Forbes

Obamacare RIP: John Roberts Cannot Save You

By: Peter Ferrara **July 5, 2012**

Progressives are desperate to prevent the country from learning that free market conservatives have long been proposing policies to assure essential health care for all, and achieve all the other goals of Obamacare, at just a small fraction of the costs. That involves a health care safety net ensuring that no one would suffer from lack of essential health care, with no individual mandate and no employer mandate, achieving that goal far more effectively than Obamacare. And it involves market incentives and competition to control costs far more effectively than, indeed contrary to, Obamacare.

The best exposition of those policies can be found in the latest book by John Goodman, *Priceless: Curing the Health Care Crisis*, just published by the Independent Institute. Goodman is the Godfather of Health Savings Accounts (HSAs), and President of the National Center for Policy Analysis in Dallas.

The safety net reforms begin with Medicaid, the health care program for the poor costing roughly $500 billion a year now in federal and state spending, and growing like Jack's beanstalk. Despite all that spending, Medicaid pays doctors and hospitals only 60% or less of costs for their health services to the poor. Consequently, the poor on Medicaid face grave difficulties in obtaining timely and essential health care, and suffer worse health outcomes as a result. As Scott Gottlieb of the New York University School of Medicine explains in a March 10, 2011 commentary in the *Wall Street Journal* ("Medicaid Is Worse Than No Coverage at All"), "Dozens of recent medical studies show that Medicaid patients suffer for it. In some cases, they'd do just as well without health insurance."

Gottlieb reports that a 2010 study of throat cancer "found that Medicaid patients and people lacking any health insurance were both 50% more likely to die when compared with privately insured patients." A 2011 study of heart patients "found that people with Medicaid who underwent coronary angioplasty were 59% more likely to have…strokes and heart attacks, compared with privately insured patients. Medicaid patients were also more than twice as likely to have a major, subsequent heart attack after angioplasty as were patients who didn't have any health insurance at all." A 2010 study of major surgical procedures "found that being on Medicaid was associated with the longest length of stay, the most total hospital costs, and the highest risk of death.

The deathly problem was illustrated by the case of 12 year old Deamonte Driver, from a poor Maryland family on Medicaid. When Deamonte complained of a toothache, his mother tried to find a dentist who would take Medicaid. But only 900 out of 5,500 dentists in Maryland do. By the time she found one, and got the boy to the appointment, his tooth had abscessed, and the infection had spread to his brain. Now she needed to find a brain specialist who took Medicaid. Before she could find one, the boy was rushed to Children's Hospital for emergency surgery. He called his mother from his hospital room one night to say, "Make sure you pray before you go to sleep." In the morning, he was dead.

Medicaid today is consequently just an institutionalized means for denying health care to the poor by refusing to pay doctors and hospitals sufficiently to assure their timely access to essential health care.

The entire problem can be solved by extending to Medicaid the enormously successful, bipartisan 1996 welfare reforms of the old, New Deal, Aid to Families with Dependent Children (AFDC) program. That reform returned the share of federal spending on AFDC to each state in the form of a "block grant" to be used in a new welfare program redesigned by the state based on mandatory work for the able bodied. Like Medicaid, federal funding for AFDC previously was based on a matching formula, with the federal government giving more to each state the more it spent on the program, effectively paying the states to spend more. The key to the 1996 reforms was that the block grants to each state were finite, not matching, so the federal funding did not vary with the amount the state spent. If a state's new program cost more, the state had to pay the extra costs itself. If the program cost less, the state could keep the savings.

The reform was shockingly successful, with two-thirds leaving the program for work within 10 years. Their incomes consequently increased by 25%, while costs to taxpayers declined by 50% after 10 years from where they would have been otherwise.

With the same block grants applied to Medicaid, the states could then each choose to use the funds to provide assistance to the poor to buy the private health insurance of their choice. The voters of each state would decide how much assistance to provide each family at different income levels to assure that the poor would be able to obtain adequate health insurance. This would rightly vary with the different income and cost levels of each state. The poor would then be free to choose the private health insurance they preferred, including Health Savings Accounts, liberating them from the Medicaid ghetto. The poor would enjoy the same health care as the middle class, because they would have the same market health insurance as the middle class.

A second step necessary to ensure a complete safety net is to allow each state to use part of their Medicaid block grant to set up a High Risk pool. Those uninsured who become too sick to purchase health insurance in the market, perhaps because they have contracted cancer or heart disease, for example, would be assured of guaranteed coverage through the risk pool. They would be charged a premium for this coverage based on their ability to pay, ensuring that they

will not be asked to pay more than they could afford. Federal and state funding would cover remaining costs. Such risk pools already exist in over 30 states, and for the most part they work well at relatively little cost to the taxpayers because few people actually become truly uninsurable.

Federal law since 1996, and state law before that, already provides that insurers cannot cut off already existing policyholders, or impose discriminatory rate increases, because they become sick *while* covered. That would be like allowing fire insurers to cut off coverage for houses once they catch on fire, a straight forward violation of standard contract law. If this law needs to be modernized, it should be.

In *Priceless*, Goodman extends these reforms, which he has been advocating for 20 years, to propose a new standard provision for insurers to offer in their health policies — protection specifically against the development of pre-existing conditions. Not only could someone who becomes sick while insured keep his policy at standard rates. If he decides to choose a new policy after he becomes sick, his old policy would be obligated to make payments to the new insurer to cover the likely added costs of the pre-existing condition.

With these reforms, those who have insurance can keep it, those who can't afford it are given the necessary help to buy it, and those who nevertheless remain uninsured and then become too sick to buy it have a back up safety net in the risk pools. Everyone is assured of being able to get essential health care when they need it, with no individual or employer mandate.

The foundation of Goodman's cost control strategy is Health Savings Accounts (HSAs), stemming from his pathbreaking 1992 book *Patient Power*. HSAs involve health insurance paying all expenses above an annual deductible of preferably $2,500 to $5,000 or possibly more. That insurance is much less expensive with those high deductibles alone, and the savings is put in the HSA savings account and used to pay health expenses below the deductible. Whatever is not spent stays in the account earning interest to pay for future expenses, and can be withdrawn and used for anything in retirement.

That means that the patient is paying for all non-catastrophic health care effectively with his own money. Now the patient has full market incentives to avoid unnecessary care, and shop around for the least expensive care he does need. Studies and experience show that such HSA incentives reduce health costs by 30% or more.

Goodman explains the potential for such HSAs: "In moving from a $1,000 annual deductible to a $2,500 deductible, the family is exposed to an additional risk of $1,500 per individual ($3,000 per family). In return, they can save almost $5,000 a year in reduced premiums. In moving from a $1,000 to a $5,000 deductible, the family takes an additional $4,000 of risk per individual (but no more than $8,000 per family). But the [annual] premium savings is nearly $8,000." Consequently, workers and families with HSAs can expect to have enough in their HSA savings accounts to cover all expenses below the deductible.

Since patients would now be concerned about controlling costs, doctors, hospitals and other health providers would now compete to control costs, as well as maximize quality, as in all normal markets. (This competition would become more intense and effective the more widespread HSAs become.) These incentives would flow all the way through to the developers of new technologies. Since both patients and health providers are now concerned with costs, technology innovators would now have incentives to develop technologies that reduce costs, as well as improve quality.

Goodman proposes Medicare reform empowering all retirees to choose HSAs for their Medicare coverage, with premium support enabling each retiree to choose among competing private plans. That proposal also uniquely includes enabling workers to save and invest their Medicare payroll taxes in personal savings and investment accounts, accumulating to finance annuities in retirement also to be used to pay for private HSA plans. Goodman produces professional actuarial calculations indicating that between the accumulation of compounding investment returns over the years, and the cost savings of HSAs, the enormous long term financing gap of Medicare could be closed entirely without any benefit cuts or tax increases. The poor could also choose among competing HSAs for their Medicaid coverage under the proposal above.

Goodman advocates as well replacing the Obamacare tax credits for the purchase of health insurance with a refundable Consumer Choice tax credit, which would effectively expand the tax relief for employer provided health insurance to everyone. The refundable credit would provide specified sums that anyone could use to help pay for insurance coverage. Paul Ryan proposed $2,300 for individuals and $5,700 for families that could be used to help pay for health insurance.

The credit would not only help workers without employer provided health insurance obtain health insurance on their own. Workers who did not like their employer's plan could use the credit to choose their own in the competitive marketplace. Workers again could use the credit to choose HSAs for their coverage. Insurance purchased with the credit would be the property of each worker, and therefore completely portable, so the worker would not lose health coverage if he changed or lost his job.

Workers would then shop for and choose the lowest cost health plans in a competitive market, which would also help to reduce health costs. Under Goodman's reforms, such market competition to reduce costs would also be established in Medicare and Medicaid. Through such market choice, workers, the poor in Medicaid, and retirees on Medicare could choose HSAs, expanding the proven cost reducing incentives of HSAs throughout the entire health care industry.

The interstate sale of health insurance would further maximize competition, which would further reduce costs. Regulations that unnecessarily increase costs should be repealed as well. That includes the thousands of state special interest benefit mandates, guaranteed issue and

community rating (completely unnecessary with Goodman's safety net), and regulations that unnecessarily prevent new health providers from entering markets and increasing competition, such as certificate of need requirements mandating a showing of need for the services. Tort reform, of course, would also reduce health costs. These reforms along with cost reducing market incentives of HSAs, and the cost savings from market wide competition, provide a thorough solution to the health cost problem.

Goodman further extends the vision in *Priceless* to creating a market for the sickest patients, where insurers would compete to best serve them and their needs rather than trying to avoid them, as under the current legal and policy regime. The foundation for that begins with the new insurance provision noted above requiring the insurer to make risk adjusted payments to any new insurer that covers the pre-existing conditions of one of the original insurer's former policy holders. Workers using the new Consumer Choice tax credit could use that to buy policies with that provision. Medicare and Medicaid would also provide additional risk adjusted payments to insurers of the sickest who need the most advanced and expensive care. Goodman explains, "In such a market, the sick would be just as desirable as the healthy to an insurance company. And there would be an active, entrepreneurial market to find low-cost ways to solve your health problems—in order to lower costs both for you and your insurer."

Obamacare RIP. John Roberts is a lawyer not a doctor. He can't save you.