Walton Francis, revised 10/3/2003
Major System/Approach
Tax Preferences for Insurance & Care Purchased through Employer
Bankruptcy System
State Regulation of Health Insurance
Tort System
COBRA/HIPAA Prohibition of Employer Vouchers
Allowing Medicare Participation by HMOs (M+C)
M+C Regulations
M+C Payment through AAPCC Method
$800 Hospital and $100 Physician Deductibles
Any Licensed Physician Standard for Medicare and Medicaid Participation
Failure to Cover Rx Costs
"Usual, Customary, and Reasonable" Payment System (now abolished)
Prospective Payment/Diagnostic Review Group (DRG) Medicare Hospital Payment System
One Price Fits All Hospital/MD payments
RVRS Physician Payment System
"Face to Face" Medicare Payment Requirement
Paying Providers a Price Near Median of Provider Costs
Wholesale Price-based Retail Payment System for Drugs
Annual Bidding for"Winner Take All" Insurance Contracts in TriCare
Minimal or No Cost Sharing for Medicaid, TriCare, and some Medicare Procedures
Conditions of Participation Regulations
EMTALA Regulations
Clinical Laboratory Regulations
Blood-borne Pathogen Regulations
Mammography Regulations
Stark I and Stark II Fraud Rules
Government-granted Monopoly on CPT (Medical Procedure) Codes and Definitions
HIPAA Electronic Medical Transactions and Records Standards Regulations

Congress and
IRS
Courts
States
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OSHA
FDA
CMS/IG/ Justice
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CMS

"One Page" Listing of Federal Health Care Regulations with Major Economic Effects
Comment/Principal Effects
Marginal 30% subsidy leads to over purchasing of first dollar coverage and adds $multi-hundred billion in needless health care spending; mainly benefits upper income taxpayers; discriminates against those who must meet 7% spending threshold to deduct medical costs.
Bankruptcy is by far the largest payer of high bills incurred by the uninsured; makes it rational for young workers to avoid insurance.
Bizarre system under which the Federal government abdicates its commerce clause powers and a company must meet 50 different sets of State standards to sell nationally; many states prohibit sale of insurance products.
Provides powerful though costly incentives for quality of care; arguably counterproductive in encouraging expensive "defensive medicine" and coverage of experimental treatments.
Employees denied vouchers to purchase individual policies; prevents market for small and large businesses relying on consumer choice.
Allows "Internalizing the Externalities" for health care; encourages disease management, innovations, and quality.
Burdensome rules governing participating HMOs such as illegal interpreter requirements and meeting Medicare standards; information dissemination both prescriptive and ineffective in contrast to OPM.
Overpays HMOs in some areas and denies HMO choices in other areas because payment levels dominated by excessive geographic weights.
Foolish Medicare design taxes involuntary costs in order to subsidize $tens of billions in over utilization of routine care.
Not only eliminates incentives for smart purchasing, but encourages "Medicaid mills" and other frauds.
Prevents disease management and discriminates by disease.
Pre-1984 payment system fueled price inflation by rewarding annual increases in physician fees, and fostered over utilization by paying on a per procedure basis.
"Prudent purchaser" system pays average cost for procedure rather than cost plus. $Tens of billion annual savings through incentives to lower length of stay and costs. Led private sector to same innovation. However, paying by procedure still rewards over utilization. Also shifts costs to private sector.
The most and least competent hospitals and surgeons are paid the same; quality sabotaged.
Application of "Comparable Worth" system of government set wages in place of market wage differentials; rewards wasteful over utilization by paying on a per visit or procedure basis.
Electronic second opinions are not paid which impedes rural access, better quality, and reduced costs.
Powerful dynamic incentive to keep costs down, which lowers next year's median; applied to nursing homes, renal dialysis, and many others, but not to drugs or physicians. Has led to quality problems.
Medicaid pays pharmacies "average wholesale price" as self-defined by drug companies, plus a dispensing fee. System is notorious for fantasy, but requires pharmacies to dispense at fees generally lower than private pay customers.
Reduces incentives for disease management; deprives consumers of stability in provider choices.
Leads to wasteful over utilization by consumers because they face no costs for services, and by providers because they know this.
Quality standards for hospitals, nursing homes, home health care, renal dialysis, organ procurement, etc. are doubtfully effective and expensive. Medicare genesis but cover all patients and practices. Forbid violations of "any law", even totally unrelated. Many unneeded credentialing requirements. Few performance standards and these minimally enforced.
Burdensome rules (recently amended) to prevent "dumping" of uninsured patients by emergency rooms.
Burdensome rules that are a major intrusion into the physician's office and have little or no effect on quality.
Burdensome rules governing not only practice of medicine and dentistry, but also matters such as washes laundry.
Rules governing mammography procedures were ineffectively administered by CMS and transferred to FDA; net cost and benefit unknown but may be positive.
Highly detailed and prescriptive standards attempt to eliminate financial inducements to spending; many bizarre side effects and do not address the most direct incentives such as more income from more visits/procedures.
AMA copyrighted system, mandated for Medicare by CMS and widely used in private sector, prevents dissemination of consumer information on prices of health care because AMA will not allow use of codes for this purpose.
Once implemented, may substantially assist in reducing administrative costs and in improving quality of care; but will greatly increase threats to privacy through access by hundreds of thousands of government officials.