

What's Driving Health Care Costs and the Uninsured?

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Mr. Chairman and Members of the Committee:

How big a role does health services regulation play in explaining the extraordinarily high level of health costs in the U.S.? And how many uninsured might be covered were we to somehow find a way to reduce this regulatory burden? My brief remarks 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.

There are two ways to answer the first question. First, we looked at the costs of regulation in other industries such as airlines, railroads, telecommunications and other sectors that have long been studied and calculate the percent of gross economic activity in those industries that is attributable to regulatory costs. 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).¹

A 30-fold difference between the minimum and maximum cost estimate is no more gratifying to me as a researcher than it is to you as policymakers. Moreover, it is easily possible that the regulatory burden in health care is even higher than a simple extrapolation from other industries might suggest. 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."²

So we also answered this question using a much more fine-grained "bottoms up" approach. 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.³ We systematically tallied both the benefits and costs associated with such regulations⁴ and found that the expected costs of regulation in health care amounted to nearly \$335 billion in 2002. As shown at the bottom of Fig. 2, our estimate of benefits was about \$207 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,

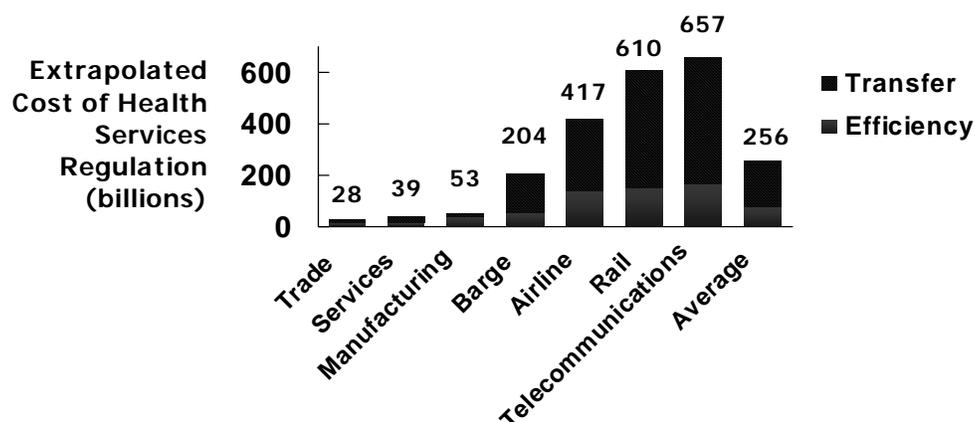
totals \$81 billion, FDA regulation adds another \$42 billion, and health facilities regulation adds \$29 billion,. Thus, the states and federal government both have roles to play in findings way to trim regulatory excess.

How does this relate to the uninsured? Our “bottoms up” look allowed us to determine that the net cost of regulation borne by 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 nearly 5 million uninsured whose plight might be attributed to excess regulatory costs.⁵

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,⁶ 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.⁷ In light of these figures, the potential opportunity costs of this regulatory burden become very clear: the average estimates from both our “topdown” 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. So a legitimate policy question is whether the benefits of regulation outweigh the benefits of coverage for all 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 not a question for me to answer, but I hope you will consider it seriously as you wrestle with one of the most challenging health policy issues now on the national agenda. Thank you for your time.

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



Source: Christopher J. Conover, Center for Health Policy, Law and Management, Duke University

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	1.8	43.7	41.9
Tort System*	32.5	113.7	81.2
TOTAL	206.6	334.8	128.2

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

Source: Christopher J. Conover, Center for Health Policy, Law and Management, Duke University

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 [S:	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 2002-2012. *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.

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
Medicare/Medicaid 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	
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	
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	
Medicare conditions of participation	F
Nursing Home Reform Act (OBRA '97)	F
State accreditation and licensure	
Other facilities accreditation and licensure	
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
Health Professionals Regulation

Regulation	Locus
Access	
Medicare assignment rules	F
Costs	
Fraud and abuse	
False Claims Act	F
Medicare/Medicaid 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	
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
Health Insurance Regulation

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

¹ See Figure 1 Supporting Documentation for details of these calculations.

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

³ Tables 1, 2 and 3 summarize all the topics that were included in our literature syntheses for health facilities, health professionals and health insurance respectively. An advisory panel of 20 national experts has provided guidance on the scope and content of this literature synthesis. We are confident that no major domain of health services regulation has been excluded. However, it might also be noted that our cost estimates do not include the costs imposed on health providers from continual changes in public payment policies.

⁴ 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 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.

⁵ Most recent estimates of the price elasticity of demand for health insurance lie in the -.4 to -.6 range (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). Assuming an average overhead cost no higher than 15 percent, a 6.4 percent increase in health spending attributable to health industry compliance costs would be associated with a 5.4% increase in health insurance premiums, so applying the lower bound elasticity estimate yields a 2.2% reduction in demand for coverage. Leaving aside the non-elderly now covered by Medicare, Medicaid and military benefits, there are more than 215 million adults and children in the private market for private health insurance: a 2.2 percent reduction in demand translates into 4.8 million uninsured. Using upper bound estimates of the net impact of health regulation (9.8%) and price elasticity (-.6) would imply that 10.7 million could be uninsured due to health regulation.

⁶ 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.

⁷ 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.