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THE PATIENT ACCESS TO RESPONSIBLE CARE ACT (PARCA) IS BAD MEDICINE

Rep. Charlie Norwood (R-GA) is sponsoring H.R. 1415, the Patient Access to Responsible Care Act (PARCA). Although the financing and delivery of health care are already very heavily regulated industries, Mr. Norwood's bill would substantially expand government control. It has attracted over 200 co-sponsors in the House on both sides of the aisle, and Senator Alfonse D'Amato (R-NY) has introduced companion legislation (S. 644) in the Senate.

PARCA would be desirable if it lowered health care costs while improving people's choices, but, in reality, it would hurt people on both fronts, raising health care costs and reducing options.

PARCA would impose many new responsibilities and requirements on managed health care plans, health-care insurers, and employers who self-insure their workers' health care coverage. One estimate is that implementing PARCA would result in 500 new federal regulations. Some of its provisions would:

- Require health plans to provide enrollees with highly detailed information in 13 separate areas;
- Bar plans from imposing "gag orders" on physicians and other health-care practitioners;
- Require plans to pay for many emergency room visits made without prior approval;
- Limit the ability of plans to use family doctors as gatekeepers between enrollees and specialists;
- Prohibit plans from denying coverage or reimbursing at a lower rate if enrollees go to physicians and other practitioners outside the plan;
- Bar plans from denying coverage to applicants on the basis of age, medical history, and certain other criteria (known as a guaranteed issue requirement) and bar plans from basing rates on age, existing conditions, and certain other criteria (known as community rating);
- Override the Employee Retirement Income Security Act (ERISA) by letting employees of businesses with self-insured plans include the businesses as defendants in malpractice suits.

PARCA is largely a reaction to the explosive growth of health maintenance organizations (HMOs) and other managed care plans. Between 1993 and 1996, HMO membership rose by 50%, from 45 million to 67 million. Managed care plans provide a trade off: they are less expensive than fee-for-service plans, but they achieve much of their cost savings by limiting medical access. That trade off is not necessarily bad. Just as people often choose to save money on a trip by traveling coach rather than first class, some people desire to accept the limitations of a managed care plan in order to enjoy its cost savings.

Because managed care plans have been growing so rapidly, however, many people are new to them and did not understand the service-cost trade off before enrolling. In addition, some plans may have restricted service too much in their efforts to control costs. Further, most people receive employer-provided health coverage, and some of those people, especially at smaller companies, were switched by their employers into cost-saving managed care plans

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without the option of selecting a higher-cost, higher-service plan.

None of these problems needs PARCA in order to be addressed. Some of the people who switched to managed care plans without recognizing the limitations will decide higher-service plans are worth the extra cost and choose to switch back. Plans that went too far in trying to control costs are under pressure in the marketplace to ease their restrictions. As for people unhappy about being switched into managed care plans by their employers, employers have no motivation needlessly to alienate their workers. If employers find that workers prefer higher-service plans sufficiently to pay higher costs, employers will switch their workers back (and the workers will pay the extra cost through higher employee premiums or by accepting lower wages.)

PARCA would be desirable if it lowered health care costs while improving people's choices, but, in reality, it would hurt people on both fronts, raising health care costs and reducing options. For example, by limiting the ability of an HMO to determine if a patient truly needs to see a specialist and by requiring managed care plans to pay for many emergency room visits that the plans do not believe are real emergencies, PARCA would destroy some of the tools that have enabled managed care plans to control costs and offer enrollees lower rates.

The higher costs would harm people in two ways. First, it would force some people to spend more for health coverage — which means less for everything else — than they would choose to spend if they had the option of purchasing lower cost coverage. Second, the higher costs would reduce the number of people with health insurance: as costs rose, some people would forgo buying coverage and some employers would stop offering it. The Congressional Budget Office (CBO) has estimated that a 1% rise in premiums would cause 200,000 workers to lose their coverage; a study by the Lewin Group puts the figure much higher: 600,000 workers. The actuarial firm of Milliman & Robertson estimated that PARCA would boost health premiums by 23%. These estimates imply that PARCA would push between 4 million and 14 million workers into the ranks of the uninsured.

Rep. Norwood says his bill would not impose guaranteed issue, community rating, and some of the other requirements assumed by Milliman & Robertson. Relying on what Rep. Norwood states is his legislative intent, Muse and Associates has produced a much lower cost estimate: a 0.7% to 2.6% rise in health insurance premiums. While that still means hundreds of thousands of people would lose their health care coverage, the Muse estimate led Rep. Norwood to call his bill "the bargain of the century." Critics, however, charge that the bill's actual statutory language is far more demanding than Rep. Norwood's description and suggest that, at a minimum, the bill needs to rewritten to remove the apparent contradictions.

To be sure, some provisions in PARCA would not be as costly as others. Its information-to-enrollees requirements are one of its less expensive provisions. (But the detailed statements PARCA demands would be more costly to prepare and confusing to read than a more basic information packet.) PARCA's anti-gag rule, at least the part saying that practitioners cannot be barred from telling patients about treatment options, has received widespread publicity, but a General Accounting Office (GAO) study of 529 HMOs found that not a single one had an explicit gag rule. Prohibiting what is not done is not costly.

On the other hand, the many sections of PARCA restricting plans from limiting services in return for lower rates strike at the heart of the concept of managed care. PARCA would also severely injure policy affordability by mandating community rating and guaranteed issue.

Under community rating, young people with few health problems must be charged as much as older people with many problems. This forces a

wealth transfer of hundreds or even thousands of dollars per policy every year from young people to older, usually better off people. In response, many young, healthy people drop their suddenly-more-expensive health insurance, which compels insurers to raise rates again and causes still more people to go uninsured. When community rating and guaranteed issue are combined, a person can delay buying health care coverage until an illness develops and then pick up coverage without penalty. The result of these government mandates is horrendous adverse selection and stratospheric rates. For example, a National Center for Policy Analysis study reports that in 1997 in New Jersey — a state with both community rating and guaranteed issue — a standard family health insurance policy had an average cost of $18,708, while in Pennsylvania — a state without those government mandates — a similar policy cost about $3,600.

Employers with self-insured plans provide about 40% of U.S. workers with their health coverage. These plans are made more economical by ERISA, which generally shields the employers from being included with doctors and hospitals in medical malpractice suits filed in state courts and by exempting self-insured plans from often costly state mandates regarding health benefits. One section of PARCA, however, would expose employers with self-insured plans to being included in state-court malpractice suits. Perversely, this new consumer "protection" would encourage businesses to terminate their workers' health benefits rather than face potentially huge tort-system risks. Businesses that did retain benefits would pass along to workers the new, high legal costs, inducing many workers to drop their coverage. Rep. Norwood has introduced a stand-alone bill, H.R. 2960, that he claims would fix this provision, but critics doubt it really would. Costs would also rise for self-insured plans because PARCA would overrule ERISA by requiring them to meet numerous, costly state mandates: wherever PARCA's requirements and state mandates overlapped and the state mandates were stricter, plans would have to meet the state mandates.

What is often called the health care crisis in America is mainly a problem of high costs and impaired affordability. Many government actions have contributed to high costs: excessive government regulations, government mandates, government-dictated cost shifting, the tax subsidy for employer-provided health coverage, and distortions caused by an out-of-control tort system. Governments ought to be reexamining their policies to eliminate unnecessary cost pressures, thereby improving affordability. If government policies did not drive medical costs so high, providers would not have to make as many quality-cost trade offs. PARCA, unfortunately, is an added dose of bad medicine that will drive costs even higher by imposing another round of costly, choice-limiting government rules and regulations.

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