

DISTRIBUTIONAL CONSIDERATIONS IN THE OVERREGULATION OF HEALTH PROFESSIONALS, HEALTH FACILITIES, AND HEALTH PLANS

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I

INTRODUCTION

Although an ample body of literature has focused squarely on the efficiency implications of the web of regulations affecting health professionals and health insurers, the issue of the distributional effects of such regulations appears to have largely escaped the notice of scholars. This article directly addresses the equity issue by offering some preliminary calculations of the magnitude of such burdens and the extent to which they contribute to the distributive injustices catalogued by Clark Havighurst and Barak Richman in this issue of *Law and Contemporary Problems*.

The article begins with some general observations in Part II about how health spending is currently distributed and what implications this has for determining the distributional effects of health-services regulations, such as those aimed at health professionals and health plans. Part III then focuses on the regulation of health professionals of all types;¹ Part IV examines regulation of health facilities (predominantly hospitals and nursing homes); and Part V discusses regulation of health plans, including conventional health insurance as well as managed care plans. Each section explores the extent to which the benefits and costs of such regulation may be distributed unevenly.

This article concludes that the marginal impact of health regulation is to make the U.S. health system more, rather than less, regressive. Though current evidence does not allow a precise estimate of the quantitative impact, it appears that the specific regulations contributing most to distributive injustice include continuation of coverage requirements, health insurance mandates, and regulation of managed care (for example, patient protection).

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1. Of course, the reader must recognize that the lion's share of literature in this area concentrates on physicians; hence our picture of the ramifications of regulation of mid-level providers or other types of health professionals may be somewhat less than complete.

II

GENERAL OBSERVATIONS

Previous work by John Holahan and Sheila Zedlewski has addressed the general question of who pays for health care in the United States.² This pioneering study carefully tracked the byzantine system of health care spending³ for the nonelderly by income decile, accounting for all the major sources of health care spending, including employer-paid health insurance premiums, worker-paid premiums, nongroup premiums, out-of-pocket spending, Medicaid, and uncompensated care. It then separately tracked the distribution of financing those funding flows, detailing how each income group contributed to the financing of Medicaid, Medicare, and the employer tax exclusion. Taking into account both direct payments (premiums and out-of-pocket spending) and tax payments, they found that individuals in the first income decile faced a health-spending burden amounting to 20.5% of their income, the second decile burden was 11.8%, and the tenth decile burden was 8.4%, as shown in Table 1.

Table 1:⁴ Health Care Spending as Percent of Income (1989)

	1st Decile	2nd Decile	10th Decile	Average
Per Capita Income	1861	4328	34,525	14,311
	Percent of Income			
Direct Payments	18.8%	9.5%	3.4%	6.1%
Employer Premiums	2.1%	3.5%	2.5%	4.2%
Value of Tax Exclusion	-0.5%	-0.9%	-0.9%	-1.5%
Worker Premiums	0.5%	1.2%	0.5%	1.0%
Non-group Premiums	3.2%	1.6%	0.2%	0.5%
Out of Pocket	13.4%	4.2%	1.1%	1.9%
Tax Payments	1.7%	2.3%	5.0%	4.7%
Medicaid	0.0%	0.0%	1.1%	0.7%
Medicare	1.2%	1.9%	2.7%	2.9%
Employer Tax Exclusion	0.5%	0.5%	1.3%	1.1%
Total	20.5%	11.8%	8.4%	10.9%

2. See generally John Holahan & Sheila Zedlewski, *Who Pays for Health Care in the United States? Implications for Health Care Reform*, 29 INQUIRY 2, 231-48 (1992) (examining health care spending distribution).

3. The data used in this study was collected in 1989. Subsequently, the share of national health spending that is federally financed increased from 23% in 1987 to 37% by 2004, nearly all through higher spending from general revenues. Cynthia Smith et al., *National Health Spending in 2004: Recent Slowdown Led by Prescription Drug Spending*, 25 HEALTH AFF. 186, 190 exhibit 4 (2006). On balance, this would make today's system somewhat more progressive than in 1989 but would not appreciably alter the general picture painted by these authors.

4. The information in Table 1 was calculated by the author based on expenditure data reported in Holahan & Zedlewski, *supra* note 2.

Health Spending	67.2%	24.2%	4.1%	8.5%
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This two-and-one-half-fold difference in burdens between the bottom and the top of the income-distribution curve confirms the general suspicions voiced by Havighurst and Richman about the regressive nature of America's system of health care financing.⁵ However, two caveats are in order. First, if each family actually had to fully bear the burden of its own health care expenditures, the first decile would be spending 67.2% of their income on health care, compared to only 4.1% for those in the tenth decile (Table 1); this admittedly is an unrealistic hypothetical insofar as the lowest-income group would surely massively defer, delay, or forego needed care altogether if faced with such a stark choice. Nevertheless, it gives a feel for how much the current system—even though it remains regressive in the aggregate—actually compresses the extent of this regressivity (that is, taking what would otherwise be a seventeen-fold differential in the hypothetical just posed and compressing this to only a two-and-one-half-fold difference).

Second, an analysis using 1987 Consumer Expenditure Survey data showed that the relative burden of food expenditures for poverty households compared to those at 400% or more of poverty was 4.6 to 1; for all nonfood, nondurable purchases, this ratio was 3.4 to 1; for shelter, it was 2.6 to 1, and for gasoline, it was 3.3 to 1.⁶ In that context, a two-and-one-half-fold differential in health spending burdens seems quite comparable to the differentials Americans tolerate with respect to spending on other necessities of life.

To the degree that health-services regulation is simply baked into all health spending as an add-on to the cost of both or either health services and health insurance, then one would expect to see this two-and-one-half-fold differential in burdens played out if an attempt were made to estimate the incidence of regulatory costs by poverty status. However, since no one proposes dispensing with regulation entirely, the more interesting policy question is whether the *excess* costs of regulation somehow are disproportionately funneled onto those with the lowest incomes. Put another way, would the poor disproportionately benefit by removal of some of this regulatory excess? Policymakers surely would like the answer to this question. What follows is a first cut at answering it.

III

OVERREGULATING HEALTH PROFESSIONALS

A recent literature synthesis conducted for the U.S. Department of Health and Human Services demonstrates that in the aggregate, various regulations

5. Clark C. Havighurst & Barak D. Richman, *Distributive Injustice(s) in American Health Care*, 69 LAW & CONTEMP. PROBS. 7, 8 (Autumn 2006).

6. Christopher J. Conover, unpublished analysis using 1987 Consumer Expenditure Survey data (July 25, 1991) (on file with author).

affecting health professionals imposed a cost of \$29.5 billion annually, but conferred benefits whose value amounted to only \$22.4 billion.⁷ Is the net burden of \$7.1 billion regressively distributed? The three largest contributors to this net cost include Medicare graduate medical education (GME) payments (\$4.3 billion), professional accreditation and licensure (\$1.8 billion), and Medicare assignment rules (\$1.2 billion).⁸

A. Medicare GME Payments

Medicare GME payments have been used to subsidize the costs of both direct medical education (DME) and indirect medical education (IME), such as the added costs of care attributable to medical residents.⁹ Since the Balanced Budget Act of 1997, there has been a cap on residency positions funded with Medicare GME dollars.¹⁰ In conjunction with licensure rules that basically preclude any physician from becoming licensed without having gone through residency training, the combination of these policies essentially regulates the future supply of physicians. Medicare Part A finances GME payments, and the payroll tax used for this purpose is arguably regressive.¹¹ On the other hand, care provided by medical residents is almost certainly skewed to the bottom end of the income scale,¹² so if one sought to calculate the net burden of this domain of regulation, it more likely would be slightly progressive than regressive.¹³

7. CHRISTOPHER J. CONOVER, CATO INSTITUTE, POLICY ANALYSIS NO. 527, HEALTH CARE REGULATION: A \$169 BILLION HIDDEN TAX 11 tbl.3 (2004), available at <http://www.cato.org/pubs/pas/pa527.pdf>. Costs and benefits are reported in 2002 dollars. This analysis was specifically conducted for the Assistant Secretary of Planning and Evaluation.

8. *Id.*

9. See Sean Nicholson & David Song, *The Incentive Effects of the Medicare Indirect Medical Education Policy*, 20 J. HEALTH ECON. 909, 910 (2001) (discussing the purpose and use of Medicare GME payments).

10. Balanced Budget Act of 1997, Pub. L. 105-33, § 4623, 111 Stat. 251, 274 (1997).

11. Even though the payroll tax is now essentially a “flat tax” of 2.9% on all earnings, compared to those in the very highest income groups, low-income families rely far more heavily on such earnings, as opposed to other sources of income such as interest income, suggesting the net effect is slightly regressive. See INTERNAL REVENUE SERV., INDIVIDUAL COMPLETE REPORT (PUBLICATION 1304) tbl.1.4 (2003) (providing data on sources of income by size of adjusted gross income), available at http://www.irs.gov/taxstats/indtaxstats/article/0,,id=96981,00.html#_grp1.

12. I am unaware of any specific study that tracks status the services provided by medical residents by patient income. However, Hadley and Holahan argue that at least \$1.6 billion of \$3.7 billion in Medicare indirect medical education (IME) payments go to the uninsured. Jack Hadley & John Holahan, *How Much Medical Care Do the Uninsured Use, and Who Pays for It?*, 2003 HEALTH AFF. (WEB EXCLUSIVE) W3-66, W3-73 to W3-74, 76 exhibit 4. The uninsured disproportionately have low incomes. See CARMEN DENAVAS-WALT ET AL., U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2004 18 tbl.7 (2005) (providing data on insurance status by income), available at <http://www.census.gov/prod/2005pubs/p60-229.pdf>.

13. In 1998, \$5.9 billion in Medicare GME funding amounted to \$76,540 per medical resident. See Christopher J. Conover, unpublished calculation (Jan. 8, 2006) (on file with author) (based on figures outlined in Nicholson & Song, *supra* note 9, at 909). In per capita terms, financing \$5.9 billion in 1989 would have increased payroll taxes for the lowest two income deciles by \$1.35 and \$10.82 per capita, respectively. See Christopher J. Conover, unpublished calculations (Jan. 8, 2006) (on file with author) (based on data in Holahan & Zedlewski, *supra* note 2, at 240 tbl.6). Put another way, these lowest two deciles accounted for only 2% of the entire burden of Medicare payroll taxes. But it seems reasonable

B. Professional Accreditation and Licensure

One of the studies of health-services regulation included in the literature synthesis was Reuben Kessel's 1958 analysis of physician licensure, in which he argued that American Medical Association (AMA) regulation effectively created a monopoly that permitted physicians to earn higher-than-competitive returns on their investments in medical education.¹⁴ This argument was echoed by Elton Rayack in a book-length treatment of the issue a decade later.¹⁵ Even though the political power of the AMA has dissipated rather considerably since that period, the hours-adjusted rate of return to physicians in subsequent decades kept rising rather than stabilizing or falling, exceeding twenty percent for some specialties, as shown in Table 2.

Table 2:¹⁶ **Rising Rates of Return to Medical Specialization**

Year	OB/GYN	General Surgery	Internal Medicine
1955	6.7	5.7	<0
1965	4.8	5.2	1.5
1967	7.5	7.4	8.3
1970	11.8	11.2	9.3
1975	12.1	11.6	12.5
1980	14.8	13.6	9.8
1987	25.9	22.1	12.7

More recent data show no signs these excess returns have abated. For example, despite a sharp slowdown in the 1990s due to the widespread adoption of managed care, the ratio of average net physician income to average earnings of full-time wage and salary workers in the United States remained the same in 2000 (5.5) as it had been in 1985 (5.5).¹⁷ Thus, it would appear that American physicians continue to command supra-competitive returns on their investments in education.

to assume these two groups got at least their pro rata share of free care provided by these residents—20%—or likely considerably more. Hence, the net effect is likely to push things in a progressive rather than a regressive direction.

14. Reuben Kessel, *Price Discrimination in Medicine*, 1 J.L. & ECON. 20, 29 (1958); see Reuben Kessel, *The AMA and the Supply of Physicians*, 35 LAW & CONTEMP. PROBS. 267, 272 (Spring 1970) (discussing the effect of regulation on educational costs and physicians' fees).

15. See generally ELTON RAYACK, PROFESSIONAL POWER AND AMERICAN MEDICINE (1967).

16. Information in Table 2 is based on data reported in Charles Phelps, HEALTH ECONOMICS 176 tbl.6.3 (1992).

17. See KAISER FAMILY FOUND., TRENDS AND INDICATORS IN THE CHANGING HEALTH CARE MARKETPLACE exhibit 6.4 (2002) (comparing mean income between physicians and full-time wage and salary workers in 1985, 1996, 1998, and 2000), <http://www.kff.org/insurance/7031/print-sec6.cfm>.

Yet a fair question is this: supra-competitive returns relative to what? It turns out that physicians are not the only profession in which supra-returns are available. The most recent available comparative data show that procedure-based, medical-doctor specialists have an hours-adjusted annual rate of return over their working lifetime of 20.9%, while that for dentists was 20.7%; even primary-care doctors had a return of 15.9%.¹⁸ In light of the average profitability for U.S. corporations (5.5%),¹⁹ these are impressive rates of return. The same study found that graduates of the top twenty business schools earned 29.0% annually on their investment in education,²⁰ nevertheless, this comparison may be flawed since it compares graduates of only elite business schools to graduates of all 114 U.S. medical schools. Indeed, the study's authors argue that "assuming that undergraduate grade point averages accurately predict relative performance in future careers, it may be more accurate to compare physicians with graduates of the top law schools."²¹ Their analysis showed that law-school graduates enjoyed returns of 25.4%.²² Thus, it is not altogether clear whether the returns to physicians truly represent "excess" monopoly returns or are simply the returns required to prevent would-be doctors from instead entering the legal profession. Ironically, these staggering returns are available to lawyers despite the conventional wisdom that the United States already has a sizable surplus of lawyers—a surplus that has been estimated to reduce economic output by more than \$1 trillion annually.²³

But, assuming for the sake of argument that returns to physicians are excessive, three additional observations are worth noting. First, it would be difficult to tease out what component of these inflated returns can be laid at the feet of regulation as opposed to the distortions created by the tax code in encouraging excessive third-party coverage.²⁴ Second, to the extent to which regulation results in higher spending on physicians across the board, the result generally would be regressive insofar as average utilization of physicians is not strongly correlated with income, since any income-related propensity to spend on physician care is apparently largely offset by the availability of public

18. William B. Weeks et al., *A Comparison of the Educational Costs and Incomes of Physicians and Other Professionals*, 330 NEW ENG. J. MED. 1280, 1283 (1994).

19. Average earnings per dollar of sales for the period of October 2000 to September 2005 are based on American Petroleum Institute calculations from data reported in various issues of *Business Week* and by PricewaterhouseCoopers LLP. *Oil and Natural Gas Industry Earnings Compared to All U.S. Industry*, ISSUE (Am. Petroleum Inst., Washington, D.C.), Winter 2006, at 1, available at <http://api-ep.api.org/filelibrary/ACF186.pdf>.

20. Weeks, *supra* note 17, at 1284.

21. *Id.*

22. *Id.*

23. James R. Garven, *Moral Hazard, Adverse Selection, and Tort Liability*, 28 J. INS. ISSUES 1, 9 (2005).

24. Havighurst and Richman do a thorough job explaining the connection between the tax code and the increased demand for health care services and price insensitivity to those services. *Supra* note 5, at 36–39. Because physicians are among many in the health industry who earn supra-competitive returns as a consequence of this price insensitivity, regulation simply aggravates an already regressive situation.

insurance and the generally worse health of the poor.²⁵ Third, public insurance and physician-provided free care should largely mitigate the regressive impact this regulatory surcharge might otherwise have.²⁶ AMA surveys show that two-thirds of physicians provide uncompensated care, with such physicians averaging 8.8 hours per week (more than fourteen percent of their time).²⁷ Other independent surveys show the figure may be even higher;²⁸ whatever the actual number is, it redounds disproportionately to the benefit of patients with the lowest incomes.

IV

OVERREGULATING HEALTH FACILITIES

The literature synthesis demonstrates that in the aggregate, various regulations affecting health facilities imposed a cost of \$47.7 billion annually, but conferred benefits whose value amounted to only \$22.6 billion.²⁹ The \$25.1 billion in net costs was accounted for largely through hospital accreditation and

25. The average number of annual physician visits in the U.S. declines as family income increases up until \$50,000, after which it increases. NAT'L CTR. FOR HEALTH STATISTICS, U.S. DEP'T OF HEALTH AND HUMAN SERVS., HEALTH, UNITED STATES 287 tbl.74 (1998), available at <http://www.cdc.gov/nchs/data/has/has98ncb.pdf>. However, controlling for health status, the number of acute, chronic, and well-care visits all increase with income. Phelps, *supra* note 16, at 130 tbl.5.7. This demonstrates that the higher use of physician services at the lower end of the income scale is driven by low-income persons' worse health status, and it is reasonable to infer that public insurance is an important factor in their being able to afford such higher use.

26. Among the nonelderly, 27.8% of those below 200% of poverty have Medicaid or state health insurance coverage, and another 32.6% are uninsured. John Holahan & Allison Cook, *Changes in Economic Conditions and Health Insurance Coverage, 2000-2004*, 2005 HEALTH AFF. (WEB EXCLUSIVE) W5-498, W5-501 exhibit 2. Average Medicaid spending per capita for those in families (as opposed to the elderly) was \$2408 annually. John Holahan & Arunabh Ghosh, *Understanding the Recent Growth in Medicaid Spending, 2000-2003*, 2005 HEALTH AFF. (WEB EXCLUSIVE) W5-52, W5-59 exhibit 6. In 2004, 45.8 million Americans were uninsured. DeNavas-Walt, *supra* note 12, at 18 tbl.7. The uninsured received \$40.7 billion in uncompensated care that year. Jack Hadley & John Holahan, *The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending?*, Presentation Prepared for the Kaiser Commission on Medicaid and the Uninsured fig.5 (May 10, 2004) [hereinafter Hadley & Holahan, Presentation], http://www.kaisernetwork.org/health_cast/uploaded_files/Hadley_and_Holahan_Slides.pdf. The average subsidized spending per uninsured in 2004 was nearly \$900. Christopher J. Conover, unpublished calculation (October 10, 2005) (on file with author) (based on data provided in DeNavas-Walt, *supra* note 12, at 18 tbl.7, and Hadley & Holahan, Presentation, *supra* at fig.5). Thus, averaged over the entire population of individuals below 200% of poverty, these subsidies amount to \$959 per capita. There is no plausible way for the regulatory costs related to physicians or other health professionals to exceed this amount.

27. CAROL KANE, AMERICAN MEDICAL ASSOCIATION, PHYSICIAN MARKETPLACE REPORT: PHYSICIAN PROVISION OF CHARITY CARE, 1988-1999 1 (2002), available at http://www.ama-assn.org/ama/upload/mm/363/charity_care_2002.pdf.

28. For example, although their survey documents a decline in physician charity care, the Community Tracking Survey shows that in 2004-2005, 68.2% of physicians provided some charity care and averaged 10.6 hours per week on such activities. Peter J. Cunningham & Jessica H. May, *A Growing Hole in the Safety Net: Physician Charity Care Declines Again*, TRACKING REP. NO. 13 (Ctr. for Studying Health Sys. Change, Washington, D.C.), Mar. 2006, at 2 tbl.1, available at <http://www.hschange.com/CONTENT/826/826.pdf>.

29. CONOVER, *supra* note 7, at 6 tbl.2.

licensure (\$8.6 billion), hospital uncompensated-care pools (\$5.2 billion), and the Clinical Laboratory Improvement Act (CLIA) of 1988³⁰ (\$3.2 billion).³¹

A. Hospital Accreditation and Licensure

Whatever benefits of hospital quality regulation exist presumably redound to the benefit of all patients. However, based on the well-established case from Medicare that the appetite for technology and services rises with income,³² if regulation improved overall hospital quality (a hornet's-nest question avoided here), a case certainly can be made that regulation would disproportionately favor socioeconomically advantaged patients over those who are disadvantaged on grounds that such patients would be more willing to pay for such improvements. If quality regulation or entry regulations (such as Certificate of Need on the hospital side) result in higher costs absorbed by all payers in the form of what amounts to an excise tax, such a tax would be undeniably regressive. However, it turns out that this tax is not nearly as regressive as the pure head tax that Havighurst and Richman argue operates in the employer health-insurance market.³³ That is, taking into account amounts they pay out of pocket as well as what they pay implicitly through private health insurance for such services, the burden on poor families is three to four times as high as it is for families at 400% of poverty or higher, as illustrated in Table 3. In contrast, a head tax would result in more than an eight-fold difference in the relative burden faced by poor versus well-to-do families.

Table 3:³⁴ Hospital Tax is Less Regressive Than a Head Tax

Family Income as Percent of Poverty	Lottery (head tax)	Hospital Tax	Physician Tax
Average Burden per \$10,000 Family Income ³⁵			
Uninsured			
Poor	930	174	192
Below Poverty	930	338	313

30. 42 U.S.C. § 263a (2000).

31. *Id.*

32. See generally Mark McClellan & Jonathan Skinner, *The Incidence of Medicare*, 90 J. PUB. ECON. 257 (2006) (providing the most empirically grounded version of this thesis).

33. Havighurst & Richman, *supra* note 5, at 24.

34. CHRISTOPHER J. CONOVER & HESTER HAVERKAMP DAVIES, DUKE UNIVERSITY CENTER FOR HEALTH POLICY, LAW AND MANAGEMENT, HEALTH CARE FOR THE MEDICALLY INDIGENT OF SOUTH CAROLINA: FINAL REPORT (1998), available at <http://www.hpolicy.duke.edu/cyberexchange/states/pdf/CHAPTER1.PDF>.

35. Figures account for all out-of-pocket spending and private-health-insurance premiums but exclude incidence of financing Medicaid, Medicare, or other public programs.

101-150%	543	283	312
151-200%	401	231	242
201-299%	298	193	187
300-399%	210	133	136
400% +	110	76	105

B. Hospital Uncompensated Care Pools

Analyzing hospital uncompensated-care pools is more complicated since in this case the benefits of such pools are tilted unquestionably in favor of those at the bottom. Thus, even if the gross costs of such pools are financed in the fashion shown in Table 2, at best this would represent a small offset to the per capita benefits of such pools for the poor as a group. Therefore, in terms of net burden, this particular regulation seems unlikely to be regressively distributed, although it is unquestionably more regressively distributed than if the “hidden tax” of hospital cost-shifting were more neutrally borne. That said, not every poor person utilizes hospital care in a year. (Among those with family incomes below \$15,000, fewer than one in seven experience a hospitalization in a typical year).³⁶ Thus, most with low incomes would experience a disproportionate burden of financing uncompensated-care pools similar to that already described for hospital accreditation and licensure.

C. Clinical Laboratory Improvement Act (CLIA)³⁷

Although clinical laboratories themselves are facilities, any burdens of regulation are ultimately borne by users of hospitals, nursing homes, and outpatient health services. Hospital laboratories account for fewer than half of all clinical laboratories.³⁸ In a typical hospital, there is a higher mark-up on ancillary services than on routine services such as per diem charges.³⁹ Thus, there is greater opportunity to discount pricing on laboratory services than on other parts of a hospital bill. Although things are now beginning to change in

36. NAT'L CTR. FOR HEALTH STATISTICS, *supra* note 25, at 302 tbl.87.

37. 42 U.S.C. § 263a (2000). CLIA imposes uniform federal regulations designed to ensure a minimal level of quality in clinical laboratories regardless of location; thus, CLIA covers not only freestanding labs to which hospitals or physicians may send blood or other biological specimens for testing, but also labs located in hospitals and physician offices. Even if quality regulation increases the cost of lab tests by an equal percentage in all locations, for example 5%, the distributional consequences may differ slightly based on how these higher costs are passed through to patients (which in turn will depend on their payer status).

38. John T. Benjamin, *The Effect of CLIA '88 and Managed Care on the Medical Lab Market*, MED. LABORATORY OBSERVER, Nov. 1996, at 54.

39. Barbara O. Wynn, Senior Health Policy Analyst, RAND, Inflation in Hospital Charges: Implications for the California Workers' Compensation Program, Testimony Presented to the California Senate Labor and Industrial Relations Committee 2 (Jan. 15, 2003), available at <http://www.rand.org/pubs/testimonies/2005/CT202.pdf>.

light of recent media attention to the high prices paid by uninsured patients,⁴⁰ on average, any regressivity in the burden of financing hospital care in general (Table 3) is likely to be even more exaggerated for hospital-provided lab services. That is, any pass-through of laboratory regulatory costs is likely to be amplified by the higher-than-average mark-ups used for such services.

Physician labs constitute approximately one in seven clinical laboratories.⁴¹ But as shown in Table 3, the distributional consequences of passing such costs through physician services are nearly identical to the distributional effects of an add-on to hospital service costs. That is, they are regressive.

V

OVERREGULATING HEALTH PLANS

The literature synthesis demonstrates that in the aggregate, various regulations affecting health insurance imposed a cost of \$99.3 billion annually but conferred benefits whose value amounted to only \$84.9 billion.⁴² The \$14.4 billion in net costs was accounted for largely through continuation of coverage requirements (\$15.0 billion), benefits mandates (\$13.5 billion), and managed-care patient-protection regulations (\$3.2 billion).⁴³

A. Continuation of Coverage Requirements

Probably the best-known continuation of coverage requirement is the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985,⁴⁴ which requires employers with twenty or more employees that provide group health insurance to provide employees and their families continued coverage if certain events occur, such as loss of the employee's job, the death of a covered employee, or divorce.⁴⁵ Because employers are permitted to charge employees who take advantage of this continuation coverage a premium not to exceed 102% of the full premium for the cost of that plan,⁴⁶ only one in six eligible workers finds it worthwhile to purchase this coverage.⁴⁷ Not surprisingly, those electing to purchase the coverage have medical costs that exceed the (capped)

40. See Conrad Meier, *Hospitals Face Pressure to Change Pricing Policies*, HEALTH CARE NEWS (Council for Affordable Health Ins., Alexandria, V.A.), Apr. 1, 2004 (noting potential changes in response to recent news articles), <http://www.cahi.org/article.asp?id=137>.

41. Benjamin, *supra* note 38.

42. CONOVER, *supra* note 7, at 12 tbl.4.

43. *Id.* These three categories of regulation together greatly exceed the net cost of health-insurance regulation because certain insurance regulations have net benefits (for example, health-provider mandates have a net cost of -\$12.2 billion) that offset net costs incurred in other areas of health-insurance regulation. *Id.*

44. 31 U.S.C. § 6701 (2000).

45. See Brigitte C. Madrian, *Health Insurance Portability: The Consequences of COBRA*, REGULATION, Winter 1998, at 27, 27–33 (more details about COBRA).

46. *Id.* at 27.

47. CHARLES D. SPENCER & ASSOCIATES INC., 2002 COBRA SURVEY (2002), *reprinted in part in* MEDICAL BENEFITS, Oct. 15, 2002, at 5, 6 tbl.2 (showing 16.2% of eligible employees elected COBRA coverage in 2002).

premiums they are required to pay, resulting in a net subsidy that amounted to \$2491 per COBRA-covered individual in 2002.⁴⁸

Thus, these regulations are doubly regressive: their benefits accrue disproportionately to employees with high enough incomes to be able to afford to pay full freight for their coverage. The costs of financing these subsidized benefits are presumably allocated back to the general pool of employees. If this is financed through the equivalent of a head tax (that is, equal premiums per employee), the result is regressive; if employee contributions are fully adjusted for in lower wages based on individual employees' willingness to pay, then the effect of *financing* this benefit is neutral, but the benefits would continue to be regressively distributed, with the lion's share going to the most well-off workers.

B. Benefits Mandates

Benefits mandates include minimum maternity stays following delivery, mandatory breast-reconstruction surgery, mental-health parity requirements, and similar requirements. There are a handful of federally imposed mandates, including the first two listed in this paragraph,⁴⁹ but the majority consist of the more than fifty different benefits mandates that states have enacted during the past half-century.⁵⁰ It is certainly beyond the scope of this article to individually analyze all these various mandates, but the federal mandates are probably indicative of the types of political pressures that have led to the adoption of various mandates. If patients were given a choice between the mandated benefit and a payment equivalent to the additional cost to the system, it is a reasonable presumption that low-income patients would be on average more likely than higher-income patients to accept the payment in lieu of the "benefit."

So, as with the continuation of coverage requirements, benefits mandates again appear to reflect a situation in which net benefits disproportionately redound to those with high incomes—that is, the amount that high incomes are "taxed" via the health plan to finance such benefits appears to be lower than their willingness to pay for such benefits, with the opposite being true for low-wage workers. Even if we believe that health benefits in general are financed through a hidden wage adjustment that fully compensates for the individual worker's willingness to pay for that benefit, it is difficult to imagine this adjustment working in the case of many mandated benefits. Admittedly, Jonathan Gruber found nearly full downward adjustment of wages for women of child-bearing ages to offset the costs of maternity benefits,⁵¹ but it is difficult

48. *Id.* at 5.

49. GAIL A. JENSEN & MICHAEL A. MORRISEY, HEALTH INS. ASS'N OF AM., MANDATED BENEFIT LAWS AND EMPLOYER-SPONSORED HEALTH INSURANCE, 5 (1999).

50. See VICTORIA CRAIG BUNCE, COUNCIL FOR AFFORDABLE HEALTH INS., HEALTH INSURANCE MANDATES IN THE STATES 2004 4–5 (2004) (listing benefits mandates by state), http://www.cahi.org/cahi_contents/resources/pdf/Mandatepub2004Electronic.pdf.

51. Jonathan Gruber, *The Incidence of Mandated Maternity Benefits*, 84 AM. ECON. REV. 622, 630–31 (1994).

to see how a similar adjustment would apply to benefits whose likelihood of being used for any given employee might be microscopic. Thus, for most employees, mandated benefits would appear to mirror the impacts described earlier for continuation of coverage.

C. Managed Care Patient Protection

Managed care patient protections include “any-willing-provider laws,” which require managed care organizations to accept any providers willing to accept the plan’s terms; external review requirements that create a review process for coverage denials that is independent of the health plan itself; and patient-protection laws that hold health-maintenance organizations (HMOs) liable for denial of coverage decisions.⁵² There is ample empirical evidence that such regulation has had the net effect of increasing the cost of managed-care plans.⁵³ Evidence from Medicare suggests that those with the lowest and highest incomes are least likely to enroll in HMOs.⁵⁴ But like any excise tax, any across-the-board increase in managed care premiums resulting from such regulations would have a regressive effect since the add-on to premiums would represent a much larger share of income for those at the bottom of the income distribution than at the top. Moreover, to the extent that such protections confer procedural protections, they are far more likely to be taken advantage of by better-educated, higher-income plan members than by those with the least education and income. So again, we have a situation in which benefits are skewed to the advantage of the well-to-do, and the burden of financing ends up being borne regressively.

VI

CONCLUSION

Far more research undoubtedly can and should be done on the distributional effects of the regulation of health professionals, health facilities, and health insurance. But this brief excursion has largely supported the general thesis proposed by Havighurst and Richman.⁵⁵ Even though the health-financing system compresses rather remarkably the regressivity in financing that would otherwise be observed, the net burden of financing remains regressive in the aggregate. And when one examines the marginal impact of health regulation on that broader picture, one could argue that the net effect on balance is to make the system more, rather than less, regressive overall. In cases in which the regressive effect of regulation is mitigated, this generally

52. See Frank A. Sloan & Mark A. Hall, *Market Failures and the Evolution of State Managed Care*, 65 LAW & CONTEMP. PROBS. 169, 187–89 tbl.2 (Autumn 2002) (listing such laws).

53. CONOVER, *supra* note 7, at 14.

54. COMM. ON WAYS AND MEANS, U.S. CONGRESS. MEDICARE AND HEALTH CARE CHARTBOOK 200 fig.4.20 (1997), available at <http://www.gpo.gov/congress/house/ways-and-means/sec4.pdf>.

55. Havighurst & Richman, *supra* note 5, at 8.

results from other aspects of policy (for example, public insurance) or the behavior of providers (for example, charity care), rather than the requirements of regulation itself. A good example of this is the impact of professional licensure, which raises costs for all (which alone has a regressive impact) but whose costs may be partially or fully offset (at least for some lucky low-income patients) by programs such as Medicaid and charity care.

In many domains of regulation, a similar pattern emerges in which the benefits of regulation were likely distributed in a fashion skewed towards those with higher incomes and in which financing the added costs of regulation was at best neutrally, but in many cases regressively, borne. This analysis has focused on impacts purely from the standpoint of patients, that is, the “demand side.” If the equation factors in the fact that much regulation results in higher incomes for those in the health field and ancillary professions such as health lawyers, then the regressive impact would be even worse than that described here. Others may calculate more precisely what the net incidence of health-services regulation might be, but I believe the picture painted herein provides a reasonable approximation of what those more precise calculations will likely find: a net impact of health services regulation that is regressively distributed.