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Medicare's Progeny:

The 1996 Health Care Legislation

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CHARLOTTE TWIGHT

On August 1 and 2, 1996, Congress cleared for the president's signature the Health Insurance Portability and Accountability Act of 1996, known in the press as the Kennedy-Kassebaum bill. There was little dissent: the House vote approving the conference report on the bill was 421 to 2, the Senate vote 98 to 0. The press response was muted but unquestioningly favorable. After all, this bill was said to bring about health insurance "portability" and "accountability." President Clinton signed the bill into law on August 21, 1996.¹

Unbeknownst to most Americans, the 1996 act contained major provisions of the Clinton administration's previously rejected 1993 Health Security Act. How did some of the most feared provisions of the 1993 proposal—potentially threatening innocent physicians with federal criminal penalties and jeopardizing the privacy of doctor-patient relations through a nationwide electronic database—become law in 1996 virtually without opposition? The remarkable truth is that the political strategies that facilitated passage of this bill are the same as those that allowed the original Medicare law to be passed in 1965 after decades of public rejection of federal health insurance measures. In both cases advocates achieved their goals by manipulating political transaction costs to deflect and silence public opposition.

1. Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (August 21, 1996). This bill was agreed to by the House-Senate conference committee appointed following passage of differing bills by the two chambers: the House of Representatives had passed H.R. 3103, the Health Coverage Availability and Affordability Act of 1996, on March 28, 1996 (267 to 151); the Senate had amended the House bill with substitute language passed as S. 1028, the Health Insurance Reform Act of 1996, on April 23, 1996 (100 to 0).

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The Independent Review, v.II, n.3, Winter 1998, ISSN 1086-1653, Copyright © 1997, pp. 373-399

Imagine a well-publicized congressional vote on a widely understood single issue: whether to mandate creation of a uniform national electronic database requiring the recording and transmission of personal health information revealed by private individuals to their doctors, with no privacy protection required to be put in place for three and a half years. That one cannot imagine passage of such a measure highlights the importance of transaction-cost manipulation in facilitating and sustaining government encroachments on what people long regarded as inviolable rights. Congress in 1996 passed exactly such a privacy-threatening database law—but not as a stand-alone measure and without either publicity or public understanding of its substance. The trick used by proponents of such measures is to raise the transaction costs to voters (and to congressmen) of resistance—a trick performed as ably in 1996 with the Health Insurance Portability and Accountability Act as in 1965 with the Medicare legislation. In both cases transaction-cost-increasing political strategies such as tying, incrementalism, and misrepresentation were used to establish new governmental powers whose implementation in turn would raise the transaction costs to citizens of resisting this expanded federal authority.

I shall consider the 1965 Medicare legislation and the 1996 Health Insurance Portability and Accountability Act as linked case studies of the accretion of federal power over U.S. health care. The facts of the individual cases and the theory linking them reveal a political process of greater regularity and generalizability than a consideration of either law in isolation would suggest. Readers concerned about the future of freedom may find my conclusions disturbing. Advocates of expanded federal authority persist, and manipulation of political transaction costs combined with induced ideological change allows them to work their will in the longest of long runs.

A Theory of Institutional Change

For many years I have worked to develop and test a theory of government manipulation of constitutional-level transaction costs (Twight 1983, 1988, 1994). That theory will serve as a backdrop for the analysis of health-care legislation that follows. Although it would be inappropriate to reiterate the full theory here, some definitions and a brief summary will be useful.

I define constitutional-level transaction costs as the costs to individuals of negotiating and enforcing collective political agreements that influence the scope of government authority—the line dividing what is handled by government from what is regarded as outside its purview. Constitutional-level political transaction costs so defined encompass both costs of *perceiving* relevant political information (information costs) and costs of *acting* on those perceptions (which I term “agreement and enforcement costs”).²

Animating the theory is the idea that government officials as individuals often have both the incentive and the capacity to manipulate the political transaction costs facing private citizens (and each other) so as to achieve more of what officeholders

want with less resistance from the public. This quest often involves transaction-cost augmentation—artificially increasing the costs to private citizens of resisting authority-changing measures favored by particular officeholders. The motive for this behavior is readily understandable: if government officials can increase the marginal costs to voters of understanding or taking political action to oppose a measure that changes the scope of government authority, they can reduce political resistance. For example, officeholders may mitigate resistance by misrepresenting a bill's contents, using incremental strategies, tying controversial measures to popular ones, using tax strategies that obscure a program's cost, and the like. The theory strongly rejects the supposition that government always functions to minimize politically relevant transaction costs.

Artificially increased political transaction costs thus drive a wedge between voter preferences and political action that reflects those preferences. The theory identifies various determinants influencing an individual officeholder's decision to favor a transaction-cost-increasing measure: executive and party support for the measure, impact on officeholder job security and perquisites, third-party payoffs, officeholder ideology, the measure's complexity and perceived importance to constituents, publicity, time, and the existence of an appealing rationale for the measure (Twight 1983, 1988).

Once in place, institutional changes that increase the public's transaction costs of resisting expanded federal authority set in motion a process of accommodative ideological change that further lessens the likelihood of restoring the status quo ante (Higgs 1985, 1987; Kuran 1995). Twentieth-century U.S. politics has supplied countless examples of government manipulation of constitutional-level transaction costs fostering institutional changes followed by sympathetic ideological change. The legislative histories of Social Security, income-tax withholding, public education, and other government-expanding measures have proved consistent with this interpretation (Twight 1993, 1995, 1996). What about Medicare?

Medicare's Passage in 1965: Tactical Blueprint for 1996

Medicare did not emerge spontaneously in 1965.³ Its passage had been sought continuously since 1934 by a group of advocates within the federal government. For three full decades the concept of compulsory national health insurance had been rejected, year after year, by Congress and the public (Twight 1997). Of interest here are the strategies proponents employed to overcome this demonstrated public opposition.

National health insurance first appeared on the federal government's agenda in a serious way in 1934,⁴ when President Franklin Roosevelt established the Committee on Economic Security (CES) and charged its members with formulating recommendations for a social security bill. Included in their initial recommendations, with

2. The phrase "political transaction costs" also is used to denote these constitutional-level transaction costs.

3. I analyze the history of Medicare in greater detail in Twight (1997).

Roosevelt's approval, was a provision for the study of national health insurance. That provision caused such resistance that President Roosevelt successfully sought its removal from the resultant bill in order to secure passage of the Social Security Act of 1935 (Corning 1969, 38; Chapman and Talmadge 1970, 342).

Nonetheless, the president and the Social Security Board proceeded as if the original statutory language had been retained. The day after the Social Security Act was signed, Roosevelt appointed the Interdepartmental Committee to Coordinate Health and Welfare Activities to consider health insurance. That committee created the Technical Committee on Medical Care, whose 1938 report led to the "climate-building" National Health Conference and Interdepartmental Committee recommendations that included, *inter alia*, a "general program of medical care, paid for either through general taxation or social insurance contributions" (Poehner 1979, 19).

Thereafter, bills on this subject were introduced in virtually every session of Congress. Beginning in 1943, the Wagner-Murray-Dingell bills sponsored by Senator Robert Wagner (D.-N.Y.), Senator James Murray (D.-Mont.), and Representative John Dingell (D.-Mich.) explicitly proposed universal compulsory national health insurance. Advocates from the Social Security Board often drafted the bills and cajoled willing legislators into introducing them. These executive-branch officials' names echo across the pages of thirty years of legislative history: Isidore Falk, Wilbur Cohen, and Robert Ball, among others. Though their positions changed when reorganizations occurred and when inclement political conditions arose, they were never far from the drafting of the bills. Throughout this period, government officials tried hard to change public opinion on this topic (surveys in 1942 showed 76.3 percent of the public opposed to government provision of free medical care), in one case successfully intervening prior to publication to persuade the authors of a *Fortune* magazine article to change their conclusions regarding the Wagner-Murray-Dingell bill (Poehner 1979, 45; Cantril 1951, 440). Martha Derthick (1979, 317) remarked that "Nowhere is the aggressiveness of social security program executives better demonstrated than in these early campaigns for national health insurance."

Deliberate reliance on incremental strategies began in earnest in 1951. It was a turning point. After discouraging results for advocates of compulsory national health insurance in the 1950 elections, program executives including Social Security officials Cohen and Falk realized that they could not succeed with a *universal* compulsory health insurance plan. As a result, in the spring of 1951 they began to work for a narrower program specifically targeted at the elderly. Such bills were introduced repeatedly throughout the Eisenhower years, as advocates tried to keep the idea alive.

4. For discussion of the history of the federal government's treatment of health-care issues in the United States from 1793 forward, see Chapman and Talmadge (1970). See Wasley (1992, 49-50, 55-58) for discussion of the federal government's role in stimulating employer-provided, first-dollar-coverage health care and in shaping the health-insurance market.

In 1956, in a political development that Derthick (1979, 319) regarded as a “necessary prelude” to Medicare, a statute providing disability coverage was passed, whereupon the AFL-CIO recommitted itself to the fight for compulsory national health insurance. Along with Cohen, Falk, and Ball, Nelson Cruikshank (head of the AFL-CIO’s Department of Social Security) spearheaded the drafting of a bill proposing hospital, surgical, and nursing-home benefits for social security recipients. Their bill became the Forand bill, introduced by Aime J. Forand (D.-R.I.) but rejected by the House Ways and Means Committee in 1959. In 1960, in an effort to forestall more comprehensive legislation, House Ways and Means Committee chairman Wilbur Mills (D.-Ark.) and Senator Robert Kerr (D.-Okla.) introduced and secured passage of the Kerr-Mills program of needs-based medical assistance for the aged.

This preemptive effort failed to stem the tide. In 1961 and again in 1963 Representative Cecil King (D.-Calif.) and Senator Clinton Anderson (D.-N.M.) introduced another bill patterned on the Forand bill. When the landslide election of President Lyndon Johnson changed the political calculus in 1964, the King-Anderson bill became the basis for the administration’s health-care proposals, H.R. 1 and S. 1.

Incrementalism in its various forms—including the decision to target the elderly in the belief that they represented the most sympathetic group—was a deliberate and sustained strategy that increased the costs to the public of resisting compulsory national health insurance. After the 1964 elections, when for the first time all of the determinants discussed earlier favored pro-Medicare transaction-cost augmentation, Congress used additional transaction-cost-increasing strategies to pass and entrench the Medicare bill (Twight 1997).

First, the Medicare bill was included within—and tied to—the Social Security Amendments of 1965. Chief among the politically irresistible features of the broader package was a 7 percent across-the-board increase in social security cash benefits—not to mention maternal and child-health services and the like. To vote against Medicare, a legislator had to vote against that 7 percent social security benefit increase, made retroactive to January 1, 1965. Congressmen in a 1964 conference deadlocked on the Medicare issue had decided to forgo a Social Security benefit increase agreed to by both houses of Congress in order to permit this tie-in and thereby give Medicare another chance in 1965 (Twight 1997).

Some legislators objected to the linkage. Representative John Byrnes (R.-Wisc.) decried the fact that Medicare’s “proponents are unwilling to let [it] stand on its own feet and rise or fall on its own merits,” instead choosing to “tie [it] to the now controversial amendments to the Social Security Act” (*Cong. Rec.*, House, April 7, 1965, 7220). Representative Delbert Latta (R.-Ohio) asked his colleagues “why the administration and the Medicare backers were afraid to let this so-called Medicare part of this bill come to the floor of the House by itself . . . and be voted up or down on its own merits. What were they afraid of?” (*Cong. Rec.*, House, April 8, 1965, 7420). When the Senate vote drew near, Senator Milward L. Simpson (R.-Wyo.)

spoke bluntly about his personal unwillingness to succumb to the incentives created by the tie-in: “I choose not to prostitute my vote in this matter and because portions of this bill are objectionable to me, I am compelled to vote against the total bill, even though I support parts of it” (*Cong. Rec.*, Senate, July 8, 1965, 15874). In the end, however, most did succumb.

Second, legislators and others in government misrepresented the Medicare bill’s contents. Although private citizens were led to believe that Medicare was designed in part to avoid the financial devastation associated with extended illness in old age, catastrophic illness was not covered by the bill. As originally introduced in 1965, H.R. 1 and S. 1 covered only sixty days of hospital care, sixty days of nursing-home care, and some laboratory and X-ray services. Senator Russell Long (D.-La.) challenged Department of Health, Education, and Welfare (HEW) Secretary Anthony Celebrezze for his duplicity on this point, stating, “Well, in arguing for your plan you say let’s not strip poor old grandma of the last dress she has and of her home and what little resources she has and you bring us a plan that does exactly that unless she gets well in 60 days” (U.S. Senate 1965, 183). Ordinary physicians’ visits, therapeutic drugs, and the like were not covered by H.R. 1 and S. 1. Nonetheless, the public widely believed that the proposal represented comprehensive coverage of all medical needs of the elderly as suggested by use of the term “Medicare,” a label originally applied to a comprehensive medical program for military dependents.

There were other misrepresentations as well. To counter the public’s fear that Medicare would allow government control over the provision of medical care, government proponents of Medicare included a provision in the bill specifically disavowing such control. The disavowal was a charade. As Representative Thomas Curtis (R.-Mo.) remarked, “If you look at the bill, right at the very beginning there is a great big label. . . . It says there will be no Federal interference, and that free choice by the patient is guaranteed. Then the next 70 pages tell you how the Federal interference will be carried out” (*Cong. Rec.*, House, April 7, 1965, 7231). Nonetheless, the statutory language made it more difficult for the public to understand that control was inevitable if government was empowered to determine and pay “reasonable” charges for medical services.

In addition, legislators and program executives falsely represented the Medicare bill as a way to “avoid dependence” in old age. As already noted, the omission of coverage for catastrophic illness guaranteed that the elderly would not be protected against this most feared condition. More important politically, the appeal of “avoiding dependence” put a favorable gloss on an unspoken rationale for much public support for Medicare—the desire of adult children to avoid responsibility for their aging parents’ medical bills.

Other transaction-cost-increasing strategies involved cost concealment associated with Medicare’s financing. Because the program was to be financed through the payroll tax, employer withholding of the Medicare taxes would make it more difficult for em-

ployees to perceive their magnitude. Moreover, the Medicare tax was nominally split between employers and employees, further obscuring the employee's full tax burden (Browning 1975). Even today few people understand that the payroll taxes nominally paid by employers are largely borne by employees. Government officials downplayed the regressivity of the payroll tax and ignored the protests of congressmen such as Senator Russell Long (D.-La.), who asked, "Why should we pay the medical bill of a man who has an income of \$100,000 a year or a million dollars a year income?" (*Cong. Rec.*, Senate, July 9, 1965, 16096). Although people were told that their money would be put in a separate Medicare trust fund and that they would be paying for "insurance" to defray the cost of illness in their later years, many legislators understood that there would be no such prepayment, referring to the "myth" of prepayment and "the subterfuge of a separate tax and a separate trust fund" (U.S. House 1965b, minority views, 251; *Cong. Rec.*, House, April 8, 1965, 7405). Only the public was fooled.

Finally, there was Wilbur Mills's "three-layer cake." Having blocked passage of Medicare legislation in previous years, Representative Mills (D.-Ark.) decided after the 1964 election that passage of a Medicare bill was inevitable. Accordingly, he would use his copious power as chairman of the House Ways and Means Committee to shape it to his liking.

Mills did so through transaction-cost manipulation. He refused to allow open public hearings on the 1965 bill. Instead, he invited only select technical experts to testify in executive sessions of the committee, allowing them to discuss only the technical aspects of the proposed bills. Discussion of "philosophy" or ideology was ruled out. After the suggestions of the experts had been heard, the executive sessions were closed; the public and the press were barred. No printed record of the closed sessions was made available to Congress or the public. In addition to discussing the administration's King-Anderson bill, Mills and his committee also debated alternative proposed bills, including Representative John Byrnes's (R.-Wisc.) "better-care" bill proposing coverage of physicians' services and the AMA bill ("elder-care") suggesting improvements in the Kerr-Mills program.

To many people's surprise, what emerged from the House Ways and Means Committee with a recommendation for passage was a composite bill that combined the three approaches—a "three-layer cake" along lines first suggested by Wilbur Cohen (U.S. House 1965a, 123-24). The first layer was the King-Anderson approach, financing compulsory federal hospital insurance for the elderly under the Social Security program through additional payroll taxes. The second layer was "voluntary" medical insurance ("supplemental medical insurance") for the elderly that would cover physicians' services, with 50 percent of the premium paid by the subscriber and—despite the ostensibly voluntary nature of the insurance—50 percent paid for out of general revenues of the federal government. The third layer was an expansion of the Kerr-Mills program for the aged poor, partly financed by the federal government and partly financed by state governments.

This bundle was tied together as the recommended Medicare legislation, which in turn was tied to the other components of the Social Security Amendments of 1965 such as the 7 percent cash benefit increase. Rechristened as H.R. 6675, the committee-recommended bill went to the House floor under a closed rule, which did not permit amendments.

The closed hearings, closed rule, and tying—along with incrementalism, misrepresentation, appealing rhetoric, and cost concealment—were significant components of the transaction-cost augmentation leading to the passage of Medicare (Twight 1997). So constructed, the package was politically irresistible, as confirmed by House and Senate action on the bill in the summer of 1965.⁵ Once in place, Medicare institutionalized transaction-cost barriers for the future. As Senator Carl Curtis (R.-Neb.) expressed it:

[I]f we button it into social security we will write it into perpetuity and will never have another opportunity to consider another plan voluntary in nature involving the private enterprise concept, once the proposed legislation is enacted. Once we start the procedures of taxation and withholding on the basis of a social security withholding tax, it then becomes too late to unscramble the omelet. (*Cong. Rec.*, Senate, July 9, 1965, 16121).

Button it in they did. Thirty years later, some of the same strategies would be used to further increase federal authority over U.S. health care.

The Health Insurance Portability and Accountability Act of 1996

I don't see the logic . . . of how we could keep that confined to that aged group. The logic looks like once we have done this we are going to have to extend it further. That is why I think logically people say this will lead to socialized medicine, not saying those who advocate it are Socialists—I want to emphasize that again—but would lead to the technique of the Government moving heavily into the entire field of health care.

Representative Thomas B. Curtis (R.-Mo.)
(U.S. House 1963-64, 137)

Representative Curtis was right about the logic. As he predicted over thirty years ago, government has continued to move ever more heavily into the “entire field of health care.” Steps taken in the intervening years, such as the Health Maintenance

5. The House of Representatives passed the Social Security Amendments (H.R. 6675) on April 8, 1965, by a vote of 313 to 115, approving the conference report by a similar margin (307 to 116) on July 27. The Senate passed a different version of H.R. 6675 on July 9, 1965, by a vote of 68 to 21 and subsequently adopted the conference report on July 29 by a vote of 70 to 24. President Lyndon Johnson signed the Social Security Amendments of 1965 into law on July 30, 1965 (Public Law 89-97).

Organization Act of 1973, will not be discussed here. Instead, I shall focus on the sequence of events beginning with the Clinton administration's proposal of the Health Security Act in 1993.

The Clinton administration's 1993 proposal, if passed, would have mandated a virtual federal takeover of health-care delivery in the United States, mandating ubiquitous price and service controls administered by regional alliances subordinate to a "National Health Board." The bill was 1,342 pages long, developed in secret by a group of Hillary Clinton's friends and associates.⁶ It was presented to the American public with great fanfare, the president touting every American's entitlement to a "health security card" and the comprehensive health benefits said to accompany it. Despite the fanfare, many people became alarmed about the bill's implications when articles were published detailing extensive criminal sanctions to be applied to physicians and regimentation to be mandated throughout U.S. health-care markets under the Health Security Act. The bill died, and many people breathed a great sigh of relief.

That sigh of relief was premature. Intentionally or unintentionally, advocates of more invasive government controls over U.S. health care took a page from the 1965 Medicare strategy book. Many of the strategies used to pass Medicare in 1965 were deployed again in 1996 to secure passage of the Health Insurance Portability and Accountability Act.

Although the title of the Health Insurance Portability and Accountability Act of 1996 sounds wholly benign, its content is not. By using the strategies of transaction-cost manipulation that served Medicare's proponents so well in 1965, advocates of government control over U.S. health care secured passage of a law that includes some of the most feared provisions of the Clinton administration's 1993 Health Security Act. Many of the 1993 provisions that potentially threaten innocent physicians with federal criminal penalties and jeopardize the privacy of doctor-patient relations through a nationwide electronic database literally were copied from the earlier bill and included verbatim in the 1996 law. Yet dissent—or even attention to these provisions—scarcely arose. With little notice in the press, the House and Senate gave virtually unanimous final approval to the Health Insurance Portability and Accountability Act in early August 1996.⁷

Little-Known Provisions of the 1996 Bill

Without doubt, the Health Insurance Portability and Accountability Act of 1996 contains some features that most Americans value highly, including portability provisions

6. Intellectual candor requires acknowledgment that it was 1,342 pages in *double-spaced* format. Perhaps in future years there will be a movement to distribute bills to the public only in single-spaced format.

7. As noted earlier, the votes giving final approval to the conference report were 421 to 2 in the House and 98 to 0 in the Senate (August 1-2, 1996). Prior votes occurred in the spring, the House of Representatives passing H.R. 3103 by a vote of 267 to 151 on March 28, 1996, and the Senate passing its version of the bill by a vote of 100 to 0 on April 23, 1996.

to prevent loss of health insurance triggered by job changes, significant health insurance access and renewability guarantees, and—on an experimental basis—medical savings accounts to establish greater individual financial stakes (and hence cost consciousness) in making health-care choices.⁸ Ironically, during the 1996 bill’s consideration few acknowledged that some of the problems at which its provisions were aimed—job lock, inadequate portability—themselves arose from earlier government interventions.⁹ This history notwithstanding, the appeal of the core ideas of portability and renewability cannot be overstated: the *Congressional Record* is rife with the stories of people whose long-standing insurance coverage was canceled after serious illness occurred and others whose continued coverage, due to family illness, depends on staying in their present job. Highlighted in congressional and media statements, the portability and renewability issues figured importantly in political strategies used to secure the bill’s passage, as will be discussed later.

But Congress and the press did not openly tell the public about other provisions, including a bevy of federal criminal sanctions potentially threatening innocent physicians and a national electronic database threatening the privacy of individuals’ medical records. Most of these provisions appear in Title II of the new law under the heading “Preventing Health Care Fraud and Abuse; Administrative Simplification.”¹⁰ Although many congressmen’s fears about these provisions were quieted as proponents insisted that “[t]his is not ‘Clinton Lite,’” such acquiescence was misguided (*Cong. Rec.*, Senate, April 18, 1996, 3543).

8. Medical savings accounts (MSAs) were hotly debated during consideration of the 1996 bills. A provision authorizing MSAs was included in the original House bill (H.R. 3103) but not in the substitute Senate bill (S. 1028). The MSA provision included in a Senate amendment offered by Senator Robert Dole (R.-Kans.) was deleted on a recorded vote of 52 to 46 (*Cong. Rec.*, Senate, April 18, 1996, 3568). During floor consideration, proponents clearly stated the positive role of MSAs in increasing patient choice: Senator Rick Santorum (R.-Pa.) suggested that they be called “Patient Choice Accounts.” Senator Phil Gramm (R.-Tex.) identified MSAs as one of two fundamental reforms capable of improving the existing health-care system (*Cong. Rec.*, Senate, April 18, 1996, 3539, 3566). Professor Milton Friedman’s (1996) article supporting MSAs was entered into the record on more than one occasion (*Cong. Rec.*, Senate, April 18, 1996, 3540-41, 3555-56). The House-Senate conference committee compromised by authorizing a four-year experiment with MSAs as described in the text.

9. Citing the origin of today’s employer-provided health care in World War II’s wage and price controls, Milton Friedman (1996) noted that “[b]ecause private expenditures on health care are not exempt from income tax, almost all employees now receive health care coverage from their employers, leading to problems of portability, third party payment and rising costs that have become increasingly serious” (A20). Even the push for a federal solution to many insurance-coverage problems flowed from earlier legislation. Senators and the General Accounting Office (GAO) said that states could not solve key problems because earlier Employee Retirement Income Security Act of 1974 (ERISA) legislation had preempted state insurance regulation for a large category of health benefit plans, namely, employer self-funded health plans. As Senator James M. Jeffords (D.-Vt.) put it, “ERISA preemption effectively blocks States from regulating most employer-based health plans. . . . [E]mployer plans that cover 44 million people have elected to self-fund and avoid the State insurance laws” (*Cong. Rec.*, Senate, April 18, 1996, 3519-20).

10. Although the outcome might have been different had the heading been phrased “Criminalizing Private Medical Practice; Compulsory Electronic Database,” such forthrightness would have been altogether inconsistent with transaction-cost manipulation theory.

One of the purposes of the new law is to limit Medicare fraud, said to cost Americans approximately \$18 billion annually (*Cong. Rec.*, Senate, April 18, 1996, 3568). Accordingly, the new law establishes a "fraud and abuse control program" to be administered by the Department of Health and Human Services (HHS) and applied to any "federal health care program," defined as "any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government" as well as any "state health care program" [§204(f)].

In provisions cribbed from §5401 of Clinton's 1993 bill, the 1996 act empowers the secretary of HHS, *inter alia*, "to conduct investigations, audits, evaluations, and inspections relating to the delivery of and payment for health care in the United States," to "arrange for the sharing of data with representatives of health plans," and to secure "qualified immunity" for those who provide information to the secretary or the attorney general [§201]. Like the rejected 1993 bill's §5402, it establishes a "Health Care Fraud and Abuse Control Account." In a section labeled "Beneficiary Incentive Programs," the 1996 law authorizes the secretary of HHS to "encourage" informants and to pay them a portion of amounts collected as a result of their disclosures [§203(b)].¹¹

Civil Penalties

Civil penalties under the 1996 act apply to medical practice involving federal health-care programs, including Medicare and other federal programs, as well as state health-care programs. Preexisting civil penalties are increased (in general from \$2,000 to \$10,000 per violation) and broadened in ways that may include innocent efforts by practitioners to render appropriate health-care services to patients. For example, a new provision makes a physician's miscoding of insurance claims filed with any federal or state agency subject to civil penalties of up to \$10,000 for each instance. Under a provision of the new law headed "Claim for Item or Service Based on Incorrect Coding or Medically Unnecessary Services," civil sanctions can be applied to any person who "engages in a pattern or practice of presenting or causing to be presented a claim for an item or service that is based on a code that the person knows or should know will result in a greater payment to the person than the code the person knows or should know is applicable to the item or service actually provided" [§231(e)]. Dr. Jane Orient, a private practitioner and the executive director of the Association of American Physicians and Surgeons, reports that "there are thousands of codes and no consistent interpretation" of them (Orient 1996). Yet the secretary of HHS and the courts are

11. Other provisions reflect lawmakers' bias in favor of health maintenance organizations (HMOs). The new law authorizes "intermediate sanctions" for HMOs that have failed to live up to their contracts with the federal government and specifically requires that the secretary of HHS "first provid[e] the organization with the reasonable opportunity to develop and implement a corrective action plan to correct the deficiencies" [§215(a)]. No such opportunity is accorded private fee-for-service physicians.

now empowered to determine after the fact what the doctor should have known about them.¹²

Civil sanctions also are to be applied if a health-care provider makes a claim “for a pattern of medical or other items or services that a person knows or should know are *not medically necessary*” [§231(e), my emphasis]. Again, the HHS secretary is empowered to determine *ex post* whether something was or was not “medically necessary.” Under such rules, every physician who serves patients participating in any federal or state health-care program is potentially subject to governmental second-guessing and the threat of concomitant civil penalties.

Reminiscent of the Medicare controversy in the 1960s over the “control” issue, again in 1996 official disclaimers were written into the record about the intended scope of the legislation. Because disclaimers in conference or committee reports, though part of the bill’s legislative history, are not part of its language and did not become statutory law, they often served chiefly to disarm opposition to questionable provisions without in fact limiting the bill’s scope.

A case in point involves the civil sanctions just described. In response to fears expressed by practitioners of alternative medicine, the conferees stated in the conference report that they “do not intend to penalize the exercise of medical judgment of health care treatment choices made in good faith and which are supported by significant evidence or held by a respectable minority of those providers who customarily provide similar methods of treatment,” adding that the act “is not intended to penalize providers simply because of a professional difference of opinion regarding diagnosis or treatment” (U.S. House 1996b, 255). Statutory language broad and ambiguous enough to trigger such a disclaimer highlights the dangerous scope of authority granted by the new law.

Physicians’ experience under prior Medicare law heightens these concerns. During the late 1980s and early 1990s the Medicare bureaucracy threatened to penalize nonparticipating physicians whose patients over age sixty-five contracted with them to obtain services outside the Medicare system, even though no reimbursement would be sought from Medicare in these cases. Physicians received official correspondence from Medicare carriers and administrators stating that such private contracting was largely inconsistent with Medicare law. Many patients were furious. As one patient stated, “Why should I wake up with fewer rights on turning 65 than I had the day before?” (Copeland 1993, 9).

In 1991 Dr. Lois Copeland and five representative patients brought suit against the secretary of HHS, Dr. Louis Sullivan, challenging this interpretation of Medicare

12. The term “should know” is defined in the statute to mean “deliberate ignorance” or “reckless disregard of the truth or falsity of the information” [§231(d)]. The relevant code sets will change with full implementation of the 1996 act. As part of new governmental authority to require creation of an electronic database (discussed later), the act requires the secretary of HHS to select or establish code sets for data elements describing “transactions” included in the database [§262(a), sec. 1173(c)].

law.¹³ Judge Nicholas Politan dismissed the case, ruling that the evidence did not establish that the HHS Secretary had a clearly articulated “policy” interpreting the Medicare law to prohibit private contracting.¹⁴ Attorneys for HHS were unable to identify the source of the Medicare carriers’ statements. As Dr. Copeland (1993, 10) put it, “physicians actually [had been] coerced into following a regulation that did not exist.”

Although the case was dismissed, Dr. Copeland stated that the plaintiffs “considered this ruling to be an absolute victory” (Copeland 1993, 10). By upholding the plaintiffs’ standing to sue in this case, the judge opened the door for their return to court if the HHS secretary subsequently issued an explicit policy against private contracting. In the meantime, their primary objective was achieved: physicians were now free to establish private contracts with their elderly patients outside of Medicare.

This victory was short-lived. As part of the Balanced Budget Act of 1997 (Public Law 105-33, 111 Stat. 251), Congress included a provision that makes such private contracts between doctors and elderly patients virtually impossible. The Balanced Budget Act effectively kills private contracting by requiring any physician who contracts privately (wholly outside Medicare) with even one patient over age 65 to file a signed affidavit with the federal government stating that he will not submit *any* claims to Medicare for *any* patient “during the 2-year period beginning on the date the affidavit is signed” [§4507(a)(3)]. That is, to form a voluntary contract outside of Medicare with one elderly patient, a physician must renounce any and all Medicare patients for a full two-year period. Commentators have pointed out that this gives elderly Americans fewer rights to pay for their medical care than British retirees possess under their country’s largely socialized system of medicine (Brown 1997)

House and Senate bills already have been drafted seeking to reverse this outrageous statutory deprivation of liberty. Court challenges also are expected. Nonetheless, the systematic efforts by the Medicare bureaucracy and compliant legislators to restrict people’s right to pay for their own health care—despite statutory language in the original Medicare legislation disavowing such control—make it clear that the federal government cannot be relied on to interpret narrowly the broad discretionary authority in the 1996 act.

New Health-Care Crimes

Equally disturbing, the 1996 act threatens innocent physicians with potential prosecution for loosely drawn new crimes accorded the Orwellian designation of “federal

13. I thank Professor Edward Zajak (University of Arizona) for calling my attention to this case and the issues it raised.

14. *Stewart et al. v. Sullivan et al.*, 816 F.Supp.281, U.S. District Court, District of New Jersey, No. 92-417, October 26, 1992. The plaintiffs’ evidence consisted of various bulletins to physicians from the official state Medicare carrier (Blue Cross/Blue Shield) and letters to physicians from various officials in the Health Care Financing Administration (HCFA), Medicare’s administrative arm.

health care offenses,” investigation of which confers broad subpoena power on the U.S. attorney general [§248]. Unlike the new law’s civil sanctions, the criminal penalties discussed here reach all private contracts for medical services: they are not limited to medical practice in connection with Medicare and other federal or state health-care programs.

In provisions copied almost verbatim from the 1993 Health Security Act, the 1996 law establishes as crimes “health care fraud,” “theft or embezzlement in connection with health care,” “false statements relating to health care matters,” and “obstruction of criminal investigations of health care offenses”¹⁵ [§§242–45]. These labels suggest that the forbidden behavior is Bad Stuff, and some of it clearly is. The question is, can any Good Stuff be prosecuted under the language of the new rules—and, if so, what effects will the threat of federal criminal prosecution have on honest medical practitioners?

The new rules penalize actions relating to “health care benefit programs,” defined in the statute to include every “public or private plan or contract” in which “any medical benefit, item, or service is provided to any individual,” specifically including “any individual or entity who is providing a medical benefit, item, or service for which payment may be made under the plan or contract” [§241]. Private fee-for-service physicians most definitely are included. The criminal penalties established for violation of the new crimes typically involve up to ten years in prison in addition to large fines and property forfeiture.

Consider the new crimes. Copied almost verbatim from the Clinton administration’s 1993 bill, §5431(a), the new federal crime of “health care fraud” specifies criminal penalties of up to ten years in prison plus fines for anyone who “knowingly and willfully executes, or attempts to execute, a scheme or artifice (1) to defraud any health care benefit program; or (2) to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program” [§242(a)]. The prison sentence is up to twenty years if the violation “results in serious bodily injury” and up to life in prison if anyone dies. Even an *attempt* to undertake the proscribed behavior could land a physician in jail for ten years. Because determination of what constitutes “knowing” and “willful” behavior can come only after the fact, innocent behavior potentially falls under the broad umbrella of this language. Moreover, attempting to secure payment for a procedure that the physician considered to be medically necessary (and that helped the patient) but that later was deemed unnecessary by government officials could be deemed a “false representation.” If a patient died in such a situation, the doctor could face a potential sentence of life in prison.

15. “Investigative demand procedures” authorized in such cases include subpoena power to require production of relevant records [§248].

Again the conference report, though not the statute, contains a disclaimer. The conference report states regarding §242 that the act “is not intended to penalize a person who exercises a health care treatment choice or makes a medical or health care judgment in good faith simply because there is a difference of opinion regarding the form of diagnosis” (U.S. House 1996b, 258). The very existence of such a disclaimer again shows that the language of the statute is broad enough to allow federal authorities to initiate prosecution in situations involving controverted medical judgments.

The second new federal crime, “Theft or embezzlement in connection with health care,” was lifted in its entirety from §5437 of the Clinton administration’s 1993 bill. Fines and imprisonment of up to ten years (or up to one year if the amount in question is *\$100 or less!*) await anyone who “knowingly and willfully . . . without authority converts to the use of any person other than the rightful owner, or intentionally misapplies any of the moneys, funds, securities, premiums, credits, property, or other assets of a health care benefit program” [§243].

The third new federal crime, making “false statements relating to health care matters,” specifies fines and up to five years of prison time for anyone who “knowingly and willfully—(1) falsifies, conceals, or covers up . . . a material fact; or (2) makes any materially false . . . statements or representations . . . in connection with the delivery of or payment for health care benefits, items, or services” [§244]. Again the language was copied almost verbatim from the Clinton administration’s 1993 bill, §5433. Because what is “knowing and willful” ultimately can be determined only in court, every fee-for-service physician becomes vulnerable under these provisions, and mistakes or controverted judgments of medical necessity may portend criminal prosecution.

Finally, there is the new federal crime of “Obstruction of criminal investigations of health care offenses.” In a provision that threatens not only physicians but also the privacy of medical records, the 1996 law specifies fines and up to five years in prison for anyone who “willfully prevents, obstructs, misleads, delays or attempts to prevent, obstruct, mislead, or delay the communication of information or records relating to a violation of a Federal health care offense to a criminal investigator” [§245]. The proscribed behavior need not be “knowing,” only “willful.” Accordingly, under this language a deliberate decision to withhold medical records for whatever reason—due to concerns about patients’ privacy or even uncertainty about the requesting party’s authority—could be used to threaten a physician with prison time.

Thus, physicians engaged in fee-for-service practice will live under constant threat of the criminal penalties that permeate this new law. The property forfeiture provision alone is noteworthy, requiring the court to order anyone convicted of a federal health-care offense “to forfeit property, real or personal, that constitutes or is derived, directly or indirectly, from gross proceeds traceable to the commission of the offense” [§249]. A doctor’s house and other assets could be at risk. Like the other provisions cited, this too was copied from the 1993 Clinton administration proposal [§5432].

Electronic Database

American citizens have more to fear in this act than the consequences of potential misapplication of the criminal penalties described. Under the heading of “Administrative Simplification,” the Health Insurance Portability and Accountability Act of 1996 mandates creation of a uniform electronic database that jeopardizes the privacy of medical records and intrudes upon doctor-patient relationships nationwide to a degree unprecedented in the United States. In circumstances to be explained later, these provisions allow the federal government to require private practitioners to divulge information about their patients, even though no federal health-care program such as Medicare is involved. Contrary provisions of state law are largely superseded [§262(a), sec. 1178].

The 1996 act empowers the federal government to require detailed information, at its discretion, on what lawmakers call “encounters” between doctors and patients. The lawmakers’ stated purpose in so doing is “to improve the Medicare program . . . , the Medicaid program . . . , and the efficiency and effectiveness of the health care system, by encouraging the development of a health information system through the establishment of standards and requirements for the electronic transmission of certain health information” [§261]. “Standards and requirements” will abound. The plan of the statute is to require medical practitioners to comply with data encoding and transmission standards, to require the secretary of HHS to establish such standards, to identify covered transactions, to require the electronic transfer and sharing of information as ordered by the secretary of HHS, and to impose penalties for failure to comply with the secretary’s standards for data recording and transmission.

The language of the statute is broad. Central to the interpretation of key sections is the meaning of the phrase “health information,” which is defined to include just about everything:

The term “health information” means any information, whether *oral or recorded* in any form or medium, that—

(A) is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and

(B) *relates to the past, present, or future physical or mental health or condition of an individual*, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual.

[§262(a), sec. 1171; my emphasis]

Subsequent language requires the secretary of HHS, within eighteen months in most cases, to “adopt *standards* for *transactions*, and data elements for such transactions, to

enable *health information* to be exchanged electronically . . . [and] establish specifications for implementing each of the standards adopted” [§262(a), secs. 1172(d), 1173(a); my emphasis]. Compliance with the standards is mandatory for all health plans, health-care clearinghouses, and any “health care provider who transmits any health information in electronic form in connection with a transaction” referred to in the preceding provision. That is, if a private physician transmits *any* patient medical information pertaining to such a transaction in electronic form (which may include most physicians who use computers in their medical practice), then the physician can be compelled to comply with “standards” that the secretary of HHS creates. Where will such information go? At a minimum, anywhere it is required by government or by private contract to be sent. Indeed, the secretary of HHS is specifically mandated to establish “standards for transferring among health plans appropriate standard data elements” [§262(a), sec. 1173(f)]. Moreover, despite intended safeguards to be described, once the information is received in electronic format it can be retransmitted at will.

The secretary’s standards are to apply to “transactions,” defined to include, among others, “Health claims or equivalent encounter information” and “Health claims attachments.” These are labeled as “financial and administrative transactions,” despite the broader reach suggested by the provision’s “encounter information” and “health claims attachments” language. Standards must be “appropriate for” any “financial and administrative transactions determined appropriate by the secretary, consistent with the goals of improving the operation of the health care system and reducing administrative costs” [§262(a), sec. 1173(a)]. Open-ended discretionary authority in these matters is given to the secretary of HHS.

Again disclaimers appear, this time in the House Ways and Means committee’s original report on the bill. The committee there stated that these provisions are “limited to financial and administrative transactions” and that the committee did “not intend for these requirements [to] apply to information collected that is beyond this scope such as . . . *personnel records* of employers who provide health plan benefits or *medical records of patients*” (US House 1996a, 99; my emphasis). No similar statement about medical records of patients appears in the conference report or in the statute.

The statutory language casts doubt on this disclaimer for at least two reasons. First, the law requires “standards for transactions . . . to enable *health information* to be exchanged electronically, that are *appropriate for*”—not limited to—financial and administrative transactions. Second, as already noted, the term “health information” as used in this provision is defined broadly, and standards are allowed to govern “transactions” that include doctor-patient “encounter information.” Had lawmakers intended to create firm limits on the targeted information, such provisions would have been easy to draft. As the 1996 act stands, because “encounter information” and “health information” clearly reach private conversations between doctors and patients, the law

seems to create a federal power much broader than the House Ways and Means Committee's disclaimer suggests.

But the secretary's authority is greater still. As noted, a key part of the power in this provision is power to adopt standards that will enable "health information"—everything a doctor or employer or university or life insurer ever learns about you—"to be exchanged electronically." To facilitate such exchange, another provision lifted from the Clinton administration's 1993 proposal requires the secretary of HHS to adopt standards "providing for a standard *unique health identifier* for each individual, employer, health plan, and health care provider for use in the health care system" [§262(a), sec. 1173(b), patterned after 1993 §5104; my emphasis]. Congressmen understood in passing the bill that the mandated standard health identifier might turn out to be people's social security numbers.

There are civil monetary penalties (not to exceed \$25,000 per calendar year) for noncompliance with the secretary's standards, with broad discretionary authority given to HHS in applying them [§262(a), sec. 1176]. Threatening more federal intrusion in the future, the new law requires an advisory committee to "study the issues related to the adoption of *uniform data standards for patient medical record information and the electronic exchange of such information*," requiring the committee to make "recommendations and legislative proposals for such standards and electronic exchange" within four years [§263(4); my emphasis].

Almost as an afterthought, lawmakers instructed the secretary to make recommendations within twelve months regarding "standards with respect to the privacy of individually identifiable health information," while explicitly permitting a total of forty-two months to elapse before privacy regulations need be applied [§264]. Another provision requires the secretary of HHS to establish limited "security standards" for health information, taking into account costs as well as the capabilities of small health-care providers [§262(a), sec. 1173(d)]. Those subject to the secretary's database-related standards also are admonished to maintain "reasonable and appropriate" safeguards. A separate provision gives nominal deference to privacy by authorizing fines and imprisonment for unlawful disclosure of individually identifiable health information or unlawful use of a unique health identifier [§262(a), sec. 1177]. But these provisions are empty boxes: violations are to be defined by standards not yet formulated.

The threats to the private practice of medicine and to doctor-patient relationships contained in the Health Insurance Portability and Accountability Act of 1996 are evident. Privacy regulations coming as much as three and one-half years after the bill's passage may be futile, as by then people's medical histories will likely be ensconced in databases held by insurance companies, government agencies, hospitals, and private consultants. Given the public outcry in 1993, how could these provisions have been approved in 1996 without substantial resistance within Congress and by the public?

Role of Political Transaction-Cost Manipulation in the 1996 Bill's Passage

The answer is, by the skillful use of transaction-cost manipulation. Its use in this case was not surprising. The theory outlined earlier predicts that government officials' incentives to support transaction-cost-increasing measures depend on specific variables. With the 1996 act, changes in these determinants were consistent with use of these strategies in passing the new law. President Clinton's renewed executive support pushed in that direction, as did the increased support of both political parties for some type of health-care legislation. Accordingly, the ideology variable more pervasively supported transaction-cost augmentation to blunt resistance to the measure. Moreover, there existed an appealing rationale: the specter of "job lock" and individuals' being denied insurance due to preexisting medical conditions evoked widespread public sympathy. Legislators perceived the measure's portability provisions as vitally important to constituents. The complexity of the 168-page single-spaced bill suggested further transaction-cost increases. Also pushing toward transaction-cost augmentation on this issue was the new law's promise of enhanced job security and potential third-party payoffs for government officials, likely products of expanded government power and increased dependence of the populace on the federal government. The passage of time since 1993 had served more to entrench relevant interest groups than to inform the public. Part of the reason for the widespread public ignorance on this topic in 1996—and perhaps the biggest change in the relevant variables since 1993—was the utter failure of the popular press to publicize negative features of the proposed legislation.

During consideration and passage of the Health Insurance Portability and Accountability Act of 1996, public resistance to its authorization of governmental encroachments on the private practice of medicine and people's private relationships with their physicians was virtually nonexistent. Gone were the outspoken protests of 1993. Dr. Jane Orient, one of the few who warned the public of the impending power shift, said she believed the passivity existed because people "don't read" (Orient 1996). I believe the explanation is more complex. Strategies used in 1996 closely paralleled those used to pass the original Medicare statute in 1965 and, like the earlier techniques, relied heavily on government manipulation of political transaction costs facing the public. Again in 1996, incrementalism, tying, misrepresentation, and appealing rhetoric were fundamental to the bill's passage. Consider the similarities.

Incrementalism

Having failed to win in the 1940s, advocates of universal national health insurance narrowed their compulsory health insurance proposals in the 1950s to cover only the elderly. A piece at a time, they got disability insurance (1956), medical assistance for the aged poor (1960), and finally Medicare.

Likewise, in the years leading up to 1996, when advocates of comprehensive federal government control over the U.S. health-care system found that they couldn't win on their broad 1993 Health Security Act proposal, they narrowed it. As with Medicare, they deliberately focused on the most appealing and popular aspects of their proposals—in this case the portability, accessibility, and renewability of health insurance and (for some) medical savings accounts.

In congressional debates, members admitted their intent to proceed incrementally. As Senator Arlen Specter (R.-Pa.) expressed it, the bill “should be viewed as the first step of an incremental approach to health care reform” (*Cong. Rec.*, Senate, April 23, 1996, 3818). On the day of final House passage of the bill, Representative Anthony C. Beilenson (D.-Calif.) conveyed his hope that “this is just a first step” (*Cong. Rec.*, House, August 1, 1996, 9777), and Representative Harris W. Fawell (R.-Ill.) said that “we will be back next year fighting . . . with renewed vigor” for further reforms (*Cong. Rec.*, House, August 1, 1996, 9779). On the Senate floor, Senator Edward M. Kennedy (D.-Mass.) stated that the “passage of the legislation is the beginning of a journey, not an end,” anticipating that in the near future Congress would “move on to the broader field of universal health care coverage in one way or another”—what Senator John D. Rockefeller IV (D.-W.Va.) called “the next round of health care reform” (*Cong. Rec.*, House, August 1, 1996, 9504, 9508, 9513).

The next round already has occurred. As part of the August 1997 Balanced Budget Act (Public Law 105-33, 111 Stat. 251), legislators approved a child-health-insurance program that has been called “the biggest new social program since Medicare” (Goldberg 1997). Though said to provide federal funds for state programs to provide health care for low-income children, the new law actually allows assistance to be provided for families whose income is up to 200 percent or more above the poverty line [§4901, sec. 2110(c)]. Between fiscal years 1998 and 2007, the law appropriates \$39,650,000,000—roughly \$40 billion—in nominal dollars for this program [§4901, sec. 2104(a)]. Anticipating that the “new ‘kid care’ plan will be available to every child in families with income of up to \$50,000 a year,” Goldberg (1997) warns that the purpose and likely outcome of the program are to “consolidate government control over health care by moving as many middle-class children into federally funded and regulated health programs as quickly as possible,” an assessment consistent with Senator Kennedy's recent statement that “‘this is a major step forward’ toward national health insurance.” We can expect legislators’ deliberate use of incrementalism to continue.

Tying

The 1965 compulsory hospital insurance for the elderly was tied to other legislation at two levels. On one level it was tied to the other two layers of Mills's three-layer cake, supplemental medical insurance and liberalization of Medicaid. Moreover, the whole Medicare package was tied to the 7 percent increase in cash benefits for Social Security

recipients and bundled with the Social Security Amendments of 1965, with the House of Representatives not even allowing a vote on the issue of deleting Medicare from the Social Security amendment package.

Similarly, in 1996 legislators tied the popular measures for health-insurance access, portability, and renewability (as well as provisions increasing self-employed people's tax deductions for health care) to the electronic database and criminal/civil penalty provisions. This package deal made it politically impossible to vote against the 1996 bill. Voting against it would have required a senator or representative to go on record appearing to support insurance-related "job lock," Medicare fraud, and continued use of widely abhorred exclusions for preexisting medical conditions. In 1996 as in 1965, tying the popular with the controversial dramatically increased the cost to voters and to dissatisfied lawmakers of resisting the proposed legislation.

Misrepresentation

Misrepresentation was fundamental to passage of the 1965 Medicare bill. Similar misrepresentation occurred with passage of the Health Insurance Portability and Accountability Act of 1996, permeating the language of the bill and official statements about its content.

The appealing language in the act's title set the tone: who could oppose such apparently desirable ends as health-insurance "portability" and "accountability"? Legislators described the bill as "consensus" legislation. Senator Nancy L. Kassebaum (R.-Kans.) stated that "There is no controversy about the central elements of the bill" (*Cong. Rec.*, House, March 28, 1996, 3034; *Cong. Rec.*, Senate, August 2, 1996, 9502). Government officials repeatedly told the press that this bill concerned health-insurance "access, portability, and renewability" and medical savings accounts (MSAs). According to official sources, the only issue was whether the House and Senate could agree on an MSA provision.

Hardly anyone spoke about the proliferation of loosely drawn new "federal health care offenses" with criminal penalties that permeated the bill. Senator Orrin G. Hatch (R.-Utah), one of the few who alluded to the issue, stated that "we need to ensure that these [antifraud] efforts do not penalize innocent behavior or unintentionally bog down the delivery of health care." He reminded his colleagues that

The practice and delivery of health care is overwhelmingly conducted by honest and well meaning individuals who should not be suspected of wrongdoing merely because they are physicians, hospital administrators or other health care providers. Creating a cloud of suspension [*sic*] over the entire health care community will not solve the fraud problem when only a few are guilty of wrongdoing. . . . Equally important is that antifraud provisions avoid penalizing innocent individuals for inadvertent or clearly innocent behavior. (*Cong. Rec.*, Senate, August 2, 1996, 9524)

Although Senator Hatch acknowledged that judgments regarding “medical necessity” may differ—in my judgment making every physician governed by the 1996 act potentially subject to prosecution under its rules that forbid false claims of “medical necessity”—he acted as if the requirement for “knowing and willful” behavior to establish criminal liability provided an adequate safeguard. He did not mention the act’s imposition of civil penalties for claims that a physician “knows or should know are not medically necessary” [§231(e)]. Nor did his colleagues raise these issues as passage neared. Only Representative Sheila Jackson-Lee (D.-Tex.) in the House protested that she was “disturbed” that the bill “would burden physicians with overly burdensome fraud provisions,” asserting that eliminating fraud “should not be at the expense of making criminals of physicians that provide us good health care across the Nation” (*Cong. Rec.*, House, August 1, 1996, 9790).

Neither did most congressmen talk publicly about the provisions for a national electronic database. Representative Jim McDermott (D.-Wash.) was almost alone in identifying the threat to privacy created by the national electronic database, reminding colleagues on the day of the bill’s passage that as a result of the provisions on administrative simplification “this is the day that we voted to give the insurance companies the right to use your Social Security number and gather all the information in a clearinghouse for which there is no privacy protection in this bill.” He added:

Now people want to think that it is called “administrative simplification,” but simply what it does is give the insurance companies the ability to shift information back and forth, use it against applicants for life insurance, auto insurance, homeowners insurance. Anything they want to do, they can do in this bill because there is not one single shred of protection of your privacy. . . . That means if a patient goes to see the doctor and tells the doctor anything that has gone on in their [*sic*] life, the doctor could be compelled by the insurance company data system to release that information because there is nothing, nothing in here that protects the doctor-patient relationship. . . . [W]e are taking away people’s privacy.” (*Cong. Rec.*, House, August 1, 1996, 9792)

In the House of Representatives, a substitute measure that omitted the antifraud and electronic database provisions failed on a vote of 192 to 226 (fourteen not voting) (*Cong. Rec.*, House, March 28, 1996, 3137-38).

On the day of the Senate’s passage of the bill, only two senators commented on its threat to privacy. Senator Paul Simon (D.-Ill.) criticized the database provision for accelerating “the creation of large data bases containing personally identifiable information” that might be perused by “prying eyes,” describing the bill’s allowance of a potential forty-two-month time lag before adopting privacy protection as “put[ting] the cart before the horse” (*Cong. Rec.*, Senate, August 2, 1996, 9516). Senator Patrick J. Leahy (D.-Vt.) added that “[w]hen the American people become aware of what this law requires and allows by way of computer transmission of individually identifiable

health information without effective privacy protection, they should demand, as I do, prompt enactment of privacy protection" (*Cong. Rec.*, Senate, August 2, 1996, 9523).

In addition to these larger misrepresentations of the bill's content, the 1996 Health Insurance Portability and Accountability Act is rife with misleading language. "Beneficiary incentive programs" include the paying of informants, "federal health care programs" include state health-care programs, and "administrative simplification" cloaks national electronic-database mandates. Threats to liberty are alternately covered with pleasant-sounding phrases or obscured by stigmatizing language of criminal misconduct ("fraud and abuse," "health care fraud"). Lip service in the new law to privacy and the protection of individually identifiable health information parallels the nominal statutory deference to avoidance of government "control" in 1965.

Likewise, few inside or outside of Congress cited the costs associated with the legislation. Senator Phil Gramm (R.-Tex.), an economist, asked if it was "somehow magic that through Government edict we can bestow billions of dollars of benefits on our fellow citizens at no cost . . . whatsoever?" Based on the bill's requirements for insuring higher-risk individuals, Senator Gramm predicted that "at the end of the first full year of its implementation, the cost of individual private health insurance policies will rise by a minimum of 10 percent," which he called a "conservative estimate" (*Cong. Rec.*, Senate, April 18, 1996, 3538).

Even the health-insurance portability, renewability, and access provisions are not what they seemed. Senator Nancy Kassebaum (R.-Kans.) stated that the new law "will guarantee that those who need coverage the most are not shut out of the system." Echoed by many supporters of the bill, she said that the bill will eliminate health-insurance barriers to changing jobs ("job lock") and "will mean the world to millions of Americans who will no longer live in fear that they will lose their health coverage when they change jobs or lose their job" (*Cong. Rec.*, Senate, August 2, 1996, 9502).

Although the new law undoubtedly will reduce job lock, its portability mandates are not as broad as many proponents implied. Its portability provisions prohibit insurance companies only from denying coverage for preexisting medical conditions and from singling out specific individuals, based on their medical history, for higher premiums.¹⁶ Less widely communicated to the public was that the law—properly from an economic point of view—allows insurance companies to raise premiums to the group as a whole or, in certain circumstances, to eliminate particular benefits entirely, so long as it is done uniformly. As Senator Kassebaum (R.-Kans.) stated:

This provision is meant to prohibit insurers or employers from excluding employees in a group from coverage or charging them higher premiums

16. In general, the maximum allowable waiting period before coverage of a pre-existing condition begins is twelve months. The law specifies circumstances in which this waiting period may be reduced by years of "creditable coverage" under another health plan [§102, sec. 2701].

based on their health status and other related factors that could lead to higher health costs. *This does not mean that an entire group cannot be charged more.* But it does preclude health plans from singling out individuals in the group for higher premiums or dropping them from coverage altogether. (*Cong. Rec.*, Senate, April 23, 1996, 3832; my emphasis)

Representative McDermott (D.-Wash.) put it more succinctly: “No one listening to this should think that portability means what I have now I will have tomorrow, because it simply is not so” (*Cong. Rec.*, House, March 28, 1996, 3087).

Moreover, some of the provisions enhancing people’s access to insurance are more limited than the public in general has been told. Although the bill does not benefit people who have never had group health insurance, it is said to assure that people who lose their coverage through a group policy will have access to individual health insurance. Yet Senator J. Robert (Bob) Kerrey (D.-Nebr.) noted that the bill will do much less: “The conference agreement will allow insurance companies to offer only two policies—and even though the bill includes some requirements for these plans, I am concerned that insurers may be able to charge these individuals exorbitant rates” (*Cong. Rec.*, Senate, August 2, 1996, 9523). In addition, access provisions aimed at the group-insurance market apply only to small businesses having fifty or fewer employees [§102, sec. 2711]. As Representative Fortney Pete Stark (D.-Calif.) noted, the bill “limited the guaranteed issue to small businesses of 50, so a firm of 51 people does not have guaranteed access while a firm of 50 does” (*Cong. Rec.*, House, August 1, 1996, 9786).

Along with the tying and the incremental strategies, misrepresentation on these key issues helped to secure passage of the act, establishing a structure that would permanently increase the transaction costs to private citizens of resisting an expanding role for the central government in their personal medical affairs.

Conclusion

Sometimes . . . I wonder who we Senators think we are when we sit in our seats and pompously say we know so much more about the affairs of the average family in America than anyone else that we can compel them to make financial determinations which they themselves think are unwise for them to make. I somehow doubt that we have the Olympian wisdom that enables us to pontificate for all of society.

Senator Karl Mundt (R.-S.D.)
(*Cong. Rec.*, Senate, July 9, 1965, 16121-22)

Most were not as modest as Senator Mundt (R.-S.D.) about Congress's "Olympian wisdom" enabling members to "pontificate for all of society" in passing Medicare. After the tying and misrepresentation that made possible its enactment, the 1965 Medicare law created built-in transaction-cost-increasing mechanisms that assured the program's growth. The insurance imagery, payroll taxes, and incentives of current recipients to foist off costs on future generations all worked to increase the transaction costs of taking political action to "unscramble the omelet." Once Medicare became part of the U.S. institutional structure, an entitlement mentality, ideological change, and baser political and economic interests combined to assure its entrenchment—regardless of costs or consequences.

The Health Insurance Portability and Accountability Act of 1996 will have similar consequences. Produced by means of transaction-cost-increasing strategies, the 1996 law authorized a superstructure of new regulations that will spawn ever-increasing federal controls over medical practice and formerly private doctor-patient relationships. Cost increases caused by forced alteration of insurers' risk pools will trigger demand for such controls, even as increased regulatory compliance costs and vulnerability to federal prosecution drive more doctors out of private practice.

The dangers transcend the immediate ones represented by the national electronic database, mandated distribution of confidential patient information, and the web of new federal civil and criminal penalties threatening honest doctors. If this law stands, people gradually will become accustomed to the new federal intrusiveness: future generations will know nothing else. Ideological change will follow, making it increasingly difficult to reestablish a system in which the privacy of medical information and the primacy of doctors' medical judgments are sacrosanct. As Representative Jim McDermott (D.-Wash.) warned his colleagues about the threat to privacy, "You are going to come to rue the day that you pass this bill without talking about it" (*Cong. Rec.*, House, March 28, 1996, 3038). Rather than talk about it, they gained short-run political benefits by uncritically applauding a measure said only to establish health insurance "portability" and "accountability." Unfortunately, the new levers of government power thereby created will long outlast those transitory personal political gains, and all Americans who cherish freedom will "come to rue the day."

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