis. *Yale Journal on Reguation* 8: 259.

## Net Regulatory Costs and the Uninsured

*Increases in the Number of Uninsured*

How do all these figures relate to the uninsured? Our "bottoms up" look allowed us to determine that the net cost of regulation imposed directly on the health industry itself is 6.4 percent, meaning that health expenditures (and health insurance premiums) are at least that much higher than they would be absent regulation.

Based on consensus estimates about the impact of higher prices on how many would likely drop health insurance, this increased cost implies a 2.2 percent reduction in the demand for coverage. **This translates into 4 million uninsured whose plight might be attributed to excess regulatory costs, or roughly 1 in 11 of the average daily uninsured**.

The foregoing figures are derived as follows. Most recent estimates of the price elasticity of demand for health insurance lie in the -.4 to -.6 range.[10] Assuming an average overhead cost no higher than 15 percent, a 6.4 percent increase in health spending (i.e., health benefits) attributable to health industry compliance costs would be associated with a 5.4% increase in overall health insurance premiums (i.e., 6.4% x 85%=5.4%), so applying the lower bound elasticity estimate yields a 2.2% reduction in demand for coverage. There are 185 million adults and children currently covered by private health insurance.[11] A 2.2 percent reduction in demand translates into 4.0 million uninsured. Using upper bound estimates of the net impact of health regulation (9.8%) and price elasticity (-.6) would imply that 9.2 million could be uninsured due to health regulation.

Our figures imply that for each 1% increase in private health insurance premiums, there would be a 0.4% reduction in demand for private coverage, which at current levels of private coverage implies 740,000 newly uninsured. There is another widespread rule of thumb based on a Lewin study estimate that each 1 percent increase in health insurance premiums results in 300,000 uninsured. The genesis of this figure and its limitations have been discussed

[10] Sherry Glied, Dahlia K. Remler and Joshua Zivin, " Inside the Sausage Factory: Improving Estimates of the Effects of Health Insurance Expansion Proposals." *Milbank Quarterly* 80, No. 4 (2002): 611

[11] Mills, Robert, and Shailesh Bhandari. 2003. *Health Insurance Coverage in the United States: 2002*, U.S. Census Bureau. U.S. Government Printing Office, Washington, DC

elsewhere,[12] but it is worth noting that it applied only to employer-based coverage and assumes that one third of those losing coverage would be able to obtain alternative group coverage through other family members, purchase less comprehensive individual coverage or qualify for public coverage such as Medicaid. A one-third reduction obviously would affect our own estimates, but from the standpoint of public policy, it is as important to know whether a newly uninsured individual is absorbed by Medicaid as whether they remain uninsured. Moreover, the Lewin estimates are based on the estimated relationship between employee contributions and decisions to retain coverage. But the typical small employer covers about half of all premium costs for group coverage, so a 1 percent premium cost could translate into anywhere from a 0 percent to 2 percent increase in the employee premium contribution depending on how much of the increase is passed through by the employer.

There also are several differences between our estimates and those used in recent cost estimates by CBO that are worth noting:

- Our estimates of the impact of health services regulation affect medical expenditures (and hence health insurance premiums) across the board; in contrast, federal mental health parity and PBOR proposals would apply only to group health plans (leaving out 16 million non-elderly with individual coverage) and in some cases exempt small employers (20 or fewer in some bills, 50 or fewer in others), exclusions that may leave out as much as 30 percent of private sector employer-based coverage; see Jennifer Bowen, Jeanne De Sa and Stuart Hagen memorandum "Estimate of S. 543, the Mental Health Equitable Treatment Act" July 12, 2002). Moreover, CBO always takes into account states that may have already enacted similar mandates or protections as their purpose is to calculate the net effect of a change in federal law. For all these reasons, the base of persons having coverage from which demand reductions are calculated is generally smaller in the CBO estimates than in ours.

[12] GAO. 1998. *Private Health Insurance: Impact of Premium Increases on the Number of Covered Individuals Is Uncertain*, GAO/HEHS-98-203R. United Sates General Accounting Office, Washington, DC.

- CBO assumes that 40 percent of premium increases would be effectively absorbed by employers and passed back to employees in the form of lower compensation; they assume the remaining 60 percent would be offset by changes in profits, by purchasers switching to less expensive plans, by cutting back on benefits or dropping coverage (see CBO, *Congressional Budget Office Cost Estimate: S. 1052 Bipartisan Patients' Bill of Rights Act* (as passed by the Senate on June 29, 2001), July 20, 2001). For all these reasons, the net amount of each 1 percent premium increase that is actually left over to influence demand for coverage is much smaller than ours (i.e., we take into account the full 1%).

The CBO approach makes sense when analyzing mandates that provide some sort of benefit at an additional cost since employees (and their employers who are presumed to reflect their preferences) presumably are willing to pay *something* for an additional benefit even if it is not the full cost. However, in our case, we had already netted out any benefits from regulation, so the residual $128 billion in costs should more appropriately be viewed as the equivalent of an excise tax. As CBO Director Douglas Holtz-Eakin has testified recently: "Clearly, an increase in premiums having nothing to do with the quality of the insurance benefit (a tax on premiums, for example) would lead to a reduction in the number of people with health insurance since the price increase would lead some people to drop their coverage."[13] In short, any differences between CBO estimates and ours are more apparent than real.

One final complicating factor is that there are huge variations in the estimated elasticity of employer offers of health insurance coverage, ranging from -.6 to –1.8 for small firms and 0 to -.2 for large firms. [14] Demand elasticity estimates for individuals show a similar range. Thus, the ultimate outcome of whether an individual becomes uninsured is a combination of a) employer decisions whether to continue offering coverage; b) employer decisions about how much of a cost to pass through to employees (and in what form); c) employee decisions whether to retain coverage; and d) alternative coverage options for employees and their

[13] Statement of Douglas Holtz-Eakin, Director of Congressional Budget Office, The Uninsured and Rising Health Insurance Premiums before the Subcommittee on Health Committee on Ways and Means U.S. House of Representatives March 9, 2004

[14] Sherry Glied, Dahlia K. Remler and Joshua Zivin, " Inside the Sausage Factory: Improving Estimates of the Effects of Health Insurance Expansion Proposals." *Milbank Quarterly* 80, No. 4 (2002): 611

dependents who drop coverage (or are dropped from coverage). Given these uncertainties, we believe our estimate is a reasonable one, but that the true figure might be lower or higher than we have estimated.

It is worth noting that for purposes of calculation today, we have simply assumed that all regulatory costs are spread relatively evenly across all payers in the system. For many forms of regulation, such as professional licensure and credentialing, this is a plausible assumption. But some forms of regulation such as state insurance regulation, tend to be more narrowly focused on selected groups, e.g., small groups and individuals. Were we to more finely calibrate our estimates to determine the percent cost increase facing small firms, for example, we undoubtedly would find that the impact was greater than the 6.4 percent average effect. This matters not only in terms of equity considerations but because the groups disproportionately impacted tend to be much more price sensitive than others. Hence, the uninsured are more likely to come from small groups and those relying on the individual market than among those covered by large employers.

*Affordability of Universal Coverage*

But of course, there's a different way to look at this burden as well. In light of the $35 billion in subsidized care already being provided to uninsured patients,[15] researchers have recently estimated that it would cost only $34 to $69 billion in added health spending to cover the all of the nation's uninsured.16 In light of these figures, the potential opportunity costs of this regulatory burden become very clear: the average estimates from both our "top down" and "bottoms up" look at this problem suggests we could cover this cost several times over. Admittedly, our estimates are still preliminary and we now are engaged in a process of careful review of them. But it seems unlikely that the adjustments yet to come would alter this central conclusion: **the net burden of health services regulation likely exceeds the annual cost of covering all 44 million uninsured by a considerable margin**. So a legitimate policy question is whether the benefits of regulation outweigh the benefits of coverage for all

[15] Jack Hadley and John Holahan. "How Much Medical Care Do the Uninsured Use and Who Pays for It?" *Health Affairs Web Exclusives*, January-June 2003. February 12, 2003: W3-66.
[16] Jack Hadley and John Holahan. "Covering the Uninsured: How Much Would it Cost?" *Health Affairs Web Exclusives*, January-June 2003. June 4, 2003: W3-250-265.

Americans. For example, in the context of the IOM finding that 18,000 uninsured die every year due to lack of coverage, is maintaining our current regime of health regulation worth letting that continue?

This is a question worthy of serious consideration especially during Cover the Uninsured week. Thank you for your time.

# Appendix A

**Fig. 1 Supporting Documentation. "Top-Down" Estimates of Cost of Health Services Regulation (billions of 2002 dollars)**

| Industry | Source | Year of Estimate | Type of Cost | | If Applied to Health | | |
|---|---|---|---|---|---|---|---|
| | | | Efficiency | Transfer | Efficiency | Transfer | Combined |
| | | | Percent | | Billions | | |
| Airline | Hahn and Hird 1991 | 1988 | 8.9% | 18.0% | 137.7 | 279.1 | 416.8 |
| Barge | Hahn and Hird 1991 | 1988 | 3.3% | 9.9% | 51.0 | 153.1 | 204.1 |
| Manufacturing | Crain and Hopkins 2001 | 2000 | 2.4% | 1.0% | 37.1 | 15.5 | 52.6 |
| Rail | Hahn and Hird 1991 | 1988 | 10.0% | 29.4% | 154.1 | 455.6 | 609.7 |
| Services | Crain and Hopkins 2001 | 2000 | 1.0% | 1.5% | 15.5 | 23.2 | 38.7 |
| Telecommunications | Hahn and Hird 1991 | 1988 | 10.6% | 31.9% | 164.3 | 492.9 | 657.3 |
| Trade | Crain and Hopkins 2001 | 2000 | 0.8% | 1.0% | 12.4 | 15.5 | 27.9 |
| U.S. Total | Crain and Hopkins 2001 | 2000 | 1.5% | 1.0% | 23.2 | 15.5 | 38.7 |
| Summary | | | | | | | |
| Mean | | | 4.8% | 11.7% | 74.4 | 181.3 | 255.7 |
| Minimum | | | 0.8% | 1.0% | 12.4 | 15.5 | 27.9 |
| Maximum | | | 10.6% | 31.9% | 164.3 | 492.9 | 657.3 |

**Note:** For estimates obtained from Hahn and Hird [S1], all percentages are calculated based on estimated regulatory costs reported by authors divided by GDP for each respective industry in the year shown. The industry categories used for the GDP estimates were a) transportation by air; b) water transportation; c) railroad transportation; and d) communications (which includes telephone/telegraph and radio/TV). These percentages were applied to estimated National Health Expenditures for 2002. Crain and Hopkins [S3] report regulatory costs as a percent of receipts, so these percentages were applied directly to NHE.

| Parameters | Year | Efficiency | Transfer | GDP |
|---|---|---|---|---|
| Airline [S1] | 1988 | 3.8 | 7.7 | 42.7 |
| Barge [S1] | 1988 | 0.3 | 0.9 | 9.1 |
| Rail [S1] | 1988 | 2.3 | 6.8 | 23.1 |
| Telecommunications [S1] | 1988 | 14.1 | 42.3 | 132.8 |
| National health expenditures, US, 2002 [S2] | 1,547.6 | | | |

**Sources**


[S1] Hahn, Robert W., and John A. Hird. 1990. The costs and benefits of regulation: review and synthesis. *Yale Journal on Regulation* 8: 233.

[S2] Heffler, Stephen, Sheila Smith, Sean Keehan, M. Kent Clemesn, Greg Won, and Mark Zezza. 2003. Health Spending Projections for 2002-20012. *Health Affairs Web Exclusive* W 3: 54-65.

[S3] Crain, Mark W., and Hopkins, Thomas D. 2001. *The impact of regulatory costs on small firms*. Office of Advocacy, Small Business Administration.