Making a Federal Case Out of Health Care

On July 31, five years after passage of the Health Insurance Portability and Accountability Act, the Cato Institute held a conference on "Making a Federal Case Out of Health Care." House Majority Leader Dick Armey (R-Tex.) delivered the keynote address, and Cato adjunct scholar Richard A. Epstein of the University of Chicago Law School and Hoover Institution delivered the luncheon address. Among the other speakers was Tom Miller, Cato's director of health policy studies. Excerpts from their remarks follow.

Richard A. Epstein: The medical privacy provisions of the Health Insurance Portability and Accountability Act of 1996 undermine our ability to get an accurate assessment of the costs and benefits of information disclosure. HIPAA contains an ostensibly innocuous command that only relevant information can be disclosed. But it offers no definition of what information counts as relevant in cases of medical uncertainty.

Let's take a very simple case: Say somebody who has medical records on file at a hospital in Illinois is involved in an automobile accident in Ohio. Which medical records does the Illinois hospital send to Ohio? Now, if it is my body, I say send the whole file fast. I don't want anything to be left out, because I don't know what the physicians in Ohio will regard as relevant. But somebody in Illinois may say, well, he only broke his arm, so we'll send only the arm-related information. That could take an hour to figure out, and in the interim I'm dead because the Ohio hospital didn't get even that limited information in a timely fashion. Apparently we're supposed to tolerate this type of mistake in a welfare state, because we understand that the government's motives are benevolent even if the consequences of its actions are unfortunate!

Such risks are real. Suppose that I am taking a leg medicine, which means that if you give me a certain arm medicine you're going to harm or kill me. Now, how do you know that in advance? I would rather trust the physician on the spot to look at the entire medical record and figure out what potential interactions to guard against than to have somebody, no matter how able, try to decide at the point of release what information to forward. I would hate to go into the operating room and hear, well, when you were in the emergency room, we didn't think that surgery would be likely, so only this information was necessary; now we've got to request an urgent update with more information, subject, perhaps, to the same mischievous relevancy constraints. Again, time turns out not only to be money but to influence the odds of survival. My own judgment is that anyone who runs the error calculations will quickly lurch to the optimal solution: the emergency room doctor gets everything, but only for restricted uses related to my well-being; he cannot turn around and sell my records to a soap vendor the next day. That's exactly the way business was done before HIPAA. Nobody used a "minimum necessary disclosure" requirement then precisely because full information is likely to minimize errors in decisions made under conditions of uncertainty. It makes no sense to spend time and effort to shrink the flow of information.

Richard Epstein: "HIPAA continued the search for government control by the salami tactic: take control of the industry one slice at a time."

A second troubling feature of HIPAA is how it works to extend the sphere of its own influence. The original mandate under HIPAA covered some but not all provider operations. What the regulators manage to do is to stipulate that any covered entity who provides a medical record to a person or firm who is not part of the HIPAA umbrella must require, by contract, that provider to observe all the HIPAA requirements. And so mandatory contracts become the weapon of choice to expand government power, when in fact there has been no clear delegation of authority.

There is something deeply troubling about these developments because of their Orwellian use of language. The mantra behind HIPAA's privacy regulations is consent—an honorable theme for those who care about liberty. But in this instance, the rules in fact use the "consent" label to disguise coercion. The key strategy: all individuals are required to give consent, not comprehensively, but for each separate transaction. What the regulations do is create a system in which each of us is required to exercise, repeatedly and against our own will, this right to permit others to use information about us. But we cannot waive the protections of the act that require individual consent to be given by putting on the Internet a form that says, "Doc, use whatever records you want in the way that you think best, in accordance with the common practice of your institution."

Putting all the pieces together, what is going on here? The single largest and most ambitious power grab in the history of American health care was the proposed Clinton Health Security Act, which failed in 1994. Essentially, that bill was an effort to create a massive regulatory apparatus to control, either directly or indirectly, the provision of all private forms of health care. It failed, so HIPAA continued the search for government control by the salami tactic: take control of the industry one slice at a time. And here the move to disarm the opposition is to announce that government insists on the various sorts of restrictions to protect against pervasive market failures in the private sector. Once those regulations are imposed, of course, the system will not be able to respond to the challenges it faces without incurring additional costs for few, if any, benefits. The upshot is that the health system will creak even further. That further decline will in turn justify further forms of regulation, and then, by the time we are done, this hodge-podge system of market-cum-regulation will be deemed unworkable so that the only sensible solution is in fact single-payer nationalized medicine. Got it?

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Dick Armey: The 20th-century American philosopher Jimmy Buffett once said, "You've just got to learn from the wrong things you've done."

That is a lesson we must constantly relearn. When you are free, you can be indifferent to government. It's only when government threatens your liberties that you have to move from indifference to vigilance. That was the case when we came to death grips with Clinton Care.

Winning the majority in 1994 gave us Republicans the chance to put our own stamp on health care. HIPAA was the test case. It started out as a modest little bill, promising to make coverage portable from job to job. It grew to become a whole package of reforms, most of them having nothing to do with portability.

It also set a dangerous precedent for the federal regulation of health insurance. It appears to have expanded bureaucrats' access to our medical records without a search warrant. Looking back at it now, it seems undeniable that the first health care law after Clinton Care was, to some extent, the first installment of Clinton Care.

The left has learned its lesson well. In the wake of that defeat, the Democrats worked step by step to obtain what they could not get all at one time. The liberals are so sure of passage of the Patients' Bill of Rights that they're already waiting in the wings with their next steps—letting parents into KidCare, putting all kids on Medicare. It doesn't take a crystal ball to see where this process is heading.

It's ironic that the Democratic Party poses as a great enemy of health maintenance organizations (HMOs). It was Senator Kennedy who wrote the first federal HMO law in 1973. It was the Democrats who tried to herd all of us into HMOs in 1994.

We conservatives need to get back on offense and work harder for free-market health reforms. Patients need more than a bill of rights. They need a declaration of independence. Patients *should* be able to sue their HMOs. But they should also be able to fire their HMOs—and take their business someplace else.

We need to expand and improve medical savings accounts (MSAs). MSAs combine peace of mind with freedom of choice, affordable insurance with tax-advantaged savings. The existing pilot project has shown MSAs to be very attractive to the uninsured. And that is why Senator Kennedy wants them stopped. He fears giving people an option because they may take it.

Once MSAs are made permanent, workable, and universally available, I'm hopeful that a real market will form, MSAs will take off, and national health insurance will become significantly harder to enact.

The government can always manage me when I'm buying something for you, but it cannot manage me when I'm buying something for myself. That's where freedom begins.

I don't necessarily want to blow up the employer-based system. We should help job-based coverage evolve to give workers more choice and control. For example, we should end the use-it-or-lose-it rule on flexible spending arrangements. If workers could accumulate flex cash for medical expenses, they would basically have job-based MSAs without the Kennedy restrictions. At the same time, we should promote a big new idea in health care: defined contribution plans. Just as 401(k) pensions have given millions of workers more choice and control, so could 401(k) health plans. It would be a shame to let a patients' rights bill become law without using the opportunity to help American workers exercise greater control over their own health care.

Dick Armey: "Patients need more than a bill of rights. Patients need a declaration of independence."

This takes us right back to Armey's axiom: Nobody spends somebody else's money as wisely as he spends his own. When we're involved in managing our own health care finances, and involved in the decisions related to them, we will do a better job. When you can hire and fire your own insurer, you are much less likely to need or want to sue your employer.

If you want freedom, you must accept responsibility. If you can figure out how to select a PC and how to make it burn a CD, you're quite capable of selecting your own health insurance and knowing before you get to the hospital the extent to which you are in fact covered. When you know that, you won't be bitterly disappointed and feel cheated because your insurance doesn't cover what you thought it did. You won't feel a compelling need to get a lawyer or to scream out that great American distress signal, "There ought to be a law!"

"You've just got to learn from the wrong things you've done." The liberals learn from their mistakes. We should learn from ours. We need to get serious about patient power and issue a declaration of health care independence for all Americans.

Tom Miller: We've seen growing signs of direct federal regulation of health insurance. Even a mixed system of federal and state regulation will not only inevitably drift toward higher and higher federal floor mandates but also encourage a state race to the bureaucratic top. HIPAA is a resort to another layer of incremental regulatory patch jobs applied to problems caused by previous public policy distortions.

Step one in a successful regulatory bypass operation is diagnosis of the underlying condition: consumers are not in control of their health care decisions, primarily because public policy discourages them from retaining control of their health care dollars and hinders the availability of empowering options in the marketplace.

Step two: Move out of the box of conventional palliative therapy and address fundamentals. Neutralize the distorting effects of the income tax exclusion that favors employer-financed group insurance. Any tax subsidy for health care spending should be at least proportionately equalized for all consumers and flow directly to

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POLICY FORUM *Continued from page 7*

them—regardless of where they work or how they choose to purchase health care.

Tax equity would provide consumers with real choices about their health care arrangements and decentralize decisionmaking. Consumers would be less likely to turn over key decisions regarding the scope and terms of their health insurance coverage to third parties without first insisting on what mattered most to them. Current tax subsidies often operate as tax penalties on consumers seeking other types of coverage, whether it's individual insurance, high-deductible policies coupled with personal saving vehicles, or simply different coverage than one's employer offers. Let's make any tax benefits for health coverage portable at the individual level.

Tom Miller: "Tax equity would provide consumers with real choices about their health care and decentralize decisionmaking."

Step Three: Develop better vehicles to pool health risks outside the workplace and provide longer-term protection against the redefinition of health risks over time. Nongovernmental purchasing pools could offer experience-rated, multiperiod contracts to willing buyers, if pool sponsors could establish the necessary ground rules.

Those rules allow competing health plans to set their own premiums; experience rate new entrants to the pool at the outset, if necessary; facilitate entry of new insurers to compete for pool business; and provide annual open enrollment periods.

Those purchasing pools would differ from the early versions of association health plan and health mart proposals. Prespecified contractual restrictions would provide incentives to remain in the pool. Exit disincentives would provide long-term protections and minimize adverse selection. Actuarially fair prices still would be required at the outset.

Step Four: Recognize the diverse preferences, characteristics, and needs of individual consumers. Respect the decisions they make. Enforce private contracts as they are written. Don't prohibit risk-based pricing. Rely instead on targeted and transparent subsidies if modification of market-based results becomes necessary.

The Patients' Bill of Rights legislation is poised to outlaw or override what remains of the already paltry and unimaginative contractual options available in today's private health insurance market. Regulatory mandates, along with "judge-made insurance" coverage rulings, already discourage most efforts by insurers to stray very far from the medical community's consensus view of what insurers should finance ("medical necessity") and instead more explicitly offer consumers a range of coverage options that vary in quality, access, and pricing.

Accurate risk assessment often conflicts with political imperatives to enhance the role of insurance in risk distribution. But the problems of potential insurance customers with inadequate income or medically uninsurable risks could and should be addressed as social problems. Other more targeted means to handle them include safety net subsidies, private charity, community-based clinics, and high-risk pools that don't alter the relative prices of health insurance and medical care services.

Instead of applying a regulatory eraser to the competitive operation of private insurance markets, it's better to use a subsidy pen to write a more transparent check that redistributes necessary care to the needy.

If public policy incorporated the four steps that I have mentioned, we would head off the race to greater federal regulation aimed at patching the gaping holes in an unstable structure of already overregulated and oversubsidized employer-based group health insurance. Further drift toward greater federal control would tend to lock in a single regulatory framework resistant to competitive pressure. It would be prone to deliver just one answer, of comprehensive scope, likely to be the wrong one but difficult to reverse.

Which brings us to step five in finding a regulatory bypass. We need revitalized state regulatory competition that can reach across geographic boundaries. Competitive federalism could facilitate diversity and experimentation in regulatory approaches. It would slow down the second-guessing of market decisions, discipline the tendency of insurance regulation to promote inefficient wealth transfers, and promote individual choice over collective decisions driven by interest group politics.

Insurers facing market competition across state lines would have strong incentives to disclose and adhere to policies that encouraged consumers to deal with them. Firms would migrate to state regulatory regimes that didn't impose unwanted mandates but instead fit the needs of their customers. State lawmakers would become more sensitive to the potential for insurer exit.

What about the "race to the bottom" warnings? We've already run a different race to the bottom with overregulation. The losers end up uninsured--because they can't afford coverage or refuse to overpay for it. The race to the market top needs a full field of state regulators running in each other's markets. ■

STUDIES *Continued from page 9*

Helms-Burton Act" (Trade Briefing Paper no. 12), Mark A. Groombridge, research fellow at Cato's Center for Trade Policy Studies, finds that Helms-Burton, which punishes foreign-owned companies that engage in supposed "wrongful trafficking in property confiscated by the Castro regime," has backfired for several reasons. First, European officials say that U.S. intransigence undermines support for valued international institutions, notably the World Trade Organization. Second, Helms-Burton has failed to promote democracy in Cuba and has strengthened the hand of the Castro regime by providing a scapegoat for its own failed economic system. Third, the act will make it more difficult to settle property claims by dramatically raising their value from the current total of about $6 billion to as much as $100 billion. ■