



P O L I C Y   R E P O R T

# Deregulating Health Insurance and Health Care Providers in North Carolina

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# **Deregulating Health Insurance and Health Care Providers in North Carolina**

*Implications for health care cost,  
quality, access and innovation*

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## Executive Summary

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North Carolina policymakers should eliminate provider licensing, certificate-of-need laws, and mandated health insurance benefits. Short of this, the state can accept alternative forms of credentialing and ensure consumers have the right to purchase optional benefits at additional cost. These regulations limit access to health care providers and health insurance by artificially constraining markets.

Licensing and scope-of-practice restrictions protect chosen groups of providers from competition at little benefit to consumers. Unregulated health care providers have proven to have similar safety records and malpractice insurance rates as their licensed counterparts. For example, naturopaths and home midwives operate in the shadows of the law, but safely provide needed care to many in the state. They are among the many groups seeking state licensure to practice legally in North Carolina.

Certificate-of-need laws make it easier for hospitals to consolidate their position. Markets with fewer hospitals have higher health care costs for consumers, whether the hospital is for-profit or nonprofit.

Higher costs limit access and reduce overall quality of the health system. Regulatory protection limits the ability of new competitors to enter a market and reduces the need for established players to innovate.

Mandated health insurance benefits have also increased costs with little to show for it besides

more people going without insurance. Useful benefits would be offered anyway, but other benefits simply act as a tax that redistributes money from consumers to providers and Blue Cross Blue Shield of North Carolina.

Further, mandated benefits lock in a standard of care, making innovations and quality enhancements difficult to achieve. With mandatory standards of care, cost-cutting improvements do not get rewarded, so costs continue to rise with little to show in better patient outcomes.

Providers benefit from mandates because those with insurance are more likely to use covered services. That's why some chiropractors bribed former House Speaker Jim Black to have a mandate written for their services.

Mandates are the final step in the regulatory and licensing hierarchy. Marriage and family therapists were certified in 1979, licensed in 1994, and by 2003 they had won a mandated benefit for their services.

Blue Cross Blue Shield of North Carolina may also benefit from mandated benefits. Its market share increased from 40 percent to 60 percent between 2001 and 2003 as mandates increased and the number of competitors fell.

Deregulating health care provision and insurance at the state level can mitigate the problems that arise from federal health care legislation.

## Introduction

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Health care reform's promises were about cost, quality, access, and the uninsured. Keep what you have if you like it, but nobody will be able to deny you care or insurance. Your insurance policy will cost less, and you will be healthier. All of this could be done from Washington based on existing best practices with no unintended consequences and at a net savings for the federal government. Best of all, it would reduce our total health care spending even more in the future.

Even some opponents of the bill focused on national, rather than state-level, changes. Most changes that could yield improvements in these areas, however, are state policies. State regulations limit where we can get treatment and from whom, how we pay for care, what our insurance has to cover, and what happens when things go wrong.

Certificate-of-need laws, provider licensing, and scope-of-practice limits restrict the availability of care by reducing the number of providers and increasing the prices of those left in the market. These

restrictions come with little or no improvement in the overall quality of health care.

Federal law protects large, self-insured employers from state insurance regulations. As a result, mandated insurance benefits affect only the small group and individual insurance markets. While some of these benefits would be offered anyway and others save money, the net result is higher cost which can lead in turn to more people going without insurance.

This paper will look first at licensing and certificate-of-need laws before examining insurance benefit mandates. Each section will review the stated reasons for the regulations and compare those with their impact on cost, quality, access to care, and innovation. To conclude each section, we will provide some alternatives to traditional regulations.

The conclusion of the paper will put the existing regulations and alternatives in the context of health care reform.

## Licensing, Scope of practice, and Certificate of Need

The standard argument for occupational licensing is that it protects consumers from frauds, charlatans, and ne'er-do-wells. Consumers of licensed services, the argument goes, do not have the expertise to ask the right questions and decide who will do a good job. Licensing provides the assurance of quality people want.

It is not clear from evidence, however, that consumers demand occupational licensing for their assurance. More often, practitioners themselves go to the legislature to seek restrictions with little if any public outcry. This is true both with medical licensing as well as other types of licensing.

Sometimes, as in the case of midwives who are not already nurses, the license is an attempt to level the field. In other cases, as with naturopaths, the license is explicitly designed to reduce the number of practitioners. We will review both cases below.

### COST

As one would expect, whatever the rationale, the practical effect of licensing is to limit the number of practitioners. With fewer providers of the service, prices rise, and there is a net welfare transfer from consumers to suppliers. In general, licensing increases prices to consumers and wages to licensees by as little as four percent to as much as 35 percent. Dentists in states that did not recognize out-of-state licenses had incomes 12 to 15 percent higher than those in states with licensing reciprocity. Consumers faced higher prices for dental services.<sup>1</sup>

A study comparing dental hygienists and dental assistants in California from 1997 to 2005 showed that the number of dental hygienists per person stayed relatively constant over the entire period and actually fell between 2000 and 2003, while the relative number of dental assistants increased 28 percent between 1997 and 2003. Wages for dental assistants were relatively flat after adjusting for inflation, but those for the more regulated dental hygienists increased by 45 percent at their peak.<sup>2</sup> This again indicates the transfer of income to licensed professionals from others.

Higher cost could be justified if it meant higher quality, but it often does not. Restrictive licensing shows little ability either to reduce risk to consumers or to reduce the cost of malpractice insurance. Licensing boards do not focus their regulatory authority on disciplining their members for poor work. Consumers who cannot afford the higher cost go without or do work themselves. Even as quality improves for those with access to licensed providers, overall quality falls because the proportion of people with access is smaller.

### QUALITY & ACCESS

David Skarbek examined what happened when Florida eased licensing restrictions on construction contractors in the wake of Hurricanes Frances and Katrina. He found “little evidence of significant detrimental effects from the policy change,” despite the greater challenge to determine who is competent and qualified to do work in a crisis.<sup>3</sup>

Similarly, Morris M. Kleiner found, among other things, no difference in complaints between certified occupations in Minnesota and their licensed counterparts in Wisconsin.<sup>4</sup> Malpractice insurance rates for practitioners of similar age and experience were not significantly lower in states that required licensing for a number of occupations than in states that did not.<sup>5</sup>

Licensing boards have often been more vigorous in their actions against those practicing without a license than licensed practitioners who have done actual harm to consumers. Since 2006, the North Carolina Medical Board has become more likely to discipline physicians and other licensed medical professionals for quality of care. False representation, however, had the largest increase in disciplinary actions, accounting for 14 percent of all disciplinary actions in 2009 compared to just two percent in 2006.<sup>6</sup>

Examples of access restrictions abound. Elictructions are more frequent in states with more restrictive licensing of electricians. Rabies is more common where veterinary limits are tighter. And more people do not wear dentures they purchase where dentists are scarce.<sup>7</sup>

## INNOVATION

Innovation also suffers from restrictive licensing. One of the most promising developments in recent years has been the in-store health clinic. These clinics provide low-cost care from nurse practitioners in convenient locations, but must have a doctor overseeing the operation. One paper finds, “Mal-practice insurance for collaborative physicians... is sometimes higher if they are expected by law to be accountable for an NP’s [nurse practitioner’s] practice.”<sup>8</sup> More expensive insurance limits both the willingness of doctors to work in collaboration and the number of nurse practitioners. A broad review of the literature on nurse practitioners found, “Nurse practitioners provided care that was equivalent to the care provided by physicians—and, in some studies, more effective care among selected measures than that provided by physicians.”<sup>9</sup>

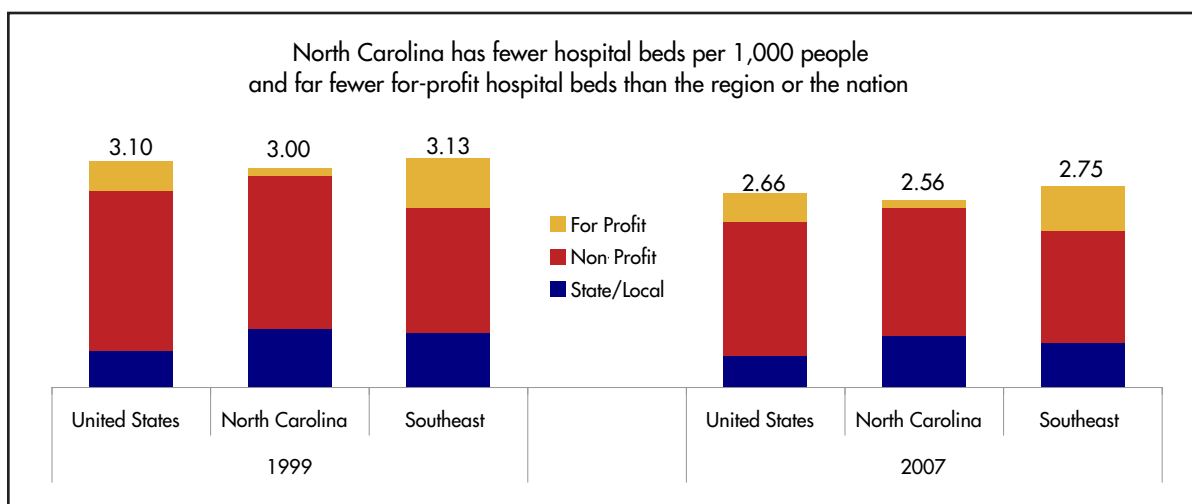
Regulations limit the ability of telemedicine, cross-border practices, and other innovations to reduce cost and increase access to care. For example, “Many states have restrictions on telemedicine that make it illegal for a physician in one state to consult with a patient in another state without an initial face-to-face meeting. It is also illegal in most states for a physician who has examined a patient from another state to continue treatment of the patient via the Internet. The physician must be licensed in the state where the patient resides or be guilty of practicing medicine without a license in that state.”<sup>10</sup> All of these restrictions will make it more difficult to provide care for all Americans if health care reform

leads to expanded insurance coverage and even greater demand for care.<sup>11</sup>

Certificate-of-need (CON) laws limit capital investments, compounding the innovation problems created by licensing restrictions. They set a high bar for outpatient facilities to provide convenient services to patients and virtually guarantee that outpatient facilities are owned by an existing hospital. CON laws also limit the ability of for-profit hospitals to compete more generally – North Carolina has fewer for-profit hospital beds per person than the region or the country.<sup>12</sup> According to Roy Cordato’s research on CON in North Carolina, “[O]nly 18 of 100 counties were served by multiple hospital systems in 2000.”<sup>13</sup> Powerful, politically connected hospitals have pushed health care costs up.<sup>14</sup> A federal review of the literature stated, “Most studies of the relationship between competition and hospital prices have found that high hospital concentration is associated with increased prices, regardless of whether the hospitals are for-profit or nonprofit.”<sup>15</sup>

## NATUROPATHS

Naturopaths in North Carolina have long sought state licensure. In written testimony to the General Assembly, the North Carolina Association of Naturopathic Physicians has used the 1999 death of Helena Rose Kolitwenzew as a central argument in their case for licensure. Kolitwenzew was a nine-year-old diabetic when her mother took her to an alternative medicine practice in Columbus. Lawrence Perry told Kolitwenzew’s mother to stop





giving her insulin and use herbal remedies instead.<sup>16</sup> Perry was charged with manslaughter and practicing medicine without a license. This appears to be the only death resulting from a naturopath in North Carolina. The Association seeks to limit licensure to those who have completed a four-year postgraduate degree program and a state exam based on national norms. Licensees would have to comply with a code of conduct and ethics, and would have continuing education requirements to maintain their licenses.<sup>17</sup>

Although others stated in testimony to the General Assembly in 2005 that such a restrictive license would have sharply reduced the number of practitioners of naturopathy,<sup>18</sup> which would have raised costs to consumers, the association stated, “The public would not have an economic disadvantage if naturopathic doctors were to be licensed.”<sup>19</sup> Rep. Paul Luebke had proposed a bill in 2003 that would have required alternative health care providers, such as naturopaths, to register with the state and disclose their professional training and qualifications, but would not have required any specific qualifications.<sup>20</sup> The Association’s own documents showed that there was little harm done to consumers without licensing and that naturopaths were already relatively safe, even those without advanced degrees. They have yet to win their fight for licensure.

### HOME MIDWIVES

Independent midwives have been no more successful at getting licensed than naturopaths, but their approach has been different. Instead of arguing that licensing would make midwifery safer by limiting the number of people practicing, Kirsti Kreutzer made the case for more choice as licensing would decriminalize midwifery: “If there was licensure in place, there would be more midwives trained here, and there would be a selection. No one’s going to move to a state that’s friendly to midwives.”<sup>21</sup> Supporters of midwife licensing pointed to the growth in this method of childbirth, despite its illegality, and argued that licensure would make it safer by making it legal.<sup>22</sup>

### ALTERNATIVES

The simplest alternative to the hodgepodge of licensing requirements, limits to scope of practice, black-market medicine, and political fighting for state approval is to eliminate the need for licensing and certificates of need. As is clear from the midwife debate and some of the discussion of naturopaths, one of the issues is that it is currently illegal to engage in some practices without a license. This also limits the ability of patients to have their care covered by insurance. Eliminate the law against practicing medicine, and you eliminate the demand for licensing. There already are a number of methods in the private sector to ensure quality.

Malpractice insurance and lawsuits already provide a legal means of disciplining medical providers that is both more effective and more comprehensive than licensing boards, though still far from perfect. Practitioners often receive credentials from a private, professional association in addition to their state license. Hospitals also review and credential doctors to practice in their facilities.<sup>23</sup>

CVS’ Minute Clinic and Walgreens’ Take Care Clinic are two examples of brand names in health care. Hospitals also capitalize on their brands, whether the Mayo Clinic or WakeMed. Brand names are useful signals of quality and value for consumers. Medical board restrictions on advertising limit the effectiveness of brand names in health care.

If eliminating licensure totally is too difficult, states can recognize licenses from other states. North Carolina is already one of twenty states that have signed on to the Nurse License Compact.<sup>24</sup> More reciprocal licensing agreements would make it easier for doctors to move where there is a need, even a temporary one in the wake of a natural disaster. This would also make telemedicine more feasible and expand access in rural areas.

States can ease formal education requirements for certain occupations or expand the scope of practice for licensed occupations so as not to limit excessively the tasks individuals can perform.

The bill proposed by Rep. Luebke in 2003 (HB 923) for alternative medicine, if broadly applied, can replace licensing and certification. A registry of practitioners provides some assurance and choice for consumers without mandating specific education or requirements that would deter otherwise able practitioners. As the example of marriage and family therapists in the next section will demonstrate, however, regulation tends to become more intrusive over time.

In short, there are a number of ways for North Carolina to expand health care access, reduce cost, and promote innovation without harming quality. The most effective way is to put more power in the

patients' hands. Pay for performance measures in the health reform bill do little to encourage competition on quality. Doctors competing for patients who pay for their own care have an incentive to demonstrate quality with credentials, testimonials, brand names, and other signals that are not currently needed.

Doctors have little reason now to differentiate services because Medicare, Medicaid, and private insurers pay by formulas. It makes more sense for them to restrict the number of competitors regardless of quality, or to force insurers to pay for their services through legislated mandates – which is the subject of the next section.

## Insurance Mandates

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North Carolina requires insurers to include 50 specific benefits in their policies.<sup>25</sup> Mandated health insurance benefits are more ambiguous in their effects than provider regulations are. Insurance companies often provide the mandated coverage anyway. Research has also shown that some mandated benefits, such as alcohol treatment, could reduce the cost of insurance. The overall effect of mandates, however, is to raise the price of insurance, limit consumer choice and product diversity, and increase the number of people without insurance. Large employers that self-insure are able to avoid these mandates because they are covered by the federal ERISA law and so one exempt from state regulations.<sup>26</sup>

The stated goal of insurance benefit mandates is to guarantee coverage of services and providers that individuals need but that insurance companies would not otherwise provide. Advocates say the mandates offset the risks of opportunism, exploitation, bounded rationality, adverse selection, and discrimination.<sup>27</sup> But in joint hearings before the Fair Trade Commission and the Department of Justice,

*Mandate proponents presented no evidence that consumers demand insufficient health insurance, and there is some evidence that many consumers actually demand excessive health insurance. Mandate proponents presented no evidence that government intervention is likely to improve the efficiency of health insurance benefit design, and there is some evidence to the contrary.*<sup>28</sup>

Mandated benefits do have one unambiguous advantage. They are free to politicians who can give something to insurance subscribers without directly raising taxes or cutting other benefits. Employers and insurance companies pass on their additional costs to workers and subscribers.

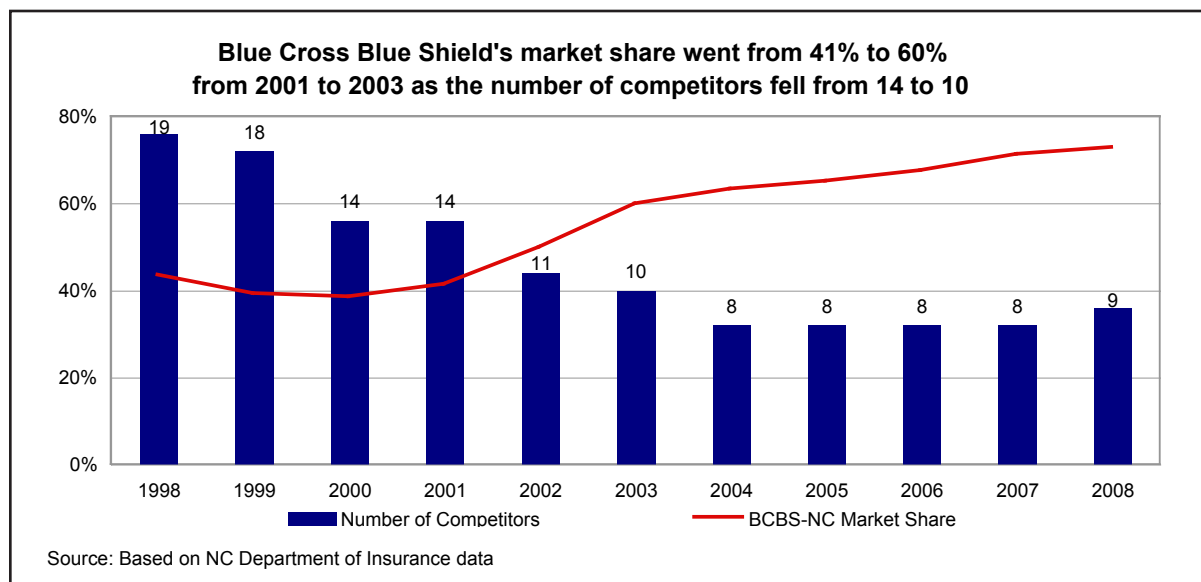
### COST

The Congressional Budget Office estimated that mandated benefits account for five percent of the cost of health insurance premiums.<sup>29</sup> These mandates are essentially a tax on health care consumers, and the cost does not include those benefits insurance companies would have provided otherwise.

Health insurers have an incentive to provide benefits their subscribers find valuable. Many provide additional benefits that are not mandated, such as smoking cessation and weight loss programs, active living discounts, breast and cervical cancer treatment, and podiatrists among others. While these benefits are another significant portion of premiums, they have no marginal cost as mandates.

For small businesses, the higher cost of insurance can lead to lower wages, fewer employees, or less generous benefits in other areas. Some studies suggest that mandates reduce wages but not employment.<sup>30</sup> Mandated benefits do increase the cost of hiring new workers and so limit the ability of companies to grow.





The higher marginal cost can also lead individual employees to refuse insurance coverage for themselves or their dependents. Consumers in the individual market may also decide to go without insurance. Mandated benefits may explain why one-fourth of the uninsured are uninsured.<sup>31</sup>

Providers are “usually the most vigorous proponents of legislation” mandating coverage of their services, which raises questions about whether the mandates are intended to help consumers or providers. Chiropractors in North Carolina went so far as to bribe former House Speaker Jim Black to mandate chiropractic coverage.

Mandated benefits may also help dominant insurers reduce competition. The North Carolina General Assembly added a number of mandated benefits and other changes to health insurance during the 2001-2002 session, including a moratorium on new health insurance mandates that began July 1, 2003.<sup>32</sup> Between 2001 and 2003, the number of competitors to Blue Cross Blue Shield North Carolina fell from 14 to 10. Blue Cross’ market share jumped from 41 percent to 60 percent over the same time period. From 2003 to 2008, Blue Cross continued to gain market share, reaching 73 percent in 2008, even as eight competitors remained.<sup>33</sup> (Figure 2)

#### QUALITY & ACCESS

“The substantial tax subsidy for employment-based health insurance encourages broader and

deeper insurance coverage than would otherwise be the case.”<sup>34</sup> This subsidy both undermines the rationale for mandated benefits and mitigates their negative impact. It undermines the rationale because individuals getting health insurance through their employer often have the coverage before it is mandated. The additional premium cost is in pre-tax dollars and so is less than the net salary increase at the same cost to the employer. Self-insurance among larger companies covered under ERISA also helps to reduce the negative impact of mandated benefits by exempting them from most state regulations. Because it reduces the number of mandated benefits for the majority of workers (though not the majority of companies), ERISA is one of the few health regulations that reduces cost.<sup>35</sup>

ERISA’s downside is that it leaves small companies and individuals to bear the greatest burden of health insurance mandates. Because ERISA protects large employers from state mandates, it reduces opposition to those mandates based on cost. Large self-insured employers may have an incentive to support mandates and increase costs for their competitors.

Tax treatment of employer-sponsored insurance removes another hurdle for mandated insurance benefits. Because employer-sponsored insurance is a tax-free benefit, employees are more likely to choose that insurance instead of taking the equivalent amount of pay and purchasing coverage on their own. The cost of insurance is further obscured in

many cases because the employee does not actually see how much her insurance premiums rise because of mandates. So those individuals who purchase insurance face even higher costs.

The burden of these mandates leads some small companies and individuals to forgo coverage, leaving the quality of insurance overall worse than it would have been without the mandates. Among those with insurance, mandated benefits insulate patients from the cost of care, so they demand more services. The excess demand then contributes to the problems discussed in the previous section of this paper on provider and capital regulations.

## **INNOVATION**

Mandates lock in current medical practices and payment methods.<sup>36</sup> They limit competition among medical providers and strengthen the position of dominant insurers. As insurers and providers seek assistance from lawmakers, they focus more on political gains than on the market.

“Health care is delivered in much the same way it was delivered 40 years ago because that is how it is reimbursed,” Shirley Svorny wrote.<sup>37</sup> The most innovative practices in recent years have been cash-only and concierge doctors who shun traditional contracts with insurers to focus on patients. Cosmetic surgery, cosmetic dentistry, and laser eye surgery are not covered by mandates but provide innovation and value for their patients.

Consumer-driven health plans with high deductibles and patient-directed accounts such as Flexible Spending Accounts (FSAs) or Health Savings Accounts (HSAs) had begun to change how we pay for care, but are in danger of being regulated out of existence themselves with federal reform legislation.<sup>38</sup>

## **CHIROPRACTORS**

The bribe to former House Speaker Jim Black led to a provision in the 2005 budget bill to treat chiropractors the same as primary care physicians. “An insurer shall not impose as a limitation on treatment or level of coverage a co-payment amount charged to the insured for chiropractic services that is higher than the co-payment amount charged to the insured for the services of a duly licensed primary

care physician for a comparable medically necessary treatment or condition.”<sup>39</sup> It was repealed in 2007 after Black resigned.

## **LINK TO LICENSING**

The General Assembly, claiming to be concerned about public health, safety, and welfare, passed a law in 1979 to certify marriage and family therapists.<sup>40</sup> Lawmakers included a sunset provision that would have eliminated certification in 1985, but instead repealed the sunset provision that year.<sup>41</sup> In 1994, lawmakers tightened restrictions and demanded marriage and family therapists become licensed instead of just certified.<sup>42</sup> Throughout, lawmakers always absolved insurers from paying for therapy. That changed in 2003 when lawmakers mandated that insurers cover the services of marriage and family therapists.

Lawmakers should keep this in mind when groups approach them seeking some minimal recognition. It took less than 25 years from the time family therapists first received state certification until the state forced insurance companies to pay for their services.

## **ALTERNATIVES**

As with restrictions on health care providers, the most direct action would be to eliminate mandated benefits altogether. This could reduce premiums by five percent, increase wages, and permit insurers to tailor less expensive policies to younger people and those with fewer health concerns.

Without blanket repeal, policymakers could insist on expiration dates for mandates and subject them to periodic review. Another option would be to mandate that insurance companies offer coverage, but give subscribers the choice of purchasing it, like maternity coverage is now handled.

A final state-level reform would be to permit residents to purchase insurance from other states without having to meet North Carolina regulations. All care under these policies would likely be out of network and so would have a higher price to the subscriber, but the premium savings in many instances would offset the difference, just as in high-deductible policies.

## Conclusion

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Provider and hospital regulations make care more expensive. Mandated benefits make insurance more expensive and encourage more provider groups to pursue state regulation. The federal health care reform law does little to address either of these state-level market restrictions. Some provisions of the federal law are directly counter to the pro-market recommendations from the Department of Justice and the Federal Trade Commission.

State deregulation of health care provision and insurance can mitigate the likely large cost increases that will result from the federal law. Such steps as outlined in this paper can also improve North Carolinians' access to health care and thereby the quality of care. Done correctly, North Carolina could build on its reputation as a leader in health practice innovations, a reputation based on successful public and private efforts.

## Notes

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- <sup>42</sup> S.L. 1993-563
- <sup>43</sup> S.L. 2003-117

## About the Author

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Joseph Coletti is Director of Health and Fiscal Policy Studies at the John Locke Foundation. In addition to the biennial Freedom Budget, he has authored reports on the state's spend-and-tax budgeting cycle, better ways to fund roads and schools, the earned-income tax credit, business incentives, tax-increment financing, government employee compensation, and an early look (in July 2005) at the infamous feasibility study behind the Randy Parton Theatre in Roanoke Rapids.

In health policy, Coletti has examined Medicaid spending, offered ways to fund the state's high-risk pool without new taxes, critiqued the current system of employer-based health insurance, assessed long-term care, and is currently trying to find a way out of the state's mental health madness.

His writing has been in publications such as *Health Care News*, *Global Corporate Xpansion*, and the *Charlotte Observer*. He has spoken at health care and tax policy conferences and to civic groups across the state. He has appeared on radio and television, including WUNC's "The State of Things" and CNBC Asia.

Before joining the Locke Foundation, Coletti was the Director of Policy and Communications for the U.S.-Japan Business Council in Washington, D.C., where he helped Fortune 1000 companies work with the U.S. and Japanese governments. He also led marketing research and forecasting projects with J.D. Power and Associates in Detroit and Tokyo.

Coletti received a bachelor's degree from the University of Michigan and a master's degree from the Johns Hopkins University Paul H. Nitze School of Advanced International Studies (SAIS). He lives in Cary with his wife and their two children.

## About the John Locke Foundation

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*“To prejudge other men’s notions  
before we have looked into them  
is not to show their darkness  
but to put out our own eyes.”*

JOHN LOCKE (1632–1704)

AUTHOR, TWO TREATISES OF GOVERNMENT AND  
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