UPDATE

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WHY CONGRESS SHOULD STOP FEDERALIZING PRIVATE HEALTH INSURANCE

(Updating *Executive Memorandum* No. 462, "Why Congress Should Not Impose Mandates on Private Health Insurance," September 18, 1996.)

A bipartisan coalition in Congress is set to impose—for the third time in as many weeks—yet another federal mandate on private health insurance. Traditionally, insurance regulation is a matter of state responsibility. Nonetheless, Senator Ron Wyden (D-OR) and Representative Greg Ganske (R-IA) are sponsoring legislation to prohibit private insurers from imposing contractual restrictions on physicians' written or oral communications with patients regarding their condition or treatment options. The sponsors in the Senate are seeking to attach this legislation to the FY 1997 omnibus appropriations bill to be voted on before the 104th Congress adjourns.

The Wyden bill would prohibit the contractual restrictions—called "gag clauses"—by which certain managed care companies limit participating doctors' communications with their patients regarding their patients' condition or treatment options. Some managed care plans use these gag clauses to control costs by limiting referrals to specialists. Many physicians and patients consider these clauses an interference with the doctor-patient relationship and thus unethical.[1] The Wyden bill would prohibit such clauses and assess civil monetary penalties up to $25,000 for each violation by an insuring entity.

The Wrong Solution to a Real Problem. The Wyden-Ganske initiative addresses a genuine concern among doctors and patients alike: their ability to communicate openly with one another about health and treatment options. At the same time, however, Congress should realize that these insurance arrangements are private employment contracts between insurers and participating doctors and are designed to "manage" the cost of care. For this reason, they are attractive to many private employers providing health insurance, though often not to patients. The problem is that under federal tax-supported employment-based insurance, patients normally have only the choice of plans and physicians that employers give them. The solution thus is not to add another layer of regulation to a system in which the patient has little power to choose plans, but to remove the bias in the tax code that effectively prevents patients from leaving plans that are not run in their interests. Moreover, to the extent plans should be regulated, that is the domain of the states, not Washington.

1 For an excellent discussion of this problem, see Kevin Vigilante, M.D., "The Ethical Imperative," in "Restoring the Doctor-Patient Relationship: A Physicians Council Symposium," *Heritage Lecture* No. 541, June 13, 1995, pp. 4-6.

Note: **Nothing written here is to be construed as necessarily reflecting the views of The Heritage Foundation or as an attempt to aid or hinder the passage of any bill before Congress.**

By enacting such federal mandates, including a clearly desirable and politically popular measure to preserve open dialogue between doctor and patients, Congress is inviting even more government control of America's health care system. Representative Rosa DeLauro (D-CT), for example, is drafting legislation to require private insurance companies to pay for "minimum" hospital stays of two days for a mastectomy and one day for a lymph node removal unless doctor and patient "decide less time is appropriate." Congress thus is getting into the business of benefit setting and legislating, in effect, the kinds and conditions, and even the duration, of medical treatments and procedures Americans must have. This is far beyond either its constitutional or its professional competence.

In commenting on the recently adopted federal health mandates, *The Washington Post* warns: "Because the estimated cost of these [proposals] is low, the sponsors say the question isn't real, not now at any rate. But sooner or later as Congress yields to the understandable impulses to help people who need it without, of course, appropriating funds, it becomes real.... What's troubling about the agreements that have just been reached is not so much what they themselves actually do as what they portend."[2]

More Federal Bureaucracy. The bureaucratic and regulatory requirements to implement the Wyden-Ganske policy could be substantial. According to Multinational Business Services, Inc. (MBS), a Washington-based regulatory consulting firm which studied the regulatory impact of Representative Ganske's legislation, H.R. 2976, the measure would require another new bureau within the Health Care Financing Administration (HCFA), the federal agency that runs Medicare and Medicaid. In 1993, according to the MBS report, there were 345,562,800 contracts between physicians and HMOs; under the proposed measure, at a minimum, between 0.25 and 0.5 percent of those contracts would be investigated for violations. According to MBS, the bureaucracy required to investigate complaints would consist of five divisions with staffing needs of between 3,640 and 7,142 full-time employees (FTEs): a Policy Unit (21 FTE); a Contract Review Unit (97 FTE); an Investigations Unit (between 2,354 and 4,708 FTEs based on complaint range of 0.25 to 0.5%); an Administrative Adjudication Unit (between 1,148 and 2,296 FTEs); and an Appellate Review Unit (20 FTE). Assuming a 0.5 percent complaint rate, HCFA would have to conduct 1,727,814 investigations per year. MBS insists that this is an "extremely conservative" estimate because it is based only on the HMO population, does not include Preferred Provider Organization (PPO) contracts, and assumes a complaint rate of less than 1 percent.[3]

More Lawsuits. MBS also says that such a policy change would create incentives for future litigation by doctors and patients against insurers, even when legitimate issues arise regarding appropriate authorization for treatment or referrals: "Accordingly, providers would have the incentive to use the filing of complaints under [this bill] as leverage against plans. Even when confronted with patently unreasonable complaints, health plans could, in many instances face the high cost of defending claims through the investigation, administration adjudication and judicial appeals levels; and the threat of the imposition of multiple penalties arising from multiple communications arising out of single disputes."[4] In addition, "this leverage to physicians would be paid for by the taxpayers of the United States who would have to finance HCFA's new bureaucracy with their tax dollars.... Thus, taxpayer dollars and patient premiums would be the linchpins providing physicians with unfair leverage."[5]

Higher Health Care Costs for Workers and Their Families. Under this legislation, the federal government would investigate and adjudicate on behalf of physicians. The insurer would be responsible for picking up the cost of defending these claims and would, in turn, pass that cost onto the consumer in the form of higher premiums. Indeed, the Congressional Budget Office (CBO) estimates that this legislation would

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2 Editorial, "Congress in a White Coat," *The Washington Post*, September 20, 1996.

3 "Regulatory Requirements of H.R. 2976," Multinational Business Services, Inc., 1996, p. 23.

4 *Ibid*., p. 5.

5 *Ibid*.

cost federal taxpayers $90 million between 1997 and 2002. This figure, however, does not take into account the administrative cost of investigating violations of the anti-gag clause measure—costs which, judging from the MBS report, could be significant. In a letter to House Commerce Committee Chairman William Bliley (R-VA), the CBO states that "the prohibition on medical communications is sufficiently broad that the bill might prevent health plans from imposing any requirements on medical communications. Depending on how courts interpreted the bill and on the level of enforcement performed by the Secretary of Health and Human Services, this limitation could be more important—and costly—that the prohibition of gag rules alone."[6]

Empowering Consumers. Two years ago, Congress and the American people rejected the wholesale attempt by the Clinton Administration to have the government dictate what kind of health care Americans get and how much they should pay for it. Apparently lacking a vision of what kind of health care system it wants, some Members of Congress—measure by measure, benefit by benefit—are federalizing and standardizing private health insurance. In effect, they are laying the foundation for the kind of Clinton-style health care system, replete with new bureaucracy and federal regulatory controls, that they once steadfastly opposed. But adopting regulatory expansions on a piecemeal basis does not make the end result more palatable.

Congress is right to be concerned about the rapid transformation in employer-based health insurance, especially if needed care is being limited or denied. Rather than move steadily in the direction of greater government control of America's health care system, reducing the freedom of doctors and patients alike, Congress should take steps to create a system of consumer choice and competition as proposed by the Heritage Foundation and many others. The best way to rectify inequities in the health care system, including the practice by which some corporations shortchange consumers, is to enable consumers to walk away from a physician or health plan that does not meet their needs.

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6 Congressional Budget Office letter to Congress, "Cost Estimate of H.R. 2976," August 1, 1996.