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THE REGULATORY RATCHET: WHY REGULATION BEGETS REGULATION—FATAL FLAW IN THE MARKET FOR HEALTH CARE

*Mark R. Lee**

Regulation routinely functions like a ratchet, a tool designed to apply force in one and only one direction. Whatever else regulation does, it almost always begets more regulation. Part I of this article explains why and how the regulatory ratchet works. It focuses on the incentives to regulate and the suppression of information about its impact.¹ Part II illustrates the explanatory power of the regulatory ratchet model by tracing a handful of its major turns in the market for health care. Finally, Part III (1) argues that the likelihood that regulation will beget more regulation ought to figure in any cost-benefit analysis of a proposed regulation and (2) suggests how the regulatory ratchet model might be refined to facilitate its use.

I. HOW THE RATCHET WORKS

Proponents of a regulation invariably advocate it as a “solution,” or “partial solution,” to one or more “problems.” Each “problem” manifests itself, according to proponents of the regulation, as a set of outcomes that they deem undesirable. If the regulation is adopted, it might ameliorate these “problems.” But it also might not. The people subject to the regulation might adapt to it in such a way that it has little or no effect on the “problem.”² The connection between the regulation and the “problem”

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1. Information suppression may be only one strategy used by proponents of a regulation to increase potential opponent’s transaction costs. Charlotte Twight, *Political Transaction Cost-Manipulation: An Integrating Theory*, 6 JOURNAL OF THEORETICAL POLITICS 189 (1994).

2. Ronald Coase, *The Problem of Social Cost*, 3 JOURNAL OF LAW AND ECONOMICS 1 (1960). Adaption to regulation plays a major role in the “law of unintended consequences.”

might be largely symbolic;³ or the “problem” might be an urban legend.⁴ For a variety of reasons, the regulation might have no discernible effect on the “problem;” it might even aggravate the problem.

Whatever the likely impact of the regulation on the “problem,” it will not dictate the behavior of the regulators. Their behavior will be dictated by the benefits that they can expect to derive and the costs that they can expect to incur as a result of adopting the regulation.⁵ These expected benefits and costs will depend little, if at all, on whether the regulation ameliorates the “problems,” has no discernible effect on them, or aggravates them. If it ameliorates them, the regulators will capture little, if any, of the resulting benefits. Regulators, like other decision makers in the wondrous world of government, almost always find it extraordinarily difficult, if not impossible, to capture an appreciable portion of the benefits resulting from their decisions. On the other hand, they rarely, if ever, bear an appreciable portion of the costs. The mechanisms that cause decision makers in markets to bear an appreciable portion of the costs resulting from their decisions, mechanisms such as price and product competition, do not operate as effectively, or simply do not operate at all in government. So, even if a regulation were to aggravate the “problems” its proponents claimed that it would “solve,” the regulators could reasonably expect to incur few, if any, of the resulting costs.

Typically, a large diffuse bunch of people will bear these costs. Bearing these costs may strike each of these people as an undesirable outcome and therefore a “problem” about which “someone ought to do something.” This “problem” would disappear, of course, if the regulators were to reverse course. Reversing course, however, is likely to garner little, if any, organized political support, and it would almost certainly generate substantial opposition. Opposition would come from three groups: (1) individuals who believe that they do or will derive net benefits from the regulation, (2) lawyers and other service providers who help people seek benefits from the regulation, and (3) the folks who supply these benefits profitably.⁶ Opposition would also come from the regulators—after all,

3. For example, in the aftermath of the “financial crisis” regulation of pay incentives for bank executives enjoyed widespread support despite lack of evidence that pay incentives played a significant role in the risky decisions made by some bank executives. Jeffrey Friedman, *Bank Pay and the Financial Crisis*, WALL ST. J. (Sept. 24, 2009), at A21.

4. Joel Best & Gerald T. Horiuchi, *The Razor Blade in the Apple: The Social Construction of Urban Legends*, 32 SOCIAL PROBLEMS 488 (1985).

5. Fred McChesney, MONEY FOR NOTHING: POLITICIANS, RENT EXTRACTION AND POLITICAL EXTORTION (1997).

6. Grocers are prominent lobbyists against any reform of the food stamp program, formally known as the Supplemental Nutrition Assistance Program, likely to appreciably reduce the number of recipients. Heather Haddon & Jesse Newman, *Retailers Worry Food-Stamp Overhaul Will Hit Them Hard*, WALL ST. J. (Apr. 6, 2018), <https://www.wsj.com/articles/retailers-worry-food-stamp-overhaul-will-hit-them-hard-1523016003>.

they adopted the regulation because they expected to derive net benefits from doing so. In the event of a political battle, the people deriving benefits from the regulation, their enablers and suppliers, and the regulators could count on loud support from the reflexively pro-regulation majority of journalists, commentators, and pundits.

Such political battles, however, do not take place often because the people who bear the costs of regulation rarely put up much of a fight. Typically, the cost-bearers will not have organized themselves to wage political battle (had they done so, they might have forestalled the regulation), and organizing them would cost far more than each individual cost-bearer could expect to gain from repealing the regulation. In most cases, only a small portion of those bearing the costs of the regulation will take notice of it. The cost per affected person usually grows over time, remaining small in the immediate aftermath of the enactment of the regulation when the cost might register with those affected and they might perceive the causal connection. Of the cost-bearers who take notice of the regulation, few will appreciate that repeal would relieve them of these costs. Appreciating the value of repeal customarily requires information about the regulation's devilish details. Precious few cost-bearers will possess such information, and they will have little, if any, incentive to acquire it since they will not expect to influence the relevant decision-makers. Moreover, the regulation itself usually obscures information about its impact, most often by relying on taxation and transfer payments or by using coercion to prevent markets from impounding such information into prices. And regulators commonly engage in supplemental efforts to suppress such information.⁷ For most people, the required information may as well have passed beyond the event horizon of a "black hole."

Typically, most of the people who bear the cost of a regulation will remain rationally ignorant of its likely impact unless the regulation fails

7. Charlotte Twight, *Medicare's Origin: The Economics and Politics of Dependency*, 16 CATO JOURNAL 309 (1997). A dramatic example occurred during the run up to Obamacare. The legislative draft proposed to slash spending on Medicare Advantage plans by \$123 billion over a ten-year period. Humana, a major issuer of such plans, sent a letter to its Medicare Advantage customers warning them that "millions of seniors and disabled individuals could lose many of the important benefits and services that make Medicare Advantage health plans so valuable." The letter urged the recipients to contact their Representatives. Senator Baucus, principal sponsor of the draft legislation complained to the Centers for Medicare and Medicaid Services which ordered Humana to cease and desist distributing "misleading and confusing" information and announced an official probe into the company's actions. *Baucus Bludgeons Humana*, WALL ST. J. (Sept. 22, 2009). Many efforts at information suppression target pharmaceuticals, especially pricey pharmaceuticals. These include refusal to disclose data used in federally funded studies purportedly showing "overuse" of various drugs, Scott Gottlieb, *The War on (Expensive) Drugs*, WALL ST. J. (Aug. 30, 2007), <https://www.wsj.com/articles/SB118843412251712953>, and FDA imposed limitations on the promotion of "off-label" uses of approved drugs. Scott Gottlieb, *Stop the War on Drugs*, WALL ST. J. (Aug. 30, 2007), <https://www.wsj.com/articles/SB119786300762133127>.

to obscure its impact or swiftly triggers headline-grabbing undesirable outcomes. But headline-grabbing outcomes do not occur often. Even when they do, they often arise or become manifest long after the adoption of the regulation, which makes it considerably more difficult to perceive the cause of these undesirable outcomes. The paucity of information about the impact of the regulation will undermine the argument for repeal. Meanwhile, the ranks of individuals who believe that they do or will derive a net benefit from the regulation and their enablers and suppliers will likely grow and become better organized.

Of course, the regulation will continue to trigger undesirable outcomes. The persistence of this “problem” may fuel calls for a “solution” or “partial solution,” one that takes the form of additional regulation. The call for such a “solution” might come from the ranks of the cost-bearers but it is more likely to come from their self-appointed advocates among journalists, commentators, and pundits. In any event, these people will provide political support for more regulation. Even regulation-skeptics may embrace more regulation as a second-best “solution” to the “problem.” For that matter, the regulators who caused the “problem” may support more regulation as a “solution” to it. Such chutzpah is unlikely to generate much, if any, blowback because of the paucity of information about the impact of the regulation, while the regulators may reasonably expect to derive benefits from engaging in additional regulation. In the political arena, more regulation is likely to defeat repeal.⁸

The new regulation, like the old, is likely to cause a large diffuse group to incur costs that they otherwise would not have incurred. Bearing these costs will strike members of this group as an undesirable outcome, perhaps amounting to a “problem” about which “someone ought to do something.” If doing something becomes sufficiently attractive politically, the ratchet is likely to be turned again.

II. THE RATCHET AT WORK IN THE HEALTH CARE MARKET

The health care market provides graphic illustrations of the regulatory ratchet at work.⁹ They are graphic, and sometimes poignant, because the “undesirable outcomes” caused or exacerbated by each turning of the ratchet frequently manifest themselves as physical suffering and, on

8. The Administrative Procedure Act and its state equivalents may make repeal more difficult. F. H. Buckley, *The ‘Swamp’ Needs a Justinian*, WALL ST. J. (Apr. 19, 2018), <https://www.wsj.com/articles/the-swamp-needs-a-justinian-1524178574>.

9. Holman Jenkins, *Libertarian Dream of Pharmaceuticals*, WALL ST. J. (OCT. 30, 2015), <https://www.wsj.com/articles/libertarian-dream-of-pharmaceuticals-1446238152>.

occasion, as death¹⁰—hence the health care market’s “fatal flaw.” Surely, proponents of these turnings did not wish to bring about these outcomes. No surprise there; the regulatory ratchet generally operates in accordance with the “law of unintended consequences.” It certainly did in connection with one of the earliest, and probably most critical, turnings of the ratchet in the health care market: giving employer-purchased health insurance a tax advantage. Part II of the article discusses this and four other turns of the ratchet: Medicare; the Prospective Payment System and HMOs; state mandated insurance coverage and claims review processes; and “Obamacare.”¹¹

A. Employer-Purchased Health Insurance Becomes Tax-Advantaged

Backstory

The Internal Revenue Code of 1939 provided that “[g]ross income include[d] gains, profits, and income derived from salaries, wages, or compensation for personal service, of whatever kind and in whatever form paid.”¹² This appeared to make payments by an employer for an employee’s health insurance taxable to the employee. The IRS had ruled that payments by employers for employees’ accidental death and disability insurance constituted “gross income.”¹³ It had not had occasion to rule in connection with payments for employees’ medical and hospitalization insurance, which were relatively rare prior to the outbreak of World War II.¹⁴

The value of such insurance was far less than it is today because doctors could do far less for the sick and injured, and the price of what they could do was comparatively low. Medical care then consisted much more than it does today of palliatives and first-generation antibiotics; it was not until World War II that penicillin went into widespread use. Even when hospitalized, patients had far fewer treatment options than they have today. Indeed, treatment options were so limited that an important health insurance benefit for a substantial number of people was a fixed sum

10. Many examples appear in Stephen Westaby, *OPEN HEARTS* (Basic Books 2017); Robert Francis, *REPORT OF THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY* (2013); John Stossel, *Sick Sob Stories*, *WALL ST. J.* (Sept. 13, 2007), at A16.

11. The health care market provides a cornucopia of ratchet turnings, including widespread and extensive regulation of drugs, physicians, and hospitals.

12. Internal Revenue Code of 1939 §22(a).

13. The IRS had ruled that payments by employers for employees’ accidental death and disability insurance constituted “gross income.” Reg. 45, Art. 33 (revised April 17, 1919).

14. In 1940 the population of the United States about 132 million of which only 12 million were covered by some form of health insurance. *SOURCE BOOK OF HEALTH INSURANCE DATA, 1981-82* (Washington Health Insurance Institute, 1982) p. 13.

payment for each day spent in the hospital.

Employer payments for employees' medical and hospitalization insurance became more common after the Office of Price Administration ("O.P.A.") adopted wage caps in 1941.¹⁵ These caps made it problematic to compete for labor by offering higher wages. So as the demand for labor grew apace with war-related production and the supply of labor shrank as civilians became soldiers, employers competed by offering benefits that were not subject to the O.P.A.'s wage limits¹⁶—such as medical and hospitalization insurance.

Even though these benefits substituted for wages, the Emergency Price Control Act of 1942, as amended by the Stabilization Act of 1942,¹⁷ excluded most insurance from employees' taxable income while preserving its deductibility by employers. Since employees faced marginal tax rates as high as 85%, this exclusion made employer-purchased health insurance extraordinarily cheap. This tax advantage survived the repeal of wage and price controls. Subsequently, Congress enshrined it in the Internal Revenue Code of 1954.¹⁸

This tax advantage triggered critical unintended consequences. For instance, health insurance coverage expired with employment. This provided ammunition for the advocates of Medicare—one of the most important turns of the regulatory ratchet. The remainder of this section explains why and how this came to pass.

Tax Advantage = Price Reduction

The tax advantage made it cheaper for an employee to obtain health insurance as part of his compensation rather than purchase it for himself

15. Exec. Order No. 9250, 1942 WL 4218, 7 F.R. 7871 (Oct. 3, 1942).

16. Cf. Offering such goodies became sufficiently commonplace that unions sought to make them the subject of negotiations. In 1949, the National Labor Relations Board opined that "wages" included insurance and pension benefits, so employers had to negotiate with unions about them. *Steelworkers (AFL-CIO) (Inland Steel Co.)*, 77 NLRB 1 (N.L.R.B. 1948), *aff'd* *Inland Steel Co. v. N.L.R.B.* 170 F.2d 247 (7th Cir. 1948).

17. Emergency Price Control Act of 1942 § 901 et seq., 56 Stat. 23, (1942).

18. I.R.C. § 105(b) (West 1954). Prior to the 1954 amendments only certain types of health benefits had to be reported as income. For instance, payments made by the employer directly to commercial insurance companies for group medical premiums of employees were not taxable as employee income, but private programs of an employee association or employer were taxable. The IRS attempted to specify which types of employer-provided health care resulted in taxable income for the employee. *See* 1943 C.B. 86; Rev. Rul. 54-1; Int. Rev. No. 13 at 2 (1953); I.T. 4107, 1952-2 C.B. 73. The distinctions drawn by the IRS were questioned by the Seventh Circuit in *Epmeier v. United States*, 199 F. 2d 508 (7th Cir. 1952). For the most part, the Internal Revenue Code of 1954 resolved this conflict in favor of the tax advantage. According to the legislative history, this was done in part to eliminate substantially different tax treatment of similarly situated recipients of employer provided health insurance based on the technical nature of the plan for providing the insurance. H.R. 1337, 83rd Cong. (2nd Sess. 1954). *See also, Taxation of Employee Accident and Health Plans before and under the 1954 Code*, 64 YALE L.J. 222, 224 (1954).

(even if he could purchase a “group policy”). To illustrate, consider Bernie, an employee paid \$50,000 in annual wages subject to income tax at the rate of 20%. If he were to purchase a health insurance policy requiring a \$3,000 annual premium, his remaining after-tax earnings would amount to \$37,000 [\$50,000 in wages minus \$10,000 in taxes (20% of \$50,000) minus the \$3,000 premium]. His remaining after-tax earnings would rise to \$37,600, however, if Bernie’s employer were to purchase the policy and provide it to him in lieu of \$3,000 in annual wages [\$47,000 in wages minus \$9,400 in taxes (20% of \$47,000)]. The tax advantage would yield what amounts to a \$600 “price” reduction for Bernie. The higher the marginal tax rate, the greater the price reduction.

Because of the price reduction, an employee like Bernie, who had planned to purchase health insurance for himself, would want his employer to purchase it for him. Indeed, he might even want his employer to purchase more insurance for him than he would have purchased for himself. Suppose that two otherwise identical policies would pay different amounts in the event of hospitalization: an insurance policy with a \$3,000 premium would pay 70% of a \$1,000 bill (\$700), while a policy with a \$3,100 premium would pay 80% of it (\$800). And further suppose that the prospect of this larger payout is worth \$90 to employee Shira. If Shira were purchasing health insurance for herself, she would choose the cheaper policy. The calculus changes, however, if Shira can obtain her insurance as part of her compensation. Assume that Shira receives \$50,000 in annual wages subject to income tax at the rate of 20%—just as Bernie does. If her employer were to purchase the \$3,000 policy for her, Shira’s after-tax earnings would amount to \$37,600 just as Bernie’s would. Obviously, her after-tax earnings would decline if her employer were to purchase the \$3,100 policy for her and reduce Shira’s wages by an additional \$100, but they would not decline by \$100. Her earnings would decline by only \$80 [\$46,900 in annual wages minus \$9,380 in taxes (20% of \$46,900) = \$37,520]. She would want her employer to purchase the more expensive policy for her because she would forego only \$80 in wages in return for additional insurance worth \$90 to her.

The same reasoning explains why an employee who would not have purchased health insurance for himself might want his employer to purchase a policy for him. Consider Nathan who is also paid \$50,000 in annual wages subject to income tax at the rate of 20%. Suppose that the \$3,000 health insurance policy was worth only \$2,600 to him, so if he had to purchase it for himself, he would not do so. Nathan’s after-tax earnings would then amount to \$40,000 [\$50,000 in annual wages minus \$10,000 in taxes]. But if he were to obtain the insurance as part of his compensation in lieu of \$3,000 in wages, his remaining after-tax earnings would amount to \$37,600 [\$47,000 in wages minus \$9,400 in taxes (20%

of \$47,000)]. The health insurance policy worth \$2,600 to Nathan would cost him only \$2,400 in foregone wages.

To sum up the tax advantage, (1) all employees who were planning to purchase health insurance would prefer that their employers purchase it for them; (2) some employees would prefer that their employers purchase more coverage for them than they would have purchased for themselves, and (3) some employees would prefer that their employers purchase health insurance for them even though they would not have purchased it for themselves. Because employees like Bernie, Shira, and Nathan would prefer to substitute employer-purchased health insurance for some of their monetary compensation, an employer can get more competitive bang for its compensation bucks by catering to this preference. If the gains from catering exceed the transaction costs of purchasing the health insurance and providing it as compensation, an employer will find it advantageous to cater. And because of the tax advantage an employer who purchases health insurance for its employees will tend to purchase more insurance than his employees would have purchased for themselves. This additional coverage helped obscure the price of medical care just as the tax advantage helped obscure the price of health insurance.

The Golden Rule of Insurance Policy Selection: He Who Dispenses the Gold Selects the Policy

While an employer who purchases health insurance for its employees will find it advantageous to purchase more insurance than his employees would have purchased for themselves, it will almost certainly not find it advantageous to select the same coverage they would have selected. It would be costly to do so because it would have to ascertain the preferences of each employee and purchase multiple policies. And irrespective of cost, coverage that served its employees' interests might not serve the employer's

To illustrate, suppose that two identically priced policies differ only in the coverage provided for (1) pregnancy and childbirth and (2) diaphragms, birth control pills, and medical procedures that prevent conception. Policy A provides comprehensive coverage for pregnancy and childbirth but barebones coverage for conception preventatives; Policy B does just the opposite. Policy A would tend to encourage conception more than Policy B. Since pregnancy and childbirth may result in increased absenteeism and turnover which would be costly to an employer, it might select Policy B even though an appreciable number of current employees would have selected Policy A.

Consider another illustration with far reaching implications for the operation of the regulatory ratchet in the health care market. Suppose two

identically priced policies differ only in duration and deductibles. Policy C has a \$750 annual deductible but provides coverage only while the employee works for the purchasing employer. Policy D has a \$7,500 annual deductible but would permit the employee to continue coverage after his employment ends at the same premium price his employer would have paid. An employer might select Policy C even though some of its present employees would have selected Policy D.

What Employer-Purchased Health Insurance Wrought

The spread of tax-advantaged employer-purchased health insurance left millions of employees and their families covered by policies that expired when their employment ended. Had these employees been purchasing coverage for themselves, most would have strongly preferred guaranteed renewable policies. But when their employers purchase their insurance, many employees prefer policies that expire when employment ends.¹⁹ Here is why: Recall that employer-provided health insurance receives advantageous tax treatment only if it is provided as part of the employment relationship. Therefore, a policy that remained in force after the expiration of the employment relationship could qualify for the tax advantage only if a cash method employer had already paid the premiums for the post-job period or paid them as deferred compensation. An employer who made these additional payments would offset them by providing his employees with less pay or less valuable benefits than the employer otherwise would have provided.²⁰ This trade off would hold little, if any, appeal to many employees and potential employees, especially those who expect that they could readily land a job with another employer who purchased health insurance for their employees if their current employment relationship ended.

Employees whose employer-purchased health insurance ended with the employment relationship would have placed some value on an option to buy post-employment health insurance for a premium that a healthy individual of the same age would have paid. The sale of the option—a renewal guarantee sold as a stand-alone policy—did not become widely available until the late 2000s. In 2009, such policies cleared regulatory approvals in 25 states.²¹ The value of these policies declined dramatically,

19. Perhaps some employers select such policies to discourage job-hopping by employees, a straightforward application of the golden rule of insurance policy selection.

20. The reduction in pay or benefits would not be as great if an employer promised the health insurance as deferred compensation (presumably, the reduction would equal the discounted cost of the insurance plus the deferred compensation scheme), but the employee would bear some risk that the employer might not abide by his promise.

21. Michael Cannon, *A Chance to Overcome ObamaCare*, WALL ST. J. (May 29, 2018), at A19.

however, when Congress enacted Obamacare which required nationwide community rating beginning in 2014. The alternative - maintaining individual insurance alongside insurance purchased by their employers - did not hold any appeal for most employees, especially the large number of employees who expected that they could readily land a new job which provided employer-purchased health insurance for employees. Even these employees might still have been interested in post-retirement health insurance, but interest in such insurance in the years following World War II was less keen than it is today when (1) life expectancy is longer, (2) doctors, hospitals, and pharmaceuticals can do more, and (3) the price of medical care is higher.²²

Employer-purchasing of health insurance eliminated vast numbers of relatively healthy individuals as potential purchasers of health insurance for themselves and their families. Most individuals purchasing insurance for themselves and their families keep their policies for less than 24 months while between jobs. Premiums for the remaining potential purchasers rose to reflect this fact, and rising premiums no doubt prompted some individuals to economize by buying less coverage or doing without health insurance. Some of these economizers surely incurred more uninsured medical expenses as a result; some may have foregone timely medical services. The frequency and severity of these unfortunate outcomes increased over time as (1) medical services became pricier, reflecting both the cost of providing advanced medical care and burgeoning moral hazard, and (2) advances made medical services more useful to more people and extended the lives of sick people.

For obvious reasons, senior citizens figure prominently among those who experienced these unfortunate outcomes. As a group, they have more frequent and more serious health problems than working-age people, and because of the substitution of employer-purchased for employee-purchased health insurance, they were more likely to have less health insurance coverage.

Eliminating the tax advantage for employer-purchased health insurance would have reduced the incidence of these outcomes, especially among senior citizens. With the tax advantage gone, more employees would have purchased their own health insurance. To compete for these customers, insurers would have had to respond to their demands for policies that met their preferences. This would have triggered a decline in the number of people lacking post-job health insurance.²³ Despite these virtues, elimination of the tax advantage garnered little, if any, political

22. Brigitte C. Madrian, Gary Burtless, & Jonathan Gruber, *The Effect of Health Insurance on Retirement*, BROOKINGS PAPERS ON ECONOMIC ACTIVITY (1994).

23. John H. Cochrane, *What to Do about Pre-existing Conditions*, WALL ST. J. (Aug. 14, 2009), <https://www.wsj.com/articles/SB10001424052970203609204574316172512242220>.

support during the 1950s and 1960s.

It appears that no Senator or Representative publicly proposed elimination of the tax advantage. Perhaps behind-the-scenes efforts by the real beneficiaries of the tax advantage helped keep the politicians in check. After all, some of the real beneficiaries, such as the people who underwrote more insurance because of the tax advantage,²⁴ wielded considerable political clout.

The “victims” of the tax advantage—including people who lacked post-job or post-retirement coverage because of it—certainly did not advocate its elimination. Elimination would have provided them with no short-term benefits. Besides, the impact of the tax advantage was probably lost on most of them, obscured in part by the passage of time. The pricing of health insurance might have brought the impact home—except because of the tax advantage, relatively few purchased health insurance for themselves. To gauge the impact of the tax advantage, an individual would have needed to expend appreciable time and energy—which most people would find difficult to justify since they could not reasonably expect to influence members of Congress. Insofar as the “victims” gave the tax advantage any thought, most of them probably considered themselves beneficiaries since they did not pay income tax on the value of the health insurance that their employers purchased.

The plight of people who lacked post-job, including post-retirement, health insurance coverage, however, did evoke loud lamentations from many journalists, commentators, and pundits. Most of the lamenters called for a “solution” to the “problem” that was manifested by the plight of the uninsured²⁵ (then, as now, most of the lamenters assumed that lack of health insurance coverage resulted not only in uninsured medical

24. Recall that, thanks to the tax advantage, some employers purchased more insurance for their employees than their employees would have purchased for themselves. And some of the people who sold health insurance to employers may have enjoyed a comparative advantage selling to them rather than individuals.

25. In 1959, the “plight of the uninsured,” especially the elderly uninsured, was the focus of hearings before the Senate Subcommittee on Problems of the Aged and Aging (of the Committee of Labor and Public Welfare Committee on Labor and Public Welfare). One retired school teacher testified:

I am one of your old retired teachers that has been forgotten. I am 80 years old and for 10 years I have been living on a bare nothing, two meals a day, one egg, a soup, because I want to be independent. I am of Scotch ancestry, my father fought in the Civil War to the end of the war, therefore, I have it in my blood to be independent and my dignity would not let me go down and be on welfare. And I worked so hard that I have pernicious anemia, \$9.95 for a little bottle of liquid for shots, wholesale, I couldn't pay for it.

U.S. Senate, 86th Congress; Washington D.C. 1959.

expenses, but a lack of medical care²⁶). In the health care market, when a “problem” becomes sufficiently salient, it always fuels demands for additional regulation. It has rarely elicited calls for revisiting existing regulation that almost certainly caused or aggravated the “problem.”²⁷ Few, if any, of those lamenting the plight of the uninsured advocated elimination of the tax advantage. Almost all of the lamenters urged another turn of the regulatory ratchet; a legislative promise to pay for some medical services, at least for retirees.

B. Medicare: Legislative Promises to Pay for Some Medical Care

In the event, the legislative promise to pay for some medical services took the form of Medicare. Once coupled with appropriations and an administrative organization to process claims, it provided covered individuals with a form of health insurance.

Legislative insurance would not necessarily reduce the frequency with which covered individuals incur uninsured medical expenses or the size of those expenses. To illustrate, consider individuals who, absent the legislation, would have been insured by a commercial policy providing equal or better coverage. For these people, the legislated insurance could not reduce either the frequency with which they incurred uninsured medical expenses or the size of those expenses. But it could trigger increases in both, and it could do so not only for those individuals, but also for the less insured. It could trigger increases due to moral hazard—the risk that insured individuals might change their behavior at the expense of an insurance provider once the insurance becomes effective.

Once the legislated insurance became effective, covered individuals would tend to demand more covered services than they would have had they borne the price charged for the services.²⁸ A rise in the amount of

26. Lack of health insurance almost certainly prompts some individuals to forego or delay obtaining some medical care. It is difficult to ascertain how many individuals do this and to what extent. Some uninsured obtain free or low-priced medical care either as the beneficiaries of charity or as non-payers. The uninsured secure better medical outcomes than do people covered by Medicaid. Scott Gottlieb, *Medicaid Is Worse Than No Coverage at All*, WALL ST. J. (Mar. 10, 2011), <https://www.wsj.com/articles/SB10001424052748704758904576188280858303612>. “Peer-reviewed studies from the National Health Insurance Experiment and other data dating back to 1980s have concluded that there is little or no causal relationship between health insurance and a person’s health outcomes.” John F. Cogan, Glenn Hubbard, & Daniel P. Kessler, *The Wrong Remedy for Health Care*, WALL ST. J. (June 29, 2012), <https://www.wsj.com/articles/SB10001424052702304870304577490212540553078>.

27. “Root causes” do not seem to hold the same appeal in this context as they do in others.

28. David Card et al, *The Impact of Nearly Universal Insurance Coverage on Health Care Utilization: Evidence from Medicare*, 98 AM. ECON. REV. 5, 2242, 2257 (2008). This tendency is especially strong among those who purchase Medicare supplemental coverage, a substantial majority of Medicare recipients.

covered services demanded would cause prices to rise for everyone, including people covered by commercial health insurance. When the commercially insured obtained these services, the companies providing this insurance bear the higher price. So, these companies must raise premiums for a given coverage, which would prompt some purchasers to economize by seeking reduced coverage or by foregoing health insurance altogether. Obviously, individuals with reduced or no coverage incur uninsured medical expenses more frequently than they would have incurred them had they not economized, and these expenses would be greater than they would have been had the legislated insurance not triggered a rise in the price of medical services. In this way, legislated insurance could trigger increases in both the frequency with which individuals incurred uninsured medical expenses and the size of these expenses.

Commercial health insurance companies respond to moral hazard risk by limiting whom they insure and the coverages they provide, and by setting deductibles and co-payments that curb their insured's demand for covered services. These measures reduce moral hazard risk, but rarely eliminate it. Therefore, commercial insurance companies charge premiums that reflect this residual risk. Absent measures to reduce moral hazard risk, increases in the amount of covered services demanded would continuously drain the coffers of insurance companies and reduce these companies' market value. Reductions in their market value would pose a serious threat to the present and future wealth of its executives. Legislators do not face this threat since the mechanisms of the business world that tie the wealth of executives to the value of their companies do not operate in the world of electoral politics. So if legislators crafting legislated insurance fail to respond to moral hazard risk as commercial insurance companies do, they face negligible, if any, threat to their present or future wealth even though their failure would cause a continuous, severe, and ultimately unsustainable drain on the U.S. Treasury.

This drain would eventually cause most voters to incur costs. If voters were likely to blame the costs on the legislated insurance, the drain could threaten the electoral prospects of the legislators supporting the insurance. But voters are far more likely to blame commercial health insurance companies, doctors, hospitals, and others demanding payment. Few voters would blame the legislated insurance because the relationship between it and the costs incurred as a result of its enactment would probably be lost on them. Prices for health insurance and medical services would not bring home the relationship. The price of employer-purchased

health insurance is embedded in a compensation package²⁹ and distorted by the tax advantage, while the price of legislated insurance is hidden by taxes and transfers. Many voters may perceive both kinds of insurance as “free.” Of course, health insurance itself obscures the price of medical services.

Tracing how the legislated insurance eventually caused one to incur costs would require data gathering and analysis that few voters would have an incentive to do. Neither task would be easy; why undertake them when your vote would almost certainly not affect the outcome of the next election, much less the fate of the legislated insurance? A voter might rely on reports prepared by interest groups with sufficient incentive to gather the requisite data and undertake the required analysis, but sorting the reliable reports from the unreliable ones would itself require work. For the vast majority of voters, information about how the legislated insurance eventually caused them to incur costs is likely to pass beyond the “event horizon” and into a “black hole.” So, if legislators crafting legislated insurance failed to respond to moral hazard risk, as commercial insurance companies do, they would probably not suffer at the polls. Indeed, they might benefit.

Advocating for legislation can help a legislator continue to hold elected office in a number of ways, including facilitating fundraising and garnering favorable, or at least neutral, media attention. Advocating legislation that promises “goodies” to millions of non-organized individuals, as legislated insurance does, can also attract votes. Since all votes count the same, the number of votes attracted by the legislation tends to matter more to a legislator than the intensity of each voter’s attraction. Thus, legislators ordinarily find it politically advantageous to sacrifice some of the total value of the promised “goodies” in favor of increasing the number of voters (and their financial dependents) to whom the promise is made, or better yet, the number likely to cash in on the promise before the next election.³⁰ When the “goodie” is legislated health insurance, the two most expedient ways to increase the number of voters to whom the promise is made are by: (1) promising to pay for medical services consumed by many people, regardless of their health or behavior,³¹ and (2) setting deductibles and co-payments at a level lower than a commercial insurance company would. This kind of expediency

29. The price of employer-purchased insurance, of course, is the difference between what the employee voter would have been paid had the employer not purchased insurance for him and the pay that he actually receives.

30. In the world of business, a decision maker who sacrificed some of the total value of a product in favor of increasing the number of people purchasing it would probably bear an appreciable portion of the resulting costs.

31. So, coverage for catastrophic expenses holds relatively little political appeal.

practically guarantees a moral hazard that, if unchecked, would threaten the U.S. Treasury with a continuous, severe, and ultimately unsustainable drain, a moral hazard that no commercial insurance company could tolerate. The original structure of Medicare's hospital cost coverage illustrates such expediency: it covered hospital costs from the first day of hospitalization with only a \$40 deductible (coinsurance of \$10 per day did not kick in until the 61st day), but Medicare did not cover hospital costs after 90 days of hospitalization.³² This meant that Medicare did not protect seniors from financial hemorrhaging due to medical costs, even though that was the "problem" for which Medicare was designed to solve, according to almost all of the program's proponents.

Congress did empower the Department of Health and Human Resources to, in effect, modify the legislated insurance through rule making,³³ and the Secretary has delegated this power to the bureaucrats at what is now known as the Centers for Medicare and Medicaid Services.³⁴ Of course, these bureaucrats have no more incentive than legislators to mimic the response of commercial health insurance companies to moral hazard risk. In fact, senior bureaucrats might have even less incentive because curbing the amount of covered services demanded might make "growing the bureaucracy" more difficult. Nevertheless, empowering bureaucrats to make modifications appeals to legislators. Doing so economizes on their time and effort, partially insulates them from the political fallout that might result if modifications were to be met with disapproval from various segments of the population, and creates a ready target for electorally advantageous criticism.³⁵

32. The "1966 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund" and "The 1966 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund" both prepared for the Speaker of the House of Representatives by Henry H. Fowler, W. Willard Wirtz, John W. Gardner, and Robert M. Ball (<https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Trustees-Reports-Items/1966-1969.html>) (1966 Medicare HI Trustees Report) - Plan A and (1966 Medicare SMI Trustees Report) - Plan B). Presently, the deductible for each benefit period of up to 90 days is \$1,346 with coinsurance of \$341 per day for days 61-90. After 90 days, a covered person has a total of 60 additional "lifetime reserve" days to use over one or multiple periods with a \$682/per day coinsurance for such days. <https://www.medicare.gov/coverage/inpatient-hospital-care>.

33. 42 U.S.C. § 1395(h)(h).

34. *Delegation of Authority; Centers for Medicare Medicaid Services*, Federal Register (Mar. 14, 2011), <https://www.federalregister.gov/documents/2011/03/14/2011-5779/delegation-of-authority-centers-for-medicare-and-medicaid-services>. Obamacare empowered CMS to modify Medicare directly on a trial basis via the Center for Medicare and Medicaid Innovation. 42 U.S.C § 1315a(a). The Center is authorized to test implementation of new payment and delivery models, which the Secretary may then expand nationwide through rulemaking. 42 U.S.C § 1315a(c). The statute provides selection criteria requiring that the models address certain groups and reduce program costs while preserving care quality. 42 U.S.C § 1315a(b)(2)(A). The statute also provides criteria by which the Secretary is to determine whether to discontinue, modify, or expand the model; these criteria focus on changes in the quality and cost of care under the model. 42 U.S.C § 1315a(b)(3)(B); § 1315a(b)(4); § 1315a(c).

35. David Schoenbrod, *Only Congress Can Undo Its Regulatory Mess*, WALL ST. J. (June 19, 2017), <https://www.wsj.com/articles/only-congress-can-undo-its-regulatory-mess-1497821745>.

Besides, legislators in succeeding Congresses could make their own modifications, and they would almost certainly find it electorally advantageous to do so as medical science advances and population demographics change. But successor legislators would have no more incentive than their predecessors to adopt terms like the ones used by commercial health insurance companies to reduce the amount of covered services demanded by insureds. To the contrary, successor legislators would almost certainly find it politically advantageous to make promises that would compound the moral hazard, such as promises to pay for additional medical services and to pay for these services for more people. Successor legislators did just that.³⁶

Of course, mounting moral hazard risk compounds the threat to continuously and severely drain the U.S. Treasury. If the drain were to go unchecked, it would eventually generate pressure to raise taxes, foster inflation, or forego otherwise electorally advantageous appropriations. These actions could prove electorally problematic, so Senators and Representatives would eventually take steps to limit the drain even though such steps would generate political opposition from the people who expected that the legislated insurance would enrich them.

C. Price Controls & Rationing: The Prospective Payment System and HMOs

Repealing Medicare would have plugged the drain on the U.S. Treasury. So too would assessing beneficiaries a charge for coverage equal to appropriate actuarially determined premiums—the functional equivalent of a repeal. Like most proposals to reverse previous turns of the regulatory ratchet, these measures lacked political appeal. So too did less radical measures that would have slowed and perhaps substantially reduced the drain on the Treasury, such as: (1) delaying the age at which Medicare coverage begins; (2) restructuring Medicare as a defined contribution or voucher program (as many employers were doing with their employee health insurance plans³⁷); (3) reducing the services covered by Medicare, say to treatment for catastrophic illnesses; or (4) employing mechanisms used by commercial health insurance companies in response to moral hazard risk.³⁸ Such measures would have required

36. For example, in 1972, Congress extended coverage to individuals under 65 suffering from long-term disabilities or end-stage renal disease. Social Security Amendments of 1972, Publ. L. 92-603, 92nd Congress, H.R. 1 (October 30, 1972). In 1980, Congress authorized reimbursement for additional home health services. The Omnibus Budget Reconciliation Act of 1980, Pub. L. 96-499 § 930, 94 Stat. 2599 (1980).

37. E.g. Textron, Inc. Barbara Martinez, *Health Plan That Puts Employees in Charge of Spending Catches On*, WALL ST. J. (Jan. 8, 2002), at B1 col. 2.

38. For example, beneficiaries could be given a choice of plans that have lower premiums, but

that members of Congress (1) forego some of the electoral advantage that had prompted their predecessors to enact Medicare and (2) incur the opposition of people who stood to derive significant wealth from the program. This our Senators and Representatives were, and are, unwilling to do. Rather, they expanded the scope of Medicare to cover more people and services. For example, in 1972, Congress extended coverage to individuals under 65 suffering from long-term disabilities or end-stage renal disease.³⁹ In 1980, Congress authorized reimbursement for additional home health services.⁴⁰ Obviously, expansions such as these increased the drain on the Treasury.

To address the drain, Congress adopted the Prospective Payment System⁴¹ (“PPS”), requiring that the Secretary of Health and Human Services establish caps on payments made for Medicare claims pursuant to a complicated formula.⁴² The caps were to be based on the average accounting cost of treating a medical problem belonging to a particular diagnostic group. According to the committee reports for the bill that mandated PPS, it was intended to give medical service providers an incentive to operate efficiently.⁴³

Under some circumstances, price controls can create such incentives in the short run. The PPS regime may have done so because it took effect when previous turns of the regulatory ratchet had made it prohibitively expensive for most providers and patients to quickly opt out of Medicare.

higher deductibles, more coinsurance, or a smaller provider network.

39. Social Security Amendments of 1972, Publ. L. 92-603, 92nd Congress, H.R. 1 (October 30, 1972).

40. The Omnibus Budget Reconciliation Act of 1980, Pub. L. 96-499 § 930, 94 Stat. 2599 (1980).

41. Social Security Amendments of 1983, Pub. L. No. 98-21 § 601, 97 Stat. 65, 149 (1983) codified as 42 USC § 1395ww (applicable to charges for in-patient hospital care), 1395xx (applicable to physician services).

42. Specific RVUs [Relative Value Units] are preassigned to the submitted CPT [Current Procedural Terminology] and HCPCS [Healthcare Common Procedure Coding System] codes and are divided into technical, professional, and global components. They are multiplied by the geographic practice cost index (GPCI), which accounts for the cost of living in different locations, and finally a conversion factor, which converts the RVUs into a dollar value. Thus, Medicare payment = total GPCI-adjusted RVU × conversion factor. The national GPCI is set at 1.0. If the cost of living in a particular area is higher than national average, then the GPCI is greater than 1 and if the cost of living is less than the national average, the GPCI is less than 1. The conversion factor is set on an annual basis by Congress and is used to convert RVU to a dollar amount. Diana L. Lam and Jonathan R. Medverd, *How Radiologists Get Paid: Resource-Based Relative Value Scale and the Revenue Cycle*, 201 AMERICAN JOURNAL OF ROENTGENOLOGY 947 (2013).

43. H.Rep. No. 25, 98th Cong., 1st Sess. 1, 132 (1983), reprinted in 1983 U.S.C.C.A.N. 219, 351 (“House Report”) (“The bill . . . is intended to reform the financial incentives hospitals face, promoting efficiency in the provision of services by rewarding cost/effective hospital practices.”); S.Rep. No. 23, 98th Cong., 1st Sess. 1, 53 (1983), reprinted in 1983 U.S.C.C.A.N. 143, 193 (“Senate Report”) (“[PPS amendments] are intended to create incentives for hospitals to operate in a more efficient manner, since hospitals would be allowed to keep payment amounts in excess of their costs and would be required to absorb any costs in excess of the DRG rates.”).

The incentive to operate efficiently in the short run, however, is not the only, nor even the most, significant incentive generated by price controls. For example, they provide a powerful incentive to reduce the impact of the controls. Because PPS prices are based on the average accounting cost of treating a medical problem belonging to a particular diagnostic group, providers can readily reduce the impact of the controls by (1) assigning the medical problem to the diagnostic group likely to maximize reimbursement and (2) allocating more joint costs—such as the costs of maintaining and operating the buildings in a hospital complex, surgical suites, and pathology labs—to treatment costs. Probably the most important incentives created by price controls are for consumers to demand more price-controlled services and simultaneously for providers and potential providers to supply less.⁴⁴ The PPS provides these incentives largely by setting below-market compensation for many services rendered to Medicare patients.⁴⁵

A provider might respond to the incentive to supply fewer medical services in a wide variety of ways. For example, a hospital administrator might reduce staffing and services and push physicians to discharge patients more quickly;⁴⁶ a physician might simply limit the number of Medicare patients he sees.⁴⁷ Because providers can respond in many

44. Distorted pricing coupled with limitations on efficiency-seeking activities that the distortions would ordinarily prompt is likely to give rise to fraud. Roger Feldman, *An Economic Explanation for Fraud and Abuse in Public Medical Care Programs*, 30 JOURNAL OF LEGAL STUDIES 569 (2001).

45. According to the American Hospital Association, in 2016, Medicare reimbursed 87 cents and for every dollar hospitals spent caring for covered patients. “Underpayment by Medicare and Medicaid Fact Sheet, December 2017 Update,” <https://www.aha.org/statistics/2018-01-03-underpayment-medicare-and-medicaid-fact-sheet-december-2017-update>. Using average price and accounting cost data to set reimbursement rates will necessarily result in below-market compensation. Even before the advent of PPS, Medicare provided powerful incentives for providers to supply less medical care simply by not covering a wide variety of relatively new procedures and drugs bearing high initial costs

46. Darren A. DeWalt, *Significance of Medicare and Medicaid Programs for the Practice of Medicine*, 27(2) HEALTHCARE FIN. REV. 79, 83 (2005-2006).

The PPS provided a strong incentive for hospitals to provide fewer services during an admission and shorten the length of stay. The role of CMS as regulatory agency became even more important: it had to monitor for both overuse and underuse of appropriate medical care.

Id.

47. According to a survey conducted by the American Academy of Family Practitioners, 17% of its members refused new Medicare patients in 2017. *AAFP Member Survey Provides Valuable Perspective*, AAFP (Aug. 1, 2017), https://www.aafp.org/news/blogs/inthetrenches/entry/20170801ITT_Survey.html. According to the Center for Medicare and Medicaid Services, it received 1,600 requests from physicians to opt-out of Medicare effective 2013, more than 3,500 effective 2015, 7,400 effective in 2016, and 3,732 effective 2017. *Opt Out Affidavits*, Data.CMS.gov (Dec. 31, 2018), <https://data.cms.gov/Medicare-Enrollment/Opt-Out-Affidavits/7yuw-754z>. (The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) eliminated the requirement that opting-out physicians reaffirm their position every two years.)

ways, the reduction in the supply of medical services can take a host of forms ranging from longer waits for an appointment to fewer life-saving procedures.⁴⁸ Whatever form the reduction takes, it will cause many covered patients to experience delay in the receipt of appropriate medical services. Delay always ensues when a service or product is rationed on some basis other than price. Delay in the receipt of appropriate medical services would cause some patients to experience “only” fear, anxiety, or added discomfort, but it would cause others to experience pain, physical or mental deterioration, and in some cases, death. Such suffering could have prompted the patients and their families to punish Congressional supporters of PPS, but only if they blamed it for their suffering. This, they were unlikely to do; few patients would even appreciate that, absent the PPS regime, they might have received appropriate medical services more quickly. For them, information about the cause of their suffering may as well have passed beyond the “event horizon” of a “black hole.”

Employers purchasing health insurance for their employees faced a potential drain on their coffers similar to the potential drain on the U.S. Treasury. But the executives of these employers lacked the power to promulgate price controls, much less the power to repeal or amend legislation. To limit the drain on their employers’ coffers they could:

- (1) purchase cheaper health insurance with higher deductibles and co-payments;
- (2) restructure their employee health plans as defined contribution or voucher programs;
- (3) offer to pay a smaller portion of the premiums;
- (4) decline to purchase health insurance for employees; or
- (5) engage “gatekeepers” to limit directly the amount of insured medical services that employees and their dependents purchased.

The appeal of each of the first four options to any particular employer purchaser would depend in part on competition in the relevant labor pool, the demographics of the employer’s work force, and the employer’s tax situation. The appeal of the fourth option, the “gatekeeping” option,

48. Many examples appear in Stephen Westaby, *OPEN HEARTS* (Basic Books 2017); Robert Francis, *REPORT OF THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY* (2013); John Stossel, *Sick Sob Stories*, *WALL ST. J.* (Sept. 13, 2007), at A16.

increased dramatically when, in 1973, Congress enacted the HMO Act,⁴⁹ which:

- (1) subsidized the establishment of independent gatekeeping businesses, known as health maintenance organizations (“HMOs”);
- (2) required many employers who purchased health insurance for their employees—all that had employed an average of 25 or more employees during any calendar quarter of the preceding year—to offer their employees at least one HMO that met the standards set forth in 42 U.S.C.A. § 300e(b); and
- (3) limited state regulation of HMOs.⁵⁰

Enrollment in HMOs increased from less than two million members in 1970⁵¹ to more than 39 million in July 1992.⁵² These HMOs provided some insulation for employers from the costly fallout that follows from decisions to keep the gates closed.

Patients enrolled in an HMO can escape the gatekeepers but only by incurring significant uninsured medical expenses. Patients who surrender to the gatekeepers experience a reduction in medical service just as patients covered by PPS-regulated Medicare do—with the same unfortunate, sometimes tragic, consequences: delay in the receipt of appropriate medical services, typically resulting in fear, anxiety, discomfort, or worse.

When these consequences manifested themselves, they probably came as a surprise to most people. Proponents of Medicare and employer-purchased HMO health insurance had not proclaimed that these programs would result in reduced medical service, much less human suffering. And few of the individuals covered by these programs had any reason to think

49. 42 U.S.C. ch. 6A § 300e et seq. Most of the HMO boom occurred after the implementing regulations were adopted in 1977. P.D. Fox & P.R. Kongstvedt, *Chapter 1: Origins of Managed Healthcare*, THE ESSENTIALS OF MANAGED HEALTHCARE (P.R. Kongstvedt, ed., 2007).

50. For example, the Act barred states from “1. [r]equir[ing] as a condition of doing business that a medical society approve of the furnishing of services by the entity; 2. [r]equir[ing] that physicians constitute all or a specified percentage of its governing body; 3. [r]equir[ing] that all physicians or a specific percentage of physicians in a locale participate or be permitted to participate in the provision of services for the HMO; 4. [r]equir[ing] that the HMO meet state requirements for health insurers respecting initial capitalization and establishment of financial reserves against insolvency that would prevent it from doing business in the state; and 5. Impose requirements which would prohibit the HMO from complying with requirements of the HMO Act.”

51. In fewer than 40 HMOs. P.D. Fox & P.R. Kongstvedt, *Chapter 1: Origins of Managed Healthcare*, THE ESSENTIALS OF MANAGED HEALTHCARE (P.R. Kongstvedt, ed., 2007).

52. InterStudy Competitive Edge, Vol. 2, No. 2 (Minneapolis InterStudy 1993) p. 1.

about the likely consequences of their coverage—other than a short run reduction in out-of-pocket costs—because they had no practical alternative. Thanks to previous turns of the regulatory ratchet, most of them found that the principal alternative, purchasing their own health insurance, had become unavailable or prohibitively expensive.

Had a practical alternative existed, it would have become extraordinarily attractive once the unfortunate consequences of Medicare and employer-purchased HMO health insurance became manifest. Indeed, the demand for a less restrictive alternative to HMOs prompted the eventual development of “Preferred Provider Organizations” which reimbursed “out-of-network” medical care but at a lower rate than for “in-network” care, and employees flocked to them.⁵³ But the development of PPOs took time. Extensive insurance regulation slowed the creation of PPOs. So, too, did the fact that PPOs did not appeal to some executives of employer-purchasers as much as they appealed to their employees.

As the unfortunate consequences of Medicare and employer-purchased HMO health insurance became manifest, legislators stood to gain by railing about “‘heartless’ bureaucrats administering the PPS regime”⁵⁴ and “‘greedy’ executives managing HMOs”⁵⁵—bureaucrats and executives who had done no more than conform to the laws passed by these legislators or respond to the incentives that these laws generated.

53. According to the Bureau of Labor Statistics’ Employee Benefits Survey, participation in PPOs increased from 1% to 1986 to 16% in 1991 while participation in HMOs increased from 14% to only 17%. Laura A. Scofea, *The Development and Growth of Employer-Provided Health Insurance*, MONTHLY LABOR REVIEW 3, 9 (Mar. 1994). In 1983, Congress discontinued subsidies for HMOs. Pub. L. 97–35, title IX, § 947(c), Aug. 13, 1981, 95 Stat. 577. Enrollment in HMOs continued to grow, fueled in large part by Medicare and Medicaid recipients, but enrollment in PPOs grew faster. By 2006, enrollment in HMOs amounted to 77.7 million; in PPOs 81 million. P.D. Fox & P.R. Kongstvedt, *Chapter 1: Origins of Managed Healthcare*, THE ESSENTIALS OF MANAGED HEALTHCARE (P.R. Kongstvedt, ed., 2007) (the authors acknowledge that it is difficult to classify hybrid plans). According to Managed Care Online (MCOL), by 2015, enrollment in HMOs had risen to 90.4 million, while enrollment in PPOs had grown to 156.4 million. *Managed Care Fact Sheets: Current Enrollments*, MANAGED CARE ONLINE, http://www.mcol.com/current_enrollment (the ratios are accurate, but the numbers are not because the study double counted spouses and dependents who had dual coverage and includes High Deductible Health Plans (HDHPs) which are classified as either HMOs or PPOs).

54. Delegating authority to bureaucrats enables the delegating legislators to mimic Captain Reneau in Casablanca, expressing their shock, shock, that the bureaucrats responded to the incentives created by the legislators. Holman W. Jenkins, *Libertarian Dream of Pharmaceuticals*, WALL ST. J. (OCT. 30, 2015), <https://www.wsj.com/articles/libertarian-dream-of-pharmaceuticals-1446238152>.

55. Such railing was part of John Edwards’ successful 1998 campaign for the Senate. Time magazine reported that:

at a panel discussion in Raleigh[,] [h]e condemned “health-care bureaucrats” who overrule doctors in determining a patient’s treatment, and asked, “Are we gonna put the law on the side of the patient or . . . leave it on the side of the big insurance companies?”

James Carney, *A Republican Who’s Taking His Medicine*, TIME (July 13, 1998) at p. 30.

Legislators also stood to gain by appearing to “do something” about those unfortunate consequences.

D. What’s a Politician to Do? Mandate More Coverages and More Elaborate Claims Review Processes

Both Congress and state legislatures required that HMOs and other health insurance companies cover more services.⁵⁶ To illustrate, New Jersey required coverage of extended stays in the hospital for women after giving birth,⁵⁷ and most other states followed suit⁵⁸ until Congress made the requirement nationwide.⁵⁹ In 1996, Congress required that HMOs cover a laundry list of medical services.⁶⁰

56. According to data compiled by the Council for Affordable Health Insurance, total state coverage mandates numbered 2,262 in 2011 (Victoria Bunce & JP Wieske, HEALTH INSURANCE MANDATES IN THE STATES 2011, Council for Affordable Health Insurance (Mar. 8, 2012), <https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=8&cad=rja&uact=8&ved=0ahUKEwiv09uW2qnbAhWFCTQIHQXMBk4QFghmMAc&url=https%3A%2F%2Fflintvwpri.files.wordpress.com%2F2013%2F10%2Fmandatesinthestates2011execsumm.pdf&usg=AOvVaw2AGgbv3GLyDd0KkQjoxcJ>) up from 1,961 in 2008 (Victoria Bunce & JP Wieske, HEALTH INSURANCE MANDATES IN THE STATES 2008, Council for Affordable Health Insurance (2009), <https://www.heartland.org/publications-resources/publications/health-insurance-mandates-in-the-states-2008>), and just a handful in the 1960s (Victoria Bunce & JP Wieske, *Mandate Update*, WALL ST. J. (Feb. 8, 2008)).

57. 1995 N.J. Sess. Law Serv. 452.

58. Debra S. Wood, *Risky Business: Lending to Health Maintenance Organizations and Physician Practice Management Companies*, 1 N.C. BANKING INST. 322, 350 (1997).

59. NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996, 29 USCA §1185, 42 USCA §300GG-4, AND 42 USCA §300GG-51.

60. 42 U.S.C.A. § 300e.

A health maintenance organization shall provide, without limitations as to time or cost other than those prescribed by or under this subchapter, basic and supplemental health services to its members in the following manner:

- (1) Each member is to be provided basic health services for a basic health services payment ...

42 U.S.C.A. § 300e-1 defines “basic health services” as

- (A) physician services (including consultant and referral services by a physician);
- (B) inpatient and outpatient hospital services;
- (C) medically necessary emergency health services;
- (D) short-term (not to exceed twenty visits), outpatient evaluative and crisis intervention mental health services;
- (E) medical treatment and referral services (including referral services to appropriate ancillary services) for the abuse of or addiction to alcohol and drugs;
- (F) diagnostic laboratory and diagnostic and therapeutic radiologic services;
- (G) home health services; and
- (H) preventive health services (including (i) immunizations, (ii) well-child care from birth, (iii) periodic health evaluations for adults, (iv) voluntary family

Many state legislatures also mandated more elaborate claims review processes for HMOs and other health insurers. For example, New York required that HMOs and other health insurers provide for appeals of some adverse coverage decisions to a wholly unaffiliated agent in addition to their internal appeal processes.⁶¹ All states have adopted analogous legislation.⁶²

These mandates, however, could not reverse the reduction in medical care caused by HMOs because HMOs caused the reduction by creating incentives to providing less covered medical service. HMOs, whose profitability depends on creating such incentives, created them via the structure of physician compensation, care protocols, and barriers to referral.⁶³ Neither coverage nor claims review mandates affect these disincentives.

Nevertheless, mandating more coverage probably appeared to “do something” about the reduction in medical care caused by HMOs. After all, these mandates could be expected to, and no doubt did, result in some people receiving more medical services than they would have received

planning services, (v) infertility services, and (vi) children's eye and ear examinations conducted to determine the need for vision and hearing correction).

Such term does not include a health service which the Secretary, upon application of a health maintenance organization, determines is unusual and infrequently provided and not necessary for the protection of individual health. The Secretary shall publish in the Federal Register each determination made by him under the preceding sentence.

61. 1998 N.Y. Laws Ch. 586 § 11, N.Y. Pub. Health Law §§ 4910 to 4916, N.Y. Insurance Law §§ 4910 to 4916.

62. Leatrice Berman-Sandler, *Independent Medical Review: Expanding Legal Remedies to Achieve Managed Care Accountability*, 13 ANNALS OF HEALTH LAW 233, 238 (2004).

63. *Pegram v. Herdrich*, 530 U.S. 211, 219 (2000), the Supreme Court observed:

Like other risk-bearing organizations, HMOs take steps to control costs. At the least, HMOs, like traditional insurers, will in some fashion make coverage determinations, scrutinizing requested services against the contractual provisions to make sure that a request for care falls within the scope of covered circumstances (pregnancy, for example), or that a given treatment falls within the scope of the care promised (surgery, for instance). They customarily issue general guidelines for their physicians about appropriate levels of care. And they commonly require utilization review (in which specific treatment decisions are reviewed by a decision maker other than the treating physician) and approval in advance (precertification) for many types of care, keyed to standards of medical necessity or the reasonableness of the proposed treatment. These cost-controlling measures are commonly complemented by specific financial incentives to physicians, rewarding them for decreasing utilization of health-care services, and penalizing them for what may be found to be excessive treatment, [citations omitted]. *Hence, in an HMO system, a physician's financial interest lies in providing less care, not more* (emphasis added).

Id. at 219.

otherwise, which sounds like a remedy for a reduction in medical care. So too does mandating more elaborate review processes because denied claims may result in a covered individual foregoing a medical service.⁶⁴ No doubt, the beneficiaries and their loved ones were pleased and stories about them played well in the media.

Proponents of these mandates argued that these “patient rights” would protect the sick from “denials of service” by “greedy” owners and senior managers of HMOs and health insurers. Interestingly, the “greedy” owners and senior managers of HMOs and health insurers, the most likely opponents of these state mandated “patients’ rights,” mounted little in the way of opposition. Perhaps they doubted their chances of political victory—or the duration of any such victory. Perhaps they feared that victory would serve mainly to fuel demand for more onerous regulation.⁶⁵ But some of them probably saw the upside of these “patient rights:” slowing the entry of competitors and eliminating some forms of competition.⁶⁶

The mandates themselves probably helped speed information about how HMOs caused reductions in medical care toward the “black hole.” Mandating additional coverages made it even more difficult to analyze the physician compensation structures, care protocols, and referral rules used by HMOs. Mandating a more elaborate claims review process likely rendered some denied claims less visible by raising the cost of seeking review and thereby deterring some people from seeking it.⁶⁷ More importantly, a more elaborate claims review process made denials look less callous and ham-handed and thereby tempered media interest in them. Less visibility and media interest reduced the chances that members of the public would learn of the denials—and this itself would foster the appearance that “something” had been “done” about “denials of service.”

The coverage mandates may well have indirectly exacerbated the reductions in medical care caused by HMOs. Requiring HMOs and health insurers to cover more treatments and procedures triggers a rise in

64. Reversal of an insurer’s denial of coverage does not necessarily result in timely delivery of the services in question. *Independent Medical Review Experiences in California, (IMR) Phase II: Cases Including Medical Necessity*, INST. FOR MED. QUALITY, CAL. HEALTHCARE FOUNDATION (2003), <https://zdoc.site/independent-medical-review-expanding-legal.html>.

65. So, too, would the fact that most of the providers who incurred these costs would incur them years after the legislation passed.

66. Robert Goldberg, *Why HMOs Now Love Regulation*, WALL ST. J. (July 17, 1998), at A15 col. 4.

67. Karen Politzet al., *Assessing State External Review Programs and the Effects of Pending Federal Patients’ Rights Legislation*, Kaiser Family Foundation (2002). David M. Studdertand & Carole Roan Gresenz, *Enrollee Appeals of Preservice Coverage Denials at 2 Health Maintenance Organizations*, 289 JAMA 864, 864 (2003).

premiums,⁶⁸ prompting some potential customers to forego some health insurance coverage; and some people with less coverage may have foregone some medical care. The greater the reduction in medical services, the greater the political advantage of once again appearing to “do something” about this unfortunate consequence.

E. More State Mandates: Coverage, “Community Rating,” and “Guaranteed Issue”

State legislatures could have actually done something about the reduction in medical services caused by HMOs.⁶⁹ They could have repealed or relaxed the health insurance regulations that limit entry, impose costs, and set premiums all of which help keep the price of health insurance up and the choice of policies down.⁷⁰ For example, state legislatures could have repealed their limits on the sale of health insurance policies issued by out-of-state insurers.⁷¹ But these measures lacked the political appeal of additional turns of the regulatory ratchet (besides, the potential political advantage of appearing to do something about the unfortunate consequences of HMOs declined as PPOs expanded their membership at the expense of HMOs).

Many legislatures adopted still more coverage mandates. For example, New York mandated coverage for alcohol and substance abuse treatment

68. Michael J. New, *The Effect of State Regulations on Health Insurance Premiums: A Preliminary Analysis*, Heritage Center for Data Analysis (October 27, 2005); William J. Congdon, Amanda Kowalski, & Mark H. Showalter, *Effect of State Regulations on the Price of Health Insurance Policies in the Non-Group Market*, Council of Economic Advisors, Washington, D.C. (July 23, 2004) (“Mandated benefits raise the expected price of an individual policy by approximately 0.4 percent per mandate. For family policies the increase is approximately 0.5 percent per mandate. The typical state has about 20 mandates (with a range from 6 to 48) so a reduction from 20 to 10 mandates would imply a 4 percent decrease in price for individual policies, and a 5 percent decrease for family policies.”)

69. Congress could have amended the income tax laws to give health insurance premiums the same treatment regardless of whether an individual or his employer purchased a policy. This would have made it appreciably cheaper for an individual to purchase his own policy and thereby escape his employers’ HMO gatekeepers.

70. State legislatures could have advanced this goal indirectly by limiting the risks created by malpractice liability.

71. The McCarran Ferguson Act places federal limits on the sale of cross border insurance policies, limits which were somewhat eased by ERISA and the Gramm-Leach-Bliley Act. Congress could have eased these limits further or eliminated them. A 2009 Manhattan Institute study reported the results of (i) a survey of New Yorkers showing that approximately 25% of the respondents would consider crossing state lines to buy insurance and (ii) a simulation showing that, if 25% percent of New Yorkers did just that, the number of uninsured New Yorkers would decline by 17%. Stephen T. Parente & Tarren Bragdon, *Healthier Choice: An Examination of Market-Based Reforms for New York’s Uninsured*, MANHATTAN INSTITUTE (Sept. 22, 2009), <https://www.manhattan-institute.org/html/healthier-choice-examination-market-based-reforms-new-yorks-uninsured-5937.html>.

in 1987,⁷² and in 1988, certain out-patient mental health care⁷³ and annual mammography screening for occult breast cancer for patients over forty-nine years old.⁷⁴ In the early 1990s, eight states did more; Kentucky,⁷⁵ Maine,⁷⁶ Massachusetts,⁷⁷ New Hampshire,⁷⁸ New Jersey,⁷⁹ New York,⁸⁰ Vermont,⁸¹ and Washington⁸² adopted “community rating,” “guaranteed issue” requirements, or both.

In its pure form, “community rating” requires an insurer to charge everyone in a given plan the same premium regardless of health and characteristics correlated with health such as age and sex. To illustrate, suppose that a healthy young woman and a sickly old man apply for the same coverage under the same plan. The insurer must charge the relatively low-risk woman the same premium as the relatively high-risk man. The insurer in this illustration would go bankrupt in short order if it were to charge both customers the premium actuarially-dictated for the healthy young woman. It must charge a premium higher than this. A higher premium, however, will make the policy less attractive to her and other low risk individuals, and fewer low-risk customers will require that the insurer either raise the premium for the same coverage or offer less coverage for the same premium. The threat of this vicious cycle, aggravated by mandated coverages, could—and did⁸³—prompt insurers to exit the states that embraced community rating.

Relaxing the community rating requirement can reduce, but not eliminate, the viciousness of this spiral. Kentucky, Maine, Massachusetts, New Hampshire, and Washington embraced relaxed community rating requirements upon adoption; New Jersey and Washington did later.⁸⁴

72. 1987 N.Y. Sess. Law Serv. 444 (McKinney).

73. 1988 N.Y. Sess. Law Serv. 98 (McKinney).

74. 1988 N.Y. Sess. Law Serv. 692 (McKinney). New York continued to mandate coverages, including treatment of autism spectrum disorder. 2013 Sess. Law News of N.Y. Ch. 56 (S. 2606-D) (McKinney).

75. Act of Apr. 15, 1994, Ch. 512, 1994 Ky. Acts 512, §55.

76. Act of July 13, 1993, Ch. 477, 1993 Me. Laws 477.

77. Act of July 24, 1996, Ch. 203, 1996 Mass. Acts 203.

78. Act of June 6, 1994, Ch. 294 1994 N.H. Laws 294.

79. Individual Health Insurance Reform Act, Ch. 161, 1992 N.J. Laws 161.

80. Act of July 17, 1992, Ch. 501, 1992 N.Y. Laws 501.

81. Act of May 11, 1992, 1991 Vt. Laws 160.

82. Act of May 17, 1993 Ch. 492, 1993 Wa. Sess. Laws 492.

83. Christopher F. Koller, *Small Group Health Insurance Reform in New Hampshire, Report of the Office of the Health Insurance Commissioner of Rhode Island to the Joint Committee on Health Care Oversight* (Feb. 2006), http://www.dbr.state.ri.us/documents/divisions/healthinsurance/HI-060227_NH_Reforms.pdf p. 24. A number of insurers had exited the New Hampshire market because it was less desirable for doing business there due to the restrictions on health insurer practices. This created the death spiral and deductibles were too high that lead to further declines in enrollment. *Id.* at p. 2.

84. 2008 N.J. LAWS 561-562 (Ch. 38, § 9 (“Modified community rating”)) (amending N.J. Stat. Ann. § 17B:27A-2; Act of Mar. 23, 2000, Ch. 79, 2000 Wa. ALS 79).

These relaxed requirements permitted premiums to reflect specified risk characteristics while limiting the variation in premiums that some of these characteristics could trigger. For example, Kentucky permitted premiums to reflect age, geography, and family composition, but it prohibited charging “the oldest policyholder in the group . . . more than three times the amount charged the youngest”⁸⁵ and it limited geographic adjustments to 15%.⁸⁶

In its pure form, “guaranteed issue” requires an insurer to sell a policy to anyone who pays the premium for it—regardless of the purchaser’s health status. Obviously, this requirement creates an incentive to delay purchasing insurance until its benefits can be claimed. Such delay increases the cost of providing health insurance because it makes assessing risk considerably more difficult, and it does so while simultaneously reducing revenues. To survive, an insurer must respond to this threat. It could charge higher premiums, reduce coverages, or both, which would make health insurance still more unattractive to people in relatively good health. Alternatively, it could exit the market. Exiting insurers, along with rising premiums and reduced coverages,⁸⁷ led Washington to modify “guaranteed issue” to allow insurers to refuse to sell to individuals identified by a standard state questionnaire as “high risk.”⁸⁸ Escalating premiums and declining coverages (often taking the form of higher deductibles) as well as exiting insurers led Kentucky⁸⁹ and New Hampshire⁹⁰ to abandon both “guaranteed issue” and “community rating,” Kentucky in 2004; New Hampshire in 2002. Massachusetts, New

85. Act of Apr. 15, 1994, ch. 512, 1994 Ky. Acts 512, §55; Michael Clark and Ginny Wilson “Market Responses to Kentucky’s Health Insurance Reforms” Center for Business and Economic Research, University of Kentucky, Gatton College of Business and Economics (Jan. 1998) <http://cber.uky.edu/Downloads/health99.htm>.

86. Act of Apr. 12, 1996, Ch. 371, 1996 Ky. Acts 371, §9.

87. According to Peter Suderman, *The Lesson of State Health-Care Reforms*, WALL ST. J. (Oct. 7, 2009), at A21, a 1999 study presented at the annual meeting of the Association for Health Services Research reported that some Washington state health insurance premiums rose 78% in the three years following the guaranteed issue mandate and that within four years, all major carriers declined to offer individual insurance plans covering maternity.

88. Act of Mar. 23, 2000, Ch. 79, 2000 Wa. ALS 79. Leigh Wachenheim & Hans Leida, *The Impact of Guaranteed Issue and Community Rating Reforms on States’ Individual Insurance Market*, Milliman Report to America’s Health Insurance Plans (Mar. 2012) p. 49, <http://docplayer.net/4806428-The-impact-of-guaranteed-issue-and-community-rating-reforms-on-states-individual-insurance-markets.html>. Those identified were eligible for Washington’s high-risk pool insurance.

89. Act of Apr. 2, 2004, Ch. 59, 2004 Ky. Acts 59.

90. Act of July 17, 2001, Ch. 295: 3, 2001 NH ALS 295. Christopher F. Koller, *Small Group Health Insurance Reform in New Hampshire*, Report of the Office of the Health Insurance Commissioner of Rhode Island to the Joint Committee on Health Care Oversight (Feb. 2006) p. 24, http://www.dbr.state.ri.us/documents/divisions/healthinsurance/HI-060227_NH_Reforms.pdf. A number of insurers had exited the New Hampshire market because it was less desirable for doing business there due to the restrictions on health insurer practices. This created the death spiral and deductibles were too high that lead to further declines in enrollment. *Id.* at p. 2.

Jersey, and New York retained both, practically insuring that health insurance premiums in these states would exceed premiums in other states by a wide margin.

F. Congress Doubles Down: “Obamacare”

Congress could have done something about the reductions in medical care caused by both the PPS regime and HMOs. It did not. It certainly declined to reverse any previous turns of the regulatory ratchet. Indeed, it double downed on many of them⁹¹ when it enacted the Patient Protection and Affordable Care Act,⁹² frequently abbreviated as the “ACA” and commonly known as “Obamacare.” (It also mandated a yet more elaborate claims review process.⁹³) For example, rather than attempt to weaken the link between employment and health insurance, the ACA attempts to strengthen the link with an “employer mandate.” This mandate applies to employers who had 50 or more employees working “full time”—at least 30 hours per week—in the preceding year.⁹⁴ The ACA provides that these employers must offer ACA-compliant health insurance to at least 95% of his employees and the employees’ dependents or become subject to a non-deductible fine, which the ACA calls an

91. Congress double downed on the PPS regime by providing for the creation of an unusually independent administrative agency—the Independent Payment Advisory Board or “IPAB”—empowered to cut Medicare payments to doctors and hospitals if government actuaries were to find that Medicare spending would soon exceed specified caps and Congress failed to promptly prevent this from happening. 42 U.S.C. § 3403 (2010). Congress repealed this provision before the IPAB came into existence. Bipartisan Budget Act of 2018, Pub.L. 115-123 § 52001.

92. The Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (to be codified at 26 USC § 38B(c)(2)(C)(i)(I),(II)), 124 Stat. 910 (2010), amended by The Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 216. For further analysis, *see*, Kopp, Paley, Bacon and Foster on Health Care Reform Legislation, 2010 Emerging Issues 4954 (LexisNexis).

93. Patient Protection and Affordable Care Act, 111 Pub. L. No. 148, 124 Stat. 119 §§ 2719 and 3321 (implemented by 45 C.F.R. § 147.140 and a series of “technical releases” issued by the Department of Labor available at <https://www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/technical-releases>

94. The ACA made the employer mandate effective in 2013, but President Obama and several executive agencies, including the Department of the Treasury and the Centers for Medicare & Medicaid (CMS), announced that they would delay its enforcement. In 2013, they announced a delay until 2015. In 2014, they announced that the delay would continue until 2016 for employers who had less than 100 covered employees. In 2014, they also announced that they would provide some relief for employers with 100 or more covered employees during the 2015 “transition” period.⁹⁴ These employers could:

- (1) fulfill the employer mandate by offering compliant health insurance only to employees working 35 or more hours per week (but an employer doing this would have to certify that it had not shrunk employee numbers in order to qualify), and
- (2) avoid some penalties by showing that they offer complying health insurance to at least 70% of their full-time workers.

“assessment payment.”⁹⁵

Rather than eliminate state insurance coverage mandates, the ACA mandates its own. To be ACA-compliant, health insurance sold to individuals or small employers must cover “essential benefits.”

According to Congress,⁹⁶ these include:

- preventive and wellness services,⁹⁷

95. If an employer subject to the ACA fails to offer health insurance providing statutorily determined “minimum essential benefits,” he may have to pay a fine if one of his full-time employees purchases his own insurance and receives a subsidy in the form of a “premium tax credit.” 26 USCA § 4980H (“Shared Responsibility for Employers Regarding Health Coverage”). The ACA set this fine initially at \$166.67 per month (\$2,000 per year) for each full-time employee in excess of 30 and provided for annual adjustment of the amount. In 2017 the fine is \$188.33 per month (\$2,260 per year). Even an employer who offers health insurance providing statutorily defined “minimum essential benefits” to at least 95% of his employees and the employees’ dependents may become subject to a fine if (1) he failed to offer it to the full-time employee who purchased his own insurance and received a “premium tax credit” or (2) if the premium for the insurance that he offered exceeded 9.66% of that employee’s “adjusted” income. In these two situations, the ACA set the fine initially at \$250 per month (\$3,000 per year) for each employee who receives a “premium tax credit.” The fine is adjusted annually; in 2017 it is \$282.50 per month (\$3,390 per year) IRS. See *Employer Shared Responsibilities Provisions*, IRS, <https://www.irs.gov/affordable-care-act/employers/employer-shared-responsibility-provisions> (last visited Sept. 9, 2017). An employer may also become subject to a fine for requiring eligible employees to wait more than 90 days for coverage. PPACA § 4980H(b)(1) – (3).

96. 42 U.S.C. § 18022(b)(1) (2012). The statute empowers the Secretary of Health and Human Services to specify required services for each statutory category. 42 U.S.C. § 18022(b)(2) (2012). These requirements, which are reviewed periodically, vary based on the state requirements. Section 18022(b)(4) (2012) sets forth the factors that the Secretary must consider when setting these requirements. On February 20, 2013, the Health and Human Services released a final rule setting forth health insurance issuer standards related to the coverage of essential health benefits. *Information on Essential Health Benefits (EHB) Benchmark Plans*, Center for Medicare and Medicaid Services, <https://www.cms.gov/ccio/resources/data-resources/ehb.html> (last visited Sep. 5, 2017).

97. The Health Resources and Services Administration interpreted “preventive and wellness services” as including annual well-woman preventive care visits, including preconception and prenatal care, screening for gestational diabetes, HPV testing for women over 30 (no more than once every three years), annual counseling on sexually transmitted infections for all sexually active women, annual counseling and screen for HIV, breastfeeding support and counseling (including the cost of renting breastfeeding equipment), annual screening for urinary incontinence, post-pregnancy screening for diabetes mellitus annual screening and counseling for interpersonal and domestic violence, and all FDA-approved contraceptive methods, sterilization methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity, as prescribed. HRSA Women’s Preventive Services Guidelines Notice, 81 Fed. Reg. 95148 (Dec. 27, 2016). HRSA Women’s Preventive Services Guidelines Notice, 83 Fed. Reg. 8487 (Feb. 27, 2018) added annual screening for urinary incontinence and post-pregnancy screening for diabetes mellitus. These HRSA guidelines become law by virtue of Treas. Reg. §54.9815-2713T(a)(1)(iv):

(a) Services—(1) In general. A group health plan, or a health insurance issuer offering group health insurance coverage, must provide coverage for and must not impose any cost-sharing requirements (such as a copayment, coinsurance, or a deductible) for— (iv) With respect to women, such additional preventive care and screenings not described in paragraph (a)(1)(i) of § 54.9815-2713 as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

- ambulatory services,
- pediatric services, including oral and vision care,
- maternity and newborn care,
- treatment of mental health and substance abuse,
- prescription drugs,
- emergency services,
- hospitalization,
- laboratory services, and
- rehabilitative care.⁹⁸

Rather than embrace mechanisms used by commercial insurance companies to cope with moral hazard risk, the ACA prohibits or limits the use of these mechanisms. Compliant policies may not saddle an insured individual with the annual cost of “essential benefits” in excess of specified dollar amounts⁹⁹ (zero in the case of preventative and wellness services is zero¹⁰⁰), nor may they limit the total annual or lifetime benefits paid for an insured.¹⁰¹ Requiring unlimited annual and lifetime benefits makes capping total outlays, and therefore risk, appreciably more difficult. Limiting the annual costs of “essential services” that a customer may bear—limits on the “out-of-pocket” maximum and annual deductible—adds to this difficulty. More importantly, these limits restrict the ability of an insurer to give its customers an incentive to economize on covered services.

On the whole, Obamacare functions much like Medicare even though it uses different mechanisms. It is the difference in mechanisms that makes Obamacare more vulnerable politically, as I will explain shortly.

The ACA’s coverage mandates and prohibitions and limitations on the use of mechanisms to cope with moral hazard risk put considerable upward pressure on premiums. Even more pressure derives from the ACA provisions mandating that premiums comport with “community rating”

98. PPACA § 1302 (“Essential Health Benefits Requirements”). Even catastrophic-only policies, which insurers may sell to those under age 30 must cover “essential benefits” and allow for at least three visits to a primary care provider. Employers offering “minimum essential coverage” must provide qualified employees with a voucher that can be applied to purchase of a health plan through an “insurance exchange.”

99. 42 U.S.C.A. § 300gg-13. In 2017, the “out-of-pocket” maximum is \$7,150 for an individual customer, \$14,300 for a family (The “out-of-pocket” maximum is lower for a customer whose income falls below 400% of the statutorily defined “poverty level.” It is also lower—\$6,550 for an individual, \$13,100 for a family—for a policy that may be used in connection with a Health Savings Account (“HSA”). The annual deductible may not exceed \$2,600 for an individual, \$5,150 for a family. The ACA also prohibits a compliant policy from limiting an insured’s choice of network doctors or requiring pre-approval for covered care in an emergency room. 42 U.S.C.A. § 300gg-19a.

100. This provision became effective immediately.

101. 42 U.S.C. § 300gg-17.

requirements¹⁰² and that insurance companies abide by its “guaranteed issue” policy.¹⁰³

This pressure may have been mitigated in the short term by the ACA’s limit on an insurance company’s “medical loss ratio” or “MLR,” the ratio between benefits paid and premiums charged. Under the ACA, the federal government requires insurers to spend 80% of revenue from premiums received for individual and small-business plans on health benefits. For large employer plans, the share is 85%. If an insurer falls short, it has to rebate the extra money to customers. In the long run, however, the MLR limit may reinforce the upward pressure on premiums by giving insurers an incentive to accept price increases by doctors, hospitals, and pharmaceutical makers. Accepting a price increase permits an insurer to raise its premiums without running afoul of the MLR limit, and if it raises its premiums, it can retain 20% or 15% of the higher premium. To illustrate, suppose the premium for an individual policy is \$100; the insurer spends \$80 on benefits and retains \$20. Now suppose that a hospital increases the price of a covered service by \$20. The insurer now spends \$100, so it raises the premium to \$125, keeps \$25, and still complies with the MLR limit.

The upward pressure on premiums was mitigated by transfers administered by the Department of Health and Human Services (“HHS”) from insurers with relatively low cost or low risk insureds to insurers with relatively high cost or “high-risk” insureds. The “risk corridor” and “reinsurance” programs, which expired in 2016, provided for transfers to insurers with relatively high-cost insureds, but never paid what they promised to pay. The “risk adjustment” program provides for payments to insurance companies with relatively “high risk” insureds. “High risk” appears in quotation marks because the HHS calculates each insurer’s risk profile on the basis of information submitted by each insurer about the

102. Under the ACA, insurers may vary rates based on the number of family members enrolled in the plan, charge different rates in different areas across within a state, charge older adults as much as 3 times what the insurers charge younger ones, and charge tobacco users as much as 1.5 times what they charge those who do not use tobacco products.

103. The “community rating” and “guaranteed issue” requirements became effective in 2014 except for “grandfathered” plans, plans in effect on the day that Obamacare was enacted, March 23, 2010, which had not undergone any substantial change. The ACA barred these plans from enrolling any new insureds. Meanwhile, the number of insured dwindled with each passing year as individuals covered by grandfathered plans went to work for a different employer, moved to a different state, found a different plan more attractive, aged into Medicare, or died. In North Carolina, for example, BlueCross BlueShield of North Carolina saw the number of individuals covered by its grandfathered plans drop from about 330,000 in 2010 to about 50,000 in 2017. See Gary Bolt, *ACA Grandfathered Plans Will Expire Dec. 31, 2017 – Individual Customers have Options for 2018 ACA Coverage*, BLUE CROSS BLUE SHIELD (Aug. 16, 2017), <http://blog.bcbnsnc.com/2017/08/aca-grandfather-plans-will-expire-dec-31-2017-customers-options-2018-aca-coverage/>. As no new customers had joined this pool since 2010, the pool of insureds not only shrank but became older and sicker, and so more expensive to insure. Effective January 1, 2018, the company discontinued its grandfathered plans. *Id.*

demographics of its insureds and the clinical codes for their treatment; codes that lend themselves to favorable selection by the insurer.

Despite these transfers, the average premiums in the individual market of the 39 states where Obamacare exchanges are federally run increased 105% from 2013 to 2017, according to the Health and Human Services Department.¹⁰⁴ In dollar terms, this increase amounts to about \$3,000 a year for the average family.¹⁰⁵

Higher premiums always prompt some purchasers of health insurance to economize. Some individuals who would have purchased health insurance for themselves or their families will decline to do so.¹⁰⁶ The demand dampening effect of higher premiums may be offset for some because of subsidies, paid as tax credits, authorized by the ACA.¹⁰⁷ These subsidies are available, however, only to people who earn less than 400% of the “poverty level” and who purchase insurance on Obamacare exchanges, where fewer policies are offered each year.

Because of higher premiums some employers who would have purchased health insurance for their employees will decline to do so—even though they become subject to fines under Obamacare. For many employers, the fine would amount to considerably less than the cost of the insurance.¹⁰⁸ Moreover, employers can escape the ACA and avoid the risk of fines for violating its employer mandate by employing fewer than 50 or more individuals working at least 30 hours per week. Such an employer might substitute independent contractors for employees or reduce the working hours of the people that they do employ.¹⁰⁹ Some potential employers may refrain from expanding or never set up shop.

Even as premiums have risen, insurers have cut back on the variety of policies they offer and their provider networks,¹¹⁰ and some have simply exited many states and counties. They have done so largely to avoid the vicious spiral threatened by Obamacare’s “community rating” and “guaranteed issue” requirements. The exit began on a relatively small

104. Dep’t of Health and Hum. Serv., *Individual Market Premium Changes: 2013-2017*, <https://aspe.hhs.gov/system/files/pdf/256751/IndividualMarketPremiumChanges.pdf>.

105. *How to Read an ObamaCare Prediction*, WALL ST. J. (May 25, 2017), at A10.

106. Scott Thurm, *Restaurant Chains Cut Estimates for Health Law Costs*, WALL ST. J. (March 27, 2013).

107. If an employer subject to the employer mandate fails to offer ACA-compliant insurance to one or more of his employees, these employees may purchase such insurance on Obamacare “exchanges” and become eligible for taxpayer funded subsidies.

108. Philip Breeden, *Obamacare’s Incentive to Drop Insurance*, WALL ST. J. (Oct. 21, 2010), at A17; Janet Adamy, *Uncle Sam to Pay More of the Tab for Health*, WALL ST. J. (July 28, 2011).

109. Julie Jargon, Louise Radnofsky, & Alexandra Berzon, *Health-Care Law Spurs a Shift to Part-Time Workers*, WALL ST. J. (Nov. 5, 2012).

110. Debra J. Saunders, *Obamacare’s next problem: Doc shock*, SAN FRANCISCO CHRONICLE (Dec. 11, 2013); Chad Terhune, *Insurers Limiting Doctors, Hospitals in Health Insurance Market*, LOS ANGELES TIMES (Sept. 14, 2013).

scale shortly after the ACA was passed when the “guaranteed issue” requirement became effective for policies covering only “children” 26 years of age or younger.¹¹¹ Aetna, Cigna, WellPoint, Humana, and UnitedHealth Group’s Golden Rule subsidiary stopped selling new child-only policies.¹¹² The “guaranteed issue” requirement became generally applicable in 2014. In 2017, Allegian, Community First, UnitedHealthcare, Coordinated Health Mutual, Healthspan, Wellcare, Health Choice, and Scott and White withdrew from the individual health insurance marketplace.¹¹³ In 2018, Aetna, Humana, and Affinity did likewise.¹¹⁴

Higher insurance policy premiums are likely to command and hold the attention of health insurance customers much more than higher Medicare payroll taxes are to command and hold the attention of taxpayers. Likewise, reductions in insurance policy options are likely to command and hold the attention of health insurance customers more than limited Medicare options are to command and hold the attention of present and future participants in this practically compulsory government program. Moreover, the higher premiums and reduced policy options caused by Obamacare have been brought home annually. This is because a typical health insurance policy has a one-year term and because, until 2018, most people not covered by employer-purchased ACA-compliant insurance risked a fine every year if they failed to purchase one for themselves (Obamacare’s “individual mandate”). As a result, the causal relationship between Obamacare, on the one hand, and higher premiums and reduced options, on the other, has not slipped beyond the event horizon into an informational “black hole”—despite efforts at information suppression. These efforts include (1) widely publicized committee hearings during which Senators or Representatives demand that insurance executives justify their premium increases¹¹⁵ and (2) scrutiny of such increases by the Department of Health and Human Services which opines on their “reasonableness.”¹¹⁶ This may help explain why Congress managed to

111. Julian Pecquet, *Stronger Children’s Coverage Rules May Raise Insurance Costs*, THE HILL (July 25, 2010), <https://thehill.com/policy/healthcare/110775-stronger-rules-for-childrens-health-coverage-may-raise-insurance-costs>.

112. Janet Adamy & Avery Johnson, *Rate Increases Denied to Some Private Medicare Plans*, WALL ST. J. (Sept. 22, 2010).

113. **Error! Main Document Only.** Rachel Fehr, Cynthia Cox & Larry Levitt, *Insurer Participation on ACA Marketplaces, 2014–2019*, Kaiser Fam. Found. (Nov. 14, 2018), <https://www.kff.org/health-reform/issue-brief/insurer-participation-on-aca-marketplaces-2014-2019/> (follow “Map Data” direct download link).

114. *Id.*

115. *See, e.g.*, the February 2010 hearings before the Oversight and Investigations Subcommittee of the Committee on Energy & Commerce of the House of Representatives. At the February 24, 2010 session, members of the Subcommittee grilled Angela Bray, then CEO of Wellpoint, Inc., about the company’s planned premium increases and her critique of what became Obamacare.

116. Janet Adamy, *Health-Plan Rates to Draw Scrutiny*, WALL ST. J. (Dec. 22, 2010), at B1.

repeal the “individual mandate” effective January 2019, and came close to repealing or cutting back the reach of other key Obamacare provisions.

As long as the other key provisions are neither repealed nor cut back, Obamacare will continue to keep premiums up and policy options down. This will cause some people to incur uninsured medical expenses and cause some to forego the timely receipt of some medical services. This state of affairs may prove unsustainable politically. The individuals suffering these unfortunate consequences and their self-styled advocates will demand that “something be done” about them. Commercial insurance companies will probably not “solve” the “problem” because the ACA has made it difficult to do so profitably. This will make additional turns of the regulatory ratchet attractive to many politicians.

PART III: THE UTILITY OF THE REGULATORY RATCHET MODEL

That regulation tends to beget more regulation does not qualify as breaking news. Indeed, opponents of some proposed regulation, including Obamacare,¹¹⁷ have invoked this observation when making their case. Understandably, however, they have not argued that it is a characteristic of all, or almost all, regulation and, therefore, a critical consideration in the cost-benefit analysis of every proposed regulation. It will probably not become a critical consideration until turnings of the regulatory ratchet are tracked in a wide variety of contexts.

Possible instances of the regulatory ratchet at work abound. Here are three, the first bearing on executive pay, the second on residential housing construction, and the third on mortgage lending.

Executive pay

The compensation of senior managers of public companies depends in part on the prospect that they will be displaced if they receive more than their market value. A takeover, especially a hostile one, is the ultimate displacement mechanism, so the threat of one tends to discipline such managers. Federal¹¹⁸ and state statutes regulating takeovers have rendered them costlier and riskier, thereby reducing the incentive to initiate them. The disciplining power of a takeover threat has declined accordingly. This has facilitated an increase in the compensation of senior managers at some public companies, and this increase has helped fuel comparable increases

117. See, e.g., Holman W. Jenkins, *Now, Can We Have Health-Care Reform?*, WALL ST. J. (Mar. 24, 2010).

118. 82 Stat. 455 (1968). The Williams Act amended the Securities Exchange Act of 1934. Perhaps the most significant amendment was the addition of §13(d) which requires disclosure by persons or groups who acquire beneficial ownership of more than 5% of any publicly traded equity securities.

at other companies as they compete for top managerial talent. Eye-popping salaries have made for attention-getting stories in the media and among the commentariat, stories often coupled with calls for Congress to do something about those salaries. Congress did not pare back its regulation of takeovers or preempt that of the states. Rather, Congress amended the tax laws to make salaries in excess of \$1 million paid to top managers non-deductible for the corporation paying them.¹¹⁹ Obviously, this changed the relative value of salaries vis-a-vis other forms of compensation, such as perks, performance bonuses, and stock options. Of these non-salary forms of compensation, stock options have attracted the most coverage, much of it critical, from the media and the commentariat. This prompted Congress not to repeal the amendment to the tax laws but, along with federal administrative agencies, to adopt measures to regulate the granting and exercising of the options.

Residential housing construction.

A wide variety of statutes and regulations adopted in the name of safety, environmental protection, and aesthetics raise the cost of residential housing construction, sometimes dramatically as in coastal California.¹²⁰ The resulting higher housing prices most afflict people with the least financial resources. Of course, they see the scarcity of acceptable housing available at prices within their budgets as a problem; a problem about which someone ought to do something. Politicians and bureaucrats in federal, state, and local governments have responded not by rolling back the costly laws, but by adopting statutes and regulations that coerce the construction of “affordable housing” or subsidize it.

Mortgage lending

During the Great Depression, many states enacted statutes that

119. I.R.C. § 162 (m).

120. In 2015, California’s Legislative Analyst Office estimated that “the cost of building a typical single-family home in California’s metros likely is between \$50,000 and \$75,000 higher than in the rest of the country.” One contributor to the difference was “the average development fee levied by California local governments (excluding water-related fees)” which according to a 2012 national survey, “was just over \$22,000 per single-family home compared with about \$6,000 per single-family home in the rest of the country. “California’s High Housing Costs: Causes and Consequences” (March 17, 2015), <http://www.lao.ca.gov/reports/2015/finance/housing-costs/housing-costs.aspx>. The difference will grow beginning in 2020 when solar panels become mandatory on all new California homes pursuant to rules adopted by the California Energy Commission in May 2018. *Energy Commission Adopts Standards Requiring Solar Systems for New Homes, First in Nation*, California Energy Commission News Release (May 9, 2018), http://www.energy.ca.gov/releases/2018_releases/2018-05-09_building_standards_adopted_nr.html. The Commission estimates that the mandate will add \$8,000 to \$12,000 to the cost of a home. *California Prays to the Sun God*, WALL ST. J. (May 12-13, 2018), at A12.

increased the risks associated with mortgage loans. For example, twelve states, including California and Texas, require that lenders make mortgage loans non-recourse.¹²¹ Twenty-seven states prohibit or substantially limit pre-payment penalties and statutes.¹²² Of course,

121. Alaska: ALASKA STAT. § 34.20.100 (2018); Arizona: ARIZ. REV. STAT. § 33-729 (2018); California: CAL. C. CIV. PRO. § 580b (Deering 2018); Connecticut: CONN. GEN. STAT. § 49-14 (2018); Idaho: IDAHO CODE § 45-1512 (2018); Minnesota: MINN. STAT. § 582.30(2018); North Carolina: N.C. GEN. STAT. § 45-21.38, N.C. GEN. STAT. § 45-21.38A (2018); North Dakota: N.D. CENT. CODE § 32-19-03 (2017); Oregon: OR. REV. STAT. § 86.797 (2018); Texas: TEX. PROP. CODE § 51.002 (2017); Utah: UTAH CODE § 57-1-32 (LexisNexis 2018); Washington: WASH. REV. CODE § 61.24.100 (LexisNexis 2018).

122. Alaska: ALASKA ADMIN. CODE tit. 3, § 14-515 (2019) (unfair or deceptive acts include charging a prepayment penalty that violates ALASKA STAT. § 45.45.010(g), i.e. loans covering one- to four-family dwellings may be prepaid without a penalty except federally insured loans that require a prepayment penalty); Arizona: ARIZ. REV. STAT. § 6-449 (2018) (prepayment penalty is capped at six months' advance interest); Arkansas: ARK. CODE ANN. § 23-39-513 (2018) (no prepayment penalty after the 36 month period after the issuance of the loan and the 3%, 2%, and 1% of the loan principal amount cap for prepayments made within first, second, or third 12 month period following the issuance of the loan, respectively); California: CAL. BUS. & PROF. CODE § 10242.6 (Deering 2018) (for single-family, owner occupied properties, prepayment penalty is allowed only within the first seven years of the issuance if the prepayment exceeds 20% of the unpaid balance in any 12-month period); Colorado: COLO. REV. STAT. § 11-38-103 (2018) (no prepayment penalties on reverse mortgage); Connecticut: CONN. GEN. STAT. § 36a-746c (2018) (no prepayment penalties on high cost home loan); Idaho: IDAHO CODE § 28-42-306 (2018) (prepayment penalty is allowed in the first three years of the contract and should not exceed 6-month interest); Illinois: ILL. ADMIN. CODE tit. 38, § 1050.1187 (2018) (penalty provisions are prohibited for payments made after 36 month period following the issuance of the loan, or exceeding 3%, 2%, and 1% for prepayments made within first, second, or third 12 month period following the issuance of the loan, respectively); Indiana: IND. CODE § 24-4.5-3-209 (2017) (prepayment penalty capped at 2% of the amount prepaid may be imposed within three years from the contract date); Iowa: IOWA CODE § 535.9 (2018) (mortgage on owner-occupied residential property can be prepaid without a penalty); Kansas: KAN. STAT. ANN. § 17-5512 (all home loans may be prepaid with a penalty not to exceed 1.5% of the prepayment); Kentucky: KY. REV. STAT. ANN. § 286.8-110 (LexisNexis 2018) (no prepayment penalty after 3 years from mortgage origination and during the first 3 years it is not to exceed 3%, 2%, and 1% for prepayments made within first, second, or third 12 month period following the issuance of the loan, respectively); Louisiana: LA. STAT. ANN. § 9:3532.1 (2018) (caps on prepayment penalty based on the year of prepayment); Maine: 02-029-119 ME. CODE R. § 4 (2018) (borrowers have the right to prepay in whole or in part without penalty at any time); Maryland: MD. CODE ANN., COM. LAW § 12-105 (2018) (prepayment penalty may be imposed only within the first 3 years from the date of loan origination and is capped); Massachusetts: 209 MASS. CODE REGS. 32.32 (2018) (prepayment penalties for high cost mortgages are prohibited without exception), MASS. GEN. LAWS ch. 183, § 56 (2018) (prepayment penalty for a dwelling of 4 or less household or owner-occupied properties is not allowed if mortgage is prepaid after 36 months from the issuance, and if it is paid before then the penalty shall be the lesser of the balance of the first year's interest or the three months' interest), 940 MASS. CODE REGS. 8.06 (2018) (it is an unfair or deceptive practice to charge a prepayment fee which violates MASS. GEN. LAWS ch. 183, § 56, significantly deviates from industry standards, or is otherwise unconscionable); Missouri: MO. REV. STAT. § 408.036 (2018) (prepayment penalties are prohibited after five years from the origination date); New Jersey: N.J. ADMIN. CODE § 3:15-10.1 (2018) (a borrower may repay a mortgage loan at any time without penalty); New Mexico: N.M. STAT. ANN. § 56-8-30 (no prepayment penalty on a home loan); New York: N.Y. GEN. OBLIG. LAW § 5-501(3)(b) (2018) (prepayment penalties are limited to the first year of a mortgage loan); Ohio: OHIO REV. CODE ANN. § 1343.011 (prepayment penalty is not allowed on residential mortgages of less than \$75,000); Oregon: OR. ADMIN. R. 441-730-0205 (2018) (prepayment penalties are permissible unless there is a refinance by the same financial institution, a foreclosure, or payment with insurance benefits due to the death of the borrower); Pennsylvania: 10 PA. CODE § 7.8

lenders took the increased risk into account in setting rates and extending credit which especially pinched people with low and moderate incomes. The Community Reinvestment Act,¹²³ as it was eventually interpreted by banking regulators, effectively imposed minimum quotas for loans to such people. Meanwhile, Congress and federal administrative agencies required that Fannie Mae and Freddie Mac, the secondary mortgage market giants, purchase these loans which meant reducing their underwriting standards. This manifested itself in a number of ways, including the authorization of subprime and Alt-A mortgages for impecunious borrowers. When the resulting housing bubble burst, Congress did not repeal the Community Reinvestment Act nor the laws effectively requiring Fannie Mae and Freddie Mac to reduce their underwriting standards. Instead, Congress, along with federal administrative agencies, substantially increased the regulation of retail financial institutions in general and mortgage lenders in particular.¹²⁴

Tracking the ratchet's turnings in a wide variety of contexts would facilitate refinement of the model sketched in this article. Presently, this model does not explain whether, in some circumstances, the ratchet might generate forces that would diminish with each succeeding turn. Nor does it explain why the ratchet ever fails to work, although the fact that opponents of Obamacare came as close as they did to repealing a substantial portion of it suggests that failure to suppress information about the impact of the regulation may play a critical role.

Even with a more refined model, taking account of the regulatory ratchet will prove challenging because it requires predicting future turns and their consequences. The resulting uncertainty may make it impractical to take account of the ratchet in a meaningfully quantifiable manner. Qualitative observations, however, might still prove useful. It might be useful, for example, to identify ratchet-turning forces that a proposed regulation would likely generate. Moreover, if prior regulations had generated similar forces, say moral hazard risk, it might also prove useful to identify the turns of the regulatory ratchet that these forces had powered and to estimate the costs of these turns.¹²⁵

(2018) (prepayment penalty on residential mortgage obligations is prohibited); Rhode Island: 11-2 R.I. CODE R. § 3:5 (no prepayment penalty is allowed on high cost home loans); South Carolina: S.C. CODE ANN. § 37-23-80 (2018) (no prepayment penalty on loans of less than \$150,000); Texas: 7 TEX. ADMIN. CODE § 83.707, 7 TEX. ADMIN. CODE § 153.7 (2018) (prohibiting prepayment penalties on secondary mortgage loans and equity loans); Vermont: VT. STAT. ANN. Tit. 9, § 45 (2018) (prepayment penalty is prohibited).

123. 12 U.S.C. 2901 (2018) (implemented by Regulations 12 CFR parts 25, 228, 345, and 195).

124. Fannie Mae and Freddie Mac went into receivership and were largely untouched by the new regulations.

125. Some opponents of Obamacare did this. *See, e.g.*, Holman Jenkins, *Now, Can We Have Health-Care Reform?*, WALL ST. J. (Mar. 24, 2010), at A15.