

Testimony of
Professor David A. Hyman, M.D., J.D.
University of Maryland School of Law
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Mr. Chairman and Members of the Committee:

Thank you for inviting me to testify before you today. I am currently a professor at the University of Maryland School of Law. As of July 1st, 2004, I will be a Professor of Law and Medicine at the University of Illinois. I am also currently serving as Special Counsel to the Federal Trade Commission. I am here only in my academic capacity; none of my remarks, whether written or oral, should be imputed to the Commission or to any of the individual Commissioners. Much of what I will say today is drawn from a series of articles I have written on the regulation of health care.¹

I commend the Committee for considering these issues. The impact of regulation on health care is a matter of vital importance, because it affects the cost, quality, and availability of medical services. Regulation has both benefits and costs. For obvious reasons, there is a tendency to focus on the benefits of regulation – and those benefits can be quite considerable. The difficulty is that regulation has costs as well – and those costs must be carefully considered, to avoid doing more harm than good. In the context of our discussion today, excess regulation makes health care more expensive and can make health care coverage unaffordable – leading to an increase in the uninsured. It is economically inefficient to adopt regulations whose costs exceed their

¹ See, e.g., David A. Hyman, "Why Competition Law Matters to Health Care Quality," 22 Health Affairs 31-44 (March/April, 2003) (with William Sage and Warren Greenberg); David A. Hyman, "What Lessons Should We Learn From Drive-Through Deliveries?" 107 Pediatrics 406-8 (2001); David A. Hyman, "Do Good Stories Make For Good Policy?" 25 J. Health, Politics, Pol'y & L. 1149-1155 (2000); David A. Hyman, "Regulating Managed Care: What's Wrong With A Patient Bill of Rights," 73 S. Cal. L. Rev. 221-275 (2000); David A. Hyman, "Accountable Managed Care: Should We Be Careful What We Wish For?," 33 U. Mich. J. L. Ref. 785-811 (1999); David A. Hyman, "Managed Care at the Millennium: Scenes From A Maul," 24 J. Health, Politics, Pol'y & L. 1061-1070 (1999); David A. Hyman, "Drive-Through Deliveries: Is Consumer Protection Just What the Doctor Ordered?," 78 N.C. L. Rev. 5-99 (1999); David A. Hyman, "Consumer Protection and Managed Care: With Friends Like These. . .," 1998 Health L. Handbook 283-305 (1998); David A. Hyman, "Consumer Protection in a Managed Care World: Should Consumers Call 911?," 43 Vill. L. Rev. 409-466 (1998); David A. Hyman, "Lies, Damned Lies, and Narrative," 73 Indiana L. J. 797-865 (1998); David A. Hyman, "Patient Dumping and EMTALA: Past

benefits – and there is plenty of evidence to suggest that we routinely do exactly that in health care. Such regulation may be popular – but that does not change the fact that it wastes our scarce resources and worsens the straits of the poorest and least powerful among us.

The problem has been studied at length by law professors, economists, and political scientists. The basic difficulties can be summarized in a few paragraphs. Few legislators and regulators have the necessary training or time to weigh the (often conflicting) evidence on the benefits of any given legislative initiative. Evidence on the cost of a particular intervention is frequently unavailable, and estimates are subject to considerable uncertainty. The time-frame for doing empirical research on the matter under consideration is counted in months and years, while the time-frame for legislation and regulation is counted in days and weeks. Because the “lowest-hanging fruit” is targeted first, incremental regulatory efforts are more likely to be non-cost-justified. The drafting of legislation is also readily hijacked by entrenched providers, who have their own interests at heart. When these factors are coupled with the emotional overlay accompanying health care issues, the off-budget feature of many of the reforms, and the extensive scope of pre-existing regulation, it should come as no surprise that health care is particularly prone to non-cost-justified regulation and legislation.

The consequences for the nation’s health are significant. Higher prices make it more difficult for many Americans to obtain health insurance and needed care. Many small employers do not offer health insurance at all because it is too expensive.² When employers offer health insurance, price increases can result in limitations on coverage, employees refusing to sign up for insurance,

Imperfect/Future Shock," 8 *Health Matrix* 29-56 (1998).

² David A. Hyman & Mark Hall, *Two Cheers for Employment-Based Health Insurance*, 2 *Yale J. Health Pol’y, L. & Ethics* 23, 26 (2001). See also Kaiser Family Foundation/Health Research and Educational Trust Employer Health Benefits 2003 Annual Survey, <http://www.kff.org/insurance/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=21185>, at Chart 12; Feldman, R., Dowd, B., Leitz, S. & Blewett, L., “The Effect of Premiums on the Small Firm’s Decision to Offer Health Insurance” *Journal of Human Resources*, 32(4):635-58 (1997) (estimating a fairly high firm-level demand elasticity for health insurance (-3.91 for single coverage, -5.82 for family coverage), and calculating that if monthly premiums to firms increased by \$1, the proportion of firms offering health insurance to employees would decline by almost 2 percentage points.)

and employers dropping coverage.³ Estimates of the price elasticity of health insurance vary, but no one believes that increasing prices above their current levels result in more people purchasing insurance.⁴ Numerous studies establish that the lack of health insurance has deleterious consequences, including increased mortality – 18,000 deaths per year by one estimate.⁵ The Institute of Medicine recently concluded that the uninsured receive too little medical care and receive it too late; are sicker and die sooner; and receive poorer care when they are in the hospital even for acute situations like a motor vehicle crash.⁶

Stated differently, non-cost-worthy regulation is likely to have a systemic adverse effect on the quality of care actually provided to the population as a whole. People may die or suffer adverse outcomes if their insurance does not cover “everything,” but they will also die or suffer adverse outcomes if they are unable to afford health insurance. A policy of “quality above all else” can price the standard of care beyond the budget of many Americans, and undermine the quality of care actually received. Stated differently, setting an inefficiently high level of health care quality as the mandatory minimum ignores both the short-term consequences for price and access and the long-term consequences of increased price and decreased access on quality. Conversely, lower prices can actually contribute to higher quality. As an article I co-authored last year in *Health Affairs* noted, “when costs are high, people who cannot afford something find substitutes or do without. The higher the cost of health insurance, the more people are uninsured. The higher the cost of pharmaceuticals, the more people skip doses or do not fill their prescriptions.”⁷

³ See <http://www.kff.org/insurance/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=21185>, at Chart 27-28.

⁴ Sherry Glied, Dahlia K. Remler & Joshua Graff Zivin, *Inside the Sausage Factory: Improving Estimates of the Effect of Health Insurance Expansion*, 80 *Milbank Q.* 603 (2002).

⁵ See Institute of Medicine, *Insuring America’s Health: Principles and Recommendations* (January, 2004) <http://www.iom.edu/includes/DBFile.asp?id=17736>

⁶ See Institute of Medicine, *Care Without Coverage: Too Little, Too Late* (May, 2002) <http://www.iom.edu/includes/DBFile.asp?id=4160>.

⁷ Sage, W., Hyman, D., & Greenburg, W., “Why Competition Law Matters to Health Care Quality” *Health Affairs*, 22:2 at 35 (March/April 2003).

We should not place the poor and less fortunate in the position of choosing between “nothing but the best and nothing” when it comes to health care coverage – but excessive regulation will do exactly that.⁸

Health Care Regulation: The Case of Mandates

Health care regulation comes in a wide variety of forms. For our purposes today, I will focus on state and federal mandates of health insurance benefits. Mandated benefits fall into three general categories: (1) *provider mandates*, which require health insurers to cover services provided by certain providers or categories of providers (*e.g.*, any-willing provider laws and laws mandating coverage of services provided by a select group of providers (*e.g.*, massage therapists or naturopaths)); (2) *coverage mandates*, which require health insurers to cover particular classes of individual patients and conditions (*e.g.*, mental health parity); and (3) *benefit mandates*, which require health insurers to provide a specified minimum level of benefits (*e.g.*, 48 hour postpartum hospitalization, direct access to specialists). Some states mandate few benefits, while others do so as a matter of routine. The federal government mandates a small number of benefits.⁹

⁸ David A. Hyman, *Accountable Managed Care*, *supra* note 1, at 802-803 (“Perhaps that result accords with our ethical sensibilities, but it is cold comfort to those who must now choose between nothing but the best and nothing.”) *See also* Uwe E. Reinhardt, Uncompensated Hospital Care, in *Uncompensated Hospital Care: Rights and Responsibilities* 1, 11 (Frank A. Sloan et al. eds., 1986) (“The champions of the poor, and the poor themselves must recognize that, in the political and budgetary climate of the 1980s [and 1990s], pursuit of the maxim ‘for the poor, nothing but the best’ may leave the poor with nothing.”).

Similar difficulties have been noted in the impact of tort law on access to medical care. *See* John A. Siliciano, Wealth, Equity, and the Unitary Malpractice Standard, 77 Va. L. Rev. 439, 486-87 (1991) (“Tort law instructs health care providers to treat the poor the same as the rich, but then blithely ignores the fundamental impact that resource scarcity and the provider’s freedom to refuse care to the poor have on the efficacy of its command... By embracing the chimera of equality between the rich the poor, [tort law] effectively disables health care providers from offering reasonable, low-cost care to large numbers of the medically indigent. Thus, through its adherence to the unitary ideal, tort law may end up killing the poor with an unthinking and misguided kindness.”)

⁹ Federal mandates include the 1978 Pregnancy Discrimination Act, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the 1996 Health Insurance Portability and Accountability Act (HIPAA), the 1996 Mental Health Parity Act, the 1996 Newborns’ and Mothers’ Health Protection Act, and the Women’s Health and Cancer Rights Act of 1998.

Proponents offer a number of reasons for supporting mandates.¹⁰ Some proponents view health care as a “merit good” and suggest that mandates are a way of preventing discrimination against particular conditions. Others believe mandates provide access to benefits valued by beneficiaries but withheld by employers or insurers. Some proponents argue that mandates can correct for informational asymmetries, bounded rationality, and adverse selection in the insurance market. If employees have more information about whether they will face high medical bills than employers do, employers that provide generous fringe benefits may end up attracting employees who are disproportionately likely to make expensive claims. This dynamic might discourage employers from offering comprehensive benefits to employees. Additionally, many insurers and employers might be reluctant to offer a benefit that attracts high cost employees or beneficiaries.

Opponents of mandated benefits argue that forced inclusion of insurance benefits raises premium costs, and may lead employers to opt out of providing health insurance, and employees to drop their coverage.¹¹ Opponents generally argue that the free market is likely to do a more efficient job allocating resources between health insurance and other consumer goods (and arriving at coverage terms for the amounts spent on health insurance) than the state or federal government. Mandating benefits takes away the option of the lower priced insurance and forces consumers to pay for insurance they may not want or to go without coverage at all. Compliance with mandates is difficult for employers and insurers operating in multiple states – unless the employer opts for a self-funded employee benefit plan, which is not subject to such mandates.¹² Thus, state mandates can actually decrease the number of covered lives in state-regulated insurance plans – and the more aggressive the state, the greater the impact. The burden of mandates is not uniformly shared. When mandates are group-specific, there is evidence that the cost of those

¹⁰ Russell Korobkin, *The Efficiency of Managed Care: A Patient Protection@ Laws: Incomplete Contracts, Bounded Rationality, and Market Failure*, 85 CORNELL L. REV. 1, 8 (Nov. 1999). See also Lawrence H. Summers, *Some Simple Economics of Mandated Benefits*, AM. ECON. REV., 79:2 (May, 1989) 177-183, at 178 (suggesting that individuals may irrationally underestimate the probability of catastrophic health expenses, or of a child's illness that would require a sustained leave.”)

¹¹ See David A. Hyman, *Consumer Protection in a Managed Care World: Should Consumers Call 911?*, 43 VILL. L. REV. 409, 437 (1998) (“Policy sellers must weigh whether broadening coverages . . . [is] worth doing if [it] price[s] the policy out of the market or result[s] in a shift in the nature of coverage from that which is most appealing to the covered pool as a whole.”); Mark A. Hall, MAKING MEDICAL SPENDING DECISIONS: THE LAW, ETHICS AND ECONOMICS OF RATIONING MECHANISMS at 22, 24 (1997) (identifying mandates as an important source of inefficiency, and observing that “[e]conomists explain that it usually makes no sense to mandate or encourage insurance that many consumers are unwilling to buy.”)

¹² It is no accident that Professor Conover found that the cost of regulation would have been substantially larger absent ERISA preemption.

mandates are regressively shifted to the targeted group.¹³ Mandates can also encourage overuse of the covered services.¹⁴

The need for many mandates is also questionable; health insurers have obvious economic incentives to offer the benefits that consumers desire and are willing to pay for. In order for mandates to improve the efficiency of the health insurance market, state and federal legislators must be able to identify services the insurance market is not currently covering for which consumers are willing to pay marginal cost. This task is challenging under the best of circumstances -- and benefits are not mandated under the best of circumstances. As noted previously, providers of the mandated benefit are usually the most vigorous proponents of the mandate. This fact makes it more likely that the mandated benefit constitutes “provider protection” and not “consumer protection.”

Mandates are likely to limit consumer choice, eliminate product diversity, and raise the cost of health insurance. The result is to increase the number of uninsured Americans, as employers and employees opt out of the market. Those who do have health insurance are forced to pay more for it than they otherwise would – limiting the amounts they have available for other needs and wants.

Regulatory Theory: Comparative Institutional Imperfection

It is elementary health economics that there are a variety of imperfections in the markets for health care coverage and delivery. These imperfections affect virtually every aspect of the relationships between providers, payors, and consumers. A non-exhaustive list of these imperfections would include the reality that physicians are at best imperfect agents for patients in providing diagnostic services and treatment options, and employers are at best imperfect agents for employees in selecting health plans and coverage terms. ERISA compounds these problems, by insulating some decisions from effective review. In addition, information is costly, and it is frequently inefficient for any given patient to invest the necessary effort to learn about such

¹³ Jonathan Gruber, *The Incidence of Mandated Maternity Benefits*, AMERICAN ECON. REV., 84:3 (Jun., 1994) 622, 639.

¹⁴ Gruber, AMERICAN ECON. REV. at 640. For example, the number of cesarean births per 1,000 population doubled from 1975 to 1981 after maternity coverage was mandated

matters in advance. Quality is difficult to assess, let alone value -- and employers and employees are likely to differ on the appropriate mix of cost, quality, and access, even before illness strikes. Many employers provide few (or no) health plan alternatives to their employees. Because plans are a "bundled" product aimed at a diverse workforce, the alternatives which any given employer offers frequently do not include desired and desirable features from the perspective of any given employee.

Additional difficulties are created by the bounded rationality of consumers. Even if consumers behave rationally when it comes to health care coverage and delivery (itself a contested assumption), there may be circumstances in which it is rational not to pay much attention to one's health insurance contract. The chronically ill may care a great deal about whether their physician is covered by their new insurance plan, but those who are well are understandably less concerned with such matters. Life is short, and reading the fine print in one's insurance contract is not high on most peoples' list of favorite weekend activities -- particularly when they do not perceive that their efforts will have any effect on the terms of the contract. Even if one is prepared to read the insurance contract, it does not follow that one will pay attention to the specific terms which, after-the-fact, turn out to be important. Against this backdrop, "bounded rationality" constrains the operation of market forces which would normally ensure the optimal mix of quality and price.

In the view of many commentators, the government can correct these imperfections with judicious regulation. The argument is quite straightforward. The government has the information, resources, and expertise to develop optimal managed care contract terms. Indeed, if such terms are a public good, no one will be willing to invest the necessary effort to develop such terms. Because the terms will be universal, the distorting effects of adverse selection are also greatly attenuated. The government also has the credibility to resolve these matters impartially, because it has no economic interest in the outcome. Finally, the whole point of living in a representative democracy is to provide a legislative forum for addressing such matters, and to protect those who cannot protect themselves.

Although these arguments might seem appealing, there are significant reasons to be skeptical about the likely merits of government intervention into these markets. It is easier to identify

agency conflicts and bounded rationality than it is to solve such problems.¹⁵ A regulatory solution will not necessarily solve these problems, and it may well make them worse. The internal plan trade-offs must be made, no matter whether it is an employer or the government doing so -- and there are no guarantees that the government can do it better than anyone else, particularly in light of the heterogeneity of employee preferences, and the reality that quality and value are difficult for both employers and government to assess. Government is also subject to symbolic blackmail on behalf of sympathetic identifiable patients, and interest group lobbying.¹⁶

Similarly, claims of bounded rationality are subject to severe hindsight bias. After illness strikes, everyone involved has an understandable incentive to exaggerate how their behavior would have been different "had they only known" -- including their willingness to have paid higher premiums to secure coverage. *Ex ante*, willingness to pay is not nearly so apparent. These facts significantly undermine the validity of bounded rationality as a basis for regulation.

Even if bounded rationality is a significant problem, the bounded rationality of any given individual is compensated for by the presence of knowledgeable repeat-player agents in the employee benefits department, who negotiate on behalf of their employees. Of course, it does not follow that employers are the only entity that could provide these services, and the use of employers as agents has certain disadvantages. Finally, if bounded rationality is actually a serious problem in the health insurance market, it is hard to explain the far-better documented phenomenon of adverse selection.¹⁷ Regardless, it is important to note that markets can function even in the presence of bounded rationality, since it only takes a few knowledgeable purchasers to drive the market.

¹⁵ See Christine Jolls, Cass R. Sunstein & Richard Thaler, *A Behavioral Approach to Law and Economics*, 50 STAN. L. REV. 1471, 1485 (1998) ("Any suggestion that the government should intervene in response to people's mistakes raises the question whether the government will be able to avoid such errors.")

¹⁶ See John P. Dwyer, *The Pathology of Symbolic Legislation*, 17 ECOLOGY L. Q. 233, 287 (1990) ("Once Congress has taken the position that public health must be protected at any cost, it is difficult for the legislature to adopt a more moderate position. Position-taking by other legislators and charges of trading lives for dollars will deter many legislators from supporting such amendments.")

¹⁷ See MARK HALL, MAKING MEDICAL SPENDING DECISIONS 53(1996) (outlining cases where severe adverse selection has been documented). Stated more concretely, adverse selection can only occur if consumers understand the terms of their insurance contracts and act accordingly, while bounded rationality can only exist if consumers do not understand the terms of their insurance contracts. It is difficult to see how these circumstances could exist simultaneously, unless, of course, only some consumers are boundedly rational. The issue is therefore an empirical one as to which effect is larger -- and that issue can not be resolved on theoretical grounds.

The legislative/regulatory process also has its own set of distortions -- a fact which regulatory enthusiasts are prone to overlook. Legislators and regulators tend to identify “necessary reforms” on the basis of bad anecdotes and popular appeal, but that strategy is hardly a recipe for sensible public policies. Legislators and regulators also tend to discount the trade-offs and costs that result from their reforms. In a voluntary insurance market, cost-increasing consumer protections will predictably price some people out of the market -- and it is hardly self-evident where the cost/quality/access equilibrium should be set, let alone whether there should be a single standard for all coverage. The drafting of consumer protections is also readily hijacked by entrenched providers, who have their own interests at heart. Finally, the emotional implications of these issues ensure that legislators will be reluctant to embrace the necessary trade-offs.

These issues are complicated by the way in which the costs of regulation have been presented. Costs are typically expressed in terms of the increased premium per subscriber per month or in terms of the annual percentage increase in premium costs. However, the use of individual costs elides the aggregate cost/benefit issue, which must be considered in weighing the merits of the regulation.¹⁸ The point may be more apparent if one compares this costing strategy to that employed in a typical design defect case against a car manufacturer. The plaintiff invariably argues that the manufacturer could have prevented some horrific accident by spending a nominal amount per car to make a particular improvement. If the jury only considers the cost per car in deciding whether the automobile manufacturer was negligent, the failure of the automotive manufacturer to incur these nominal costs virtually ensures a whopping verdict. However, if the jury must multiply the cost per car by the number of cars sold, and then evaluate how many lives would be saved and lost by incurring that expense, the trade-offs look vastly different. In like fashion, the relevant inquiry for assessing the merits of a proposed regulation is whether it will improve the mix of health care with regard to cost, quality, and access, and by how much, and at what aggregate cost. A debate which focuses on the cost per subscriber per month provides no useful information about the desirability or lack thereof of a patient bill of rights.¹⁹

¹⁸ Stated in terms of the Hand formula, an investment in a particular consumer protection is worth doing only if the cost of the initiative (B) is less than the probability of an adverse outcome (p) multiplied by the resulting costs and damages (L). See *United States v. Carroll Towing*, 159 F.2d 169, 173 (2d Cir. 1947).

¹⁹ The argument sometimes made that the cost of a particular treatment was so *de minimus* that the MCO had

These considerations demonstrate that the merits of regulation can not be resolved on the basis of platitudes about “market failure” and “unaccountability.” Enthusiasm is not a sufficient precondition to ensure that legislation and regulation will improve on the status quo. The critical institutional competence questions are whether legislators/regulators have the necessary information, preferences, and incentives to beat the alternatives in setting the terms of trade. In economic terms, the issue is which agency relationship (consumer/employer-insurer or constituent/state-federal legislature) is less imperfect across the relevant dimensions of cost, quality, and access. As Richard Epstein has pointedly noted, "it would be easy to assume that collective responses are preferred when markets are corrupt and governments virtuous. It is far harder to reach that conclusion when self-interest and corruption creates difficulties from both quarters."²⁰

Health Insurance: An Overview of the Trade-Offs

Although health care contributes to health, not all services are equally beneficial. Fraud aside, there is considerable controversy about how and whether expenses that make a variable contribution to health should be constrained.²¹ There is general agreement that it is appropriate for private insurance to provide coverage for services so long as benefits exceed costs. There is equally general agreement that it is appropriate to exclude coverage for services which provide no benefit. However, there is a considerable amount of controversy about the exclusion of services which provide a positive benefit, but one which is less than its social cost (cost-benefit-no-man’s-land).²² Indeed, the prevalence of third-party insurance encourages patients to demand

no real economic interest in denying coverage is meritless for precisely the same reason.

²⁰ Richard A. Epstein, *Why is Health Care Special?*, 40 KANS. L. REV. 307, 311 (1992).

²¹ Health policy scholars are essentially unanimous that cost-benefit tradeoffs are inevitable. *See, e.g.*, Henry Aaron & William B. Schwartz, *Rationing Health Care: The Choice Before Us*, 247 SCIENCE 418, 419 (1990); David M. Eddy, *Health System Reform: Will Controlling Costs Require Rationing Services?*, 272 JAMA 324, 326 (1994); VICTOR R. FUCHS, WHO SHALL LIVE?: HEALTH, ECONOMICS, AND SOCIAL CHOICE 29 (“We must recognize that we can’t have everything”); Lester C. Thurow, *Learning to Say “No,”* 311 NEW ENG. J. MED. 1569, 1569 (1984) (“Instead of stopping treatments when all benefits cease to exist, physicians must stop treatments when marginal benefits are equal to marginal costs.”)

²² *See* Clark Havighurst, *Contract Failure in the Market for Health Services*, 29 WAKE FOREST L. REV. 47, 51-54 (1994) (reviewing realities of the cost-benefit-no-man’s land).

such services, because from their perspective, the subsidized cost is less than the benefit.²³ Attempts to constrain coverage of services in the cost-benefit no-man's land invariably triggers complaints about the evils of rationing and profit-driven health care.

Coverage which is more generous is also more expensive. Copayments and deductibles help fine-tune the coverage (and deal with the problem of moral hazard) by allowing for a mix of self-insurance and third-party coverage. Not surprisingly, a policy with a substantial copayment and deductible is substantially cheaper than one which pays for all medically necessary expenses. Similarly, a policy with generous hospitalization benefits is generally more expensive than one which encourages outpatient treatment, provides coverage at a limited number of inpatient facilities, or places strict restrictions on length-of-stay once hospitalized.

Willingness to purchase health insurance is heterogenous, and greatly affected by the premium. As the premium increases, the policy becomes less affordable for people at the margin. Those who are selling the policy must weigh whether better coverage is worth offering if it prices the policy out of the market. Those who would willingly have bought a more limited policy must self-insure (*i.e.*, become one of the approximately forty million uninsured Americans) once the cost of the minimum product exceeds their willingness to pay.

The demand for health care also varies in ways that are generally predictable along a number of parameters, including age, race, and sex. For example, individuals in their 20s and 30s require more sports medicine than those in their 50s; those in their 50s require more cardiac rehabilitation than those in their 20s; elderly men require urologists, younger women require obstetricians and family planning services; children require pediatricians; African-Americans require more treatment for hypertension and renal failure, while European Americans require

²³ Because an individual with insurance has an out-of-pocket cost much less than the true cost, the social cost-benefit no-man's-land is far larger than the individual cost-benefit no-man's land. In the interest of simplicity, I focus on the social cost – although the growth of managed care arrangements has modified the dynamic somewhat, since individuals now face fewer financial barriers, but greater structural barriers to the consumption of health care services -- precisely the approach suggested by Professor Kenneth Arrow to deal with the moral hazard problems which result from the existence of health insurance:

If individuals are free to spend as they will with the assurance that the insurance company will pay, the resulting resource allocation will certainly not be socially optimal. This makes perfectly reasonable the idea that an insurance company can improve the allocation of resources to all concerned by a policy which rations the amount of medical services it will support under the insurance policy.

more treatment for malignant melanoma. Because insurance only shifts and spreads risk for which the policy provides coverage, the specification of such coverage necessarily implies a series of tradeoffs within the common pool, with significant distributional implications within and across identifiable groups. For example, coverage of routine mammograms for women in their 40s may preclude coverage of bone marrow transplants for advanced breast cancer patients. Coverage of family-planning services may preclude coverage of more aggressive screening for sexually transmitted diseases. Coverage of aggressive screening for prostate cancer may result in more limited coverage for screening for uterine cancer. Mandates can reallocate resources within the common pool, but new or enhanced services are covered at the expense of something else -- or of increased premiums -- or both.

A Case Study of Regulation in Action: Drive-Through Deliveries

One can examine these dynamics in numerous legislative and regulatory contexts, including EMTALA, and the patient bill of rights. For current purposes, I focus on the campaign against drive-through deliveries. The campaign, which limited or eliminated the economic incentive for an “early” postpartum discharge was waged in state and federal legislatures during the mid-1990s.²⁴ Maryland was the first state to pass a law on the subject on May 25, 1995, followed by four more states by the end of 1995, and twenty-four more states by the end of 1996. Federal legislation was signed into law on September 26, 1996.

Despite this overwhelming legislative enthusiasm for a prohibition on drive-through deliveries, the case for such a law is actually extraordinarily flimsy. There is little or no evidence indicating postpartum stays of the specified length provide *any* benefit, regardless of how one defines benefit. Even if such stays provide a benefit, it does not follow that the benefit justifies the associated cost, or that same results can not be achieved in some other way at lesser cost. It is equally significant what these laws did not do. Drive-through deliveries were treated as a narrow, free-standing problem, rather than as part of the continuum of maternity care. The

Kenneth Arrow, *The Economics of Moral Hazard: Further Comment*, 58 AM. ECON. REV. 537, 538 (1968).

²⁴ It is important to note the normative implications of labeling a postpartum discharge as “early” or “drive-through.” See Eugene Declercq & Diane Simmes, *The Politics of "Drive-Through Deliveries": Putting Early Postpartum Discharge on the Legislative Agenda*, 75 MILBANK Q. 175, 184 (1997) (“The widespread adoption of the phrase “early discharge” was a victory in itself for advocates because it described the problem in a way that suggested mothers and babies might have been sent home prematurely.”)

legislation did nothing about the availability of post-discharge services, the quality of services rendered before, during, and after the postpartum hospitalization, the distortions created by hospitals' use of per-diem pricing, and the manner in which managed care organizations ("MCOs") make coverage decisions.

The campaign against drive-through deliveries illustrates many of the problems outlined previously. The case for extended postpartum stays was based almost entirely on wrenching, but extraordinarily unrepresentative anecdotal horror stories and overheated rhetoric. The "reform" exploited social reluctance to make explicit cost/benefit tradeoffs in matters of public health and safety.²⁵ When even a portion of the costs was on-budget, legislative opposition to drive-through deliveries developed some exceedingly large loopholes. The health care providers who testified in favor of the proposed "consumer protection" neglected to mention that the issue was merely the opening salvo in their campaign against managed care -- and their preferred remedy was a return to the model of professional dominance whose excesses led to managed care in the first place.

As noted previously, twenty-nine states prohibited drive-through deliveries within a year of the issue appearing on the policy agenda. The most interesting feature of the state statutes was their tendency to expressly exclude certain portions of the population from their protections. Of the twenty-nine states which initially enacted such legislation, eighteen states excluded Medicaid beneficiaries. Since Medicaid pays for approximately forty percent of the births in the United States, with the percentage considerably higher in some states, the on-budget costs of such legislation was an obvious factor in the exclusion of the Medicaid population from the statutory ambit. Indeed, California considered such legislation, but deferred action for one year after it determined that the costs associated with prohibiting drive-through deliveries for its Medicaid population were too high. Similarly, nineteen states excluded state employees from the statutory ambit. As with the Medicaid population, the state government would incur on-budget costs if it had to purchase coverage for extended postpartum stays for state employees. Thus, most of the state legislatures displayed concern for the plight of women and infants victimized by a drive-

²⁵ See Clark Havighurst & James F. Blumstein, *Coping with Quality/Cost Trade-offs in Medical Care: The Role of PSROs*, 70 NW. U. L. REV. 6, 7 (1975) ("A policy in which a taboo surrounds any concession to the reality of limited resources is bound to be rich in posturing and assertion"); GUIDO CALABRESI AND PHILIP BOBBITT, TRAGIC CHOICES 26 (1978) ("evasion, disguise, temporizing [and] deception are all ways by which artfully chosen allocation

through delivery only if the state did not have to foot the bill to fix the problem.

Numerous bills prohibiting drive-through deliveries were introduced in Congress in 1995, but Senate Bill 969 became the vehicle for consideration of the issue.²⁶ In August, 1995, the Senate Labor and Human Relations Committee held its only hearing on the issue. Senators from both parties issued stern warnings about the hazards of drive-through deliveries. The witness list was stacked in favor of the legislation. Although there was a substantial delay due to budgetary disputes between the 104th Congress and President Clinton, the Newborns' Act eventually passed Congress virtually unanimously, and was signed by President Clinton on September 26, 1996.²⁷ The Newborns' Act incorporated elements from many of the state statutes, but encompassed all insurers in the United States, including self-funded employee benefit plans.

Effective January 1, 1998, the Newborns Act required coverage of at least forty-eight hours of hospitalization following a normal vaginal delivery and ninety-six hours of hospitalization following a cesarean section.²⁸ An earlier discharge was possible if the physician, in consultation with the mother, decided it was appropriate. However, monetary payments, rebates or offering additional services to mothers to encourage them to accept less than the minimum benefits, or adjusting the compensation of physicians to induce them to discharge patients more rapidly were prohibited as well.

In a striking omission, the Newborns' Act excluded Medicaid recipients from its protections – an omission that was corrected a year later for states employing managed care in their Medicaid programs.²⁹ Although the original bill that ultimately became the Newborns' Act modestly encouraged the substitution of post-discharge care for postpartum hospitalization, the statute as enacted is silent on this issue and simply specifies that the attending provider, in consultation with the mother, makes the decision as to the time of discharge. For those states that had already

methods can avoid the appearance of failing to reconcile values in conflict.")

²⁶ The federal measures included H. Con. Res. 79, 105th Cong.(1995); H.R. 1936, 105th Cong.(1995); H.R. 1948, 105th Cong.(1995); H.R. 1950, 105th Cong.(1995); H.R. 1955, 105th Cong.(1995); H.R. 1970, 105th Cong.(1995); and H.R. 1948/S.969, 105th Cong.(1995).

²⁷ Newborn and Mothers' Health Protection Act, Pub. L. No. 104-204, 110 Stat. 2935, codified at 29 U.S.C.A. § 1185, 42 U.S.C.A. §§ 300gg-4, 300gg-51 (1996).

²⁸ 29 U.S.C. § 1185. The same provision restricted the ability of insurers to require physicians to obtain authorization for any particular hospitalization, so long as it was less than the mandated coverage. *See id.*

²⁹ *See* Balanced Budget Act of 1997, Pub. L. No. 105-33, 4001, 4704, 111 Stat. 275, 496 (1997).

passed legislation, the Newborns' Act provided that state law would govern, so long as it was at least as strict as the federal legislation. During the fourteen month delay between passage of the Newborns' Act and implementation, a number of additional states enacted such legislation.

As it happens, the appropriate postpartum length-of-stay is an exceedingly complex issue, heavily influenced by both social and economic considerations. In recent years, there has been a fairly precipitous broad-based decline in the rate and length of hospitalization for all conditions. If one looks at actual postpartum lengths of stay, it is remarkable how quickly one-day postpartum stays have become commonplace. One-day stays accounted for only 7.6% of vaginal deliveries in 1980, but by 1990, had almost tripled, to 21.2%. In the intervening five years, one-day stays more than doubled again, to almost 47% of vaginal deliveries.³⁰ There is substantial geographic variation in these figures; maternal postpartum lengths of stay following a vaginal delivery have long been substantially longer in the Northeast and shorter in the West than in the rest of the nation.³¹ Postpartum stay following a Cesarean section demonstrates a similar pattern. Surprisingly, states that had the highest percentage of short postpartum stays were exceedingly slow to adopt legislation restricting such practices, while states that had the lowest percentage of short postpartum stays were quickest to adopt such legislation.³² This pattern is peculiar; from a relative-risk perspective, one would have expected that states that had the highest percentage of such deliveries would face the highest risk from such practices, and thus would be most enthusiastic about such legislation – unless, of course, the legislation was the result of lobbying by providers seeking to maintain their preferred practice patterns in states with relatively low numbers of rapid postpartum discharges.

³⁰ National Center for Health Statistics, *National Hospital Discharge Survey: Annual Summary, 1996*, Table 32 (1999) [hereinafter NCHS Discharge Survey]

³¹ See NCHS Discharge Survey, *supra* at tbl.31; National Center for Health Statistics, *Utilization of Short-Stay Hospitals By Diagnosis-Related Groups: United States, 1980-1984*, tbl.33 (1986); National Center for Health Statistics, *Inpatient Utilization of Short-Stay Hospitals by Diagnosis: United States, 1980*, tbl.4 (1983).

³² See Declercq & Simmes, *supra* note 24, at 192 (“It is therefore in the western region of the country, where postpartum lengths of stay are currently shortest, that legislative actions to lengthen stays are least successful”); Julie A. Gazmararian & Jeggrey P. Koplan, *Length-of-stay after delivery: Managed care versus fee-for-service*, 15 *Health Affairs* 74, 79 (1996) (“Interestingly, some of the states that recently have enacted legislation mandating hospital stays of forty-eight hours after normal delivery are in the Northeast (New Jersey, Massachusetts, and New York), where lengths-of-stay are the longest and do not vary by plan type and where managed care penetration is lower than

The evidence on the safety of rapid postpartum discharge is outlined in considerable detail in my article on the subject.³³ To summarize briefly, the empirical scholarship does not support the conventional wisdom that there are significant perils associated with rapid postpartum discharge. The major preventable causes of postpartum hospital readmission are jaundice, infection, and dehydration. The risk of readmission for jaundice is the same if the infant is discharged at any time earlier than seventy-two hours, the risk of infection is actually increased by a lengthier stay in the hospital, and the risk of dehydration is not really addressed by postpartum stays of forty-eight hours. Bluntly stated, a small percentage of postpartum women and newborn infants will be readmitted, and a tiny percentage of postpartum women and newborns will die, regardless of the length of their initial hospitalization -- a fact which makes clear the perils of an anecdote-driven approach to the issue. Even if rapid postpartum discharge increases the number of readmissions, in order to prevent one incremental readmission (which will last on average 2.5 days), we will have to provide extended postpartum hospitalization for at least 232 well newborns -- and perhaps as many as 866.³⁴

Thus, mandated coverage of forty-eight hours of postpartum hospitalization simply misses the point. Mandated coverage of postpartum hospitalization of the specified lengths has little or no nexus with the detection and prevention of problems likely to result in a bad outcome. Given these results, it is not all that surprising that the Congressionally-mandated report on the Newborns' Act implicitly criticizes the Newborns' Act for its focus on the number of hours of postpartum hospital care, instead of the "needs of the mother and newborn and [] the content and quality of the care they receive."³⁵

On the cost side of the ledger, it is no accident that early discharge laws were supported by physicians and nursing groups who provided hospital-based services, and opposed by nursing

it is in other parts of the country.”).

³³ Hyman, *Drive-Through Deliveries*, *supra* note 1.

³⁴ See Alvah R. Cass & Robert J. Volk, *Early Discharge of Newborns*, 278 JAMA 2065 (1997); Edmonson, *supra* note , at 2067.

³⁵ See Advisory Commission to the Secretary of the Department of Health and Human Services, *Initial Report to Congress Mandated by the Newborns' and Mothers' Health Protection Act of 1996*. The first recommendation of the report is to “broaden the focus of concern beyond the issue of length of stay to the multiple important factors affecting maternal and infant health,” and the third recommendation is to “ensure the delivery of health care needed after leaving the hospital, regardless of length of stay. In like fashion, the Report implicitly criticizes the manner in which the campaign against drive-through deliveries was waged by observing that “the goal of postnatal and postpartum services should be to achieve optimal newborn and maternal health in the short-and long-term, and not

groups who provided home care services.³⁶ As one set of commentators dryly noted, “for those (physicians and nurses associated) with hospital based care, an extra day of hospitalization is a perfectly sensible policy, while those involved in home care see it as a waste of limited resources. As is often the case in health policy issues, self-interest and concern with patients’ well-being were likely entangled.”³⁷ Estimates of the cost of extended postpartum stays vary, but childbirth is the most common reason for hospitalization in the United States. I estimated in 1999 that extended postpartum stays impose a cost on this nation of somewhere between \$900 million and \$1.8 billion every year. If one expresses my estimate of \$900 million to \$1.8 billion as a percentage of the total cost of health care in the United States, it turns out to be a relatively modest .12 to .24%.³⁸ On the other hand, if the cost is so modest, it is rather striking that a majority of the states and the federal government were willing to mandate coverage for everyone except the 40% of births in the United States to mothers on Medicaid – and a majority of the states behaved the same with regard to state employees.³⁹

From a distributional perspective, a prohibition on drive-through deliveries effectively compels the insurer to transfer resources from the common (insured) pool to those who take advantage of the extended postpartum hospitalization. In Maryland, those individuals were white women, between the ages of nineteen and thirty-five, with private health insurance, who delivered in rural and suburban hospitals.⁴⁰ As noted previously, similar results were obtained in another study; women who insisted on forty-eight hours of hospitalization were disproportionately married, college educated, with multiple children, and more than 35 years old.⁴¹ It is very hard to make

only to prevent rare occurrences such as hospital readmission or catastrophic events leading to death.”

³⁶ See Declercq & Simmes, *supra* note 24, at 187 (noting that nursing groups “took positions on this legislation according to whether or not they provided hospital or home care services.”)

³⁷ *See id.*

³⁸ If one excludes the cost of Medicare and the elderly and disabled Medicaid, the cost is significantly larger, but still modest, ranging from .18% to .35%. As a percentage of the amount currently spent on postpartum hospitalizations, it is a substantially greater amount. See *Nduka U. Udom & Charles Betley, Effects of Maternity-Stay Legislation on ‘Drive-Through Deliveries,’* 17 Health Aff. 208, 211 (1998) (finding statute resulted in a 10% increase in charges for vaginal deliveries and 6.3% increase in charges for vaginal delivery).

³⁹ To be sure, Congress subsequently included Medicaid beneficiaries within the protections of the Newborns’ Act – but only so long as beneficiaries were enrolled in a Medicaid managed care plan. Because most of the states now have this portion of the Medicaid population in a managed care program, the Balanced Budget Act effectively extended the protections of the Newborns’ Act to the Medicaid population. However, because the costs of the Medicaid program are shared between the state and federal government, the latter was being virtuous at least in part at the former’s expense -- and the majority of the former had already indicated their unwillingness to incur such expenses when given the option.

⁴⁰ See *Udom & Betley, supra* at 215.

⁴¹ See Julie A. Gazmararian *et al, Maternity Experiences in a Managed Care Organization*, 16 Health Aff. 198, 200 (1997).

the case that such women are particularly in need of a governmental mandate to protect their interests -- or that they face significant risks as a result of drive-through deliveries.

The net result of the Newborns' Act is thus the worst of all worlds – a non-solution which misses the point of the real problem, and simultaneously makes it less likely the real problem will ever be addressed. From an economic perspective, the law effectively requires MCOs and insurers to spend money on hospital stays that do not appear to provide *any* clear benefit – let alone benefit in excess of the costs. The law also constrains the ability of MCOs and insurers to arrange for post-discharge care that does, in fact, provide a clear benefit well in excess of its costs. From an autonomy/liberty perspective, the law effectively prohibits the parties to an insurance contract from making the coverage arrangements they find most beneficial. From a feminist perspective, the Newborns' Act infantilizes women by allocating decision-making authority to the attending provider, and precluding any and all incremental payments from the insurer to the mother in exchange for an early discharge.

The law also does nothing to address the quality of care rendered during the postpartum hospitalization, nor does it encourage the development of better systems (or any systems for that matter) for delivering post-discharge postpartum care. Indeed, the Newborns' Act actually decreases the incentive to develop such systems, because the MCO must demonstrate that the post-discharge visit only replicates the services which would have been offered in the hospital -- even if women would prefer a different package of services, and even if a different package of services is more cost-effective. This implicit legislative bias is particularly problematic, because many physicians are unenthusiastic about the development of post-discharge services to begin with.

It is also worth noting the regulatory costs associated with such legislation. Legislative and regulatory time and attention are in short supply. It is hard to make the case that a prohibition on drive-through deliveries was the best use of these scarce resources. To be sure, Congress is under no obligation to tackle problems in any particular order -- although there are reasons to wonder about a reform strategy which ignores the overwhelming evidence of quality-based problems with most of American medicine, and focuses on an area where the evidence for quality-based problems is hardly colorable. Worse still, by embracing a “reform” based on the

sanctity of physician discretion, the Newborns' Act makes it much more difficult to address the real quality-based problems with American medicine, which, in fact, *are* attributable to the unconstrained discretion previously accorded physicians.

The only real lesson of the Newborns' Act appears to be that we want MCOs to cut costs in ways that are less visible -- hardly an ideal incentive, all things considered. Indeed, the potential for overly vigorous cost-containment by MCOs is such that it is far more sensible to encourage MCOs to cut costs in a manner that is open and obvious. Unfortunately, the Newborns' Act creates precisely the wrong incentives, because it signals that cost-cutting which is overly transparent will result in a legislative backlash -- meaning that cost-cutting which is well hidden will not be questioned. The Newborns' Act may well have stemmed the tide of short postpartum stays, but it undermines the very goal of quality managed care at an affordable price at which it is ostensibly aimed.

The anecdotes which led Congress and a majority of states to prohibit drive-through deliveries were heartbreaking, but extraordinarily unrepresentative. As such, they provide further proof (were any actually needed) that isolated observations do not provide a sound basis for legislation -- or much of anything else, for that matter. Focusing on the "bad outcomes" anecdotal numerator, without factoring in the "millions of successful deliveries at lower cost" empirical denominator, is a recipe for public policies that are either silly or symbolic -- and usually both.