



National Center for Policy Analysis

# **Handbook on State Health Care Reform**

by

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**Foreword by Jeb Bush**

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*Handbook on State Health Care Reform*

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## *Foreword*

# HEALTH CARE REFORM

Reforming health care is one of the great challenges facing our country today. Based on our experience, true transformational reform must begin in state capitols, not in the halls of Congress. States can introduce and vet a variety of reforms. Through a process of trial-and-error, state reforms can provide an empirical basis for comprehensive action by the federal government.

The *Handbook on State Health Care Reform* provides an in-depth examination and analysis of our health care system. It is a valuable resource and practical tool for guiding policy decisions to improve quality, expand access and control the escalating costs of health care. Even in states where reform is already underway, policymakers will benefit from the insights, advice and visionary approach to solutions outlined in the *Handbook*.

## HANDBOOK ON STATE HEALTH CARE REFORM

Rather than complicate an already complex problem, the *Handbook* focuses on universal principles of human nature and market forces. Individuals, with the advice of their doctors, make better health care decisions for themselves and their families than institutional bureaucracies. A freer and more transparent market for health care will produce the financial incentives for providers to improve health care to compete for patients. Consequently, empowering individuals with greater freedom to spend their health care dollars in a competitive marketplace will control costs better than regulatory limits mandated across the spectrum of services.

Countering critics of market-based reform who decry the profits currently earned in the health care industry, the authors point to the real culprit — the ability to earn rewards in a system that does not serve patients well. In this light, placing patients in charge of health spending is clearly the essential ingredient for empowering them to get what they want — quality care at a reasonable price. Using unequivocal examples, the *Handbook* pinpoints the obstacles embedded in today's health system and illuminates the exceptions that prove the potential in a market-based re-design. For example,

**“Horse and Buggy Medical Care...**doctors and patients are still interacting in the same way as they did in the horse and buggy era...At last count, there were about 7,500 specific tasks Medicare pays for. Telephone consultations are not among them. Nor are email consultations or electronic record keeping. In general, when third parties pay by task there will always be valuable services not on the list of reimbursable activities. The incentives of physicians are to perform those tasks for which there is payment and avoid those tasks for which there is no payment.”

## FOREWORD

**“Health Care without Insurance...** Parkland (Hospital in Dallas) operates what Harvard Professor Regina Herzlinger has described in other contexts as a ‘focused factory.’ They are so good at delivering babies, they helped produce an internationally praised textbook on how to deliver babies and their methods are being copied in Britain and other countries... Were all of Parkland’s 16,000 expectant mothers enrolled in Medicaid, or private insurance, however, the experience might be worse. Prenatal care delivered by nurses rather than doctors might not be allowed under many states’ Medicaid rules. Ditto for deliveries performed by midwives. And under typical state insurance regulations, patients with private coverage would be encouraged to see OBGYNs (because of zero patient cost sharing), where the cost would be higher and the overall quality of the pregnancy/delivery episode might not be as good (because of fragmented care).”

The *Handbook on State Health Care Reform* successfully challenges the prevailing assumption that the only responsible reform for health care is more government, more centralized decision-making, more mandates and more third party payment. These authors provide a rational and practical alternative to this conventional viewpoint. Greater freedom and proven market principles will provide lasting access to affordable, quality health care.

Jeb Bush

## *Introduction*

# THE CASE FOR A NEW APPROACH TO HEALTH POLICY

Why another book on health care? Because no previous book actually shows how to solve the three most important health care problems: cost, quality and access to care.

Nor for that matter does any previous book tell how to reliably insure the uninsured, or make health insurance portable, or make the insurance marketplace functional rather than dysfunctional, or solve the problems of workers' compensation or medical malpractice, or reform Medicaid, or shore up the charity care safety net, or deal with innumerable other problems.

This book is a “how to” book. It is designed to help legislators, policy analysts, think tanks and other interested parties solve the very difficult problems of health policy. We don't claim to have all the answers, but we suspect there will be much of value here that readers have not seen before.

## HANDBOOK ON STATE HEALTH CARE REFORM

The problem of health care spending is by far the most serious U.S. domestic policy problem. Health care spending is on a course to crowd out every other government program at the local, state and federal levels. It is also on a course to crowd out everything else in the average family budget. This problem will become progressively worse year by year until 2011, when the first of the baby boomers become eligible for Medicare. At that point, the severity of the problem will begin to soar.

As we are constantly reminded by the national news media, our health care system also has problems of quality and access to medical care. Moreover, in the face of escalating health care costs, the problems of quality and access are likely to get even worse. The way most other countries try to control costs is by denying patients access to the highest quality care.

Before considering solutions, however, let's first set the stage. There are three features of health policy everyone needs to understand to get properly oriented.

Number one, health care is far and away the most complex social system there is. In fact, it may be even more complex than all other social systems combined.

Number two, health policy has been the object of more studies than any other market or area of human activity. In fact, the number of health policy studies must exceed by several orders of magnitude whatever field of endeavor is in second place.

Number three, despite the huge volume of research, the large number of active researchers and the best of all possible motivations, health policy researchers have managed to produce hardly any truly workable solutions to the problems of cost, quality and access. They haven't solved the lesser problems either. Indeed, with each passing year, the problems only seem to get worse and the solutions seem to grow increasingly elusive.

So the first important question to ask about health policy is not, what is the solution to this problem or that? It is, why have so many very bright

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people toiled for so long in so many different ways without finding serious solutions to much of anything?

We believe we know the answer to this question, and it marks the point of departure for this book.

All too often, health policy analysts take the problems as given — as natural and inevitable characteristics of health care delivery. Given this assumption, they seek solutions from the outside — usually in the form of government efforts to force the system to change. To control costs, the conventional solution is to artificially push down provider incomes or restrict access to new technology. To improve quality, the conventional solution is for government to dictate standards, in effect telling doctors how to practice medicine. To improve access, the conventional solution is to expand government-funded health care to more and more groups and to make health care free at the point of delivery.

These conventional solutions have been tried in other developed countries and to a large extent they have been tried in the United States as well.<sup>1</sup> It is probably no exaggeration to say they have not worked very well.

In contrast to the conventional approach, we do not take the most important problems in health care as natural or inevitable. They are instead the artificial byproduct of the systematic suppression of normal market forces — which took place over the course of the 20th century.<sup>2</sup> Further, the solution to these problems does not lie in top-down, government-imposed remedies. It instead lies in bottom-up liberation. In particular, we need to free people from institutions that prevent them from solving problems on their own.

The most common source of problems in our health care system is the fact that most of the time people do not bear the full costs of their bad decisions or realize the full benefits of their good ones. On the buyer side of the medical marketplace, this means that patients who wastefully overuse health care resources usually pay only a small fraction of the cost of that

waste. Conversely, patients who economize and avoid waste usually reap only a small fraction of the savings from their economizing.

On the provider side of the market, incentives are also distorted. In fact, health care providers rarely reap the benefits of being better at what they do. Consider that:

- In a normal market, producers compete vigorously to meet consumer needs; in fact, the more unmet needs there are, the greater the producer opportunities.
- In a normal market, insurers price and manage risk; in fact, the more risk there is, the greater are the insurer's opportunities.
- In a normal market, firms compete based on price and quality; in fact price reductions and quality enhancements are the principal ways to attract customers and boost profits.

In health care, by contrast, these normal market processes are subverted:

- Providers, more often than not, try to avoid the sickest patients with the hardest cases — rather than compete to attract them.
- Health insurers, more often than not, try to avoid the riskiest customers rather than viewing them as market opportunities.
- Doctors, hospitals and other providers rarely compete for patients based on price or quality; in fact, they rarely compete at all, in any meaningful sense.

Yet these problems are not insolvable. One of the most amazing facts about our health care system is that for virtually every problem there are tangible, visible solutions — not hypotheticals, but real flesh and blood answers operating here and there, in diverse places.

For example, there are numerous examples of high-quality, low-cost health care in America — they are just not the norm. If we all got our health care at the Mayo Clinic, the nation's health care bill could be reduced by one-fourth and the quality of care would be improved. If everyone went

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to Intermountain Healthcare in Utah, total spending would be reduced by one-third, again with higher quality.<sup>3</sup>

Not only does health not have to be expensive, there is no reason in principle why we should have to wait for it. In pharmacies, shopping malls and “big box” retailers around the country, people are getting high quality primary care at walk-in clinics for half the normal cost and with very little waiting.<sup>4</sup>

Nor does price and quality information have to be hidden. In the international marketplace hospitals routinely quote package prices for all manner of standard surgical procedures and publish quality data (including their mortality rates) as well. Furthermore, patients can get top quality care at a fraction of what it would cost at most U.S. hospitals.<sup>5</sup>

So how do we get from here to there? How do we take advantage of these examples of success and get the rest of the system to copy and improve on them?

Complex systems cannot be successfully managed, regulated or reformed from above. They are simply too complex. To have any hope of making such a system functional and workable, reform must start from below. Specifically:

- Hospitals that follow the procedures at Mayo or Intermountain should find that the change attracts customers and improves the bottom line; and, if this is not the case, we should ask: what public policy changes are needed to encourage that outcome?
- Primary care doctors who increase patient convenience, consult with patients by telephone or e-mail, keep patient records electronically and order prescriptions online should find such patient pleasing improvements boost their net income; and if that is not the case, what policy changes are needed to make it so?
- Hospitals that offer package prices, make public their quality data and compete for patients based on price and quality should find

these activities rewarding; and if not, how can we make them rewarding?

- Patients who find ways to economize by avoiding unnecessary procedures, comparing prices and shopping for drugs online in a national marketplace should find that smart shopping is good for the pocketbook; and if not, what can we do to change this feature of our system as well?

Ultimately, every problem in our health care system begins with perverse incentives faced by individuals — patients, doctors, nurses, hospital managers and others. Correcting the problems means changing those incentives.

The policy proposals advanced in this book will not by themselves solve any problems. Instead they will change the institutional environment. In so doing, they will liberate everyone in the system. Problems are ultimately solved by people. The best government can do is remove the legal obstacles that prevent people from doing just that. For example:

- Our solution to the problem of the uninsured is to allow people to take dollars now spent on free care — largely in hospital emergency rooms — and buy private health insurance instead.
- Our solution to the problem of people trapped in such government health programs as Medicaid and the State Children's Health Insurance Program (S-CHIP) is to allow them to apply those same dollars to private insurance instead.
- Our solution to the problem of lack of continuity of insurance and health care is to give employees and their employers access to personal and portable insurance.
- Our solution to the problem of quality is to allow doctors and hospitals to repackage and reprice their services under government health care payment systems — allowing them to gain financially from providing better care.

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- Our solution to the problem of cost is to allow patients to control more of their own health care dollars, and to allow patients and providers to benefit from new arrangements that produce lower-cost, higher-quality care.
- Our solution to the problem of long-term care is to allow people to insure for this contingency in a way that does not cause complete asset depletion if they eventually have to rely on Medicaid.
- Our solution to the problem of Workers' Compensation is to give employers and employees access to integrated health and disability plans as well as other contractual opportunities.
- Our solution to the dysfunctional medical malpractice system is to give doctors and patients the opportunity to resolve tort liability issues by contract rather than in the courtroom.

None of these solutions involve telling people what to do. Instead, we propose in every case to lower barriers, remove restrictions, repeal laws and otherwise give people the freedom to solve problems using their intelligence, creativity and innovative abilities.

We are confident that, given the freedom to do so, 300 million Americans will find better answers to health care problems than any government agency.

In producing this book we received help from many quarters. Linda Gorman (Independence Institute) and Greg Scandlen (Consumers for Health Care Choices) were kind enough to allow us to use some of their research as sidebars. Earl Grinos (Baylor University) read through an early manuscript as did Jason Turner, John Courtney, Ted Abram, Mark Hoover and Marc Kane (all with the American Institute for Full Employment) and Steve Buckstein (Cascade Policy Institute).

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John C. Goodman

## INTRODUCTION

### Notes

<sup>1</sup> For a comprehensive analysis of how the national health insurance systems of other countries have not solved the problems of cost, quality and access, see John C. Goodman, Gerald L. Musgrave and Devon M. Herrick, *Lives at Risk: Single-Payer National Health Insurance around the World* (Lanham, Md.: Rowman & Littlefield, 2004).

<sup>2</sup> To understand how markets were systematically suppressed in the twentieth century see John C. Goodman, *Regulation of Medical Care: Is the Price Too High* (San Francisco: Cato Institute, 1980); and the summary in John C. Goodman and Gerald L. Musgrave, *Patient Power: Solving America's Health Care Crisis* (Washington, D.C.: Cato Institute, 1992).

<sup>3</sup> John E. Wennberg et al., "The Care of Patients with Severe Chronic Illness: an Online Report on the Medicare Program by the Dartmouth Atlas Project," Dartmouth Atlas of Health Care, Center for the Evaluative Clinical Sciences, Dartmouth Medical School, 2006. Available at [http://www.dartmouthatlas.org/atlas/2006\\_Chronic\\_Care\\_Atlas.pdf](http://www.dartmouthatlas.org/atlas/2006_Chronic_Care_Atlas.pdf). Accessed February 19, 2007.

<sup>4</sup> Rik Kirkland, "Wal-Mart's RX for Health Care," *Fortune*, April 17, 2006.

<sup>5</sup> Devon M. Herrick, "Medical Tourism: Global Competition in Health Care," National Center for Policy Analysis, forthcoming.

## *Chapter I*

# THE GOALS OF REFORM

The goals of any worthwhile health reform plan should be to solve the three problems of the American health care system: cost, quality and access.

**Problem of Cost.** Health care spending per capita is growing twice as fast as national income. If this trend continues, health care will crowd out every other form of consumption by the time today's college students retire. For example:

- Based on the trend of the past 30 years and the expected aging of the population, economist Laurence Kotlikoff and his colleagues estimate that government spending on health care will reach 33 percent of gross domestic product (GDP) by 2050.<sup>1</sup>
- Since government spending for all purposes today is roughly one-third of national income, health care is on a course to crowd out

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virtually everything else government does — that means no spending on schools, roads, national defense, Social Security and so forth.

- If private-sector spending on health care keeps up with government spending (which it has for the past 30 years), the country as a whole will be spending two-thirds of national income on health care by the time today's college students reach retirement age.
- Since consumption of all goods and services is roughly two-thirds of national income, health care is on a course to crowd out every other form of consumption including food, clothing, housing and so forth.

A recent Congressional Budget Office study looks at this same problem from a different angle. The CBO assumes that the federal government will meet all its health obligations (under Medicare and Medicaid, for example) and that income tax rates will rise in order to fund the spending. The result: by mid-century middle-income families will face a tax rate of 66 percent and high-income families will face a tax rate of 92 percent.<sup>2</sup>

Clearly, spending is on an impossible path, and the longer the United States stays on this course the more painful it will be to get off it. Why is health care spending rising so rapidly in the first place? On the demand side, it is because — unlike other consumer goods — people very rarely have to choose between health care and other goods and services.

- On the average, every time an American spends a dollar on physician's services, only 10 cents comes out of his or her own pocket.<sup>3</sup>
- The incentive for a patient, therefore, is to consume physician services up to the point at which the next dollar spent buys services worth only a dime.
- For the health care system as a whole, every time a dollar is spent, only 13 cents is paid out of pocket.<sup>4</sup>
- So the incentive for a patient is to consume health care generally until the next dollar spent is worth only 13 cents.

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On the supply side, medical providers who discover cost-reducing innovations are not rewarded, whereas those who invent new ways to spend money on health care are. The message is: show an innovation will improve health (if only modestly) and insurers will pay for it.

So what can be done? Some proposals appear to casual observers to solve this problem, but upon closer inspection it becomes clear they would result in a one-time reduction in costs or a shift of costs from one group to another, but not a change in the long-term trend. Ultimately, there are only two solutions: (1) on the demand side, Americans must choose between spending on health care and other uses of money, and (2) on the supply side, cost-reducing innovations must be rewarded through the discipline of a competitive marketplace.

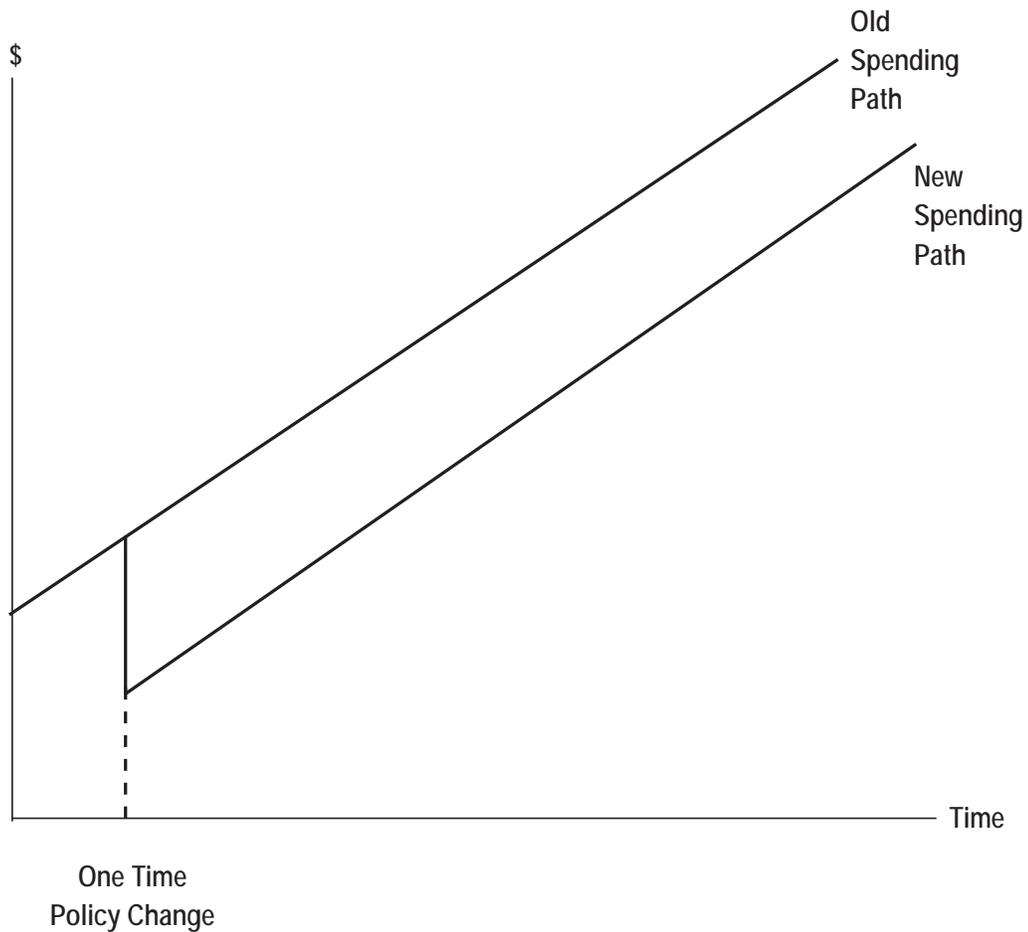
*Illusory Solution: Implementing One-Time Cost Reductions.* One set of proposals focuses on one-time changes in behaviors or systems. For example, suppose everyone exercises, eats right and engages in healthy behavior. Or suppose cost-reducing computer technology or other measures to reduce waste are instituted. Commendable as all these measures are, they will make a one-time impact only; they cannot be repeated. As a result, these measures cause a one-time reduction in cost — but no change in trend. [See Figure I.]

*Illusory Solution: Shifting Costs.* Another set of proposals would shift costs from one group to another. For example, Physicians for a National Health Program, an advocacy group, argues that if government were the sole (monopolistic) buyer of health services, it could force reductions in fees paid to doctors, nurses and other health personnel to everyone else's benefit. This is apparently what happens in other developed countries. For example, on average the income of a physician is 5.5 times that of the average worker in the United States. The ratio for Germany and Canada is 3.4 and 3.2, respectively. The comparable ratio is 1.5 in Sweden and 1.4 in the United Kingdom.<sup>5</sup>

When government buyers force down provider fees, costs are shifted from taxpayers to providers (usually in ways that disguise costs); but that

does not change the long-term trend. [See Figure I.] Cost shifting is one of the reasons other developed countries appear to spend less of their income on health care, even though the rate of growth of U.S. per capita spending on health care over the past 40 years is about equal to the average growth

FIGURE I  
*Health Care Spending*



in health care spending among countries in the Organization for Economic Cooperation and Development (OECD).<sup>6</sup> The total cost of health care in other OECD countries is understated in official statistics, and one reason why is that some costs are shifted onto providers.

## CHAPTER I — GOALS OF REFORM

*Real Solution: Choosing between Health Care and Other Goods and Services.* On the demand side, real reform means someone choosing between spending on health care and other uses of money. That is, someone must decide that the value of one more MRI scan is not worth the money it costs; or that the value of one more knee replacement is not worth the money it costs; or that spending one-third of Medicare dollars on patients in the last year of their lives is not worth the expense. If no one is forced to make these choices, costs will continue on their current course.

If choices must be made, who should make them? In principle, there are only a few possibilities. In other countries, government often decides. Another option is for decisions to be made by employers or insurance companies using cost-benefit analysis or some other criteria. (Indeed, this is one way to look at the failed promises of managed care.) Or, patients themselves could make most of the choices.<sup>7</sup>

*Real Solution: Producing Health Care Services in a Competitive Marketplace.* In a normal, competitive marketplace, producers who find ways to improve efficiency and lower costs or raise quality are rewarded with higher profits; producers who are inefficient and fail to lower costs or improve quality are punished with losses and eventually go out of business. In health care, all too often the opposite is the case. In general, the health care market rewards high-cost, low-quality providers and punishes low-cost, high-quality providers.

There are, however, health care markets where providers do compete on price. These are invariably markets where patients, rather than third-parties — employers, insurers or the government — pay the bills. They also prove that competition can play the same role in health care as it plays in other markets. For example, although the medical price index invariably exceeds the price index for all consumer goods, this is not the case for cosmetic surgery or Lasik surgery. In fact, the real price of cosmetic surgery fell over the last 15 years, despite soaring demand and all manner of technological innovations.<sup>8</sup> The real price of Lasik surgery fell 30 per-

cent over the past decade.<sup>9</sup> In addition, there is a booming international marketplace for high-quality surgery (called “medical tourism”) in which procedures are performed for one-third, one-fourth or even as little as one-fifth of the expected cost in the United States.<sup>10</sup>

**Problem of Quality.** There are three indicators that suggest serious quality problems in the U.S. health care system. First, a RAND Corporation study finds that, on the average, patients get appropriate care only about one-half of the time. Further, the type of health insurance people have — or whether they have insurance at all — does not seem to affect the quality of care.<sup>11</sup>

Second, there is a serious problem of medical errors. An Institute of Medicine (IOM) report, *To Err Is Human*, concludes that 4 million to 5 million hospitalized patients nationwide are harmed by medical errors each year, and from 44,000 and 98,000 Americans die each year in hospitals as a result of medical errors.<sup>12</sup> These mistakes take many forms, but drug errors and hospital-acquired infections top the list.

Some experts think these estimates are too high.<sup>13</sup> Others think they are too low.<sup>14</sup> Health economist Linda Gorman argues that it is the Institute of Medicine that has made too many errors. [See the sidebar.] Even so, hospitals clearly are far less safe than they could be. For example, handwritten prescriptions are a major source of medical errors; nearly 200,000 adverse drug events occur each year in hospitals due to manual order systems.<sup>15</sup> An estimated 2 million infections are acquired during hospitalizations each year, and it costs more than \$30 billion just to treat infections acquired *inside* the hospital! Oddly enough, everyone knows what the problem is: There would be far fewer infections acquired within hospitals if health care workers used an alcohol-based hand washing foam before (and after) seeing every patient. An additional measure that would help prevent the spread of infectious agents is wearing disposable gowns, and then discarding them, when treating patients who have infections. Yet even when solutions are known there is poor compliance.<sup>16</sup>

## Too Many Errors?

A 1999 Institute of Medicine (IOM) report, *To Err Is Human*, asserted that “medical injuries account for between 48,000 and 98,000 deaths per year in the United States ... ahead of breast cancer, AIDS, or motor vehicle accidents.”<sup>1</sup>

The IOM did not do its own study of medical errors, but instead extrapolated results from two well-known Harvard University studies based on data from three states.

In 2000, an author of one of the two original studies wrote that “neither study cited by the IOM as the source of data on the incidence of injuries due to medical care involved judgments by the physicians reviewing medical records about whether the injuries were caused by errors. Indeed, there is no evidence that such judgments can be made reliably.” Furthermore, the IOM recommendations gave “the impression that doctors and hospitals are doing very little about the problem of injuries caused by medical care ... yet the evidence suggests that safety has improved, not deteriorated.”<sup>2</sup>

Another critique explained that the IOM figure of 98,000 deaths was extrapolated from the Harvard Medical Practice study that looked at 173 actual deaths in a 1984 hospital admissions database of 31,429 acutely ill patients. The authors had said only that adverse events *may have contributed* to the 173 deaths they identified; they did not conclude that the errors caused the deaths.

Furthermore, U.S. hospitals do well in international comparisons. One study of adverse hospital events found that the U.S. error rate was half the rate in Canada, a third of the rate in Britain and New Zealand, and less than a fourth of the error rate in Australia.<sup>3</sup>

<sup>1</sup> Linda T. Kohn, Janet M. Corrigan and Molla S. Donaldson, eds., *To Err is Human: Building a Safer Health System* (Washington, D.C.: National Academy Press, 2000).

<sup>2</sup> Troyen A. Brennan, “The Institute of Medicine Report on Medical Errors — Could it Do Harm?” *New England Journal of Medicine*, Vol. 342, No. 15, April 13, 2000, pages 1,123-25.

<sup>3</sup> G. Ross Baker et al., “The Canadian Adverse Events Study: the Incidence of Adverse Events Among Hospital Patients in Canada,” *Canadian Medical Association Journal*, Vol. 170, No. 11, pages 1,678-86.

Source: Linda Gorman, Independence Institute.

Third, the medical community is not taking advantage of computer software that would greatly reduce errors and improve quality. For example, a handwritten prescription is a potential source of several types of errors: wrong drug, wrong dose, wrong instructions and so forth. By contrast, electronic prescriptions have much less chance of error, and they can be combined with software that alerts the doctor, the pharmacist and even the patient when an apparent mistake is about to be made. Electronic medical records (EMRs) could greatly reduce medical errors, but fewer than one in five physicians and only one in four hospitals use them.<sup>17</sup>

It is instructive to compare the U.S. health care system to the U.S. airline industry, where the Federal Aviation Administration and the National Transportation Safety Board continually look for ways to improve safety. Over the past two decades, U.S. airline fatalities plummeted nearly 90 percent. In 1987, one airline fatality occurred for every 18.8 million passenger miles flown. By 2006, airline passenger miles had about doubled, but there was only 1 death per 165.4 million passenger miles flown.<sup>18</sup>

So what can be done to improve health care quality? The most common solutions focus on the demand side of the market. Lasting solutions, however, must come from the supply side.

*Illusory Solution: Paying for Performance.* One set of proposals would have insurance companies and government tell doctors what to do. For example, there are programs being implemented in which insurers pay doctors more if patient care meets certain objectively verifiable standards and pay less if those standards are not met.

Preliminary evidence suggests that pay for performance (sometimes called P4P), or refusing to pay for nonperformance, doesn't improve quality.<sup>19</sup> It's not hard to understand why. The whole idea is that buyers of care will tell providers of care how to practice medicine. But buyers never have as much knowledge as producers and sellers in any market. The people in the best position to know how to increase quality are not on the demand side of the market. They are on the supply side.

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Another problem is that P4P extends the practice of buyers of care paying providers specific fees for enumerated tasks. As the discussion below will show, this entire approach to paying for medical care runs the risk of encouraging doctors to focus on some tasks (those that are highly compensated) while ignoring others (those that are meagerly compensated), irrespective of what is best for patients.

Britain has recently developed an extensive pay-for-performance system for primary care in its National Health Service. For example, doctors there can increase their practice income by as much as 20 percent for performing specific tasks, such as checking blood glucose levels and giving eye exams to diabetics. Predictably, doctors responded by doing almost all of the procedures for which they received extra pay, and many tout this accomplishment as proof that P4P can work.<sup>20</sup>

But as one British doctor explained on the *Health Affairs* Web site, the amount of overall care for British patients may not have increased. The new system, which encourages extra services for about 15 percent of the patients, may result in shortchanging the other 85 percent. Further, P4P schedules reward treatment measures for patients with diabetics and hypertension, but there is no extra reward for diagnosing these conditions in the first place. So doctors respond by spending less time identifying new cases to treat in order to spend more time treating those previously diagnosed — in the process undoubtedly missing patients in need of treatment.<sup>21</sup>

*Illusory Solution: Letting Buyers Set the Quality Standards.* Having buyers set the standards that providers must meet is similar to the idea of P4P. It also means buyers of health care telling doctors how to practice medicine. There are bills before Congress that would not only require electronic medical records, but also dictate the very software that is to be used. And Medicare recently announced that it will not pay for certain avoidable mistakes; for example, it will not reimburse a hospital when it readmits a patient to correct problems created by inadequate care during the original admission.

The problem with these solutions is that they ignore the source of the problem: the way in which health care is purchased. Electronic medical records, for example, are commonplace and routine in almost every health market where patients buy their own health care:

- TelaDoc Medical Services provides telephone consultations, a service for which ordinary third-party health insurers do not pay. Patients have personal electronic medical records and doctors can prescribe electronically, taking advantage of error-reducing software.<sup>22</sup>
- Walk-in clinics in pharmacies, big box retail stores and shopping malls are manned by nurse practitioners who keep patient records on computers and follow computerized protocols in making treatment decisions; they too can prescribe electronically.<sup>23</sup>
- Overseas, hospitals competing for patients in the international medical marketplace almost all have electronic medical records and use error-reducing software.<sup>24</sup>

Some of these enterprises are discussed more fully below. They all illustrate that there is nothing on the provider side of the market — not culture, not tradition, not stubbornness — that is keeping the computer out of medicine. The computer tends to be absent where third-parties pay the bills. Can third-party payers get better results by bullying providers with laws, regulations and their sheer market power? That approach is unlikely to work. In fact, attempts to substitute buyer judgment for supplier judgment could make things worse.

Take Medicare's new payment policy, for instance. Medicare's refusal to pay for avoidable mistakes applies only to hospitals, not to doctors.<sup>25</sup> Yet in most hospitals, doctors are independent agents, making almost all medical decisions. Thus Medicare's new reimbursement system is likely to deprive hospitals of revenue (and perhaps encourage them to avoid patients with more difficult problems) without changing any of the incentives of the decision makers.

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*Real Solution: Letting Providers Compete for Patients Based on Price and Quality.* Why does the problem of quality exist? The short answer is: Health care providers do not compete for patients based on quality. As a rule, quality improvements do not increase their profits and quality reductions do not reduce their profits. Moreover, the primary reason providers do not compete on quality is that they do not compete on price.<sup>26</sup>

**Problem of Access.** Although low-income, uninsured families in the United States get a considerable amount of free medical care, there is evidence of a problem with access. Some believe the solution is to remove all financial barriers to care. Yet when there are no financial barriers to care, people invariably face nonprice barriers — usually in the form of high time costs. In general, whenever care is not rationed by price, it is rationed by waiting.

To appreciate why this happens, consider that about 12 billion times a year, Americans buy over-the-counter drugs — presumably they do so because they have a medical problem. But suppose that on their way to engage in these acts of self-medication everyone took the time to get professional advice. To meet this increased demand, there would need to be 25 times the number of primary care physicians currently in this country.<sup>27</sup> Why don't people get professional advice in these cases? Presumably because they judge that the value of the advice would not be worth the time cost (and perhaps also the financial cost) of the visit.

But suppose we made it easy for them. Suppose they were offered free professional advice by e-mail, or by cell phone in their car on the way to the pharmacy? Or suppose a doctor were available at the pharmacy counter to offer advice at the point of purchase? Most people would probably take advantage of such opportunities. Yet if they did, the demand for advice would completely overwhelm the primary care system.

The underlying principle is: Health care can be free (no money cost) or convenient (very little time cost) — but not both. At walk-in clinics in shopping malls, health care is convenient but not free. At hospital emergency rooms, care is often free but not convenient.

This principle is important to keep in mind when thinking about access to care for low-income patients. Because they lack money, they cannot afford to shop in the medical marketplace the way middle-income patients can. Instead, they are more likely to go to a clinic or hospital emergency room where care is delivered free of charge. But at these places, rationing by waiting supplants rationing by price.

*Illusory Solution: Expanding Government Insurance Programs.* A common assumption is that access to care would improve if the uninsured were enrolled in Medicaid or the State Children's Health Insurance Program (S-CHIP), the federal/state program that provides insurance for children in near-poor families who earn too much income to qualify for Medicaid. What this view overlooks is that uninsured and Medicaid patients tend to get their care at the same places — the same clinics, same emergency rooms and so forth. More often than not, the barriers to care are the same, regardless of insurance status.

*Real Solution: Creating Access to the Private Marketplace.* The only real solution to the problem of access is to allow low-income patients access to the same range of doctors and facilities as those who are privately insured. In general, this will only be possible if they are enrolled in the same health plans.

**Why Most Reform Proposals Would Not Solve Our Most Important Health Care Problems.** Lobbyists and politicians do not lack health reform ideas. From Hillary Clinton's health reform proposal a decade and a half ago up to the reforms recently proposed by Gov. Arnold Schwarzenegger and by many of the current candidates for president, dozens of proposals have been advanced for the public's consideration. Various organizations, associations and coalitions have also proposed reform ideas, many of which have been championed by different politicians.

Many of these proposals are quite radical. Some would (metaphorically) turn the health care system on its head. Many include mandates and other provisions that would have government telling citizens what they can and cannot do. Almost all would raise taxes, and in some cases the new

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tax burden would be considerable. Yet none of these proposals seriously address the fundamental problems of cost, quality and access.

*Failing to Control Costs.* Given the assumption that costs cannot be controlled unless someone is forced to choose between health care and other uses of money, there is no plan on the political landscape that proposes any serious cost control. Advocates of managed care, for example, almost always deny that they block access to useful medical care. Physicians for a National Health Program favors Canada's system, but denies there would be any serious rationing in the United States. Many groups want to shift costs from one group to another. But, as previously noted, shifting costs is not the same thing as controlling costs.

Not only do these plans fail to propose any serious reform on the demand side, they also fail to propose any serious supply-side changes. None, for example, has any mechanism that would cause providers to compete for patients based on price. Thus none promises any of the benefits of a competitive market.

One popular idea may be thought to be an exception to this rule: managed competition. This idea, enshrined in the federal employees health benefits program, was the centerpiece of Hillary Clinton's health care reform plan and has been incorporated in many other proposals. However, in these proposals, health plans compete by offering community-rated premiums that bear no relationship to any particular enrollee's health care costs. Not only do such plans fail to encourage doctors and hospitals to compete for individual patients based on price, they create perverse incentives for health plans to over-provide to the healthy and under-provide to the sick.<sup>28</sup>

*Failing to Increase Quality.* There are numerous proposals to address the problem of quality from the demand side, including the general concept of managed care, pay-for-performance and similar ideas. Yet all of these initiatives involve buyers of care telling doctors how to practice medicine. None sets up mechanisms that independently reward providers for finding ways to raise quality. In general, providers will not improve quality

unless they compete on quality. Yet among major reform proposals, not one encourages providers to compete for patients based on the quality of services rendered.

*Failing to Improve Access.* When uninsured people are enrolled in Medicaid and S-CHIP, does their access to care improve? As argued below, there is no convincing evidence that it does and much anecdotal evidence that it does not. If this is correct, there are hardly any health plans being seriously proposed that would even come close to solving the problem of access to care.

Compare health care to housing: One way to house low-income families is to create public housing. This practice segregates housing for the poor from housing for the nonpoor. It almost always results in lower-quality housing for the poor, regardless of the amount of money spent. An alternative is to provide rent subsidies. This approach empowers the buyer and allows low-income renters to compete with middle-income renters for similar housing space.

The same principle applies to health care. Like public housing, programs such as Medicaid and S-CHIP segregate low-income families into a separate system where the perception (and probably also the reality) is that quality is not as good. The solution is to allow low-income patients to participate in the same health care system as middle-income patients. That means low-income patients must be empowered to see the same doctors and obtain access to the same facilities.

This goal will not be reached, however, if everyone is put in a health care system that rations care by waiting — as is done in Canada and Britain. There is ample evidence that nonprice rationing schemes work to the advantage of people with higher incomes and education and discriminate against those at the bottom of the income ladder.<sup>29</sup>

**Reform Ideas to Avoid.** Even reformers with the best of intentions can fall into certain traps — mistakes that undermine the laudable goals of the reform. Here are five things not to do.

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*Avoid turning a tax subsidy into an entitlement.* The primary way the government encourages private insurance is through tax subsidies. Many reform proposals would completely change the nature of the subsidies — for example, by creating refundable tax credits. The risk is that the new tax subsidy could become an entitlement. Yet as noted above, Medicare and Medicaid entitlements are already on a course to crowd out every other government program. The government cannot survive the creation of more health care entitlements.

That means government's commitment must be to a defined contribution, not to a defined benefit. Tax subsidies will grow roughly at the rate of growth of national income. Health care spending is growing at twice that rate. The new system of tax subsidies must also grow with national income, not with health care costs.

*Avoid requiring people to buy insurance.* Proposals that require everyone to have health insurance increase the likelihood that the government subsidy will become an entitlement. If government forces people to buy something, there will be enormous pressure to ensure that the cost does not consume an increasing fraction of people's incomes. Furthermore, it makes no sense to mandate a benefit package if the cost of the package is going to grow at twice the rate of the subsidy. Keeping the subsidy restrained would force health plans to curtail costs somehow — by creating Health Savings Accounts, restricting payments to evidence-based medicine, limiting covered services and so forth.

A closely related (but better) idea is called “pay or play.” Under this concept, people who are uninsured pay higher taxes (a fine) because they are uninsured. In fact, under our current system the uninsured pay higher income and payroll taxes than people at the same income level who have tax advantaged, employer-provided insurance. The problem with the current system is that these higher taxes go to the general Treasury in Washington, D.C., while free care delivered to those who cannot pay their medical bills is delivered locally.

In principle, pay-or-play is much better than a mandate. And mandates are largely unenforceable anyway, since rigorous attempts at enforcement would cost far more than they are worth. So let people choose whether to be insured or not. If they choose to be insured, give them a subsidy; if they choose not to be insured, make them pay a tax penalty and put the unclaimed subsidy (or the tax penalty) into the safety net. (See the discussion below.) Also, pay-or-play does not require the government to define a mandated benefit package, vulnerable to cost-increasing special interest measures.

*Avoid creating perverse incentives for health plans.* Insurance pricing restrictions create perverse incentives. If people can switch plans annually at premiums that are unrelated to expected costs, the plans will seek out the healthy and avoid the sick. Once people are enrolled, the plans will over-provide to the healthy and under-provide to the sick. A much better idea is to give plans an incentive to compete for the sick.<sup>30</sup>

*Avoid crowding out private coverage by expanding public coverage.* Medicaid and S-CHIP should not be expanded in ways that encourage people to drop their private coverage in order to get free public coverage. As will be shown below, these programs are currently crowding out private insurance — replacing private financial responsibility with a heavy taxpayer burden. Instead, the incentives should work the other way. Public money should be used to encourage private insurance instead.

*Avoid crowding out private coverage with excessive regulation.* States discourage private insurance in two fundamental ways. First, they raise the price of insurance by imposing costly mandated benefits. Second, they force employers to pay more of the worker's compensation package in the form of wages and other benefits — thus leaving less money available for health insurance.

State-imposed mandates cover services ranging from acupuncture to in vitro fertilization. (See the table of state mandates.) They cover providers ranging from chiropractors to naturopaths. They cover heart transplants in

Georgia, liver transplants in Illinois, hair pieces for chemotherapy patients in Minnesota, marriage counseling in California and pastoral counseling in Vermont.<sup>31</sup> These mandates drive up costs, making health insurance more expensive than it otherwise would be. In fact, studies show that as many as one in four people who are uninsured have been priced out of the market by the cost-increasing consequences of mandated benefits.<sup>32</sup> Other regulations, such as community rating and guaranteed issue laws (discussed below), also raise insurance costs and discourage private purchase.

Under federal law, the minimum wage will rise from \$5.15 an hour in the first half of 2007 to \$7.25 an hour, as of July 2009. Many state and local governments have higher minimums. For example, San Francisco mandates a \$9.14 an hour wage. These laws put a floor under the amount employers can pay in cash wages, but leave the market free to determine other benefits.

Not surprisingly, employers respond to minimum wage increases by cutting back on the nonregulated benefits — the most important of which is health insurance. In fact, economic studies show that the crowd out is dollar for dollar. Overly costly Workers' Compensation systems (see the discussion in Chapter VIII) have the same effect. States could ameliorate some of the harm by allowing health insurance costs to count against the required minimum. [See the sidebar on the minimum wage.]

**Adopting Reform Proposals that Begin to Solve the Problems.** It is impossible to solve the three most important health care problems in a short period of time. However, every reform can be judged against guidelines that indicate whether the reform would move closer to or further away from a solution. Specifically, every proposal should be judged according to the answers it provides to following questions:

1. Does the plan force anyone — patient, doctor, nurse, hospital, insurer, employer, government agency or anyone else — to choose between health care and other uses of money?
2. Does the plan force any provider of care to compete for patients based on price and/or quality of care?

## HANDBOOK ON STATE HEALTH CARE REFORM

### *State Health Insurance Mandates*

<u>Mandated Benefits</u>	<u>Number of States</u>	<u>Estimated Cost of Mandate<sup>1</sup></u>
Mammogram	50	<1%
Maternity Stay	50	<1%
Breast Reconstruction	49	<1%
Diabetic supplies	47	<1%
Mental Health Parity	45	5% to 10%
Alcoholism	45	1% to 3%
Off-Label Drug Use	36	<1%
Drug Abuse Treatment	34	<1%
Contraceptives	30	1% to 3%
PKU/Formula	32	<1%
Prostate Cancer Screening	32	<1%
Well-Child Care	31	1% to 3%
Cervical Cancer/HPV Screening	28	<1%
In Vitro Fertilization	13	3% to 5%
Hair Protheses	9	<1%
Hearing Aid	9	<1%
 <u>Mandated Providers</u>		
Chiropractors	46	1% to 3%
Psychologists	44	1% to 3%
Optometrists	43	1% to 3%
Podiatrists	35	<1%
Dentists	35	3% to 5%
Nurse Midwives	30	<1%
Nurse Practitioners	29	<1%
Social Workers	27	1% to 3%
Osteopaths	22	1% to 3%
Nurse Anesthetists	21	<1%
Speech or Hearing Therapists	20	<1%
Physical Therapists	16	1% to 3%
Marriage Therapists	13	<1%
Acupuncturists	11	1% to 3%
Massage Therapists	4	<1%
Chiropracist	4	<1%
Pastoral Counselors	3	<1%
Dieticians	3	<1%
Lay Midwives	3	<1%
Naturopaths	3	<1%
Denturists	2	<1%

<sup>1</sup> As a percent of total premiums.

Source: Victoria Craig Bunce, J.P. Wieske and Vlasta Prikazsky, "Health Insurance Mandates in the States 2007," Council for Affordable Health Insurance, 2007.

## **Saving Health Insurance from the Minimum Wage**

Earlier this year, Congress and the president approved an increase in the hourly federal minimum wage from \$5.15 to \$7.25 by July 2009. Economists have traditionally warned that a higher minimum wage causes more people to be unemployed. But a number of studies point to an even more serious consequence: fewer fringe benefits, including health insurance.

Cash wages are just one part of total compensation. Fringe benefits make up the remainder. Employers who are forced to increase cash wages will cut back on noncash wages. Thus, an unintended consequence of these minimum wage increases will likely be a rise in the number of working Americans who aren't offered health insurance through their jobs and a further increase in the share of health care costs borne by employees who are offered workplace coverage.

More than half the states had already raised their minimum wage above the federal level. Often several dollars higher than the federal law (San Francisco's is \$9.14 an hour). Congress and the states could avoid adding to the ranks of the uninsured by allowing employers and employees to use one of the three following options to apply minimum wage increases to health insurance instead:

1. Allow employers to count health insurance expenses against the minimum wage increase (so up to \$4,200 of the mandated increase for a full-time worker could go to health insurance).
2. Allow employers who do not provide health insurance to use the increase to purchase non-taxed, individually owned insurance instead of paying taxable wages.
3. Allow employees to choose between taxable wages and non-taxed, individually owned health insurance.

A recent study analyzing the impact of various federal minimum wage increases over a decade found that a 20 percent increase in the minimum wage reduces employer-sponsored health insurance coverage by 4 percent. In most cases the trade-off is dollar for dollar — thus, a \$1 per hour increase in the minimum wage could result in a \$1 per hour decrease in employer-provided health insurance. Nationwide, about one-fourth of people below the poverty line lack health insurance, according to the U.S. Census Bureau.

Source: John C. Goodman and Richard B. McKenzie, "Saving Health Insurance from the Minimum Wage," National Center for Policy Analysis, Brief Analysis No. 565, July 28, 2006.

3. Does the plan allow patients now trapped in schemes that ration care by waiting — Medicaid, S-CHIP, Medicare, emergency-room free care, Veterans Administration system and so forth — to have the same access to doctors, hospitals and clinics that privately insured patients have?

If the answer to the first question is no, the plan will not control costs. If the answer to the second question is no, the plan will not improve quality. If the answer to the third question is no, the plan will not increase access to care. If the answer to the full set is no (and in almost all the reform plans currently proposed the answer is no), the plan's prospects are very bleak indeed.

Health care is a complex system. It may be the most complex of any social system. Complex systems cannot be managed, planned or controlled from above. They can only function if decision-making is decentralized and the people making the myriad of individual decisions face good incentives. If 300 million potential patients make just 10 health care decisions every year, that is 3 billion decisions on the demand side of the market alone. No one can manage, plan or control 3 billion decisions, to say nothing of the supply side of the market. The problem with the currently proposed plans is that they all violate this principle.

How can we know whether or not participants in a complex system face good incentives? The place to begin is by asking whether or not they have the power to make things better. Although the three questions above are telling, here are three that are even more fundamental:

4. Does the plan allow doctors and patients to freely recontract, so that a better, higher-quality bundle of care can be provided for the same or less money?
5. Does the plan allow providers to freely contract with each other to reduce costs or raise quality?
6. Does the plan allow the insured and the insurers to freely recontract in order to change the boundaries between self-insurance and

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third-party insurance and arrive at more desirable allocations of risk?

Unfortunately, the answer for almost all reform plans being currently discussed is no. Equally disheartening, the answer is also no for the current system.

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## *Chapter II*

# PRINCIPLES OF REFORM

What are the principles of health reform? One might suppose they are fairly easy to enumerate and command widespread support. As it turns out, that is not the case. Here are five recommended principles. If they are followed, the odds of successful health policy reform will be greatly enhanced.

**Principle No. 1: No One Should Be Denied Basic Care because of a Lack of Ability to Pay.**

A good society does not withhold basic health care from people because they lack the resources to pay for it at the time of delivery. This does not imply that people have a “right” to free care. If that were the case, everyone would have a perverse incentive to become “free riders,” wastefully over-

consuming care at everyone else's expense. Instead, most people should be expected to pay their own way most of the time. But no one should have to forgo basic care because they can't pay for it at the time of delivery.

**Principle No. 2: Health Care Should Be Provided in a Competitive Marketplace.**

The economic definition of efficiency is: Whatever is produced should be produced at minimum cost. Some studies lend credence to the idea that one out of every three dollars of health care spending is wasted.<sup>1</sup> This implies that, in principle, the same health care could be provided for two-thirds the cost. Alternatively, there could be 50 percent more care for the same amount of money. In other markets, entrepreneurs spur efficient production by repackaging, repricing and taking advantage of new products and innovations. Principle No. 2 is not being followed whenever entrepreneurs are arbitrarily prevented from serving this function.

**Principle No. 3: The Appropriate Level of Insurance Depends on the Assets to Be Protected.**

If Principle No. 1 is followed, people will not need insurance to receive care. Instead, they will need insurance in order to protect their earning power and other assets from unexpected health care costs. Other forms of insurance serve as a useful guide. The purpose of life insurance is primarily to protect earning capacity against the consequences of premature death. Accordingly, the appropriate level of insurance depends on current assets and expected income. The purpose of casualty insurance is to protect the value of, say, a home or automobile. The appropriate level of insurance depends on the anticipated risk and the replacement value of the home or car. Similarly, the purpose of health insurance should be to protect assets against unexpected medical costs.

**Principle No. 4: Health Insurance Should Be Personal, Portable and Renewable.**

It is a mistake to have a system in which a change of health plans is virtually mandated whenever people change employers. Instead, health insurance should be portable (traveling with the employee from job to job). Also, it defeats the whole purpose of insurance if premiums can rise in response to an adverse health event. Life insurers do not get to charge more to the insured who get AIDs or cancer. Insurance exists to transfer risk from the individual to an (insurance) pool. The price of that transfer is the periodic premium payment. Once the insurance contract is set, the practice of increasing premiums after an adverse event occurs would be like changing the odds on a horse race after the race is underway.<sup>2</sup> Accordingly, people should be able to buy health insurance that is renewable at rates that are independent of adverse health events. In most states, this is required under the laws governing individual insurance. However, such insurance is generally unavailable in the small group market.

Notwithstanding all of the above, from time to time people may wish to change their insurance coverage. At that point they should be able to buy real insurance in a real market. It is to everyone's advantage to be able to face real prices for risk when making changes in insurance coverage. Otherwise, people who are undercharged will overinsure, and people who are overcharged will underinsure.

**Principle No. 5: Private Insurance Should Be at Least as Attractive as Health Care Provided at Taxpayer Expense.**

For many people, the implicit alternative to private insurance is to rely on charity care paid for by others. For those who qualify, Medicaid and S-CHIP programs are alternatives to private insurance. Perversely, these alternatives encourage people to forgo private coverage paid from their own pockets in order to take advantage of care provided at taxpayer

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expense. Rational public policy would create the opposite incentives. At a minimum, government should be neutral — giving people just as much incentive to be in the private sector as in the public sector.

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### Notes

- 1 Interestingly, there are three completely different contexts in which this idea arises and they are by no means mutually exclusive. First, the RAND Health Insurance Experiment found that when people are exposed to significant cost-sharing (through copayments and deductibles), they reduce medical expenditure by about 30 percent with few significant health effects. See Joseph Newhouse, *Free for All? Lessons from the RAND Health Insurance Experiment* (Cambridge, Mass.: Harvard University Press, 1993). Second, a different RAND study concluded that about one-third of all medical procedures are unnecessary. See Robert H. Brook, “The RAND/UCLA Appropriateness Method,” in K. A. McCormick, S. R. Moore and R. A. Siegel, *Clinical Practice Guidelines Development: Methodology Perspectives* (Rockville, Md.: Government Printing Office, 1994). However, see the NCPA critique of this conclusion in John C. Goodman and Gerald L. Musgrave, *Patient Power: Solving America’s Health Care Crisis* (Washington, D.C.: Cato Institute, 1992), pages 517-21; and in John C. Goodman, Gerald L. Musgrave and Devon M. Herrick, *Lives at Risk: Single-Payer National Health Insurance around the World* (Lanham, Md.: Rowman & Littlefield, 2004). Third, a Dartmouth study concluded that Intermountain Health System in Salt Lake City treats patients for about one-third less with better health outcomes. See John E. Wennberg et al., “The Care of Patients with Severe Chronic Illness: an Online Report on the Medicare Program by the Dartmouth Atlas Project,” Dartmouth Atlas of Health Care, Center for the Evaluative Clinical Sciences, Dartmouth Medical School, 2006. Available at [http://www.dartmouthatlas.org/atlas/2006\\_Chronic\\_Care\\_Atlas.pdf](http://www.dartmouthatlas.org/atlas/2006_Chronic_Care_Atlas.pdf). Accessed February 19, 2007.
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### *Chapter III*

## IMPLEMENTING THE PRINCIPLES OF REFORM

The principles of reform stated above are logical, commonsensical and perhaps even self-evident. Surprisingly, however, a survey of the health proposals of a dozen or so of the most prestigious national organizations and associations shows that these five principles have been almost completely ignored!

At the risk of stating the obvious, it is difficult to have a workable reform without a coherent view of the goals of reform and a clear understanding of what principles need to be followed in pursuit of those goals. The following is an explanation of how these principles could be implemented to achieve the goals of health care reform and how the implied policy changes differ substantially — even radically — from those currently proposed.

## Implementing Principle No. 1: Health Care versus Health Insurance

To most people, health care and health insurance are inextricably intertwined. That is unfortunate. If people cannot think about one concept without the other, odds are they will be unable to think about either concept very clearly. In general, the best way to think about Principle No. 1 (no denial of care) is to imagine a world in which there is no health insurance at all — or what is equivalent, a world in which health insurance doesn't matter. By contrast, the best way to think about Principle No. 3 (protection of assets) is to imagine a world in which the level of health care costs matters, not the particulars of the care.

**How Much Does Health Insurance Matter?** For people who have a hard time imagining a world in which health insurance does not matter, consider the case of Parkland Memorial Hospital in Dallas, Texas. Both uninsured and Medicaid patients enter the same emergency room door and see the same doctors. The hospital rooms are the same, the beds are the same and the care is the same. As a result, patients have no reason to fill out the lengthy forms and answer the intrusive questions that Medicaid enrollment so often requires. Furthermore, the doctors and nurses who treat these patients are paid the same, regardless of patients' enrollment in an insurance plan. Therefore, they tend to be indifferent about who is insured by whom, or if they're even insured at all. In fact, the only people concerned about who is or is not enrolled in what plan are hospital administrators, who worry about who will pay the bills.<sup>1</sup>

At Children's Medical Center, next door to Parkland, a similar exercise takes place. Medicaid, S-CHIP and uninsured children all enter the same emergency room door; they all see the same doctors and receive the same care.

Interestingly, at both institutions, paid staffers make a heroic effort to enroll people in public programs — even as patients wait in the emergency

room for medical care. Yet they apparently fail to enroll eligible patients more than half the time! After patients are admitted, staffers valiantly go from room to room to continue this bureaucratic exercise. But even among those in hospital beds, the failure-to-enroll rate is significant — apparently because it has no impact on the care they receive.

The conventional wisdom among health experts across the ideological spectrum is that people need health insurance to get good health care. Indeed, to some politicians the terms “no health care” and “no health insurance” are interchangeable. Almost as widely accepted is the view that some health plans are a ticket to better health care than others. But a RAND Corporation study shatters those assumptions:<sup>2</sup>

- Among people who seek care (actually see a doctor), RAND researchers found virtually no difference in the quality of care received by the insured and uninsured.
- They also found very little difference in the care provided by different types of insurance — Medicaid, managed care, fee-for-service and so forth.

Unfortunately, the care received was less than ideal. As noted above, the study concluded that patients received recommended care only about half the time. The implication is that reforming the supply side of the medical marketplace is far more important than getting everyone on the demand side insured.

Innumerable studies have claimed that the uninsured get less health care than the insured. The most recent and well known is an Institute of Medicine (IOM) study which claimed that 18,000 people die every year because they do not have health insurance.<sup>3</sup> However, the IOM study (and most others as well) failed to make the crucial distinction between people who seek care and those who do not. For whatever reason, people who are formally uninsured do not see doctors as often as their cohorts, and they get less care.<sup>4</sup> Yet RAND found that once people enter the system, their insurance status appears to have no effect on the quality of their care.

## Who Are the Uninsured?

Despite claims that there is a growing health insurance crisis in the United States, the percentage of U.S. residents without insurance has fallen slightly over the last decade. The number of uninsured has grown; however, this increase is largely due to immigration and population growth. In 2006, according to Census Bureau data:

- More than 84 percent (250.4 million) of the 297.4 million U.S. residents were privately insured or enrolled in a government health program, such as Medicare, Medicaid or State Children's Health Insurance Programs (S-CHIP).
- An additional 10 million to 14 million adults and children qualified for government programs but had not enrolled, experts estimate.
- Nearly 18 million additional uninsured people live in households with annual incomes above \$50,000 and could likely afford health insurance.

Thus, nearly 10 percent of people theoretically have access to insurance but have chosen to forgo it. The remaining portion (about 6 percent of the population) earn less than \$50,000 annually.

Typically, those who lack insurance are uninsured for only a short period of time — around 75 percent of uninsured spells last one year or less. The Congressional Budget Office (CBO) estimated that 21 million to 31 million people had been uninsured for a year or more in 2002 — far short of the 46 million figure often cited.

The uninsured include diverse groups, each uninsured for a different reason.

*Immigrants.* Nearly 12 million foreign-born residents lack health coverage. More than one-third of foreign-born U.S. residents lacked health insurance compared with only 13 percent of native-born Americans. Income may be a factor — but another explanation is that many immigrants come from cultures without a strong history of paying premiums for health insurance.

*The Poor.* Among households earning up to \$25,000, the number of uninsured actually decreased by about 24 percent over the past 10 years.

*The Young and Healthy.* Nearly 19 million people ages 18 to 34 are uninsured. Most of them are healthy.

*Higher-Income Workers.* The number of uninsured among higher-income households actually increased during the past decade. Nearly 18 million uninsured individuals live in households earning more than \$50,000. More than half of those earn more than \$75,000.

*Individuals Using the "Free Care" Alternative.* Many people forgo health insurance because they know that free health care is available once they get sick. Federal law forbids hospital emergency rooms from turning away critical care patients. With the certainty of receiving free emergency care, many people forgo paying for coverage.

Government policies that drive up the cost of private health insurance may partly explain why millions of people forgo coverage:

- Many states try to make it easy for a person to obtain insurance after becoming sick by requiring insurance companies to offer immediate coverage for pre-existing conditions with no waiting period.
- Thus, when people are healthy they have little incentive to participate and tend to avoid paying for coverage until they need care.
- Some states also impose "community rating," which forces insurers to charge the same premium to all, no matter how sick or healthy they are when they purchase insurance. This mandate drives up the cost of insurance for the healthy.

Because their premiums are far higher than their anticipated medical needs, healthy people are often priced out of the market due to these regulations.

Source: Devon M. Herrick, "Crisis of the Uninsured: 2006 Update," National Center for Policy Analysis, Brief Analysis No. 568, September 6, 2006. See also Carmen DeNavas-Walt, Bernadette D. Proctor and Jessica Smith, "Income, Poverty, and Health Insurance Coverage in the United States: 2006," U.S. Department of Commerce, U.S. Census Bureau, publication P6-233, August 2007.

**How Much Do Medicaid and S-CHIP Matter?** Of the 47 million<sup>5</sup> people who are uninsured at any one time, more than one in four — or about 14 million people — are eligible for free health care through Medicaid or S-CHIP.<sup>6</sup> [See the sidebar.] All they have to do is fill out a form, or in the case of many hospital emergency rooms, let someone else fill out the form for them. That they demur is not necessarily evidence of negligence on their part. It is evidence that they see no value in enrollment. Put differently, enrollment in a public health insurance plan is unlikely to result in better care or less out-of-pocket cost from the patients' point of view.

By way of contrast, imagine dropping a \$100 bill on the floor of a typical inner-city hospital emergency room. How long would it remain there? Probably not long. But suppose a Medicaid application form was dropped on the same floor. How long would it remain there? Probably until the next janitor comes by with a broom. In the eyes of most health policy analysts Medicaid insurance is worth a lot more than \$100. On paper, it is worth thousands of dollars. But millions of people are revealing through their actions that they do not view Medicaid enrollment as very valuable.<sup>7</sup> So far, no one has made a persuasive case that they are wrong.

All of this suggests that what matters most (especially to low-income families) is access to care, not health insurance. On paper, Medicaid coverage appears more generous than the benefits the vast majority of Americans receive through private health insurance. Potentially, Medicaid enrollees can see any doctor or enter any facility and pay nothing. In practice, things are different.

Nearly one-third of doctors do not accept any Medicaid patients and, among those who do, many limit the number they will treat.<sup>8</sup> Access to care at ambulatory (outpatient) clinics is also limited for Medicaid patients, as is access to specialist care.<sup>9</sup> According to a recent *New York Times* investigation on access to care in New York City:<sup>10</sup>

- A child on Medicaid with an irregular heartbeat was not able to see a cardiac specialist for nearly four months.

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- The parents of a boy needing corrective ear surgery were told the wait could be as long as five years.
- At specialty clinics run by teaching hospitals, Medicaid patients often have to wait one to three hours for a 5 to 10 minute appointment with a less-experienced medical resident or intern.

The problem is not limited to New York City. The *Denver Post* reported that the University of Colorado Hospital refused Medicaid patients, and that Medicaid enrollees face six- to eight-month waits for appointments at specialty clinics.<sup>11</sup> In Washington, a 45-year-old Seattle woman admitted to a hospital with a triple fracture of her ankle waited nine days for a doctor to agree to take her case because none of the orthopedic surgeons on staff would accept Medicaid.<sup>12</sup>

A central element in most state health care reform plans is an effort to enroll people who are eligible in public insurance programs, even while they are at public health clinics and in hospital emergency rooms. But why? Does anyone seriously believe that filling out forms in hospital emergency rooms is going to lead to more care or better care? In fact, it may lead to worse care — as the following discussion shows. It almost certainly leads to worse care if the availability of free care from the state leads families to drop their private insurance coverage. And it could lead to serious discontinuities of coverage as people's eligibility seesaws back and forth with changes in their income. Amazingly:<sup>13</sup>

- Two-thirds of all the children in the United States were eligible (based on family income) for Medicaid or S-CHIP at some point from 1996 to 2000.
- One in five children were eligible for both programs at some point, and 73 percent of children eligible for S-CHIP over the whole period were eligible at some time for Medicaid.

What this means is that public coverage is available sporadically as family income rises and falls, leading to significant discontinuities in coverage.

In fact, one study concludes that the main reason why six million children are eligible but not enrolled in Medicaid and S-CHIP is due to changes in eligibility.<sup>14</sup> Also, children with discontinuous coverage are 13 times as likely to delay care as children who are continuously insured, according to another study.<sup>15</sup>

In contrast to spending money on programs for which people's eligibility constantly changes, a better strategy is income support. Under this approach, the state offers a subsidy to be applied to private insurance. As family income rises and falls from year to year, the subsidy falls and rises in an offsetting way. In the process, there is no reason for the underlying health insurance to change.

**Case Study: Health Care without Insurance in Dallas.** Return to the case of Parkland Memorial Hospital in Dallas. This hospital delivers 16,000 babies a year — more than any other hospital in the nation. Almost all the mothers are uninsured. The vast majority are Hispanic (82 percent) and illegal (70 percent). By almost any definition, these mothers are “at risk.”<sup>16</sup> But among those who take advantage of Parkland's prenatal program (more than 90 percent), the infant mortality rate is only half the national average.<sup>17</sup> How does Parkland do it? By being very good at what they do. Despite being a publicly funded health delivery system,<sup>18</sup> Parkland operates what Regina Herzlinger, of Harvard University, has described in other contexts as a “focused factory.” They are so good at delivering babies, they produce an annually updated, internationally praised textbook on how to deliver babies, and their methods are being copied in Britain and other countries.<sup>19</sup>

However, Parkland's methods will not satisfy everybody. Prenatal care is delivered in clinics staffed by nurses, not doctors. Hospital deliveries are usually executed by midwives rather than OBGYNs. And like public hospitals in Toronto and London, Parkland is perpetually overcrowded. In fact it is not unusual to find patients on beds in hallways.<sup>20</sup>

If all of Parkland's 16,000 expectant mothers were enrolled in Medicaid or had private insurance, however, the experience might be worse. Prenatal

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care delivered by nurses rather than doctors might not be allowed under many states' Medicaid rules. Ditto for deliveries performed by midwives. And under typical state insurance regulations, patients with private coverage would be encouraged to see OBGYNs (because of zero patient cost sharing), where the cost would be higher and the overall quality of the pregnancy/delivery episode might not be as good (because of fragmented care).

Bottom line: If the goal is high-quality, low-cost care for at-risk expectant mothers, clearly the Parkland system should be continued and its replication encouraged in other cities instead of trying to replace it with some other health insurance scheme.

In fact, the Parkland model could easily be expanded to other services. MinuteClinics (described below) and other walk-in clinics, for example, are staffed by nurses following computerized protocols. They charge half as much as a typical general practitioner, and a recent Minnesota study concluded that the quality in these clinics matches the quality of conventional care for routine problems. There is also probably far less variation in practice patterns.<sup>21</sup>

It is easy to imagine providing subsidized care at walk-in clinics located in shopping malls, drug stores and other places convenient for low-income patients. People would be encouraged to get low-cost, high-quality care for a wide range of services (such as flu shots, strep throat and allergies). Note that walk-in clinics are an alternative to health insurance. Indeed, walk-in clinics exist only because so many patients pay for routine care out of their own pockets. There would be no walk-in clinics if Blue Cross were paying all the bills.<sup>22</sup>

Although Parkland is quite good at some things, it is not as good at others. As is the case with many other inner-city public hospitals, patients who do not face life-or-death emergencies can wait hours for care in Parkland's emergency room. A migraine headache patient might wait all day. In fact, almost any nonemergency service involves inordinate waiting. Getting a

refill on a phoned-in prescription, for example, can typically take three days. By contrast, Dallas-area Walgreens stores refill prescriptions in less than an hour and some Walgreens outlets will do it in the middle of the night.

These are some of the reasons why it is not desirable to trap patients in a system where the only care they have access to is a monopoly health care provider.

**Case Study: Dental Care without Health Insurance in Dallas.**<sup>23</sup>

One of the more remarkable studies in health economics in recent years is economist Amy Finkelstein's finding that Medicare did not really improve the quality of care seniors received; instead it merely added to health care inflation for the county as a whole.<sup>24</sup>

To appreciate what health care for the elderly was like before Medicare and Medicaid, one can look at the market for dental care for seniors today. Only about one in five senior citizens has insurance for dental care in the United States, according to Oral Health America. So the other 80 percent must pay for care out of pocket.

What that means in Dallas, Texas, is that seniors who can afford to pay market prices go into the private sector for their care. For those who cannot afford those prices, there are numerous other options — including discounts and even free care. Dallas' dental colleges, for example, charge about half the private sector rate to all patients. Community health clinics, United Way and other agencies charge about half price to low-income seniors. The Texas Dental Association's Smiles Foundation provides services for free.

There are also some unconventional insurance options. Dental plans that offer discounted prices can be had for a premium of about \$10 to \$12 a month. Medicare Advantage plans often make dental care available for free for seniors who enroll in these private sector, comprehensive care alternatives to traditional Medicare.

**A Different View of National Health Insurance.** It is sometimes said that the United States is the only developed country that does not have a system of national health insurance. Yet what Britons and Canadians have is not insurance in any real sense of the word. What they have is an imperfect system of free care.

Absent government intervention, people tend to purchase insurance for rare, high-dollar events that could be financially devastating. By contrast, they tend to self-insure (pay out of their own pocket) for small-dollar, routine costs that are easily managed. Casualty insurance for an automobile covers expensive accidents, not oil changes.

In Britain and Canada, this principle is turned on its head. Citizens of these countries have ready access to free, routine primary care and tend to see general practitioners more often than do U.S. citizens.<sup>25</sup> But the British and Canadians have less access to specialists and sophisticated diagnostic tests (such as CAT scans, MRI scans and PET scans). They have even less access to really expensive medical interventions, such as kidney dialysis and/or transplants.<sup>26</sup> Moreover, when the British go into the private market to buy services they cannot get from their National Health Service, and when Canadians come to the United States for services they cannot get from their Medicare system, they are in no sense “insured” for those costs. Instead, they must pay out of pocket.

In response, about 10 percent of the British population buys real insurance on top of the system of free care to provide financial protection against the out-of-pocket costs of expensive care they are forced to purchase on their own.<sup>27</sup> Canada outlaws private insurance for treatments covered by the government plan, so people must essentially self-insure for these costs.

Now consider a low-income population, including perhaps illegal immigrants, who will need help from others to pay for almost any kind of health care beyond the most basic and inexpensive. In this scenario, the idea behind the British system may not be all bad. In fact, virtually every country south of the U.S. border (with the exception of Argentina and possibly

Chile) provides free health care to the population at large. However, everyone in these countries who obtains even a modest standard of living goes to the private sector for health care, buying private health insurance in many cases. The trouble with all of these systems is that government-provided monopoly care tends to be inefficient and wasteful, marked by highly variable quality and access (despite the claims of “single payer” advocates).<sup>28</sup>

Since free, or highly subsidized care, is already largely available in the United States, what is needed is not an alternative to free care but a way to subject the free care system to market forces. Reflecting again on the experience of Parkland’s baby delivery focused factory, the suppliers of care need to be given appropriate incentives so that they realize economic gains from producing higher-quality, low-cost care and realize economic losses if they produce the opposite.

It is here that a special type of insurance plan may be of value. This plan would not really be insurance at all. Instead, it would put money that is likely to be spent anyway into the hands of patients — perhaps through a vehicle similar to a health savings account — and make providers compete for those dollars.

To implement this approach, however, most people need to change how they think about health insurance.

## Implementing Principle No. 2: Entrepreneurship versus Bureaucracy

America’s public school system and health care system may seem as different as night and day. Yet both systems share something in common: Mediocrity is the rule and excellence, where it exists, is distributed randomly. In both cases the reason is the same. There is no systematic reward for excellence and no penalty for mediocrity. As a result, excellence tends to be the result of the energy and enthusiasm of a few individuals, who

usually receive no financial reward for their efforts. In a normal market, entrepreneurs in search of profit would solve this problem by repackaging and repricing their services in order to make customer-pleasing adjustments. The same thing needs to happen in health care.

**The Missing Entrepreneur.** Studies suggest that if everyone in America got health care at the Mayo Clinic, the nation's health care bill would be lowered by one-fourth. If everyone got health care at the Intermountain Hospital System in Salt Lake City, national health care spending could be lowered by one-third. Not only would costs be dramatically lower, the quality of care would be higher.<sup>29</sup>

Of course, not everyone can go to Mayo Clinic or Intermountain for health care. But why aren't the methods and practices used at these two institutions copied and implemented elsewhere around the country? If health care were delivered in a competitive market, they would be. In normal markets, entrepreneurs discover ways of lowering costs or raising quality. Competitors find they must emulate these innovations or risk losing customers and going out of business.

Surprisingly, in health care the opposite forces are at work. More often than not, providers make more money by providing high-cost, low-quality care. The reason why doctors and hospitals don't copy the methods used at the Mayo Clinic is because they would be financially worse off if they did.

But why don't physician entrepreneurs offer payers a different deal? For example, suppose a group of doctors offered to emulate the practices followed at the Mayo Clinic in return for a 12.5 percent increase in fees. For a 25 percent reduction in overall costs, the doctors would get half the gain and the payers would get the other half. Unfortunately, in our heavily bureaucratic health care system, such an arrangement is almost impossible. (Although we recommend precisely this for Medicaid in Chapter V.)

In the United States, third-party payers pay for some services and do not pay for others. For the services that insurers reimburse, large, impersonal bureaucracies set the prices. The individual physician has virtually no

opportunity to offer a different bundle of services for a different price. As a result, very little entrepreneurship is possible.<sup>30</sup>

Moreover, state laws discourage innovative medical practices or prevent medical practices from being organized in innovative ways.<sup>31</sup> The states have long licensed and regulated physicians with the ostensible goal of maintaining the quality of medical care.<sup>32</sup> However, state medical boards are dominated by physicians and, like the boards governing other regulated professions, they tend to be run for the benefit of practitioners.<sup>33</sup> In the past, these organizations tried to suppress competition among physicians by declaring certain practices unethical and subject to sanctions (such as denial of hospital privileges and even the loss of their license to practice medicine).<sup>34</sup> Ethical cannons and state laws once forbade the medical establishment to advertise prices. Even though these regulations and sanctions have been repealed or overridden by the courts, a cultural bias remains against advertising or competing on the basis of price. Similarly, hospital trade associations have discouraged price competition for years; and the industry has always quietly discouraged quality comparisons.<sup>35</sup>

**Horse and Buggy Medical Care.** One consequence of the way medical care is paid for is that doctors and patients still interact in the same way they did in the horse and buggy era. Although medical science has progressed by leaps and bounds, the doctor-patient relationship has not. In the early 20th century, lawyers, accountants and most other professionals discovered that the telephone was a useful instrument for communicating with clients. Yet even today, doctors rarely consult with their patients by telephone. In the late 20th century most other professionals discovered e-mail. Yet only one-fourth of physicians exchange e-mail with their patients; and of these, only a small percentage do so on a frequent basis.<sup>36</sup>

One would be hard-pressed to find a lawyer in the United States today who does not keep client records electronically. Accountants, architects, engineers and virtually every other profession follow suit. Yet even though studies show that electronic medical record systems have the capacity to

improve quality and greatly reduce medical errors, no more than one in five physicians or one in four hospitals use computerized systems for patient recordkeeping.

Why has the practice of medicine (as opposed to the science of medicine) changed so little in the modern era? The answer is: a cumbersome third party payer system.

At last count, Medicare pays for about 7,500 specific tasks. Not included are telephone consultations, e-mail consultations or electronic record keeping. What is true of Medicare is also true of Blue Cross and most employer plans. In general, when third parties pay by task there will always be valuable services that go unreimbursed. The incentives are for physicians to perform only those tasks for which they are paid and avoid those for which there is no payment.

**Rationing by Waiting.** When patients do not pay for health care with money, because they typically pay with their time instead. As in Canada and most other developed countries, health care in the United States is mainly rationed by waiting, not by price.

When the doctor's time is rationed by waiting, the primary care physician's practice is usually fully booked (unless it is a new practice or located in a rural area). As a result, doctors have little incentive to compete for patients the way other professionals compete for clients. Because time — not money — is the currency we use to pay for care, the physician does not benefit very much from patient-pleasing improvements and is not harmed very much by an increase in patient irritations. Bottom line: When doctors and hospitals do not compete on the basis of price, they do not compete at all.

**Exceptions to the Rule.** Where third-party payment is the norm, markets tend to be bureaucratic and stifling; and doctors and hospitals rarely compete for patients on price or on quality. But in those health care sectors where third-party payment is rare or nonexistent, the market is vibrant, entrepreneurial and competitive.

Health care markets without third-party payers tend to have three characteristics. First, innovations in these markets invariably originate on the supply side. As in any normal market, new ideas arise from people who provide patient services, not from those who pay the bills. Second, in the absence of third-party payment, providers are free to repackage and reprice their services in order to meet patient needs. Finally, in these markets, providers compete for patients based on price and quality. Some notable examples follow.

*Cosmetic Surgery.* Unlike most other forms of surgery, patients in this market can typically find and compare package prices covering all services in advance. Over the past decade and a half, the number of cosmetic surgery procedures has grown six-fold, and the market has seen numerous technological innovations similar to those blamed for rising costs for other surgical procedures. Yet, as noted above, despite tremendous growth and technological change, the real price of cosmetic surgery has declined.<sup>37</sup>

*Lasik Surgery.* Here too, patients can find package prices and can compare prices. Over the past decade the real price has fallen by 30 percent. Unlike most other surgery markets, higher-quality services command a premium. Patient satisfaction is 93 percent, and it is even higher for higher-quality providers.<sup>38</sup>

*Retail Walk-In Clinics.* These clinics are small health care centers located inside shopping malls and big-box retailers, or operating as storefronts in strip shopping centers. They are staffed by nurse practitioners and offer a limited scope of services, but added convenience. MinuteClinic, the pioneer of the concept, allows shoppers to get routine medical services such as immunizations and strep tests. No appointment is necessary, and most visits take only 15 minutes. MinuteClinics post their prices, which often are about half those of a traditional medical practice. Quality is also comparable, and there is less unwarranted variation in treatments because MinuteClinics nurses follow computerized protocols. Medical records are stored electronically, and prescriptions can also be ordered that way.<sup>39</sup>

Other entrepreneurs are launching similar limited-service clinics. CVS pharmacy recently bought MinuteClinic. Wal-Mart leases space for walk-in clinics to RediClinic (among others) in a number of stores and has begun to expand these operations nationwide.<sup>40</sup> RediClinic also allows patients to order numerous lab tests for fees that are nearly 50 percent less than tests ordered by physician offices.<sup>41</sup> Today, a growing number of insurers cover these services, and more clinics accept insurance. Competition from these new clinics may lead traditional physician practices to offer more convenient weekend and extended hours.

*Telephone and E-mail Consultations.* TelaDoc Medical Services, located in Dallas, is a telephone-based medical consultation service that works with physicians across the country. Consultations are available around the clock. Calls are usually returned within 30 to 40 minutes. The physician can access and update the patient's medical history online and e-mail a prescription to a pharmacy.<sup>42</sup>

*Cash-Friendly Practices.* PATMOS EmergiClinic, in Greenville, Tenn., represents a growing trend toward cash-only practices that accept no third-party (insurance) payments. Founded by physician Robert S. Berry, it is a walk-in clinic for routine minor illnesses and injuries, open Monday through Saturday mornings and some afternoons by appointment. Established patients are occasionally treated via phone consultation. The clinic uses electronic medical records, and its physicians prescribe drugs electronically.

*Concierge Doctors.* An estimated 300 to 400 doctors nationwide now practice concierge or boutique medicine. Patients pay an annual fee that can be as low as \$1,500 or as high as \$15,000. (Although, see the discussion of low-cost concierge services below.) In return, they get same-day or next-day appointments and experience very little waiting, much more personal service and a portable, credit-card-size electronic medical record. They also get their doctor's cell phone number and the right to call or page day or night. Under the most expensive options, some doctors make house calls, deliver medications or accompany the patient to see a specialist.

*Medical Tourism.* Increasingly, cash-paying patients are traveling outside the United States for surgery. Facilities that cater to medical tourists typically offer package prices that cover all the costs of treatment, including physician and hospital fees, and sometimes airfare and lodging as well. Prices are often one-third to one-fifth the cost of the same procedure if done in the United States. Further, care is often delivered in high-quality facilities that keep electronic medical records and meet American accreditation standards.<sup>43</sup>

**An Exception to the Exceptions: Hospital Emergency Rooms.** As a general rule, whenever patients pay with their own money, the price is set in advance and is almost always lower than the price third-parties are paying. This principle holds for hospital services, as well as for the rest of the health care system. Although they do not advertise the fact, many hospitals will give uninsured patients who need elective surgery a price as low as any other payer is charged — provided payment is made in advance.

The exception to the rule is the hospital emergency room, where uninsured patients can get caught up in a third-party payment Rube Goldberg pricing scheme that requires them to pay higher prices than anyone else! Why is that? It is because hospital list prices are not real prices. That is, they are not prices anyone is expected to actually pay. As a result, some uninsured patients can end up being charged fees that are two-and-one-half times as much as the average privately insured patient pays and three times what Medicare patients are charged.<sup>44</sup>

Health economists have long known that hospital list prices are not really prices at all. Instead they are artifacts of the old cost-plus payment system that has been largely abandoned.<sup>45</sup> These days, list prices for hospital services are likely to be chosen by a computer program, whose job is to maximize hospital revenues against insurance reimbursement formulas. When insurance companies negotiate with hospitals, they negotiate discounts as a percentage reduction against the list prices. But hospitals and insurers are unconcerned about the actual list prices. They only care about

the discounts. No one, in fact, is concerned with list prices except the uninsured patients who may get stuck with the highest bills.

More regulation is not the answer to this problem. Hospitals should not necessarily be required to post package prices in advance of treatment. However, it does seem reasonable to require hospitals to give uninsured patients advance warning of *how* they price. For example, a visible sign might warn the patient “Uninsured patients are charged four times the Medicare rate, on the average, and three times the Blue Cross rate.” Such warnings ought to be posted on the insides of ambulances as well.

### Implementing Principle No. 3: Health Insurance Tailored to Individual and Family Needs

There are three empirical questions to ask about health insurance:

1. Does health insurance affect the amount of health care people obtain?
2. Does health insurance affect the quality of care providers deliver?
3. Among people whose only other option is charity care, does health insurance affect the quantity or quality of care obtained?

The first two questions have been answered by rigorous research. In general, people who are insured consume twice as much care as those who pay out of pocket.<sup>46</sup> This finding makes intuitive sense. Most people will consume more of anything if they are spending someone else’s money rather than their own. And among people who see a physician, the quality of care delivered is largely independent of the presence or type of insurance.<sup>47</sup> The third question has not been answered, but there is circumstantial evidence the answer is no. The reason: millions of people eligible to enroll in Medicaid and S-CHIP fail to do so.

**Health Insurance as Asset Protection.** At first glance, the answers to the questions above may seem contradictory. In fact they are not. They are

consistent with the observation that the real purpose of health insurance is not to provide access to health care but to protect assets from unforeseen medical costs.

Several important public policy implications follow from these observations. First, since the assets that need protection differ from family to family, the nature and extent of appropriate insurance will also differ. This fact is in sharp contrast to the almost universal public policy assumption that everyone needs the same insurance coverage. Second, disability insurance for some people may be more important than health insurance; and, in any event, the two should be integrated. The reason: The most important asset most people own is their human capital.

**Health Insurance as Access to Care.** Assume for a moment that the argument above is wrong. Suppose that the most important function of insurance is not to protect assets but to guarantee access to care. This, of course, is the conventional view. But if this view is correct, it has very unconventional implications about what type of insurance is appropriate for most people.

One implication is that health insurance should make possible the purchase of care that would otherwise be unaffordable. Most middle-class families, for example, can easily afford the cost of primary care but might be priced out of the market if they had to pay for expensive care from their own resources. It follows that the appropriate insurance for a middle-income family is catastrophic insurance.

By contrast, low-income families may have difficulty affording even primary care physician visits. Couple this with the observation that, once they are in the system, the quality of care they receive tends to be independent of insurance status. It follows that the most important type of insurance for this family is primary care insurance.

Considerations such as these have prompted a new approach to health insurance. An example is Utah, which began providing limited benefit coverage under a Medicaid waiver in 2002.<sup>48</sup> Under the plan, enrollees are

## Utah's Limited Benefits Health Insurance

Utah has used waivers under the Health Insurance Flexibility and Accountability Act (HIFA) to revolutionize its Medicaid program. The Utah plan uses unexpended federal matching funds for its State Children's Health Insurance Program (S-CHIP), reduces benefits for some currently eligible Medicaid recipients and expands eligibility to cover uninsured low-income workers. The waiver also permits an enrollment fee and copayments of up to 11 percent of annual income.

On the cost-reduction side, Utah replicates the benefit package of the Utah Public Employees Plan (Utah PEP) rather than the more generous Medicaid program.<sup>1</sup> Utah also changed its laws so that private insurers can offer employers plans with the same benefits as the PEP. Thus the state can buy Medicaid enrollees into employer plans — relying on the private market rather than expanding public programs.

In addition, the state uses fact-based evaluations to guide disease management and care coordination in ways that achieve the desired outcomes. For example, by providing appropriate treatment during pregnancy, the state can significantly reduce the number of low-weight births, resulting in better outcomes and lower costs.

On the cost-expansion side, Utah extended eligibility under the waiver to cover two groups with incomes below 150 percent of poverty: parents with children enrolled in Medicaid or S-CHIP and childless adults.

In 2005, Utah established a Primary Care Network (PCN) that stresses preventive care and disease management.<sup>2</sup> In fact, in a 2005 performance survey, recipients rated the Utah plan (on a scale of 1 to 10) more highly than recipients rated Medicaid nationwide with respect to getting needed care, how well doctors communicated with patients, and the helpfulness of office staff. Furthermore, Utah's plan ranked above the national average in the timeliness of prenatal and post-partum care, and the rate of immunizations for children up to two years of age.<sup>3</sup>

<sup>1</sup> This more limited benefit package is also the package made available under Utah's S-CHIP.

<sup>2</sup> Susan Konig, "Medicaid Reform: Florida, South Carolina Lead the Way," Heartland Institute, August 1, 2005.

<sup>3</sup> "2005 Performance Report for Utah Commercial HMOs and Medicaid and S-CHIP Health Plans," Utah Department of Health, November 2005.

covered for basic primary care but are not covered for most hospital care. [See the sidebar.] Similar reforms have been implemented in the Maryland and Pennsylvania Medicaid programs. Arkansas, Florida, Montana and some other states have also introduced limited benefit plans in the private market.<sup>49</sup>

**Expanding Access through Health Savings Accounts.** Unfortunately, Utah's approach follows Medicaid's practice of setting low provider fees and paying doctors based on narrowly defined tasks. There are three negative results. First, the low fees guarantee that patients will have access to a limited range of providers rather than the entire field. Second, because a third party pays the full bill, provider time is rationed by patient waiting rather than by price — which is another way of creating impediments to care. Third, providers have no way to repackage and reprice their services in patient-pleasing ways. So unless the service just happens to be included in the package, patients are unable to access the convenient, low-cost services offered by walk-in clinics in shopping malls or a low-cost, high-quality birthing center like the one at Parkland Memorial Hospital in Dallas.

One solution to this dilemma is to establish health savings accounts (HSAs) that allow patients to manage their own health care dollars and purchase medical care in the marketplace, just as they purchase other goods and services. As explained in Chapter V, up to 10 states can create a type of health savings account called Health Opportunity Accounts (HOAs), for Medicaid enrollees as part of a pilot program under federal law. Also, more than half the states have set up cash accounts for disabled Medicaid enrollees to manage their own health care dollars and directly purchase needed services.<sup>50</sup> These programs, often called “cash and counseling,” are also described in Chapter V.

With flexible HSAs, Medicaid enrollees and other government-subsidized individuals would be able to purchase care that is convenient, high quality and low cost. Further, these individuals and families collectively could have a major influence on the supply of care. Providers of flu shots,

allergy treatments, antibiotic remedies and other primary care services would be encouraged to actively compete for patients based on price and quality of service. The market for primary care for low-income families could be transformed overnight into a teeming, energetic, competitive institution.

**Case Study: The Venamher Clinic in Miami.**<sup>51</sup> This facility opened in 2002 and now has about 2,700 regular patients, about the same number of patients managed by a typical family practice physician. Patients pay a monthly fee, comparable to an insurance premium, to be an “affiliated member” of the clinic. These monthly fees range from \$15 (single) to \$35 (family). Members also pay a fee at the time of service. The clinic’s in-house staff includes two doctors and a dentist who charge reduced rates for their services. For example, a physician or dental visit costs \$25. The clinic also maintains agreements with specialists (including cardiologists, surgeons and obstetricians) that offer its members treatment at discounted prices.

The clinic was started by two civic organizations — Hermandad Venezolana-Americana and the Coral Way Colombian Lions Clinic — to help Hispanic families who lack health insurance. Most of its clients come from a tightly knit community of Venezuelan immigrants. The clinic raises operating funds through fees, member dues, donations and subsidies from civic organizations. “This clinic can give the otherwise uninsured the care they need at a low cost, preventing major medical problems that would otherwise send them to the [hospital] emergency room,” says Jose Ramon Martin, the clinic’s medical director.

**Case Study: Three-Share Plans in Michigan.**<sup>52</sup> Three-Share plans are designed to increase access to private health insurance for employees of small firms by sharing premium costs among employees, employers and the government. The most notable Three-Share plans operate in Muskegon and Wayne counties, in Michigan, with a combined enrollment of more than 7,500 participants. Enrollees must be employed by a company

that pays a median wage of \$14 an hour or less, and they cannot qualify for Medicaid or other state or federal health programs.

Members pay about the same premium they would pay for other employer-provided insurance, but the cost to the employer (who must match the employees' contributions) is much less than what most conventional health insurance plans cost.<sup>53</sup> In 2004, the average total premium for these plans was \$160 per month. But Three-Share plan benefits are very limited. Benefits are determined at the local level and can vary; however, the plans generally impose copays, cost-sharing and limitations on medical visits, hospitalization and prescription drugs.

Enrollees can only see participating physicians and hospitals within their county of residence, and patients must go through a gatekeeper to see specialists. Plans may exclude dental, vision and chiropractic services. They also may avoid mental health parity and may impose significant patient cost-sharing for specialty services.<sup>54</sup> The public share of funding is financed from federal Disproportionate Share Hospital (DSH) funds.

**Case Study: Low-Cost “Concierge Medicine” in Dallas.**<sup>55</sup> Concierge medicine is normally associated with personalized services for the wealthy. As noted above, these services can be expensive. However, in Collin County, Texas, a Dallas suburb, physician Nelson Simmons offers a version of that service for less than \$500 a year.

About 70 small business owners pay \$40 per employee per month for Simmons' plan. In return, employees get same-day primary care services and steep discounts on diagnostic tests and specialist care. Enrollees must pay out-of-pocket for specialist care, surgeries and diagnostic tests. But Simmons negotiates the rates, which are typically much lower than what others pay. For example, a tonsillectomy for a child costs less than half of the normal fee (\$2,100 versus \$4,800) and an MRI scan can be less than one-fourth of the standard charge (\$350 versus \$1,600).

**Case Study: Tennessee's Minimedical Plan.** Not long ago, Tennessee was best known in health insurance circles for a disastrous attempt to

insure everyone in the state through TennCare. As people with private insurance dropped their coverage to get free care from the state, the cost soared and threatened to bankrupt state government. In response, the state pared back eligibility, cut 170,000 adults from the rolls and went back to the drawing board.<sup>56</sup>

The state conducted focus groups with blue-collar workers and discovered that what people wanted was very different from what health policy experts thought they should have. For example, there was very little interest in buying insurance for catastrophic events. Instead, people wanted insurance benefits that help them pay for primary care visits or prescription drugs. The state now offers limited benefit plans designed to meet these patients' preferences.

“You walk into the hospital emergency room without insurance, it's like you don't even matter,” said Ashly Robinson, who tells of long waits and rude treatment. Today Robinson has a limited benefit health plan that allows her to obtain routine care with small copays but does not pay for expensive health care costs.

Robinson also participates in a “minimedical plan” called CoverTN. The plan is available to low-income employees who earn too much to qualify for Medicaid. The costs are split between the employee, the employer and the state government — each paying less than \$100 a month in premiums. In return, the employees get limited health care benefits. These include up to five doctor visits (with a \$15 copay), generic drugs (\$10 copay) and brand drugs (\$15 copay) up to \$250 per quarter, and up to \$10,000 of hospital care (\$100 copay). The overall coverage limit is \$25,000 per year. The plan, administered by BlueCross BlueShield of Tennessee, is proving to be popular, and many people are dropping traditional coverage to enroll.<sup>57</sup>

**Case Study: Employer-Sponsored Minimedical Plans.** Employers also are establishing their own limited-benefit plans, especially for part-time workers. For example, Lowe's, the home improvement retailer, has enrolled about 7,000 part-time employees in health plans with benefits

capped at \$2,500 to \$5,000 a year. Avon, IBM and Sears also offer mini-medical plans to entry-level and part-time workers.<sup>58</sup> Other employers offering such plans to their part-time employees and contract workers include McDonalds, the Hair Cuttery salons and Friendly's restaurants.<sup>59</sup> Insurers say more than a million people are in such plans.<sup>60</sup>

**Case Study: Minimedical Plans Offered by Commercial Insurers.** Aetna, WellPoint and Humana are among the large insurers that have created limited benefit plans aimed at young people. Humana's plan, for example, costs as little as \$26 per month. The benefit packages do not always measure up to the health planners' ideals. Some plans may cover such benefits as teeth whitening and spa memberships, while excluding coverage for maternity and drugs. WellPoint's "Tonik" program is now in six states and will expand to five more in the near future. In fact, 20 percent of WellPoint's new sales are coming from these low-cost plans.<sup>61</sup> Insurers are targeting employers who do not now offer health insurance, and overall, the new "mini" plans appear to represent the fastest growing part of the health insurance marketplace.<sup>62</sup>

**Case Study: Minimedical Plans with Foreign Providers.** Rudy Rupak, president and founder of the medical tourism company PlanetHospital, is working with a major insurer to design an inexpensive health plan that includes low-cost foreign providers in its network. The unique part of Rupak's plan is that the way it works is similar to casualty insurance. Primary care is provided locally, but major medical conditions have specific dollar allowances that can be used anywhere, including local hospitals and clinics as well as foreign hospitals, where prices may be much lower than in the United States.<sup>63</sup> The idea is to provide enrollees with inexpensive coverage that still provides meaningful benefits in the event of serious illness.

**Case Study: Health Savings Accounts in Indiana.** The cornerstone of Indiana's new plan to cover the uninsured, is Personal Wellness Responsibility (or POWER) Accounts. Power Accounts, which are similar to health savings accounts, will be paired with high-deductible health plans. The

## CHAPTER III — IMPLEMENTING THE PRINCIPLES OF REFORM

plans will provide a standard benefit package, defined by the state, and will be offered by several insurers.

Once the program goes into effect on January 1, 2008, the plans will be available to state residents earning less than 200 percent of the federal poverty level (\$40,000 for a family of four). State officials estimate that about 350,000 state residents will be eligible — and they hope more than one-third of them will sign up. Among those who are ineligible are people with access to coverage through work, those eligible for Medicaid, and those who have been uninsured less than six months.

The plans will have a deductible of \$1,100 per adult, and the state will cover the cost of the premiums. Enrollees will be required to contribute between two and five percent of their income to their Power Accounts, from which they can pay medical expenses up to the deductible. If the enrollee's contributions fall short of the required annual \$1,100 needed to fund the account, the state will make up the difference. Enrollees will access their Power Account using a debit card to pay medical bills below the deductible. Once the \$1,100 deductible is met, insurance will pay all other costs. Funds remaining in the Power Account at the end of the year can be rolled over for the following year. The enrollee may withdraw any unspent funds above a \$500 minimum balance.

Employers who wish to participate will be allowed to pay up to half of an employee's share of contributions if they so choose. However, there is no employer mandate requiring them to do so.

The health plans will include first dollar coverage for up to \$500 worth of preventative care. In addition, the plans cover office visits, inpatient care, prescription drugs, treatment for mental health, substance abuse and home health care. Annual benefits will be capped at \$300,000, and lifetime benefits will be capped at \$1 million. To encourage health care providers to participate, reimbursement to providers will be based on Medicare (rather than Medicaid) rates.

## Implementing Principle No. 4: Creating a Workable Market for Health Insurance

In an ideal system health insurance would travel with employees from job to job (as other forms of insurance do), and renewal rates would be independent of health status. Yet when people opt to change insurance coverage, they need access to institutions in which risk can be transferred at market prices. For example, an employee who has recently contracted diabetes should, during his annual reenrollment period or after a move to a new employer, be able to choose a provider he trusts to give excellent diabetic care, rather than be forced into a lower quality plan. How can this objective be achieved?

**Personal and Portable Health Insurance.** One of the strange features of our health care system is that most health insurance is not guaranteed to last for any significant period of time. Most insurance contracts are only for 12 months. Each year, employers can decide on a new health insurance plan or they may decide to cease offering health insurance altogether. In the intervening period, an employee might be laid off or voluntarily leave employment, and a change of jobs almost always entails a loss of the original insurance.

Similarly, a change of health plans usually means a change in coverage, and benefits provided under one plan may not be provided under the next or, if they are, the coverage may not be as extensive. A change of plans also usually entails a change of provider networks. For a person with a medical condition, a change of doctors means no continuity of care.

Clearly, personal and portable health insurance is an idea whose time has come; and employers could play a role in helping workers obtain it. Imagine a system in which people owned their own health insurance and that it traveled with them as they moved from job to job. Employers could pay some or all of the premium, with payroll deductions for the balance, similar to the procedures for contributions to 401(k) accounts. The federal

government could implement such a system, as could individual states.<sup>64</sup> (See the discussion below in Chapter VII.)

**Guaranteed Renewable Insurance.** If personal and portable health insurance were similar to products in the individual insurance market, the insurance would be guaranteed renewable indefinitely into the future. Like individual insurance (and in contrast to the small group market in most states), premium increases would reflect cost increases for the pool as a whole and would be the same for everyone. Insurers would not be permitted to single out people who became ill and charge them higher premiums. Nor could they reduce rates for those who remained healthy. Such a system would be far superior to today's dysfunctional small group market — where groups are frequently rewarded or punished with premium changes in response to changes in health costs over which the members of the group have no control.

Portable health insurance would also solve a major social problem: under the current system, people who lose their job-connected insurance may be denied new coverage or face very high premiums because of a health condition.

**Destroying the Market for Risk.** Unfortunately, many states have tried to address these problems with unwise legislation — including laws that encourage people to stay uninsured. A proliferation of state laws, for example, has made it increasingly easy for people to obtain insurance after they get sick. Guaranteed issue regulations (requiring insurers to take all applicants, regardless of health status) and community rating regulations (requiring insurers to charge the same premium to all enrollees, regardless of health status) are a free rider's heaven. They encourage everyone to remain uninsured while healthy, confident that they will always be able to obtain insurance once they get sick. Moreover, as healthy people respond by electing to be uninsured, the premiums to cover costs for those who remain in the insurance pool rises. These higher premiums, in turn, encourage even more healthy people to drop their coverage.

Federal legislation deserves a lot of blame for these developments. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 had a noble intent: to guarantee that people who have been paying premiums into the private insurance system do not lose coverage simply because they change jobs. However, HIPAA also includes a provision that allows any small business to obtain insurance regardless of the health status of its employees. This means that a small mom-and-pop operation can remain uninsured until a family member gets sick. Individuals also can opt out of an employer's plan and re-enroll after they get sick. They are entitled to full coverage for a preexisting condition after an 18-month waiting period. A group health plan can apply pre-existing condition exclusions for no more than 12 months, except in the case of late enrollees, to whom exclusions can apply for only 18 months.

By far the worst consequence of this government regulation is the unintended harm done to the very people the laws intend to help. Precisely because high-risk individuals' expected health care costs are much higher than their premiums, insurers seek to avoid enrolling them in the first place. Because providers payments also do not reflect expected costs, they, too, have an incentive to avoid attracting the hard cases, especially among the chronically ill.

**Recreating a Market for Risk.** If health care markets worked the way normal markets do, health insurers and providers would vigorously compete for the business of the sick. In normal markets, entrepreneurs make profits by figuring out how to better solve other people's problems. In health care, by contrast, entrepreneurs run from sick people's problems.

People cannot make rational choices about risk if the price of risk avoidance is not set by the market. For that reason, risk should be freely priced in the marketplace, with government intervening to help specific individuals only in special cases.

The risk-adjusted premiums in the Medicare Advantage program are a step in the right direction. When seniors enroll in private Medicare plans,

the plans receive a premium payment based on the senior's expected health care costs. In the early years these adjustments were limited and inadequate. However, the federal government is developing a payment system that reflects 60 or 70 different variables.<sup>65</sup> Similar risk-adjusted payments are being used in Florida's Medicaid program.<sup>66</sup>

### Implementing Principle No. 5: Private Insurance versus Taxpayer-Funded Care

Given that people need insurance, which option is best: private insurance, reliance on a taxpayer-funded social safety net or enrollment in a taxpayer-funded health insurance plan (Medicaid or S-CHIP)? Self-evidently, private insurance is better for the taxpayers. But it is also likely to be better for patients.

**Private Insurance versus Free Care.** The current system offers a vast array of free services (often of uneven quality) to indigent patients. This free care system, or safety net, is an alternative to private insurance for many families — especially those without access to employer-provided coverage.

By one estimate, each person who is uninsured for a significant period of time receives an average of \$1,500 in free medical care annually, or \$6,000 for a family of four.<sup>67</sup> This sum of money is adequate to buy private family coverage in many places, especially if the family is young and healthy. But why pay \$6,000 for private insurance when comparable insurance (through the safety net) is available free of charge?

The incentives are made more perverse by the way insurance is subsidized through the tax system. In general, employer payments for health insurance are made with pretax dollars, a generous subsidy that cuts the cost of health insurance in half for a middle-income family in the 50 percent tax bracket. By contrast, the tax law offers very meager (or no) relief for people who purchase insurance on their own. For example, a family

## The Massachusetts Health Plan

In the spring of 2006, Massachusetts enacted a program designed to ensure that every resident in the state has health insurance. Under the leadership of Gov. Mitt Romney, the state took a number of steps to enroll qualified individuals in MassHealth, the state Medicaid and S-CHIP program. The legislation addressed the remaining uninsured in four important ways:<sup>1</sup>

**Individual Mandate.** Under the law, everyone in Massachusetts will be required to have health insurance. If not eligible for a government insurance program, individuals will have to enroll in an employer plan or purchase insurance on their own. Failure to comply will result in a fine equal to half the cost of the lowest-priced insurance plan. The fine will be enforced through the state income tax system.

**Employer Mandate.** Employers who do not make a “fair and reasonable” contribution to their employees’ health insurance will be forced to pay an annual fee to the state. This mandate was resisted by Gov. Romney and is set at only \$295 per employee, per year — well below the cost of health insurance. Employers are also required to create a cafeteria plan under Section 125 of the Internal Revenue Code. This will allow employees who purchase their own insurance to do so with pretax dollars.

**Insurance Reform.** The legislation attempts to replace the individual and small group markets with a single market called the Connector. Insurers who participate will have to offer a plan approved by the governing board of the Connector and charge community-rated premiums. Individuals will be able to select from approved plans during an annual open season. Because the new system encourages individually owned insurance, the insurance will be portable whenever employees change jobs — at least up to 12 months. The Connector arrangement is basically managed competition — modeled after the program available to federal employees and many employees of state governments.

**Subsidies.** Currently, the state receives almost \$300 million a year in federal funds to subsidize indigent health care. Under the legislation, these funds, along with state matching money, will be used to subsidize private insurance for people who were previously getting free care. People below the federal poverty level will be completely subsidized and will not have to pay premiums.

<sup>1</sup> Summary, “Health Care Access and Affordability Conference Committee Report,” Massachusetts Legislature, April 3, 2006. Available at: <http://www.mass.gov/legis/summary.pdf>. Accessed September 6, 2007.

## Making the Massachusetts Plan Better

The following steps would improve the Massachusetts plan's chances for success.

**Eliminate the Individual Mandate.** Mandates do not work. For example, all but three states mandate auto liability insurance. Yet, nationwide, the auto liability uninsured rate is only a couple of percentage points lower than the rate of uninsurance for health care.

**Eliminate the Employer Mandate.** The Massachusetts plan requires employers to offer health insurance or to pay \$295 per employee into a state fund. Although the penalty is now small, political pressure will build to raise it, since so many people think the burden falls on employers rather than employees. However, when government forces employers to pay for health coverage, employees ultimately bear the cost of those health benefits in the form of lower wages and fewer nonhealth benefits.

**Eliminate Managed Competition.** The Connector is a managed competition-type, artificial marketplace. The model for it is the Federal Employee Health Benefits Plan. The problem with these systems is that they create perverse incentives to over-provide to the healthy and under-provide to the sick.

**Eliminate Costly Benefit Mandates.** Massachusetts' 40 mandated benefits add significantly to costs. For instance, Massachusetts is one of only seven states to mandate coverage for hair prostheses (hairpieces) for cancer patients. It is one of only 14 states that mandate coverage for in vitro fertilization — which adds 3 percent to 5 percent to the cost of premiums. Nationwide, as many as one-quarter of the uninsured may have been priced out of the market by costly mandates.

**Eliminate Other Costly Insurance Regulations.** Two costly regulations, guaranteed issue and community rating, make private coverage more expensive. Guaranteed issue requires insurers to sell policies to all state residents who apply, regardless of their health status or pre-existing medical conditions. When insurance companies are forced to accept all applicants, they raise premiums to guard against the increased risk of losses. As a result, insurance is a poor value for everyone except those with serious health conditions.

**Request a Block Grant.** Massachusetts will subsidize private coverage for low-income families using more than \$300 million in funds it receives for care of the indigent, one of the many pots of federal health care money. A better way to fund such initiatives would be to request a block grant for all federal Medicaid funds. This would give the state the flexibility to provide care in the most efficient way.

Source: Devon M. Herrick, "Insuring the Uninsured: Five Steps to Improve the Massachusetts Plan," National Center for Policy Analysis, Brief Analysis No. 585, April 19, 2007.

facing a 50 percent marginal tax rate must earn \$12,000 to be able to pay taxes and buy \$6,000 of insurance with what's left over.

A better approach would be to offer \$1,500 to people who would otherwise qualify for safety net care to purchase private insurance. Instead of encouraging people to become uninsured, this policy would have the opposite effect. This was the core idea behind Gov. Romney's health care reform plan in Massachusetts. [See the sidebar on the Massachusetts plan.] In fact, had the proposal been accepted as originally proposed, Massachusetts potentially could have insured its entire uninsured population without spending any extra money. [See the sidebar on making the Massachusetts plan better.] This idea was also the starting point for Gov. Arnold Schwarzenegger's proposed reform plan for California. Unfortunately, that plan is bogged down with a great many unattractive additions. [See the sidebar on California.]

**Are Mandates Needed?** One of the most common proposals for health care reform is the idea of requiring people to have health insurance. It is also one of the most weakly argued ideas. This discussion usually focuses on people who are basically healthy, and not poor and who are uninsured by choice. One argument is that such people are potential free riders. They can run up health care bills they cannot pay for and shift the cost to others. But if that is the concern, the simple and direct solution is to fine or tax them (something already being done through the tax system) and keep the funds on hand in case there are unpaid health care bills (something that is not being done).

A second argument for mandates is that healthy people are needed in insurance pools to make the pools financially viable. A variation on that idea is that when healthy people enter and leave the insurance system they create instability. The hidden premise behind both arguments is that insurance pools need healthy people so they can be exploited. If the healthy pay their own way (that is, are charged fair premiums) they do not increase the pools' stability or viability. That only happens if they are overcharged. But

if it is socially desirable to subsidize some people's health insurance, why pick on the healthy? Why not spread the burden over all taxpayers?

Against the flimsy case for imposing mandates, there are three strong arguments for not doing so and a much better reform to address the problem.

First, mandates do not work. For example, all but three states mandate auto liability insurance. Yet nationwide, the auto liability uninsured rate is only a couple of percentage points lower than the rate of uninsurance for health care. And auto liability insurance mandates are much easier to enforce.<sup>68</sup> [See the sidebar "Do Mandates Work?"]

Second, a mandate invariably requires the government to spell out the particulars of what precisely is mandated. This creates an invitation to special interests to add to the package and increase its costs. Compare the federal government's relationship to health insurance with that of the states. The federal government's relationship is largely financial, allowing employers and employees to spend pretax dollars on virtually anything the IRS considers a health expense.<sup>69</sup> The states, by contrast, regulate the content of health insurance and countless lobbies try to force insurance buyers to purchase policies that cover their services.

Third, there is no practical way to enforce a mandate other than by imposing a financial penalty. And if financial penalties are the only threat, why not formalize that policy and assign higher taxes to those who avoid insurance and incur medical bills they cannot pay from their own resources?

Uninsured people already pay higher income taxes because they do not receive the tax subsidies enjoyed by people who have employer-paid coverage. Those "fines" are probably adequate, but they could be increased. The problem: The extra taxes paid by the uninsured today go to the U.S. Treasury, while uncompensated care is delivered locally. A means to integrate tax and spending policies is needed.

**Universal Coverage without Mandates.** Suppose the government offered every individual a uniform, fixed-dollar subsidy of \$1,500. If the

## The California Health Care Plan

Like Gov. Mitt Romney's plan for Massachusetts, Gov. Arnold Schwarzenegger's California plan would require people to buy insurance. Yet it would also spend more money, create more perverse incentives than it eliminates, raise everyone's health care costs and create new burdens for low-income families. Here are a few significant features:<sup>1</sup>

- Medicaid (Medi-Cal) and S-CHIP (Healthy Families) will be expanded, and everyone eligible will be required to join.
- Everyone else will be required to buy private insurance, and a minimum coverage plan will have a \$5,000 deductible.
- The state will subsidize insurance for lower-income families, based on income.
- Insurers will be compelled to sell to all comers, without regard to health status.
- Employers who do not offer insurance will have to pay a 4 percent wage tax.
- Doctors will face a new 2 percent tax on their revenues, and hospitals will pay 4 percent.
- Only about one-fifth of the state's cost will be covered by the diversion of charity care funds; the bulk of the cost will be paid by new taxes imposed on employers and providers.

The plan is designed from top to bottom to maximize federal matching funds; for every new dollar of state spending there will be an additional dollar of federal spending. Good for California perhaps, but bad for other federal taxpayers. If the plan succeeds, California will increase federal spending by \$50 billion (over 10 years), and no member of Congress will even have the opportunity to vote on it!

Like the Massachusetts plan (but much worse), the California plan:

- Encourages people with unsubsidized insurance to instead get subsidized insurance (many employers of low-income workers will drop their coverage and pay a 4 percent fine), which will cause system costs to soar.

- Expands Medicaid and S-CHIP, which will encourage employers of low-paid workers to drop their coverage.
- Encourages healthy people to exit the system (for example, by self insuring under federal law), leaving the sickest and most costly people behind – again driving up costs.
- Opens the door for future legislatures to convert an individual mandate into an employer mandate, thereby encouraging businesses to leave the state.

Perhaps the worst feature of the plan is the new burdens it creates for the people it claims to help: low-income, uninsured families. Under the new plan:

- Workers will get hit by the 4 percent wage tax (a tax nominally imposed on their employers).
- If they do not buy insurance, they will have wages garnished and tax refunds withheld.
- If they do buy insurance, they will have a \$5,000 deductible catastrophic policy – of great benefit to California hospitals (and perhaps even to the family if they have assets), but of no benefit for the purchase of primary care.
- When they do seek care, they will face a new tax on their medical bills (nominally imposed on the providers).

Although Medicaid reimbursement rates will be increased, the poor will not become empowered consumers in a medical marketplace; instead they will likely continue to get care exactly where they get care today (for example, hospital emergency rooms).

<sup>14</sup>Governor's Health Care Proposal," January 8, 2007. Available at [http://gov.ca.gov/pdf/press/Governors\\_HC\\_Proposal.pdf](http://gov.ca.gov/pdf/press/Governors_HC_Proposal.pdf).

## Do Mandates Work?

### Auto Liability Insurance versus Health Insurance

Many policymakers advocate forcing individuals to buy health insurance. This is the cornerstone of the Massachusetts health reform law and many other universal coverage proposals.

We can get an idea of how well mandatory health insurance would reduce the number of uninsured by looking at another type of mandated coverage: auto insurance. Enforcement is relatively easy — making people show proof of insurance when they register their cars. Despite this fact, the number of drivers on the road without coverage is quite high. Consider:

- All but three states mandate automobile insurance, but 14.6 percent of America's drivers remained uninsured in 2004, according to the Insurance Research Council.
- Aside from the new reforms in Massachusetts, no state mandates health insurance, but 15.8 percent of the population lacked health coverage in 2004, according to the Census Bureau.
- In 17 states, the uninsured rate for auto is higher than for health.

The state-by-state breakdown of coverage is even more illuminating when penalties are considered. In some cases the penalty for noncompliance is severe. In Kentucky an uninsured motorist can be fined \$1,000 and 6 months in jail; Wyoming also has a 6 month jail term and a \$750 fine. In Louisiana, the driver's car can be impounded for failure to insure. Yet the rate of noncompliance is 12 percent in Kentucky, 11 percent in Wyoming and 10 percent in Louisiana.

On the other hand, some of the least punitive states have the lowest rates of uninsured motorists. For instance, New Hampshire has no mandate but its uninsured rate is only 9 percent, well below its rate of noncoverage for health insurance (11.3 percent). By contrast, Texas, Nevada and New Mexico levy a fine of only \$100 for noncompliance and their rates of uninsured motorists are very high (16 percent, 17 percent and 24 percent, respectively); their uninsured rate for health care is even higher — 27.1 percent, 20.5 percent and 24.4 percent.

Source: Greg Scandlen, "Will Mandatory Health Insurance Work?" National Center for Policy Analysis, Brief Analysis No. 569, September 6, 2006. See also Carmen DeNavas-Walt, Bernadette D. Proctor and Jessica Smith, "Income, Poverty, and Health Insurance Coverage in the United States: 2006," U.S. Department of Commerce, U.S. Census Bureau, August 2007.

individual obtained private insurance, the subsidy would be realized in the form of a tax credit. The credit would be refundable, so that it would be available even to those with no tax liability. If the individual chose to be uninsured, the subsidy would be sent to a safety net agency in the community where the person lives. [See Figure IIa.]

To implement this program, government needs to know how many people live in each community and pledge to each community \$1,500 times that number. In principle, it will be offering each individual an annual \$1,500 tax credit. Some will claim the full credit. Some will claim a partial credit (because they will only be insured for part of a year). Others will claim no credit. Whatever sums are not claimed on tax returns should be available as block grants for indigent health care at the local level.

What about differences in health status among people who rely on the safety net? In a private insurance market, insurers will not agree to insure someone for \$1,500 if the expected cost of care is, say, \$5,000. If the safety net agency expects a \$5,000 savings as a result of transferring a patient to a private insurer, however, the agency should be willing to pay up to \$5,000 to subsidize the private insurance premium. The additional higher subsidy could be added as a supplement to the tax credit.

One way to think about this arrangement is to see it as a system under which the uninsured as a group pay for their own free care. That is, in turning down a refundable tax credit (by choosing not to insure), uninsured individuals would pay extra taxes equal to the average amount of free care given annually to the uninsured. [See Figure IIb.]

How can subsidies be funded for those who choose to move from being uninsured to insured? By reversing the process. At the margin, the subsidy should be funded by the reduction in expected free care that person would have consumed if uninsured. So another way to think about this arrangement is to see it as a system under which people who insure “pay” for their own tax subsidy through the “release” of free care dollars. For example, suppose everyone in Dallas County chose to obtain private insurance, rely-

FIGURE IIa  
*Government Subsidy*

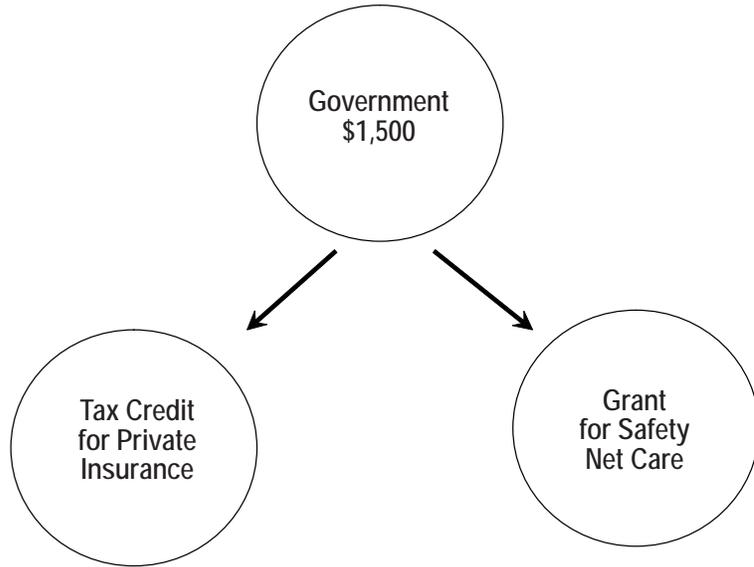
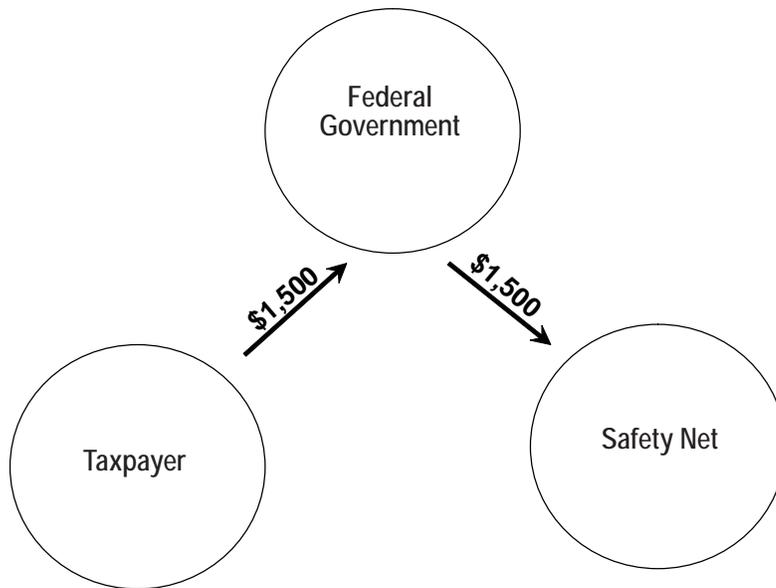


FIGURE IIb  
*The Marginal Effect of Choosing to be Uninsured*



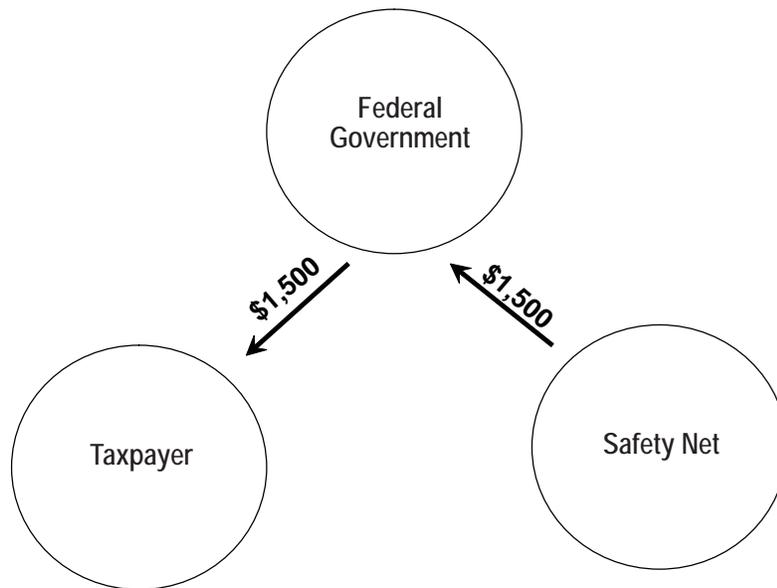
ing on a refundable \$1,500 income tax credit to pay the premiums. As a result, Dallas County no longer would need to spend \$1,500 per person on the uninsured. Thus, all of the money that previously funded safety net medical care could be used to fund private insurance premiums. [See Figure IIc.]

A common misconception is that health insurance reform costs money. For example, if health insurance for 40 million uninsured people costs \$1,500 a person, some conclude that the government would need to spend an additional \$60 billion a year to get the job done. But this conclusion overlooks the fact that taxpayers are already spending \$60 billion on free care for the uninsured, and if all 40 million uninsured suddenly became insured they would — in that act — free up the \$60 billion from the social safety net.

Our health care system costs more than two trillion dollars a year. Spending even more money on the uninsured would only contribute to

FIGURE IIc

*The Marginal Effect of Choosing to be Insured*



health care inflation. Getting all the incentives right may involve shifting around substantial sums of money, such as reducing subsidies that are currently too large and increasing those that are too small. It may also mean making some portion of people's tax liability contingent on proof of insurance.<sup>70</sup> But it need not add to budgetary outlays.

Under the proposal outlined here, money would follow individuals. If people move from the safety net to private insurance, safety net funds would contract and subsidies for private insurance would expand. Conversely, if people move from insured to uninsured status, subsidies for private insurance would contract and money available for the safety net would expand.

Thus, this is a proposal that *both* guarantees a fixed dollar subsidy for all those who choose to insure and a fixed dollar subsidy for the safety net, based on the number who choose to be uninsured. The latter guarantee is just as important as the former in creating "universal coverage." Under the current system, many inner city hospitals are overcrowded, underfunded and in danger of closing.<sup>71</sup> This proposal secures the safety net and encourages private insurance at the same time.

**Federal versus State Implementation.** The universal coverage plan outlined above would ideally be implemented by the federal government. The reason: The income tax system is basically a federal system and the bulk of "safety net" money is actually federal money.<sup>72</sup> Indeed, federal policies have caused most of the important distortions in the health care system, and comprehensive reform is almost unimaginable without reform at the federal level. [See the sidebar.] Nonetheless a version of the idea is being attempted in Massachusetts and has been proposed in California. We will propose our own state-level version of the plan in Chapter IV.

**Private Insurance versus Public Insurance.** Many poor and near-poor families have a choice of public or private insurance. A low-income family may qualify for either Medicaid or State Children's Health Insurance Program (S-CHIP) enrollment, or obtain private insurance (typically through

an employer). Clearly, we should not be indifferent about this option. Private insurance means people are paying their own way. It also almost always means that people have more options in the medical marketplace.

How does government policy affect this choice? Unfortunately, public policy overwhelmingly encourages people to drop private insurance and enroll in public programs instead. As noted, tax subsidies for private insurance are quite meager for those with near-poverty incomes, whereas public programs are free. Further, except for a few pilot programs underway,<sup>73</sup> states do not allow Medicaid enrollees to use their Medicaid dollars to buy into an employer plan or directly purchase private insurance.

Many people assume Medicaid insures people who otherwise would not have access to private insurance.<sup>74</sup> However, Medicaid induces some people to turn down or drop private coverage to take advantage of free health insurance offered by the state. As a result of such crowding out, the cost of expanding public insurance programs has been high relative to the gain.

Economists David Cutler and Jonathan Gruber found that Medicaid expansions in the early 1990s were substantially offset by reductions in private coverage.<sup>75</sup> For every additional dollar spent on Medicaid, private-sector health care spending was reduced by 50 cents to 75 cents, on the average.<sup>76</sup> Thus taxpayers incurred a considerable burden, but at least half, and perhaps as much as three-fourths, of the expenditures replaced private-sector spending rather than buying more or better medical services.

A similar principle applies to S-CHIP. A recent Congressional Budget Office report estimated a crowd-out rate of 25 percent to 50 percent.<sup>77</sup> Jonathon Gruber estimates the crowd-out rate at 60 percent.<sup>78</sup> Take a low-income working family covered by an employer-sponsored health plan. The employer might have covered some or all of the cost of insurance premiums for the employee and family with pretax dollars. However, receiving wages is more attractive to the employee if health coverage is provided by the state. So it is in the interest of both employee and employer to substitute wages for health insurance. In this way, S-CHIP offers some

## How the Federal Government Can Help: The “Do No Harm” Approach to Health Policy

“First, do no harm.” This principle is well known to physicians as part of the Hippocratic Oath. No similar oath is taken by politicians, of course. But suppose they did. Suppose that, before they pass any new health legislation, our political representatives were required to reexamine existing laws and make sure that government is not the cause of the very problems it attempts to solve.

Perform a thought experiment: Identify the major ways in which government policies create perverse incentives to do socially bad things. Then imagine replacing those harmful policies — not with good policies, but with policies that are completely neutral. Some of these reforms require federal action. They all would work better with federal cooperation:

**Distortion Number 1:** The U.S. system of government-funded free care encourages people to forgo insurance and rely on the charity of others.

**Neutral Solution:** Let government offer just as much financial incentive for people to privately insure as expected free-care spending.

**Distortion Number 2:** The existence of government-funded insurance (e.g., Medicaid) encourages people to drop their private coverage and become insured at taxpayer expense.

**Neutral Solution:** Let people apply their Medicaid subsidy to the purchase of private insurance, making the two types of insurance equally attractive financially.

**Distortion Number 3:** The current system lavishes tax subsidies on employer-specific insurance, but provides very little tax relief for individually-owned, personal and portable insurance.

**Neutral Solution:** Create a level playing field for all forms of insurance under tax law.

**Distortion Number 4:** Although there is, in principle, no limit to the tax subsidy for spending on third-party insurance, tax relief for self-insurance (through a savings account) is very limited.

**Neutral Solution:** Put third-party insurance and individual self-insurance on a level playing field under the tax law.

**Distortion Number 5:** Government has essentially outlawed a real market for risk — encouraging individuals to be uninsured while healthy, secure in the knowledge that insurance will be available, at premiums totally unrelated to the expected cost of their care, if they get sick.

**Neutral Solution:** Like the life insurance market, allow the health insurance market to price and manage risk.

Under a policy of neutrality, government no longer would be a cause of the problems so many people complain about. If government were removed as a source of problems, the resulting system would have some remarkably attractive features: Every citizen would be promise a fixed sum of money in the form of a tax credit or subsidy toward private insurance or to fund the health care safety net for the uninsured. Low-income families would no longer be trapped in public systems where care is rationed by waiting.

Furthermore, tax law would grant the same subsidy to all forms of insurance, whether employer-provided or individually-purchased. The law would no longer encourage the HMO form of insurance by subsidizing third-party insurance while penalizing self-insurance. Finally, governments would no longer require insurers to charge prices for risk that are totally unrelated to an individual's real health costs. Instead, healthy people would be able to buy into the system at prices that reflect their lower expected costs.

Notice that adopting these solutions does not do good. It simply avoids doing harm. The result: a system so completely different from the current one, it would hardly be recognizable.

Source: John C. Goodman, "Applying the 'Do No Harm' Principle to Health Policy," *Journal of Legal Medicine*, Vol. 28, No. 1, 2007, pages 37-52.

employees the opportunity to increase their wages and reduce their health insurance costs at the same time.

Between 1997 and 2003, enrollment of low-income children in public programs increased from 29 percent to 49 percent.<sup>79</sup> At the same time, private insurance coverage fell from 47 percent to 35 percent, although there was little change in the percentage of privately insured children in households at higher income levels. Confirming Gruber's estimates it appears that the crowd out of private insurance due to the expansion of public programs was 0.6, meaning that every percentage point increase in public coverage resulted in a reduction of about 0.6 percentage points in private coverage among low-income children.<sup>80</sup>

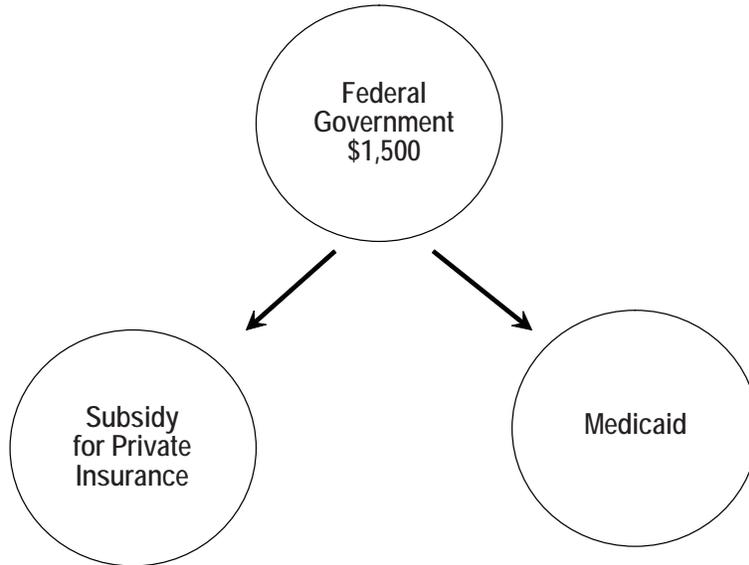
The solution here is very similar to the solution to the previous problem. If government is spending \$1,500 a year per person enrolled in Medicaid, it ought to be willing to spend an identical sum on private insurance instead. [See Figure III.] Florida's Medicaid reform, whereby the state uses federal Medicaid dollars to enroll beneficiaries in employer plans, is a step in the right direction.<sup>81</sup> (See the discussion below.) The failure to follow this principle is illustrated by the DirigoChoice program in Maine.

**Case Study: Maine's DirigoChoice Program.**<sup>82</sup> This was one of the first universal health care programs in the nation, with an ambitious goal of covering 130,000 uninsured residents through a state-subsidized program. But costs were higher than expected and only 18,000 people have enrolled.

DirigoChoice is available to the unemployed, part-time employees or employees who work for small businesses (50 employees or less) that do not provide health insurance. The plan is generous, providing 100 percent coverage for preventive care, as well as mental health parity and no deductibles for prescription drugs (although nominal copays do apply). Additionally, pre-existing conditions are covered with no waiting period, and the plan has no lifetime maximum benefit cap.<sup>83</sup> Administered by Anthem Health, the state's primary insurer, the program has many flaws:<sup>84</sup>

**FIGURE III**

*A Level Playing Field for  
Private and Public Insurance*



- It crowds out private insurance — 60 percent of enrollees on the plan were previously covered by private insurance, which they dropped in favor of the state’s plan.
- Its generous benefits appeal to the sickest enrollees who cost the most, while its high premiums discourage the healthy from signing up.
- Small businesses enrolled in the program are required to cover 75 percent of their employees and pay 60 percent of the costs — which they say makes it just as unaffordable for them as private insurance.

Furthermore, most of the state’s private insurers have left Maine’s individual market due to the unprofitability of providing coverage in the state. This exodus has led to even less competition among the remaining firms, further adding to premium costs.

## HANDBOOK ON STATE HEALTH CARE REFORM

DirigoChoice is an example of how a state can spend a great deal of money and accomplish very little, other than shifting health care costs from the private sector to the taxpayers.

## CHAPTER III — IMPLEMENTING THE PRINCIPLES OF REFORM

### Notes

- 1 See the discussion in John C. Goodman, Gerald L. Musgrave and Devon M. Herrick, *Lives at Risk: Single-Payer National Health Insurance Around the World* (Lanham, Md.: Rowman & Littlefield, 2004).
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## *Chapter IV*

# TEN STEPS TO INSURING THE UNINSURED

This chapter builds on the goals and implementation strategies of the previous two chapters in order to address the problem of uninsurance. We propose the 10 steps outlined below.

### **Step No. 1: Use Free Care Dollars to Subsidize Private Insurance.**

As noted, the current system encourages people to be uninsured because it offers highly subsidized, or free, care to the uninsured and very little subsidy for the purchase of private insurance. As outlined above, states should correct this perverse incentive by offering the uninsured just as much subsidy for private insurance as people can expect in free care.

**Step No. 2: Create a “Pay or Play” System and Use the Proceeds to Fund a Social Safety Net.**

All but a handful of states have income taxes, and most of these piggyback on the federal system by duplicating what the federal government taxes, right down to inclusions and exclusions. As a consequence, people almost everywhere pay higher taxes to state governments if they fail to get insurance through an employer. These higher taxes become part of the state’s general revenues. Instead, they should be dedicated to providing safety net care for uninsured patients who cannot pay their medical bills. In this way, the uninsured will pay a financial penalty for being uninsured and that financial penalty will help offset the costs of any charity care they may require.

**Step No. 3: Enforce Maintenance of Effort Rules for Individuals and Employers.**

The reforms to insure the uninsured will not have achieved their purpose if they encourage individuals to drop their coverage in order to get a subsidy, or if they encourage employers to lower their compensation costs by dropping group health insurance in order to dump their employees on the state subsidy system. Accordingly, the subsidies must be accompanied by maintenance of effort regulations.<sup>1</sup> Individuals who willingly drop their insurance coverage must face a required waiting period before they become eligible for a subsidy from the state. A similar principle would apply to employees of employers who discontinue their group health insurance.

It is important to recognize that maintenance of effort rules are a stop-gap measure and not a permanent solution. Ultimately everyone needs to be brought under the same system of taxes and subsidies — and that almost certainly will have to be done at the federal level.

**Step No. 4: Make the Form of Subsidy Premium Support  
Conditional on Health Status.**

The subsidy from the state should be in the form of a fixed-dollar commitment. This implies two features. First, the form of the subsidy is defined contribution, not defined benefit. In other words, the insurance purchased must fit the subsidy (by reducing benefits and coverage limits if needed), not the other way around. Second, any additional premium (if needed) is paid by the beneficiary. This means that the cost of any additional insurance is fully borne by the person who expects to benefit from the added coverage.

The subsidy should be based on health status. A healthy uninsured person is not expected to use very many resources in the free care, safety net system. A person with chronic, recurring health problems, by contrast, is expected to cost much more. Ideally, each person should receive a risk-rated subsidy, dependent on health condition.

**Step No. 5: Make the Availability of Free Health Care and the  
Subsidy for Private Insurance Vary by Family Income.**

As noted, people should have just as much financial incentive to purchase private insurance as they have to rely on government provided free care. However, the higher an individual's income, the less help he or she should receive from the state, other things being equal. This means wealthier uninsured patients should pay more of their medical bills than lower-income patients. The same principle applies to the purchase of health insurance. Neutrality requires the private insurance subsidy and the free care subsidy to be the same. Equity requires the size of the subsidy to be reduced as income rises.

**Step No. 6: Apply the Subsidy to any Currently Available Plan.**

The subsidy should not be restricted to a particular kind of insurance. Rather it should apply to any currently available plan. This includes any plan that has been approved for the individual market, any approved group plan and any self-insured employer plan operating within the state. Individuals would enter group plans, of course, through their employers.

**Step No. 7: Create New Health Insurance Opportunities.**

Although the uninsured should be able to apply their subsidy to any plan approved for sale by the state, they should not be restricted to the currently available options. For example, insurers should be able to offer the uninsured any plan currently available to state employees as individual insurance. These plans typically are exempt from mandated benefits that legislatures impose on the private sector and, thus, should be less costly. The state should also consider limited benefit plans, such as the plan available for Utah Medicaid enrollees (discussed in Chapter III).

Special-needs delivery systems should also qualify as recipients of subsidy dollars. For example, a “center of excellence” for diabetes care should be able to offer subsidized care for diabetes so long as it covers entire episodes of diabetes-related care.<sup>2</sup> Care for at-risk pregnant mothers is another example. Parkland Memorial Hospital in Dallas (discussed above) should be a potential recipient of subsidies along with any private centers that want to compete with Parkland.<sup>3</sup>

**Step No. 8: Create New Entry Points Into the Insurance Marketplace.**

There are many ways in which state governments could make it easier for the uninsured to enroll in private insurance plans. For example, the vast majority of H&R Block’s clientele consists of people who are filing

for earned income tax credit (EITC) refunds prior to April 15. Since the EITC “refund” is a grant of cash to people who might otherwise live from paycheck to paycheck, this is an ideal time of year to combine personal funds with a state subsidy and buy private insurance. Further, EITC families almost always have children, and children in general are inexpensive to insure. So allowing H&R Block and similar agencies to receive a commission for enrolling people in health plans would be a good idea.

There are also other vehicles. Hospitals and clinics could serve as entry points (as they do today for Medicaid); but unlike Medicaid, the insurance would not be retroactive. That is, newly acquired insurance would pay for future health costs, not costs that have already been incurred.

States could also facilitate entry into the health insurance system by setting up “entry offices” that would collect information about benefits and premiums and post them. The function of such offices would be informational, not regulatory, however.

### **Step No. 9: Allow the Issuance of Insurance to Follow Current State Rules.**

No special rules (such as a guaranteed issue or community-rated pricing) are needed or desirable. If the uninsured are to be integrated into the same system as the privately insured, the same rules should apply. In most states, insurance in the individual market is medically underwritten. (People with health problems may face exclusions or higher premiums or be denied coverage altogether.) For those who are unable to obtain insurance at a reasonable price, most states now have subsidized risk pool insurance — which could also be a recipient of state subsidies for the uninsured. In all states, group insurance is guaranteed issue.

### Step No. 10: Instead of Managed Competition, Encourage a Market for Sick People.

A number of state reforms currently underway — Massachusetts being the most notable example — envision creating a system in which people can switch health plans every 12 months at community-rated premiums. The model for these systems is the Federal Employee Health Benefits Plan.

The problem with these systems is that they create perverse incentives. By design, the premium any single individual pays has no relationship to his or her own expected health costs. Instead, the premium is an average of the expected costs for the group as a whole. As a result, health plans gain (make a profit) when healthy people enroll and lose (incur a loss) when high-cost people enroll. Perversely, this gives plans an incentive to seek the healthy and avoid the sick. Even worse, it leaves health plans with a perverse incentive to over-provide to the healthy and under-provide to the sick.<sup>4</sup>

Clearly these perverse incentives are not consistent with the desire to promote high-quality health care. The alternative to a system in which health plans have incentives to avoid the sick is a system in which the plans have incentives to compete for them the way producers and sellers compete for customers in other markets. In other words, what really is needed is a market for sick people. It might work something like the following description.

Imagine individuals who buy their own insurance (say, with a subsidy from the state). As is characteristic of the individual market, such insurance is guaranteed renewable. People tend to form long-term relationships with their insurer instead of rechoosing every 12 months. This in turn allows a long-term relationship with medical providers. Premium increases reflect the costs incurred by the group as a whole, and the increases from year to year are the same for all members of the insurance pool.

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Not every health plan is equally efficient at providing all types of care, however. For example, some excel at cancer care while others excel at heart care. Specialization is a normal feature of other markets; why should health care be any different? A desirable system, therefore, allows people with a serious health problem to switch to the health plan that is most proficient at solving their problems.

A switch of health plans cannot be at community-rated prices, however. If it were, the plans would have no incentive to specialize, become efficient and attract sick people. So there must be a payment of money from the plan the patient leaves to his or her new plan, and the payment should be one that leaves all parties better off, including the patient.

Such a system would encourage health plans to specialize and produce efficient, high-quality care. Plans would seek to attract patients with serious health problems because they would profit from being the most efficient provider of care. Patients would gain because they would get more care and better care for the same premium. Yet this win-win solution is outwardly discouraged day in and day out by the current insurance regulatory structure.

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### Notes

- 1 Maintenance of effort requires that a new subsidy cannot offset or replace prior spending by either the individual or employer. If an employer drops pre-existing coverage so workers can take up a subsidy, there will be no maintenance of effort.
- 2 For instance, diabetic care integrates treatment of not just blood glucose levels, but also the associated complications common to diabetes. Diabetics must monitor kidney function, potential vision problems and extremities at risk of complications that might lead to amputations. Diabetics are also at much higher risk of cardiovascular problems.
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## *Chapter V*

# TEN STEPS TO REFORMING MEDICAID

A National Center for Policy Analysis study, “Opportunities for State Medicaid Reform,” discussed in detail how Medicaid can be radically reformed. Many of the ideas in that report are included in the following summary.<sup>1</sup>

### **Step No. 1: Free the Patients.**

The Deficit Reduction Act of 2005 allows 10 state Medicaid programs to set up 5-year demonstration projects to provide Medicaid recipients with Health Opportunity Accounts (HOAs), similar to Health Savings Accounts (HSAs) used in the private sector.<sup>2</sup> The idea is to allow Medicaid enrollees to control some of their own health care dollars and become empowered consumers in the medical marketplace. The states that choose to participate will receive federal matching funds to contribute up to \$1,000 per

## Cash Accounts for Disabled Medicaid Patients

Disabled Medicaid enrollees often need assistance performing activities of daily life, including help with meal preparation, bathing and dressing.<sup>1</sup> A number of states have received federal waivers that allow them set up personal cash accounts so that these patients can manage their own health care dollars and have direct control over the purchase of needed services. All told, about half of the states have these programs, often called “cash and counseling.”<sup>2</sup> The patient is given a set dollar contribution and is free to choose his or her providers. The programs also involve counseling to assure that the patient is well-informed.

Under traditional Medicaid, the states select the providers without patient input. Under this program, the patients can now hire and fire their own providers. Surveys of participants in the program show that they have a higher quality of life, with fewer unmet health needs.<sup>3</sup> Although initially the accounts were used only to purchase custodial services, in many states their use has expanded to cover conventional health services as well. Remarkably, patient satisfaction is almost 100 percent.<sup>4</sup>

<sup>1</sup> Stacy Dale et al., “The Effects Of Cash and Counseling On Personal Care Services and Medicaid Costs In Arkansas,” *Health Affairs*, Web Exclusive W3-566, November 19, 2003.

<sup>2</sup> Jeffrey S. Crowley, “An Overview of the Independence Plus Initiative to Promote Consumer-Direction of Services in Medicaid,” Kaiser Commission on Medicaid and the Uninsured, Henry J. Kaiser Family Foundation, Issue Paper, November 2003.

<sup>3</sup> Leslie Foster et al., “Does Consumer Direction Affect the Quality of Medicaid Personal Assistance in Arkansas?” Mathematica Policy Research, Inc., March 2003.

<sup>4</sup> James Frogue, “The Future of Medicaid: Consumer-Directed Care,” Heritage Foundation, Backgrounder No. 1618, January 10, 2003. Available at <http://www.heritage.org/research/healthcare/BG1618.cfm>. Access verified August 10, 2006.

child and \$2,500 per adult into the HOAs. These funds can be used to purchase a variety of medical goods and services, and unused funds will be available for future use by participants.<sup>3</sup> Moreover, if patients become ineligible for Medicaid, they have up to three years to use up to 75 percent of their HOA balances to purchase private health insurance.<sup>4</sup>

One objection to cash-balance accounts is that people will forgo needed health care to accrue more cash. However, unlike private-sector HSAs, the use of personal health accounts can be limited by Medicaid. By allowing enrollees to access their HOA funds with a debit card and by monitoring the debit card activity, a state could better ensure that recipients obtain such medical services as child immunizations or prenatal care.

As noted in Chapter III, a special type of health savings account is now widely used by Medicaid disabled patients. Under pilot programs that are active in more than half the states, these patients manage their own funds and can hire and fire the people who provide them with services. Although initially restricted to custodial care, the program has expanded to include conventional health care services in many states. [See the sidebar on disabled patients.] The recipient can then use unspent funds for health care, social services, child education or job training needs.

**Case Study: Diabetes.** Patients who manage their own health care dollars are in a better position to reap the benefits of managing their own care. Patients can be taught to inject insulin, monitor and maintain a log of blood glucose levels, and use the results to adjust their dietary intake, activity levels and medicine doses.<sup>5</sup> Numerous studies have shown considerable benefits from self-management by for patients with Type 2 diabetes.<sup>6</sup> By one estimate, nearly \$2.5 billion in annual hospital costs for diabetes complications could be averted with appropriate self-managed care.<sup>7</sup>

Many diabetics can reduce their reliance on medications and control their diabetes completely by adhering to a meal plan, losing weight and exercising.<sup>8</sup> At the other extreme, some patients have diabetic complications that require continuous monitoring and a complex drug regimen

administered throughout the day.<sup>9</sup> Since it would be impossible for these patients to seek the expertise of a physician on a daily basis, self-management of care is essential.

**Case Study: Asthma.** Uncontrolled asthma is another costly chronic disease.<sup>10</sup> The Asthma and Allergy Foundations of America estimates nearly 20 million Americans suffer from asthma — resulting in 500,000 hospital stays each year.<sup>11</sup> More than 2.5 million school-age children suffer from asthma, missing nearly 15 million school days per year. The economic loss averages out to nearly \$800 per child per year.<sup>12</sup>

Yet, 75 percent of asthma admissions are preventable. Patients who properly manage their own asthma fare better than those who rely on conventional care.<sup>13</sup> A Dutch study comparing self-management to standard care with a primary physician found that the treatment costs of those patients who monitored their own asthma were about 7 percent less than conventional care the first year and 28 percent less the second year.<sup>14</sup> In consultation with a physician or a nurse, patients can develop a self-management plan, which is essentially a list of established guidelines indicating which actions to take in response to various symptoms.<sup>15</sup>

Asthma patients can use a spirometer to measure the speed and volume of their exhalations to determine their peak air flow. They can then enter the readings into a computer software system called Asthma Assistant to monitor their condition on a daily basis. The program analyzes the data and alerts the patient to conditions that can trigger symptoms.<sup>16</sup> Such biometric data can be transmitted over the Internet from a patient's computer to a physician's office computer for evaluation by a doctor or technician (a process called telemonitoring).

## Step No. 2: Free the Providers.

As noted, all too often our health care system rewards high-cost, low-quality care and penalizes low-cost, high-quality care. Clearly, this incentive

system needs to be turned on its head, and the people who are in the best position to respond to appropriate incentives are doctors. It should be easy for doctors to get paid a different way by Medicaid if they propose to repackage and reprice their services in ways that raise quality and lower taxpayer costs.

Take diabetes, for example. Care tends to be delivered in discrete bundles, each with its own price. No one provider is responsible for the end result (fewer ER visits, lower blood sugar level, etc). This is because no one has bundled “diabetic care” as such — taking responsibility for final outcomes over a period of time — in return for a fee.<sup>17</sup>

To appreciate how different diabetes care could be, imagine a conversation in which a doctor says to a diabetic patient: “You do not need to come to my office as often as you do. Most of our communication can be by telephone or e-mail. For these consultations you will pay less. I need to put your records on a computer so that I can take advantage of safety protocols and order your prescriptions electronically. For these quality improvements, you will pay a bit more. I’m also going to teach you how to manage your own care and I’m going charge for the instruction. But you’ll get your money back through fewer consultations. Also, I’m going to show you how to cut your drug costs by shopping in a national online marketplace and I’m going to charge you for that advice as well. But you’ll get that money back too through lower drug prices.”

This conversation cannot take place in the current system. Why? Because each of the bundles of care mentioned above are services Blue Cross does not pay for. (No e-mail, no telephone, no electronic records.) Medicare doesn’t pay for these bundles either. Nor do most employer plans. But this conversation, and thousands of others just like it, would take place if doctors were free to repackage and rebundle their services and get paid.

So how do we get from here to there? A reasonable reform might work like this. A state Medicaid office announces that it welcomes offers from doctors, hospitals and other providers to repackage and reprice their ser-

vices. The parameters are: (1) the repriced, repackaged services must not increase total spending by the state, (2) the quality of care received by patients must not decline and (3) the provider/entrepreneur must propose a way to measure cost and quality to make sure that requirements (1) and (2) are satisfied.

For the reform to be workable, the transactions must be easy to negotiate and consummate. Paperwork and time delays are the enemy of entrepreneurship. However, given a willing state administrator, the process of reform should not take long. There are already low-cost, high-quality pockets of excellence just waiting to be replicated.

**Case Study: Surgery with a Warranty in Pennsylvania.**<sup>18</sup> As noted, patients on the average receive recommended hospital care — such as an aspirin after a heart attack or antibiotics before hip surgery — only about half the time. There is also a lot of variation in quality. In Pennsylvania alone, the mortality rate for heart surgery among hospitals varies from zero to 10 percent. Even more surprising, hospitals usually profit from their mistakes. When patients have to be readmitted to deal with complications from the initial surgery, the hospital is in a position to bill again.

Geisinger Health System in central Pennsylvania has discovered a better way — better at least for patients and their insurers. It offers a 90-day warranty, similar to the type of warranties found in consumer product markets. Specifically, Geisinger charges a flat fee that includes three months of follow-up treatment. Even if the patient returns with complications in that period, Geisinger promises not to send the patient or the insurer another bill.

The problem is that Geisinger loses money on the proposition. Right now, its 90-day warranty saves money for Medicaid, Medicare and private insurers. What is needed is a Medicaid administration willing to pay more for such guarantees than it would pay for surgery without a warranty. In other words, Medicaid should be willing to pay more to hospitals that save taxpayers money.

**Case Study: Efficient Treatment of Back Pain in Seattle.**<sup>19</sup> Virginia Mason Medical Center in Seattle has a modest goal: To produce health care as efficiently as Toyota produces cars. In fact, the senior staff has actually traveled to Japan to witness Japanese auto production firsthand. Continuous quality improvement is part of its company mantra.

Treatment of back pain, a source of considerable medical spending nationwide, is an example of how Virginia Mason is changing its approach to health care. Under the old system, a patient with back pain would first receive an MRI scan and other tests before referral to a physical therapist. Today, patients are referred to a therapist first, and only if therapy doesn't work are they scheduled for an MRI scan. The result: The cost of care is cut in half.

The trouble is, Virginia Mason loses money by treating back pain efficiently. So far only Aetna has been willing to increase its payments to reward the center for lowering Aetna's overall costs. Yet Aetna makes up only a small part of the Center's revenues. As in the case of Geisinger, the state could play a useful role by making new contracts with centers like Virginia Mason quick and easy to consummate.

### Step No. 3: Substitute Less-Expensive for More-Expensive Therapies.

Treatment in outpatient settings, such as doctors' offices, is generally less expensive than treatment in a hospital. However, Medicaid patients have limited access to physicians other than in public health clinics or hospital emergency rooms. Paying higher physician fees for examinations, tests and procedures that can be performed in a doctor's office would increase patients' access to health care and reduce unnecessary reliance on hospital emergency rooms.

Performing more procedures in outpatient settings that were formerly performed in hospitals (such as minor surgeries that don't require an over-

night stay) is a common way of reducing costs.<sup>20</sup> A Pennsylvania study found that about 10 percent of all hospitalizations for patients under age 65 are potentially avoidable. Caring for these patients in lower-cost, more-appropriate settings could have saved the state about \$2.8 billion in 2003. In some cases, procedures performed in hospitals could have been done in outpatient clinics. In other cases, inpatient care could have been avoided by timely physician care.<sup>21</sup>

#### **Step No. 4: Substitute Less-Expensive for More-Expensive Providers.**

Why pay more when the same quality of care is available for less? Private-sector health plans routinely contract selectively, choosing to direct enrollees to providers who charge less for the same level of quality. These plans typically require enrollees to use facilities and physicians that are “in-network,” or to pay a larger share of the cost if they use providers that are “out-of-network.”

Medicaid could selectively contract for specific high-cost procedures with centers of Excellence — hospitals that perform a high volume of particular procedures for which there is a demonstrated relationship between volume and quality. Hospitals that do not receive contracts would not be reimbursed unless the services were preauthorized or the patient was admitted due to an emergency. This is a modest reform that is long overdue.<sup>22</sup>

Selective contracting provides opportunities to negotiate discounts for most medical services. Many states use competitive bidding and selective contracting for eyeglasses, medical equipment, transportation and other services.<sup>23</sup> For example, Medi-Cal, California’s Medicaid program, began selective contracting for hospital services in the early 1980s. Four years later the state was spending nearly 8 percent less than it was projected to spend without selective contracting.<sup>24</sup> The Centers for Medicare and Medicaid Services (CMS) found that contracting reduced the daily cost

of a hospital stay about 16 percent below what it otherwise would have been. The greatest savings were in areas with robust competition among hospitals.<sup>25</sup>

At the other end of the treatment spectrum is the walk-in clinic, discussed above. These clinics are spreading like wild fire around the country and they developed entirely outside the third-party payment system. Entrepreneurs created their own bundles and set their own prices. They charged half the normal fee and provided better quality. (More adherence to protocols.) Some third-parties are now reimbursing MinuteClinic and RediClinic and other walk-in clinic fees because they have concluded the services are cheaper than the alternatives. Others do not.

However, this should be a no-brainer for Medicaid. It should immediately cover the services of walk-in clinics, encouraging enrollees to get convenient, high-quality (and often preventive) primary care.

### **Step No. 5: Substitute Less-Expensive for More-Expensive Drugs.**

Private-sector managed care plans use a variety of techniques to control drug costs, including preferred-drug lists, formularies, negotiated prices with drug companies and single-source drug distributors. For example, many plans require enrollees to use a specific mail-order drug supplier to avoid higher copays. Health plans frequently contract with a pharmacy benefit manager (PBM) to handle drug benefits. PBMs require enrollees to obtain a preauthorization to purchase brand-name drugs that aren't on their list of preferred or formulary drugs, or to use a non-network pharmacy.

Medicaid managed care plans generally also use PBMs to manage their drug benefits. However, some states have rules and regulations that limit the ability of PBMs to control drug costs. For instance, some states have laws that prevent a PBM from requiring the substitution of generic drugs for expensive brand-name drugs.<sup>26</sup> Bills have occasionally been intro-

duced in other states to further limit PBMs. For instance, during the 2006 legislative session, several bills were introduced in the New York State Legislature that would have limited the ability of PBMs to require the use of mail-order pharmacies. A separate bill would have also required PBMs to reimburse any pharmacy willing to meet the prices negotiated by the PBM with pharmacies in its network.<sup>27</sup> Pharmacy chains or mail-order pharmacies will agree to deeper discounts on drugs if they are the sole provider (or part of a small group) because they can spread their costs over a larger volume of sales. If PBMs must give the same terms to “any willing provider,” they cannot offer as great a volume of sales to their network or sole-source provider. As a result, the PBMs will not be able to negotiate as steep discounts as they would be able to otherwise, and consumers will pay higher prices for drugs.

Additionally, states should encourage the use of less-expensive drug alternatives when quality is the same — including therapeutic, generic and over-the-counter substitutes. Patients who prefer brand-name drugs should be able to choose them if they pay more, as they do in many private insurance plans.

In the past few years, a number of prescription drugs have become available over the counter at a much lower cost and without a prescription. For example, when Claritin, a prescription drug used by allergy sufferers, became available over the counter, the price fell substantially. Unfortunately, Medicaid (and Medicare) will not pay for over-the-counter drugs!

Note there is a danger that drug formularies will become bureaucratic obstacles to needed therapies, particularly for patients who cannot pay higher copays for nonformulary drugs. Economist Linda Gorman of the Independence Institute reports that substituting generics for brand-name drugs can adversely affect patients. For example:<sup>28</sup>

- A survey of 200 physicians in Tennessee’s TennCare program found that two-thirds of doctors reported they had patients who had serious adverse reactions, including death and stroke, when they were switched to generic substitutes.

- In a British Columbia survey, 27 percent of doctors reported admitting patients to hospital emergency rooms as a result of having switched them to drugs mandated by government formularies.

One way to resolve these problems is to allow Medicaid patients to control some of the funds for their own health care, as discussed above.

### Step No. 6: Contract with the Private Sector.

Instead of paying for Medicaid services on a fee-for-service basis, states could contract with hospitals, clinics and physicians for specific services and therapies. This would allow the program to coordinate care and establish quality standards.

**Disease Management and Care Coordination.** Many patients have multiple illnesses that require treatment by different specialists or in different facilities.<sup>29</sup> Unfortunately, these health care providers often have little (if any) contact with one another. The lack of coordination leads to poor-quality health care and medical errors, such as harmful drug interactions.

Coordinating care typically involves a case manager who reviews the patient's medical history and claims data, ensures that providers communicate with each other about the patient's condition and monitors the patient's progress. Disease management involves developing a treatment plan based on current treatment protocols for patients and teaching them how to follow the protocols.<sup>30</sup> As of 2004, nine states had implemented disease management programs. While results are preliminary, these programs appear to reduce costs and improve treatment for chronic conditions:<sup>31</sup>

- In Colorado, average costs for asthmatics participating in disease management programs dropped 37 percent.
- The proportion of asthmatics receiving inhaled steroid treatment increased from 49 percent to 95 percent.
- In Washington, a diabetic disease management program saved \$900,000 in its first year, and the percentage of diabetics taking

daily aspirin or other blood thinners increased from 41 percent to 64 percent.

Here again, the best results are likely to be produced by innovation on the supply side rather than on the demand side. There are already examples of efficient, coordinated care delivered to low-income populations. For example, Community Health Works in Forsyth, Georgia, has a program under which patients use 40 percent less hospital care and 18 percent less emergency room care compared to a national control group.<sup>32</sup> What Medicaid needs to do is make sure it rewards entities like this that save taxpayer dollars. Ideally, Medicaid should encourage competition among provider groups for low-income, chronic care patients.

**Caring for Special-Needs Patients.** The problems of people with disabilities and chronic conditions range from schizophrenia to mental retardation to blindness to diabetes. These conditions require special therapies and specialists that many Medicaid patients may have difficulty accessing. Ideally, care should be provided by a provider or provider group that agrees to provide a full regimen of care — not disconnected bundles of care delivered by unrelated specialists. (See the discussion of diabetic care above.) But if payments to provider groups are not adjusted for the cost of caring for these patients, the plans will have an incentive to avoid enrolling them or to skimp on care. Medicaid should pay risk-adjusted premiums based on the cost of care and let specialists with specialized facilities compete for these patients. Medicaid should also be ready to reward providers who are able to provide higher quality services for less cost. For example, a group that provides psychiatric patients with outpatient therapy and drug treatment rather than more costly institutional care to achieve the same therapeutic outcomes should be rewarded for doing so.

Florida contracts with various private-sector entities to serve people with specific types of disabilities. This allows benefits to be tailored to the needs of the individual enrollee.<sup>33</sup> Different providers could serve the mentally ill, the physically disabled, the drug addicted and so forth. The

comparative advantage of these various providers would potentially reduce costs and increase the quality of service.<sup>34</sup> Ideally, the market — rather than bureaucracies — should determine the right product mix. [See the sidebar on Florida’s consumer-driven reform.]

### **Step No. 7: Pay More for Better Results.**

A National Bureau of Economic Research study found that with respect to cardiac treatment:<sup>35</sup>

- *Quality matters:* Moving from a low-quality to a higher-quality hospital significantly reduces a patient’s risk-adjusted mortality rate.
- *Good Publicity matters:* Patient admissions increased at hospitals with low mortality rates the first year following a favorable report on their cardiac treatment; however, the increased number of cases dropped off after the first year.
- *Bad Publicity matters:* Patient admissions at hospitals identified as having a lower quality of surgery declined by about 10 percent during the year following a poor report; the decline remained stable for three years.
- *Choice matters:* Low-quality hospitals were still performing the same number of emergency surgeries as before the report, indicating that some patients cannot or do not shop around for better-quality hospitals in emergency situations.

Furthermore, the NBER study suggests that since cardiac surgery is profitable for hospitals, they will improve their quality of care to compete for patients.

Also, Medicaid should contract only with providers that institute infection-control programs. Payments to hospitals could be adjusted to reward facilities that achieve low infection rates and penalize those with higher infection rates. Hospital-acquired infections are a type of medical error that should be measured for quality ratings and addressed in contracts with

## Florida's Consumer-Driven Medicaid Reform Plan

Florida began implementing an ambitious Medicaid reform plan in 2006 with a federal waiver and the approval of the state legislature.<sup>1</sup> It is designed to cover most Medicaid enrollees, including children, parents, pregnant women and disabled persons who are not institutionalized. Under the plan:

- Private-sector health care provider networks compete to enroll various Medicaid populations by offering different benefit packages to cater to their needs.
- Participants can choose among the plans, or use their state-paid premium to purchase employer-sponsored insurance instead.<sup>2</sup>
- Florida pays the networks a monthly, risk-adjusted premium per patient, and providers compete by offering innovative care, convenient networks and optional services.

The competition among providers is similar to private health insurance plans that offer various coverage options. Three basic packages of Medicaid benefits will be offered:

- Comprehensive Benefits is a basic benefit package covering all mandatory Medicaid services and needed optional services, although the amount, duration and scope of services may vary.
- Catastrophic Care covers those who require more care than is covered by comprehensive benefits plans. These patients will be re-insured for all medically necessary services.
- Enhanced Benefits is an incentive to Medicaid beneficiaries who engage in healthy practices. Qualified recipients may use accumulated funds in their accounts to purchase additional health care services that are not covered by their plan or for employer-sponsored insurance when they become ineligible for Medicaid.

The program is being piloted in Broward County, where beneficiaries have a choice of 14 plans, and in more rural Duval County, where they have a choice of five plans. It will be expanded to three more counties, but the goal is to implement it statewide by 2011, with legislative approval.

<sup>1</sup> See approved waiver proposal, "Florida Medicaid Reform: Approved 1115 Research and Demonstration Waiver Application," Agency for Health Care Administration, Florida Department of Health Care. Available at [http://ahca.myflorida.com/Medicaid/medicaid\\_reform/waiver/index.shtml](http://ahca.myflorida.com/Medicaid/medicaid_reform/waiver/index.shtml).

<sup>2</sup> Michael Bond, "Florida's Medicaid Reforms: A Progress Report," James Madison Institute, Backgrounder No. 52, August 2007.

# Progress Report on Florida's Medicaid Reform

The first opportunity to conduct a valid evaluation of Florida's path-breaking Medicaid reform occurred after data had been compiled from the pilot project's first six months. What is known so far about the reform is mostly positive.

**1. The pilot project in Broward and Duval Counties has increased the number and types of plans available to beneficiaries.** In Broward County enrollees can choose from 15 competing plans (including one special-needs provider) while people in Duval County have six choices. The plans have somewhat different benefits, which is crucial given the diverse needs of the Medicaid population.

**2. The reform has increased access to services not previously covered by providers.** All of the reform health plans offer benefits which are not mandated by the federal government. These range from over-the-counter drugs to home-delivered meals after surgery. Has the increase in plan choices and larger benefits packages improved beneficiary health? The answer isn't yet known.

**3. The project's innovative Enhanced Benefits Program is growing rapidly.** These are zero balance accounts where beneficiaries can earn credits by engaging in "healthy behaviors." Those earning credits have increased from under 1 percent initially to around 30 percent after nine months of reform. Unused balances now total more than \$1,700,000.

**4. The reform's "opt out" provision is small and growing slowly.** This reform allows individuals to use the actuarial value of their Medicaid benefit to buy into an employer health plan. At this time, 10 individuals have opted into employer coverage.

**5. Although the effect on beneficiary satisfaction is not yet known, the signs are positive.** No formal grievances with the reform plans have been filed as of yet and only 20 complaints have been made about counselors hired to assist beneficiaries with plan selection information.

Source: Michael Bond, "Florida's Medicaid Reforms: A Progress Report," James Madison Institute, Background No. 52, August 2007.

providers. Some hospitals are taking aggressive steps to improve quality of care by reducing infection rates, and both state and federal policies are changing to reduce this spreading epidemic.<sup>36</sup>

- Some hospitals, such as the University of Pittsburgh system, are imposing stiff penalties, including termination and suspension of practice privileges, for staff and doctors who fail to wash their hands.
- Some states have passed laws that publicize a hospital's "infection report card," allowing patients to compare hospital infection rates before surgery; ideally, hospitals would compete for patients by reducing infection rates.

As noted, the best results will be produced by supply side initiatives, rather than demand side efforts. Let hospitals propose to be paid differently provided they raise quality and reduce overall costs — and let the hospital bear the burden of proving the cost and quality objectives have been met.

### **Step No. 8: Pursue Fraud Aggressively.**

Some states have established Medicaid provider information exchange databases to identify fraud, abuse, overuse and unnecessary care. In other states, most abuse is identified through tips and other unreliable means. Establishing a state database of billing information on Medicaid providers in New York has proven useful. If one provider's Medicaid billing begins to increase significantly, case workers can quickly identify the aberration and check into it.<sup>37</sup> The provisions of current "whistleblower" laws, allowing private citizens who identify fraudulent providers to receive some of the recovered funds may also be useful in fighting fraud.

Software firms have developed information technology to more easily examine Medicaid billings using a number of different criteria. Salient Corporation is working with Chemung County, New York, to better man-

age Medicaid spending. Using Salient's Muni-Minder software, officials can analyze the billings of individual suppliers and track product and service utilization, allowing them to uncover inefficiency, waste and abuse anywhere in the program. For example, Muni-Minder allows investigators to quickly identify the number and cost of prescriptions for brand-name drugs filled when a generic was available. A chart of the amount spent per recipient for any provider is easily created with only a few keystrokes.<sup>38</sup>

Some states have been more aggressive than others in pursuing and prosecuting fraud. In 2003, Texas established an inspector general's office with responsibility for detecting Medicaid fraud. As a result, Texas recovered \$441 million in 2005 from erroneous or fraudulent charges.<sup>39</sup> Kansas followed suit by making Medicaid fraud a civil matter, as well as a criminal offense, thereby enabling the state to recover improperly paid Medicaid money through civil court.<sup>40</sup>

### **Step No. 9: Encourage Private Insurance.**

As noted, private-sector plans may appear less generous on paper than the current Medicaid program, but they usually allow enrollees access to a greater range of providers and facilities. Enrollees in a Florida pilot program can opt out of government coverage and use their Medicaid funds to pay some of the premiums for employer-sponsored insurance where they work or choose coverage from among competing private insurers.<sup>41</sup> For some patients, this premium support essentially converts Florida Medicaid from a defined benefit entitlement to a defined contribution plan.<sup>42</sup> The premium payments Florida's Medicaid beneficiaries receive to apply toward the purchase of a health plan are risk-adjusted to reflect their health status.<sup>43</sup> They can also choose from among competing plans with different benefit packages.<sup>44</sup> [See the sidebar on progress in Florida's Medicaid reform.]

Private-sector plans have incentives to control costs and improve quality when they compete for customers in the marketplace. Both the state and the beneficiary benefit from this competition when Medicaid beneficiaries

can enroll in private-sector plans, including employer plans and individually owned insurance.

**Step No. 10: Obtain a Block Grant.**

Under the current system, every time a state wastes a dollar, at least half of that waste is paid for by the federal government. Every time a state eliminates a dollar of waste, at least half the savings stays in the state, while the remainder is realized in Washington, D.C. Block grants would allow states to realize the full benefits of every dollar saved and pay the full costs of every dollar of additional spending. Put differently, block grants would allow states to realize the full benefits of their good decisions and pay the full costs of their bad decisions.

In 2003, the Bush Administration proposed converting Medicaid's federal match to a fixed block grant to the states.<sup>45</sup> A block grant converts a defined benefit into a defined contribution. Under the former system, payments are based on the state's willingness to spend. Under the latter, spending is based on the federal government's willingness to pay. This is similar to how Congress allocates federal funds for state welfare programs. One of the advantages of a block grant is predictability.<sup>46</sup> It would limit the federal government's financial exposure while allowing states to design programs to meet their unique needs with maximum flexibility.

If five or six states requested a block grant, Congress would probably approve the request. However, some states are concerned that the federal government might renege on a block grant deal, giving the state less money in future years than it otherwise would have received. One solution to this problem is to write into a pilot program the specific formula that would determine how much participating states will receive. For example, if New York currently receives 13 percent of all federal Medicaid dollars, the agreement could specify that it would continue to receive 13 percent of all federal Medicaid dollars for the next few years.

## CHAPTER V — TEN STEPS TO REFORMING MEDICAID

### Notes

- 1 John C. Goodman, Michael Bond, Devon M. Herrick and Pamela Villarreal, “Opportunities for State Medicaid Reform,” National Center for Policy Analysis, Policy Report No. 288, September 28, 2006. See also, John C. Goodman, Michael Bond, Devon M. Herrick, Joe Barnett and Pamela Villarreal, “Medicaid Empire: Why New York Spends so much on Health Care for the Poor and Near Poor and How the System Can Be Reformed,” National Center for Policy Analysis, Policy Report No. 284, March 20, 2006.
- 2 Enrollees will face a deductible before they can access Medicaid benefits. States will contribute deposit funds in a health opportunity account (HOA), from which enrollees will pay out-of-pocket for care up to the deductible. The deductible can be no more than 110 percent of the state’s contribution to the HOA and no less than 100 percent of the annual contribution. The maximum average annual contribution to an HOA is \$2,500 for adults and \$1,000 for children (indexed in future years). States may provide preventive care coverage without a deductible. In spending from their HOA, individuals may purchase services from Medicaid-participating providers at Medicaid rates, and from nonparticipating providers at 125 percent of Medicaid rates.
- 3 Three-fourths of the unused balances in the HOA account is available to the individual for three years, and may be used to purchase health insurance or (after participating for one year) for such services as job training and tuition expenses. Not everyone is happy with the arrangement. For a critical review, see Edwin Park and Judith Solomon, “Health Opportunity Accounts for Low-Income Medicaid Beneficiaries: A Risky Approach,” Center for Budget and Policy Priorities, November 1, 2005.
- 4 Medicaid Health Opportunity Account Act (H.R. 3757) was signed into law as part of the Deficit Reduction Act. See Rep. Mike Rogers, “The Truth About Medicaid Reform: Puts America’s Most Vulnerable Families on Road to Self-Sufficiency,” Letter, U.S. House of Representatives, November 7, 2005.
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- 10 Tjard R. Schermer et al., “Randomized Controlled Economic Evaluation of Asthma Self-Management in Primary Health Care,” *American Journal of Respiratory and Critical Care Medicine*, Vol. 166, No. 8, August 2002, pages 1,062-72. For an evaluation of direct medical treatment costs for asthma, see Michael T. Halpern et al., “Asthma: Resource Use and Costs for Inhaled Corticosteroid vs. Leukotriene Modifier Treatment — A Meta-Analysis,” *Journal of Family Practice*, Vol. 54, No. 5, May 23, 2005.
- 11 “Asthma Overview,” Asthma and Allergy Foundations of America. Available at <http://www.aafa.org/display.cfm?id=8&cont=5>. Accessed August 10, 2006.
- 12 Li Yan Wang, Yuna Zhong and Lani Wheeler, “Direct and Indirect Costs of Asthma in School-Age Children,” *Preventing Chronic Disease*, Vol. 2, No. 1, January 2005.
- 13 Aarne Lahdensuo, “Guided Self Management of Asthma — How to Do It,” *British Medical Journal*, Vol. 319, No. 7212, September 18, 1999, pages 759-760.
- 14 Ibid. Implementation costs were mostly incurred in year one and amounted to about \$200.
- 15 See “Take Control - Q&A to Having a Self Management Plan,” AsthmaAssistant.com. For instance, an asthma self management plan could stipulate that if a patient’s “peak airflow” falls to 80 percent of their personal best peak airflow, they should increase medications at a pre-established rate and schedule a physician appointment. Patients should go to the emergency room if their peak airflow falls below 50 percent.
- 16 For information see <http://www.asthmaassistant.com>.
- 17 Michael E. Porter and Elizabeth Olmsted Teisberg, *Redefining Health Care: Creating Value-Based Competition on Results* (Boston, Mass.: Harvard Business School Publishing, 2006).
- 18 Reed Abelson, “In a Bid for Better Care, Surgery With a Warranty,” *New York Times*, May 17, 2007.
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## *Chapter VI*

# FOUR STEPS TO REFORMING LONG-TERM CARE

Although it is optional, every state provides a long-term care benefit through its Medicaid program — and not just to the poor. Medicaid is paying for the long-term care of a growing number of middle-class seniors and this is one of the fastest growing areas of state spending. At the time they retire, most seniors do not meet Medicaid income and asset tests for long-term care coverage. Yet, by “spending down” their assets, over time a great many eventually do qualify. In fact, an entire industry of attorneys practicing “elder law” has sprung up in recent years to help seniors transfer assets in order to qualify.

### **Step No. 1: Encourage Community Care over Institutional Care.**

Medicaid encourages institutional care over home care. Although many state programs are changing, they could increase their use of less-expensive

home care.<sup>1</sup> Home care often costs only half as much as a nursing home, and in some high-cost areas, the cost savings from home care may be even greater.<sup>2</sup> Home care in Washington, D.C., costs less than one-third of nursing home care. In Manhattan, a year of home care costs only about one-fifth as much as a year-long stay in a nursing home.<sup>3</sup> And in-home providers offer a range of medical services, including occupational and/or physical therapy.

Ohio, Oregon, Washington and Wisconsin expanded home care and community-based care to help control rapidly increasing institutional care expenditures. These states were able to serve more people while controlling the growth in overall long-term care spending. Between 1982 and 1992 the combined total of nursing home beds in the four states declined 1.3 percent, while total nursing facility beds nationwide increased 20.5 percent.<sup>4</sup>

Ohio's Commission to Reform Medicaid proposed rewarding families who choose lower-cost options that save the state money. This reform would allow the elderly living with family members to receive a few hours of home or personal care per week that could delay their entry into a nursing home. To increase the financial incentives, some assets could be excluded from eligibility tests or shielded from cost recovery.<sup>5</sup>

## **Step No. 2: Encourage the Use of Assets to Finance Long-Term Care.**

There are more than 13 million households headed by people aged 62 years or older. Many seniors own their and homes but are reluctant to tap their equity to pay for nursing home care for fear of losing those homes. A possible solution to this problem is a reverse mortgage. This is a home loan that does not have to be repaid as long as the owner (which could include the spouse of a nursing home resident) lives in the house.<sup>6</sup> By one estimate, more than 6 million senior households could access more than \$72,000 in home equity per household using reverse mortgages.<sup>7</sup> This would pay for

a year or more of nursing home care and two or more years of home care in most areas.

Currently, seniors rarely use reverse mortgages for long-term care. Why should they? Home equity is generally an exempt asset when qualifying for Medicaid long-term care. So seniors can obtain long-term care without it.<sup>8</sup> However, the Deficit Reduction Act of 2005 now makes cash-poor seniors ineligible for Medicaid nursing home coverage if their home equity value is greater than \$500,000.<sup>9</sup>

Seniors could be required to first tap home equity using reverse mortgages before qualifying for Medicaid. However, such a requirement would have to take into account the needs of a spouse who remains in the home after a partner is institutionalized.<sup>10</sup> A possible alternative is to place a lien on property jointly owned by the spouse, so that the state could recover some of its long-term care costs from the couple's estate. The spouse would be free to live in the house for the rest of his or her life. An added benefit is that more people may plan ahead and purchase long-term care insurance if they are not allowed to shelter their largest asset when qualifying for Medicaid.

### **Step No. 3: Increase Estate Recovery.**

When beneficiaries die, states can recover nursing home costs from their estates. Since seniors can own a home and still qualify for Medicaid in most cases, the estate could include a house, for example.<sup>11</sup> Federal law also permits states to recover personal and real property in which the individual has an interest or legal title. Some states are aggressively pursuing estate recovery, and all states receive federal funds to do so.<sup>12</sup>

Future legislation should require that any funds placed in a trust be considered income for determining Medicaid eligibility.<sup>13</sup> It could even eliminate the use of trusts that reduce a senior's current income (which helps them meet the income qualification). The Deficit Reduction Act of 2005 created a five-year waiting period to apply for Medicaid coverage

after a significant gift of property. Property settlements in divorces made prior to Medicaid eligibility should be subject to the same five-year rule as other divisions of property.

#### **Step No. 4: Encourage Private Insurance.**

The states now have a new way to encourage private long-term care insurance. It is an outgrowth of a pilot project in New York, Connecticut, California and Indiana called the Partnerships for Long-Term Care that provided financial incentives to purchase long-term care insurance. The plan allowed people to shelter their assets by purchasing a qualifying private insurance policy with a defined amount of coverage. When a policyholder entered a nursing home, he or she first relied on the insurance. When the insurance was exhausted, special eligibility rules allowed them to receive Medicaid benefits while retaining assets equal to the value of the policy.

In the California and Connecticut Partnership programs, individuals purchased coverage from competing private insurers. For each dollar of coverage, they protected a dollar's worth of assets. For instance, a long-term care policy with \$120,000 in benefits allowed an individual to shelter \$120,000 in assets and still qualify for Medicaid long-term care. Since most nursing home stays are less than one year, very few of those who purchased these policies applied for Medicaid benefits.

The Deficit Reduction Act allows all 50 states to establish partnership programs. Individuals who purchase such policies can access Medicaid benefits after their insurance runs out — without the means testing required for non-insured applicants.<sup>14</sup>

Long-term care is the fastest growing expense in the Medicaid program. As 77 million baby boomers reach retirement within the coming decade, the program can only grow more insolvent. However, with proper estate planning — using techniques and programs that are already largely available — the impact on seniors does not have to be as bleak.

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### Notes

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## *Chapter VII*

# FOUR STEPS TO PERSONAL AND PORTABLE HEALTH INSURANCE

If one looks at the major health policy reform proposals both at the national level and at the state level, portability is rarely a concern. Yet NCPA polling and focus groups with swing women voters (women who sometimes vote Republican and sometimes vote Democrat and therefore determine election outcomes) show that “insurance you can take with you from job to job” receives higher support than almost any other issue.<sup>1</sup>

Why the disconnect? Part of the reason is that health reform proposals are invariably constructed either by people who pay the bills or by people who do the billing and neither group ordinarily includes patients.

Yet the case for portability is strong and goes far beyond the fact that most people want it. First, as noted above, portability allows a long-lasting relationship with a health plan, which in turn allows a long-lasting relationship with providers of care. This means that people who switch jobs

frequently can still have continuity of care — which is usually a prerequisite for high quality care. Second, people who have portable insurance (as well as portable retirement and other benefits) will not be “locked into jobs” solely because of the nonportable nature of their benefits. Portable benefits are consistent with a mobile labor market, which is a necessary component of a dynamic, competitive economy. Finally, a system of portable benefits is one in which the employer’s role is financial, rather than administrative. Employers, therefore, can specialize in what they do best, leaving health insurance to the insurance firms.

If the case for portability is so strong, why isn’t it available? As noted, federal tax law favors employer-specific, nonportable insurance and discriminates against individually purchased and individually owned insurance. So the simplest and easiest way to achieve portability nationwide is to change the federal tax law. In the absence of that, what can individual states do to create portability?<sup>2</sup>

The Massachusetts Health Plan offers a limited solution. Individuals (and their employers) buy coverage through a health insurance “Connector.” The insurance is individually owned and travels with the employee from job to job. However, since these insurance contracts last at most 12 months (after which, the individual must again choose among competing plans in an annual open season), this type of portability falls far short of the ideal.

A second approach to portability was pioneered by the National Center for Policy Analysis and Blue Cross/Blue Shield of Texas. Under this system, employers would initially buy individually owned insurance for all their employees, the way they buy group insurance today. On day one, all the employees of a firm would have the same insurance. Over time, however, as employees come and go, a typical place of employment would have employees in many different plans. But each employee would likely have the same individually owned policy he or she had initially. The employer’s obligation would be to make a defined contribution for each employee,

deduct any additional premium owed from the employee's wages each pay period and remit the total premium to the employee's insurer. However, in carrying out this reform the states risk violating certain federal laws.<sup>3</sup>

A third approach is to take advantage of Health Reimbursement Arrangements (HRAs), which specifically allow employers to reimburse employees for insurance premium expenses. Interpreted literally, this means the premium check is drawn on the employee's bank account and the employer reimburses the employee with another check. Most states prohibit (either directly or indirectly) the use of employer contributions for individually owned (and individually underwritten) insurance, and some argue that federal law requires such prohibitions. As a result, many insurers ask employees to claim that they are not being reimbursed by their employers for individual insurance premiums. In most states, however, the de facto practice is don't-ask-don't-tell on the part of the regulators.<sup>4</sup>

Clearly, better federal guidelines are needed. The following is a brief summary of what could be accomplished.

### Step No. 1: Free the Employee.

Given the federal tax code, money used to purchase tax free health insurance must originate at the workplace. But in an ideal world, insurance premiums should pay for insurance that each employee has selected, owns and controls. A model is the 401(k) plan (in the for-profit sector) or the 403(b) plan (in the nonprofit sector). Although employers make matching contributions to these accounts, the accounts are owned by the employees, and they select their portfolio of investments. In health insurance, each employee could, in principle, be enrolled in a different plan. Further, employees would not lose the right to participate in the plan of their choice as a result of a job change, unemployment or even retirement.

## Step No. 2: Free the Employer.

When benefits are company specific, the employer is necessarily involved in the management and administration of those benefits. Manufacturers of automobiles, housing or appliances, for example, find that they are in the health insurance business as well. Most employers, and certainly all small employers, would prefer not to be in the health insurance business, however. In a world of portable insurance, they would not be.

Rather than offering a defined benefit health insurance fringe benefit, employers could offer a defined contribution benefit instead. They could do so by offering a monetary contribution to be applied to the health insurance premiums of each employee, each pay period. Again, the 401(k) retirement plan is a model. New employees would know not only their salary, but also how much the new employer would be willing to pay toward the premium cost of insurance which they already would own and bring with them to the new place of employment. In this way, the employer's role in health insurance is purely financial. In fact, employers would have no more involvement in the employee's health plans than they would have in their employee's 401(k) portfolio.

## Step No. 3: Free the Health Insurer.

In many ways the health insurance marketplace is very dysfunctional. In fact, to a large extent it is not insurance at all; it is instead prepayment for the consumption of health insurance. Life insurance provides an interesting point of contrast. Once a contract is signed, an individual's future life insurance premiums are independent of changes in health status (which presumably change an individual's probability of dying). That is because the life insurance contract transfers the full financial risk of death to the insurer.

Health insurance contracts are very different. For large companies, virtually all insurance is actually self insurance. A self-insured firm maintains

reserves equal to expected treatment costs and pays bills directly, or through a health plan administrator. That is, the large company's insurance costs are roughly equal to the employees' health care costs. So no risk is being transferred to any other entity.<sup>5</sup> As a result, large firms rarely buy genuine insurance.

In the small group market, a form of insurance exists, but only for periods of brief duration. Typically, after a 12 month period, the insurance ends and must be recontracted. But the new insurance rates are dependent on changes in the health status of the employees of each firm. Companies that have experienced unexpected bouts of employee illness (as indicated by unexpected increases in health care spending) must pay higher premiums in order to insure again. By contrast, companies whose employees remain healthy or have unexpectedly low health care spending face smaller premium increases, no increase or perhaps even a decrease. It is as if the small firm is able to join an insurance pool for 12 months; then is kicked out of the pool and forced to rejoin at rates that reflect changes in the health status of the employees over the previous 12 months.

In all states the small group market is governed by "guaranteed issue" regulations (insurers must take all comers) and many also have rating bands (setting a limit on how much the highest premium charged can exceed the lowest). Yet far from improvements, these regulations are likely to make things worse. Suppose the same thing happened in life insurance. The ability of the insurer to recontract every 12 months would harm those who develop a life threatening condition, such as AIDS. Their premiums would unfairly rise. Yet the existence of rating bands would compound the problem because the rise in premiums for the AIDS victim would not rise enough to compensate for the new higher risk, and the premiums for the healthy would not fall enough. As a result, the AIDS victim would buy more insurance (even at a higher rate). To cover those costs, insurers would have to raise premiums for the healthy, resulting in their buying less insurance. Furthermore, if insurers were required to accept new people into the pool (who may also have AIDS), it would encourage everyone to

go without life insurance until it is really “needed.” Life insurance, in this case, would become just as dysfunctional as health insurance.

Today’s dysfunctional health insurance market could work more like today’s functional life insurance market if insurers were freed to (a) form long-term relationships with those whom they insure and (b) charge every new entrant to the insurance pool an actuarially fair price, but (c) make subsequent premium increases the same for all enrollees. Such arrangements would allow people to buy a product that is much closer to real insurance. Policy changes are needed that actually allow health insurers to get into the business of insurance.

#### **Step No. 4: Transition Rules.**

Moving to a new health insurance system is easy if all the participants are healthy. It is much less easy when some people are sick. For example, some employers have ended their group health insurance plans and offered a defined contribution reimbursement for individually incurred health insurance expenses through an HRA. The employees are free to buy insurance in the individual market and get reimbursed (up to a predetermined sum) with pretax dollars. This works well for healthy employees who are able to obtain individual insurance, despite medical underwriting. However, those with health problems may find they are shut out of the individual market or face exclusions and/or higher premiums.

Most states now have risk pools with standard Blue Cross-type plans. However, even with state subsidies the premiums are higher than what others pay. As a result, an HRA approach is likely to impose increased financial costs on those employees with the highest-cost health problems.

Policymakers must decide whether this type of transition is acceptable. If it is not, there are other options to consider. For one, employers could risk-rate their contributions (at least during a transition period) so that high-cost employees (and their families) get higher reimbursements than

## CHAPTER VII — PERSONAL AND PORTABLE HEALTH INSURANCE

healthy ones. Another option is to use state funds to subsidize premiums for those with high expected costs. A third possibility is to have employers initially buy individually owned insurance for all their employees at premiums that vary only by age. That is, employers would start out buying individually owned insurance the same way they buy group insurance (and realize the economies of group purchase). After a transition period, people would be free to switch plans.<sup>6</sup>

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### Notes

- 1 Also rating high were “flexible benefits,” such as allowing people to choose between nontaxed health, and retirement benefits and taxable wages.
- 2 John C. Goodman, “Employer-Sponsored, Personal and Portable Health Insurance,” *Health Affairs*, Vol. 25, No. 6, November/December 2006, pages 1,556-66.
- 3 Ibid. The standard interpretation is that employers cannot use pretax dollars to purchase individually owned insurance.
- 4 Paul Zane Pilzer, *The New Health Insurance Solution: How to Get Cheaper, Better Coverage without a Traditional Employer Plan* (New York: John Wiley & Sons, 2007).
- 5 The exception is the ability of employers to buy stop-loss insurance, covering all costs above a very high amount.
- 6 See the discussion of how such a transition can be made at actuarially fair prices in John C. Goodman, “Employer-Sponsored, Personal and Portable Health Insurance.”

## *Chapter VIII*

# SIX STEPS TO IMPROVE WORKERS' COMPENSATION<sup>1</sup>

Workers' compensation is often neglected in discussions of state health care reform. That is unfortunate. Employers who think they have achieved real savings after a significant change in their group health insurance plan often discover their lower health insurance costs are partially offset by higher workers' compensation costs. The reason: Employees often exercise discretion (even if they are not supposed to do so) in choosing whether to file a claim for a medical condition under workers' compensation or under group health insurance. Thus, when employers make health insurance coverage less attractive, often their workers' compensation claims rise instead.

Although each state has its own workers' compensation system, when a worker is injured on the job or has a work-related illness, all states provide three basic types of benefits: (a) coverage of medical costs, (b) replacement of lost wages and (c) payment for death or dismemberment. Each state sets employee benefit levels and regulates insurance arrangements and

premiums that cover benefit costs. Employers are obligated by law either to purchase insurance or to self-insure and pay claim costs. Every state holds employers strictly liable for all the costs of medical treatment and lost wages, with few exceptions. (Some state courts have held employers responsible even when an employee was drunk or high on drugs when the accident occurred!)

Ironically, although workplaces have become much safer in the last several decades and job-related injuries have declined, the cost of state-mandated workers' compensation insurance has not experienced a parallel decline. Instead, costs have soared.<sup>2</sup> Costs are increasing because state systems provide incentives for employers, employees and others to behave in ways that cause costs to be higher than they otherwise would be. Although the goal of workers' compensation is to protect workers, the costs of the system are ultimately paid by employees in the form of lower wages. Conversely, cost-reducing improvements in the system will ultimately lead to higher wages.

In general, the current system has six underlying problems: 1) employers and employees are unable to choose more efficient health coverage; 2) employers and employees are unable to choose more efficient disability coverage; 3) employers face imperfect incentives to create safer workplaces; 4) there is an inefficient market for workers' compensation insurance; 5) there is a lack of portable insurance coverage; and 6) employers and employees are unable to modify strict employer liability by contract. The following is a discussion of how these problems might be solved.

### **Step No. 1: Expand Health Insurance Options.**

Group health plans frequently require employees to pay some of the costs of their health care spending directly through copayments and deductibles. This encourages employees to economize on their use of medical services and avoid wasteful overconsumption. By contrast, under work-

ers' compensation, employees typically face no copayments or deductibles. As a result, when they (and the doctors who treat them) obtain excessive tests, schedule excessive doctor visits and abuse the system in other ways, the costs of their overconsumption are borne by others. Unsurprisingly, treatment costs for similar injuries are higher when paid for by workers' compensation insurance compared to group health plans.<sup>3</sup>

Ideally, employers and employees should be able to cover workers' compensation claims under the employer's regular health plan. And, absent state and federal laws, fully integrating workers' compensation into group health plans would probably be the norm.<sup>4</sup>

The argument for using the employees' group health plan (or choice of plans) for workers' compensation is straightforward. Employee benefits are a substitute for wages. Employee health plans can always be made more generous, at the price of lower wages. They can be made less generous in return for higher wages. The trade-off between money spent on health insurance and money spent on wages is currently determined in the labor market.

Employers who find a more worker-pleasing way to spend the employees' total compensation cost will have an edge in the competition for labor. Workers presumably prefer compensation packages to which they voluntarily agree to benefits chosen by state legislatures. Thus, employers and employees should have the option to choose higher wages or other benefits instead of first-dollar coverage of treatment costs under workers' compensation.

Accordingly, any employer-provided health plan that has been agreed to as a part of a union contract or that has survived the market test in the competition for employees should be de facto adequate for workers' compensation as well. If employers do not have a group health plan, the legislature or department of insurance could designate a list of acceptable plans from among those common in the labor market. For example, any of the plans offered to state employees might be deemed reasonable per se.

Integrated health care plans would provide both group health and workers' compensation medical benefits to employees. They would have the following advantages:

- Employees could use the same provider networks for job-related injuries they use for regular health coverage, and in most cases they would have the option to change doctors or (for an additional fee) go out of network if not satisfied with the services provided.
- Employers and insurers could use the same negotiated fee schedules for work-related injuries and illnesses as under regular health plans — fees that are generally lower than those paid by workers' compensation.
- Since employees would pay the same deductibles and copayments as in their regular health plan, there would no longer be any incentive to claim that a nonwork injury or illness is work-related or vice versa.
- Where workers are given a choice of health plans, they would be able to choose a single plan to cover both types of health needs.

Savings from the introduction of integrated health plans would be passed on to workers as higher wages or other types of benefits. Some employers allow employees to choose less expensive plans and “bank” the premium savings in Health Savings Accounts (HSAs), from which they can pay small medical bills. Employees could be given a similar choice for their workers' compensation coverage. Alternatively, employees could use the workers' compensation premium savings to purchase other benefits or make deposits into a disability account (described below).

## **Step No. 2: Expand Disability Insurance Options.**

Employers are also prevented from integrating workers' compensation wage replacement benefits with their regular disability insurance. This is

unfortunate. Compared to private disability policies, workers' compensation generally has a shorter waiting period before a claim can be filed and often has a lower wage replacement rate. Workers' compensation disability benefits typically replace only about half of a worker's lost wages, and employees who miss work for long periods earn lower wages afterward.<sup>5</sup>

As with medical benefits, the current system keeps employers and employees from choosing more efficient ways of delivering income-replacement benefits. It also forces employees to accept more of their compensation in the form of income-replacement insurance, when they might prefer higher wages or other benefits. There are significant premium savings from choosing longer waiting periods (for example, 30, 60 or 90 days) before insurance eligibility for income-replacement insurance. The choice of a longer waiting period requires a willingness to self-insure for a certain number of days, after which the employee relies on disability insurance. These same choices should be available under workers' comp. To remedy these problems:

- Employers should be able to self-insure and pay disability claims directly — reserving third-party insurance for catastrophic claims.
- Employers should be allowed to integrate workers' compensation wage replacement benefits with their regular disability plan so that employees face the same waiting periods and wage replacement rates whether an injury or illness is work-related or not.
- Small employers without disability plans should be allowed to provide a benefit that resembles standard disability policies sold in the state or one that replicates disability benefits available to state employees.

As with the health insurance reform discussed above, the costs savings from these reforms would be used to pay higher wages or applied to other benefits.

Also, employers should be allowed to offer, and employees to accept, options for employees to self-insure for some of their disability costs. For

example, in return for a worker accepting a disability plan with a 90-day waiting period, the employer should be able to put the premium savings in a disability savings account that belongs to that employee. The build-up in this account might roll over into a retirement account when the employee leaves the company or retires.<sup>6</sup>

### **Step No. 3: Free the Actuaries.**

In general, the insurance premiums employers pay cover benefit and claim management costs in each state. Rating bureaus collect claims data from private insurers and state funds and determine actuarial insurance rates by occupation. However, not every employer in the insurance pool has the same incentive to promote safety. Large employers are generally experience-rated — their premiums vary according to employee claims histories. Employers that have lower-than-expected losses for their occupation or industry are rewarded with lower premiums. Those that have higher-than-expected losses are penalized with higher premiums.

Smaller firms are generally not experience-rated, however, and tend to pay state-regulated premiums based on occupational categories alone. Firms that are not individually rated do not reap the full rewards of safety improvements, nor do they bear the full cost if safety deteriorates. Thus they have less incentive to promote safety. To correct this problem, state systems should re-rate companies that take steps to reduce injuries and charge them lower premiums. Conversely, higher premiums should be charged when a firm's safety record deteriorates. Private insurers will naturally experience-rate employers in this way, if they are allowed to do so.

### **Step No. 4: Free the Employers.**

A number of inefficiencies exist in state workers' compensation insurance markets. These inefficiencies primarily arise because employers are not able to choose more cost-effective forms of insurance.

In a number of states, large employers have access to high-deductible policies under which they self-insure for smaller claims. These employers have added incentives to promote workplace safety because they pay workers' compensation costs directly and thus directly benefit from a reduction in claims costs. However, in many states, smaller firms are not allowed to self-insure. Texas is an exception.<sup>7</sup> Any Texas employer can self-insure, and 43 percent of the state's smallest employers (1 to 4 employees) do not participate in the state workers' compensation system, in contrast to 21 percent of firms with 500 or more employees.<sup>8</sup> [See the sidebar on Workers' Compensation in Texas.]

### Step No. 5: Free the Workers.

Workers' compensation premiums are based on the collective claims history of all a firm's employees rather than individual workers. Workers could be rewarded or penalized for their individual behavior, however, through workers' compensation coverage that is individually owned and portable, traveling with the employee from job to job. Workers who know they will be financially rewarded for a good safety record and low claims costs or penalized for a poor safety record and high claims costs have incentives to prevent workplace injuries or to economize on the use of benefits if injured.

A step in the direction of portability would be to allow employers to establish Workers' Compensation Accounts (WCAs) for each employee who agrees to select more limited, conventional coverage (see below). The WCA could be funded by the employer's savings on insurance premiums. Individually-owned WCAs are a form of self-insurance that would give workers an alternative to third-party workers' compensation benefits; for example, a worker might self-insure for the first three months of disability. Any unused balance in the WCA would move with the employee to a different job or could be paid out in cash upon retirement. A model for WCAs can be found in Chile, which has successfully combined three major

## Opting Out of Workers' Compensation in Texas

Texas is the only state that freely allows employers to opt out of the workers' compensation system.<sup>1</sup> Employers in the system must purchase a workers' compensation policy from a licensed insurance company, be certified to self-insure by the Texas Department of Insurance or be a member of an approved self-insurance group.<sup>2</sup> Firms that do not participate in the system, called "nonsubscribers," can make a variety of alternative arrangements, including integrating treatment of injured workers with their regular health plans and wage replacement benefits with their disability plans.

Nonsubscribing firms can also "go bare." That is, they make no alternative arrangements and take the chance that they will not be held liable in court for a worker's injury. The liability of nonsubscribers is unlimited under the traditional tort liability system, if an injured employee can prove in court that the employer was negligent. On the other hand, firms that participate in workers' compensation are held strictly liable for injured workers' medical expenses and lost wages, regardless of fault, but there are limits on the compensation workers receive.

Whereas the workers' compensation system pays the cost of legal representation for participating employees, attorneys for workers who sue nonsubscribing employers receive compensation only if their litigation is successful. Thus the workers' compensation system encourages attorney involvement, while the tort liability system discourages the pursuit of weak cases. Only 3 percent of nonsubscribers report being sued over a work-related injury in a five-year period.<sup>3</sup>

The most common reasons Texas employers cite for opting out is the increasing cost of workers' compensation insurance. According to the most recent data from the Texas Department of Insurance:

- About 37 percent of Texas businesses, employing 23 percent of Texas workers, opted out of the workers' compensation system in 2006.

- In the past, nonsubscribing employers were mostly smaller-size firms, but in more recent years the largest employers — firms with more than 500 employees — are increasingly opting out, rising from 14 percent in 2001 to 26 percent in 2006.

What difference does nonsubscription make? One study found that the nonsubscriber option helps Texas employers control workers' compensation costs.<sup>3</sup>

- Accident frequency was slightly greater among nonsubscribing firms than subscribing firms.
- However, subscribing firms had 10 percent to 50 percent more lost days from work (per occurrence) than nonsubscribing firms.
- In about half of industries examined in the study, payments for lost time (indemnity costs) were less for nonsubscribing firms than subscribing firms, ranging from 0.5 percent lower in the personal services industry to 169 percent less in food stores.

Finally, the study concluded that litigation costs per employee (combined employer and claimant legal expenses) were similar, though slightly higher for nonsubscribing firms than subscribing firms (\$9.20 and \$9.02, respectively). Thus, although the Workers' Compensation system is supposed to be an alternative to the tort liability system for subscribing firms, they still incurred significant legal expenses.

<sup>1</sup> N. Michael Helvacian, "Workers' Compensation: Rx for Policy Reform," National Center for Policy Analysis, Policy Report No. 287, September 2006. Available at <http://www.ncpa.org/pub/st/st287/>.

<sup>2</sup> See "Information for Workers' Compensation Nonsubscribers," Texas Department of Insurance, revised March 2006, available at <http://www.tdi.state.tx.us/consumer/cb007.html>.

<sup>4</sup> Joseph Shields and D.C. Campbell, "A Study of Nonsubscription to the Workers' Compensation System: 2001 Estimates," Research and Oversight Council on Workers' Compensation, February 2002.

<sup>5</sup> Richard Butler, "Lost Injury Days: Moral Hazard Differences Between Tort and Workers' Compensation," *Journal of Risk and Insurance*, Sept. 1996, Vol. 63, No. 4, pages 405-433.

employee benefits into one integrated system that covers unemployment, disability and retirement benefits. [See the sidebar on disability insurance in Chile.]

### **Step No. 6: Allow Liability by Contract.**

Today, employers are strictly liable for workers' injuries, whether or not the worker is at fault. Therefore, workers' compensation pays 100 percent of a worker's medical costs and replaces wages after a short period away from work. The incentive for injured workers is to prolong the period away from work in order to receive cash benefits. But what if workers were willing to trade less complete coverage for higher wages or other benefits?

For instance, workers might be willing to pay a deductible toward their medical costs or receive wage replacement only after 90 days away from work if they shared in the resulting premium savings. Since each individual has a different tolerance for risk, different employees would likely make different trade-offs. Under the current system, they cannot do so.

Such an agreement might state that the employer's liability is strict only if the employee follows certain safety rules and, if not, the employee bears some of the costs of the injury. In return for agreeing to such changes, there must be a showing that employees have materially gained. If a union represents the workforce, such agreements might be deemed reasonable *per se*. If not, some constraints could be imposed. For example, if employers want workers to accept \$1,000 of exposure, the rules could say the employer has to deposit at least \$200 in a WCA each year.

Disability insurance also could provide direct financial incentives to workers for safe behavior and impose financial penalties for unsafe behavior. Such incentives would discourage excessive claim filings and, when a worker is injured, encourage a prompt return to work.

## Private Disability Insurance in Chile

Twenty-five years ago, when Chile replaced its traditional social security retirement system with one in which workers contribute to investment accounts they individually own, it also reformed its disability insurance system.<sup>1</sup> Like the old age system, the new disability system is prefunded, so each generation covers its own disability costs. Workers make additional contributions to their retirement accounts to cover the contingency of disability, and they pay fees for group disability policies for any portion of their wages that can't be replaced from their accounts (up to 70 percent of their average wage).

Since workers partially fund their own disability benefits from their accounts, they have less incentive than American workers to claim disability. The private pension funds that handle their investment accounts and the insurance companies that provide group coverage participate in the process of assessing workers' disabilities, and they financially benefit from controlling costs. Workers also benefit from this private-sector participation through lower premiums for the disability insurance. This has led to lower disability rates and costs in Chile than in other countries or under the old system. For example, the disability rate among middle-aged workers in Chile is less than half that of U.S. workers and less than one-third that of western Europeans. Insurance costs for disability in Chile would be four times greater without investment accounts.

More recently, Chile introduced a new unemployment benefit system, which also combines group insurance with investment accounts in which workers save for spells out of the workforce. As with the disability accounts, any unused funds roll over into workers' retirement accounts.

Although Chile currently uses a different system for workers' compensation, the same principles of prefunding and individual savings apply. Wage replacement benefits under workers' compensation, disability, unemployment and early retirement are close substitutes. If workers fund their own benefits, they have greater incentives to stay in the workforce and do not have perverse incentives to claim benefits unnecessarily.

<sup>1</sup> Estelle James and Augusto Iglesias, "Integrated Retirement and Disability Systems in Chile," National Center for Policy Analysis, Policy Report No. 302, September 2007.

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### Notes

- 1 Adapted from N. Michael Helvacian, “Workers’ Compensation: Rx for Policy Reform,” National Center for Policy Analysis, Policy Report No. 287, September 2006. Available at <http://www.ncpa.org/pub/st/st287/>.
- 2 “Basis of Rates (1/1/2006 Relatives),” Texas Department of Insurance, Division of Workers’ Compensation; available at <http://www.tdi.state.tx.us/wc/regulation/wcrate06.html>. Accessed March 22, 2006.
- 3 David Durbin, D. Corro and N. Michael Helvacian, “Workers’ Compensation Medical Expenditures: Price vs. Quantity,” *Journal of Risk and Insurance*, Vol. 63, No. 1, March 1996, pages 13-33.
- 4 See N. Michael Helvacian, “Workers’ Compensation: Rx for Policy Reform.” Currently, in 24 states employers can use the same managed care plan that covers their employees’ regular health care, but they are not allowed to charge employees copayments or deductibles. (Fee-for-service coverage is required in 26 states.) Managed care plans lower medical costs and claims frequency in states where they are now used.
- 5 A RAND Corporation study concludes that permanent partial disability (PPD) benefits to employees who lose significant time from work replace about 50 percent of the employees’ wage loss over a 10-year period. The analysis is based on a comparison of the income of employees who received PPD benefits with their cohorts who were not injured and lost no time from work. See R. T. Reville, L. Boden, J. Biddle and C. Mardesich, “An Evaluation of New Mexico Workers’ Compensation Permanent Partial Disability and Return to Work,” RAND Corporation, 2004.
- 6 In Chile, workers who contribute to personal retirement accounts also self-insure for about half of their disability benefits, on the average, although compensation for work-related illnesses and injuries are handled differently. See Estelle James and Augusto Iglesias, “Integrated Retirement and Disability Systems in Chile,” National Center for Policy Analysis, Policy Report No. 302, September 2007. Also, a worker’s compensation account could be integrated with an individual unemployment insurance account. See William B. Conerly, “Chile Leads the Way with Individual Unemployment Accounts,” National Center for Policy Analysis, Brief Analysis No. 424, November 12, 2002. Available at <http://www.ncpa.org/pub/ba/ba424/>.
- 7 “Workers’ Compensation,” Insurance Information Institute, August 2007.
- 8 “Survey of Employer Participation in the Texas Workers’ Compensation System: 2006 Estimates,” Texas A&M University and the Texas Department of Insurance Workers’ Compensation Research Group, October 2006. Available at [http://www.tdi.state.tx.us/reports/wcreg/documents/Employer\\_Participati.ppt](http://www.tdi.state.tx.us/reports/wcreg/documents/Employer_Participati.ppt). Nonparticipating, or nonsubscribing, firms are by definition self-insured. However, in Texas they are not required to have reserves to pay losses.

## *Chapter IX*

# MALPRACTICE REFORM: TEN PRINCIPLES OF A RATIONAL TORT SYSTEM<sup>1</sup>

The malpractice system is supposed to compensate victims of negligent medical practice for their injuries and discourage future errors by medical providers. It does both jobs poorly. Consider that:

- Less than 2 percent of patients (or the families of patients) who are negligently injured ever file a malpractice lawsuit; and even fewer receive any compensation.<sup>2</sup>
- Moreover, of the lawsuits filed, fully one out of every three cases does not involve any medical error.<sup>3</sup>

Further, the legal system does a bad job of sorting out good claims from bad ones:<sup>4</sup>

- Among those who pursue legal remedies, almost one in every six victims of malpractice receives no compensation, whereas one in every 10 meritless lawsuits results in a compensation award.

- Furthermore, malpractice victims receive less than half of every dollar (46 cents) recovered through settlements or jury verdicts; the rest pays for administration, claimant's attorney fees and defense costs.

Even as the current system fails to do a good job of ferreting out malpractice and compensating victims, it imposes large costs on doctors. Consider that one in every four physicians is sued every year, and more than half are sued at least once during their career.<sup>5</sup> To protect against such lawsuits, doctors purchase malpractice insurance. Yet the premiums can be staggering — for example, more than \$200,000 a year for OBGYNs in Dade County (Miami) — and reflect the likelihood of being sued much more than the likelihood of committing actual acts of malpractice.<sup>6</sup> As a result, many physicians now avoid specialties where the risk of being sued is high, especially obstetrics.<sup>7</sup>

Most of these costs are passed on to patients, whether or not they are victims of a medical error. The total cost of the medical tort system is estimated between \$129 billion and \$207 billion a year — or as much as \$2,000 per year for every household in America.<sup>8</sup>

Is there a better way of dealing with these problems? Those who have lived their entire lives under the American system of jurisprudence rarely have occasion to contemplate how things could be different. However, radically different systems can be found in other countries and civilizations. In ancient Rome, for example, there was no criminal law system, only civil law. If one Roman wrongfully killed another, the victim's family could seek redress under Roman civil law.<sup>9</sup> At the opposite extreme, some European countries have no civil law system, at least as we know it, for torts. In these countries, tort claims are handled in a manner similar to criminal cases — with judges making decisions about what is to be done, without drawn-out trials and arguing attorneys. [See the sidebar on no-fault malpractice in Sweden.]

None of these systems is ideal. Take a wrongful death, for example. The primary harm that has been done is the harm to the deceased. Since any

## No-Fault Malpractice in Sweden

In the 1970s, the Swedish government determined that the tort system was an inefficient mechanism for compensating victims of medical injury. The owners and funders of the nation's health care system (the Federation of County Councils) worked out a "no-fault" agreement to provide compensation to injured patients, regardless of who is at fault.<sup>1</sup>

Compared to the tort system, the Swedish no-fault system is quick. Once a claim is made, the average resolution time is only six months. Furthermore, 82 percent of payments in Sweden go directly to the patient compared to just half of awards to plaintiffs made in the U.S. tort system. Claims are managed by adjustors in a central office in Stockholm. They determine the patient's eligibility for compensation and forward valid claims to a board of physicians who manage the compensation fund and determine payments. Compensation is awarded through periodic payments or annuities.<sup>2</sup>

Using data on 15,000 medical records from Utah and Colorado in 1992, Harvard Public Health researchers applied the Swedish criteria for a compensable injury to determine if a no-fault system would reduce costs compared to the current U.S. tort system. They found:<sup>3</sup>

- In Utah, a Swedish no-fault system would cost about the same as the state's tort system (\$55 million to \$60 million) but would compensate roughly six times as many patients — 1,465 compared to 210 to 240 under tort.
- In Colorado, no-fault would cost more than the tort system, \$110 million versus \$82 million, but would compensate more patients (973 compared to 270 to 300).

In other words, the Swedish model is more efficient, based on the cost per compensated individual. However, compensation costs are rising in countries with no-fault systems, and those countries are responding by limiting the conditions under which injuries can be compensated.

<sup>1</sup> David M. Studdert et al., "Can the United States Afford a 'No-Fault' System of Compensation for Medical Injury?" *Law and Contemporary Problems*, Vol. 60, No. 2, Spring 1997, pages 1-34.

<sup>2</sup> The Swedish model determines compensation based on the occurrence of an "avoidable" injury, which is determined by the answers to these questions: Did medical management cause the adverse event? Was treatment appropriate or acceptable according to a medical standard? Was the injury avoidable?

<sup>3</sup> David M. Studdert et al., "Can the United States Afford a 'No-Fault' System of Compensation for Medical Injury?"

Source: Pamela Villarreal and Joe Barnett, "Medical Malpractice Reform," National Center for Policy Analysis, forthcoming.

harm suffered by surviving relatives is manifestly different from the harm suffered by the deceased, a spouse or family member suing for damages is an inherently imperfect way to redress the damage done.

The clearest case of this imperfection is that of a wrongful death of a child. Ordinarily, in tort cases juries are asked to assess the economic harm to the survivors. But parents don't suffer economic harm when they lose a child. If anything, they realize an economic gain (child rearing and other expenses they will no longer incur).

We believe there is no good solution to this problem in the court system. So wherever possible, people should have the opportunity to avoid the courts and turn to the marketplace — resolving disagreements by contract. The following proposals would remove some obviously perverse incentives in the current system. A reformed system will not be perfect, but it will be superior to the current system. The next chapter shows how people could have contract alternatives to litigation.

**Principle No. 1: Victims of torts should be fully compensated — no more, and no less.**

The goal of rational tort law should be to make the victim whole. In the case of a wrongful death, the goal should be to make the surviving family members whole. Clearly, this goal is not achieved if victims are under-compensated. Failure to fully compensate implies that the perpetrators are paying less than the full cost of the injury they cause others. That, in turn, implies that people will commit more torts than they otherwise would.

The reason for the converse principle (that victims of torts should not be overcompensated) may be less obvious. In general, we do not want people to gain from being victims. If they are able to “profit” from their victimhood, they will exercise less care and fail to take optimal precautions to avoid being victims. To the degree that loved ones influence each other's behavior, the same principle applies to compensation in wrongful death

cases. If people financially benefit from the death, say, of a family member, they will be less disposed to act in ways that prevent such deaths.

There are two immediate implications of Principle No. 1. First, assuming that an award to the plaintiff (victim) represents full and just compensation, the award should be reduced by the amount of any collateral source income, net of the cost of that income. Such income might consist of life insurance (in the case of wrongful death), disability insurance (for wrongful disability) or health insurance (for wrongful injury). Failure to reduce the award by such collateral source income would result in overcompensation to the victim.

Note that people who purchase life insurance have reduced their consumption of other goods and services in order to pay the premiums. People who fail to insure and do not pay such premiums enjoy a higher level of consumption. A rational tort system does not punish people who take the precaution of insuring or reward people who fail to insure.

Hence “net collateral income” is the proper measure of the amount that should be deducted from an award. Before reducing the plaintiff’s award by his collateral income, the premiums the plaintiff or his employer paid in order to generate that income should be returned. Put differently, the plaintiff’s award should be reduced by any collateral source income net of the premiums paid to produce that income.

The second implication of Principle No. 1 is that in cases where punitive damages are justified, the plaintiff (victim) should not be the recipient of such awards. The reason, again, is to avoid overcompensation.<sup>10</sup>

**Principle No. 2: Tort-feasors should pay the full cost of their harmful acts — no more, no less.**

The idea that tort-feasors should pay the full cost of their wrongful acts is likely to be widely accepted. What may be less obvious is why they should not pay more. By way of analogy, consider fines for traffic viola-

tions, such as speeding, failure to stop at traffic lights and so forth. Think of these fines as prices people pay for committing misdemeanors, and note that people may often have good reasons (at least in their own minds) for committing the violations. A husband rushing his pregnant wife to the hospital for an emergency delivery is one example. A businessman rushing to meet a deadline in order to consummate an important transaction is another. By extension, the same line of reasoning applies to the commission of torts (including, for example, torts committed by the husband or businessman in the act of committing traffic violations). A world of zero torts is not socially optimal.

From the first two principles it follows that in a rational tort system, tort-feasors (defendants) will often pay a penalty greater than what is awarded to the plaintiff. This surplus penalty consists of full compensation for damages minus net collateral source income plus punitive damages. What should happen to this surplus penalty?

A possible way to dispose of such funds is to give them to the government or use them to defray the cost of the judiciary. This remedy is not without risks, however. In general, it is probably unwise for judges to realize financial gain from their decisions, even if the gain is indirect. Similarly, the legislature which writes rules governing tort law should not get more revenue to spend as a result of their decisions.

For these reasons, a better disposition is to give the funds to worthwhile charities. The electorate could even vote on the charities that receive the funds. (However, jurors should never be told what the exact disposition of funds will be at the time they decide on the award — lest they be swayed by considerations which should have no bearing on their decision.)

**Principle No. 3: Whenever possible, damages should be determined in the marketplace.**

One of the most difficult issues in malpractice cases is determining actual damages. This is especially true where an injury is likely to lead to a

lifetime of continued medical care. In the typical case, the litigating parties call on expert witnesses who make educated guesses, at best. Fortunately, there is a better way. Insurance companies could bid for the right to provide continuing care indefinitely. Their bids would consist of the dollar amount they would have to receive in order to assume responsibility for the care.

Wrongful death cases are another example. A widow loses the income her husband would have earned (minus his probable consumption) plus loss of companionship. In calculating her economic loss the court must choose an appropriate discount rate, if a lump-sum award is to be made. Since courts have no special expertise in making these decisions, why not turn to those who do? For example, the defendant could be ordered to purchase an annuity to provide the widow with a continuing income.

**Principle No. 4: Structured awards are generally preferable to lump-sum awards.**

Under the current system, awards often require a lump-sum payment. But this only makes sense if it is a market-determined amount (for example, a bid from an insurance company). Otherwise, a better solution is a structured award — allowing for payment of damages over time. Since the loss that is being adjudicated is one that occurs over time, compensation for the loss should occur over the same period of time.

Structured settlements would allow issues to be determined in the marketplace that would otherwise be subject to arbitrary decision-making. They may also be a more efficient way of handling other issues that are fraught with uncertainty.

Consider the lifetime of continuing medical care. A jury does not know whether or not a new drug will make continuing care unnecessary five years from now. It should not have to guess. With a structured award, the financial burdens for the defendant could be reduced, say, to the cost of the

new drug if and when it is developed. Such adjustments are not possible with lump-sum, up-front awards.

With respect to the surviving spouse, it is impossible to know whether or not she will find new companionship (and a new income stream) five years from the time of the verdict, and a jury should not have to guess. A structured award can be adjusted at a future date in light of such changes in circumstances.

**Principle No. 5: Parties should always be free to alter by contract a court-determined award.**

Although structured awards of the type described above constitute good public policy, there are innumerable reasons why the parties in a specific case may prefer a different arrangement. If so, they should be allowed (and even encouraged) to voluntarily make mutually beneficial adjustments. In this way, the court sets the parameters, but the particulars of the compensation are determined by contract. (A structured award, for example, could be replaced by a lump-sum payment if both parties are willing.)

**Principle No. 6: Reasonable limits should be set on damages for pain and suffering, subject to market-based rebuttable evidence.**

The difficulty with assessing damages for pain and suffering is that the injuries are experienced subjectively. Since there is no objective test, a case can be made for limiting their size.<sup>11</sup>

At first glance, Principle No. 6 may seem to completely contradict the spirit behind Principle No. 3 — determining damages in the marketplace. In fact the two principles can complement each other. Take the case of wrongful deaths. Many states place a limit of about \$250,000 on non-economic damages (pain and suffering) for a surviving spouse. Obviously people differ in what they subjectively experience. But there is a way that

markets may again be used to reveal these differences. Suppose a husband has a \$1 million life insurance policy on his own life and his wife is the beneficiary. After his wrongful death, economists calculate that the economic loss to the wife is \$600,000. In this case, a reasonable inference is that the couple places an additional value of \$400,000 on the noneconomic loss — as evidenced by the payment of life insurance premiums. The couple has revealed through their actions that \$400,000 rather than \$250,000 is the appropriate value for noneconomic damages.

**Principle No. 7: Punitive damages are justified only if there are social costs over and above the victim's private costs.**

Why should there ever be punitive damages? Phrases such as “send them a message” or “teach them a lesson” have no real place in a rational tort system and should not be allowed as arguments before a jury. For the reasons given above, under ordinary circumstances the defendant should pay full damages and only full damages.

The case for punitive damages rests solely on the proof that there are social costs in addition to the private costs. Suppose a doctor has committed malpractice, and the course of discovery reveals the existence of other probable victims who never learned of the malpractice that led to their injuries. In this case, awarding full damages to the plaintiff is not enough penalty. The reason: The total probable harm done by the doctor is much greater than the harm done to the defendant. In assessing punitive damages, jurors should be encouraged to consider social harm, and only social harm.

**Principle No. 8: Contingency fees should be paid entirely by the defendants, with meritorious exceptions.**

If Principle No. 1 is followed, the plaintiff's award will be reduced by net collateral source income, and no punitive damages will be received by

the plaintiff. So if there is a contingency fee arrangement under which the plaintiff's attorney receives, say, one-third of the judgment, the fee must be based on the amount the plaintiff actually receives. Furthermore, if there is a structured award — requiring the defendant to make periodic payments over time — the plaintiff attorney's fee will also have to be paid over time. But are these rules really fair?

Consider a plaintiff with no collateral source income. The attorney gets one-third of the full award under a typical contingency fee agreement. Now suppose there is \$100,000 of net collateral source income. The plaintiff's award will be reduced by that amount because the collateral source income replaces part of the defendant's damage payment. The attorney and client in this case could agree that the attorney will receive one-third of the collateral source income, to be paid by the plaintiff, as well as one-third of the reduced award.

Now consider punitive damages. These are imposed because there are social costs over and above the damages at issue in the lawsuit. Just as it would be overcompensation for patients to receive punitive damages, it would also be overcompensation for the plaintiff's attorney to receive one-third of them.

The general principle is: Lawyers should be paid the way their clients (plaintiffs) are paid. This principle should also apply to class action lawsuits, which sometimes involve millions of consumers with small individual losses. Awards should not be allowed that give cash to lawyers and “dollar-off” coupons to their clients. If the clients are paid in coupons, the lawyers should be paid in coupons as well. An exception should be made for especially meritorious suits. These are cases, for example, where an attorney invests considerable time and expense to uncover wrongdoing that would otherwise go undetected. The principle here should be: The lawyer's share of the private award is determined by contract (the contract between lawyer and client), while the lawyer's share of the social award (punitive damages) is determined by the court.

**Principle No. 9: Attorney's fees should be awarded in cases of bad faith.**

There is far more bad faith in the judicial system than there are attorney fee awards. That's unfortunate. There would be much less bad faith if the penalties for engaging in it were higher.

Bad faith on the plaintiff's side often consists of filing frivolous lawsuits. Bad faith on the defendant's side often consists of intentional delays — forcing plaintiffs to spend time, money and effort to collect on claims when fault is not really in question.

To enforce Principle No. 9, judges should be more aggressive. Where bad faith is strongly suspected, the attorney-client privilege should be suspended as well as work product shields and other traditional privileges in order to ferret it out.

**Principle No. 10: The first nine principles do not apply to settlements.**

If the first nine principles are desirable rules to govern tort cases before the court, why shouldn't judges insist they also apply to any settlement? The practical reason is that the administration of justice is costly. In the very act of going to court, both the plaintiff and the defendant are imposing costs on everyone else as taxpayers. For this reason, there is a social interest in encouraging settlements.

If the first nine principles are followed at trial, there would be a substantial sum of money given to charity in many cases. Principle No. 10 says that the sum of money does not have to be given to charitable institutions if there is an agreed-upon settlement. Thus, the first nine principles create a powerful economic incentive for the two parties to reach a middle ground and avoid a trial. Even if they misjudge their prospects by a wide margin, both parties may still view a compromise as financially attractive.

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An exception to this principle is the class action suit, and the reason for the exception is that in a class action lawsuit plaintiffs do not really have full standing. Typically, they do not appear in court and have not entered into a formal contract with the lawyer who represents them.

## CHAPTER XI — TEN PRINCIPLES OF A RATIONAL TORT SYSTEM

### Notes

- 1 The authors are indebted to Richard Epstein, Paul Rubin and Thomas Saving for helpful comments on this section.
- 2 A. Russell Localio et al., “Relation between Malpractice Claims and Adverse Events Due to Negligence. Results of the Harvard Medical Practice Study III,” *New England Journal of Medicine*, Vol. 325, No. 4, July 25, 1991, pages 245-251.
- 3 David M. Studdert et al., “Claims, Errors and Compensation Payments in Medical Malpractice Litigation,” *New England Journal of Medicine*, Vol. 354, No. 19, May 2006, pages 2,024-33.
- 4 Ibid.
- 5 Angela M. Dodge and Steven F. Fitzer, “When Good Doctors Get Sued,” Dodge Publications, 2001; cited in “How Often Doctors Get Sued for Medical Malpractice: Medical Malpractice.” Available at [http://www.wrongdiagnosis.com/medical-malpractice/how\\_often\\_doctors\\_get\\_sued\\_for\\_medical\\_malpractice.htm](http://www.wrongdiagnosis.com/medical-malpractice/how_often_doctors_get_sued_for_medical_malpractice.htm).
- 6 Government Accountability Office, “Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates,” GAO-03-702, June 2003. Available at <http://www.gao.gov/new.items/d03702.pdf>.
- 7 Robert Quinn, “Medical Malpractice Insurance: The Reputation Effect and Defensive Medicine,” *Journal of Risk and Insurance*, Vol. 65, No. 3, September 1998, pages 467-84.
- 8 Calculations are based on estimated costs of defensive medicine from Daniel Kessler and Mark McClellan, “How Liability Law Affects Medical Productivity,” *Journal of Health Economics*, Vol. 21, No. 6, November 2002, pages 491-522; health care expenditures are from “National Health Expenditures by Type of Service and Source of Funds: Calendar Years 2005-1960,” Centers for Medicare and Medicaid Services; and estimated tort costs are from Towers Perrin Tillinghast, “2006 Update on U.S. Tort Cost Trends.”
- 9 See, for example, Henry Sumner Maine, *Ancient Law: Its Connection With the Early History of Society, and Its Relation to Modern Ideas* (London: John Murray, 1861).
- 10 In several states (Alaska, Indiana, Iowa, Missouri, Oregon, Utah, Florida, Georgia and Illinois), punitive damages paid to the plaintiff are shared with the state. For example, Oregon requires 60 percent of punitive damages paid go into the state’s victims’ compensation fund. See “Litigation Statistics,” available at <http://www.footnotetv.com>; and McCullough, Campbell and Lane, LLP, “Summary of United States Medical Malpractice Law.” Available at <http://www.mcandl.com/publications.html>.
- 11 For an argument that no noneconomic damages should be awarded, see Paul V. Niemeyer, “Awards for Pain and Suffering: The Irrational Centerpiece of Our Tort System,” *Virginia Law Review*, Vol. 90, No. 5, September 2004, pages 1,401-21. Rubin argues that while there exists a insurance market for health, disability and life insurance, no market exists for “pain and suffering” or other noneconomic damages. The reason: individuals are unwilling to buy this type of coverage because the costs outweighs the benefits. He concludes that people have revealed through their actions that they place a low value on pain and suffering compensation. See Paul H. Rubin, *Tort Reform by Contract* (Washington, D.C.: American Enterprise Institute, 1996).

## *Chapter X*

# MALPRACTICE REFORM: FIVE STEPS TO LIABILITY BY CONTRACT

In the mid-1980s, University of Chicago law professor Richard Epstein argued for replacing the tort-law malpractice system with a system in which liability would be determined by contract.<sup>1</sup> One drawback of Epstein's proposal was the lack of an institutional mechanism that would make such contracts palatable. As explained below, courts have been reluctant to accept contracts signed in the hospital admissions office, let alone in the emergency room, as a true meeting of the minds.

In 1993, Emory University professor Paul Rubin extended Epstein's idea by describing a reasonable institutional environment for contracts.<sup>2</sup> Insurance companies would contract with providers and then offer people insurance governed by different legal regimes. In return for waiving the right to sue for pain and suffering and settling for economic damages only, people would be able to purchase lower-priced insurance.

While Rubin's contribution is important and moves in the right direction, it does not go far enough. In general, market-based (contract) solutions should be encouraged for all medical malpractice claims — both economic and noneconomic. The following discussion shows how most malpractice issues could be resolved better in the marketplace.

### **Step No. 1: Reform the Tort System.**

A reformed tort system is one that is governed by the 10 principles of a rational tort system, discussed above. This is the default system, and all cases of malpractice will be tried in this system unless patients and providers contract out prior to the occurrence of the alleged malpractice.

### **Step No. 2: Free the Patients.**

Under the traditional system, most hospitals and doctors ask their patients to sign a form at the time of treatment releasing the provider from any legal liability in case of negligence. In malpractice suits, the defendants point to the form and claim the plaintiff (victim) has waived her right to sue by contract, as a condition of treatment. Courts have routinely dismissed such arguments, however, on the grounds that they do not really constitute informed consent. After all, how can a patient who is ill, frightened and intimidated by the health care system make rational decisions about complex legal liability issues?

The position of the courts is understandable, but it has had an unfortunate side effect: Doctors and patients are unable to avoid the costs of the malpractice system through any contract whatsoever. In other words, we have thrown the baby out with the bathwater.

How can the system give patients and doctors other options, while at the same time protecting patients from making unwise decisions when they are least able to negotiate contracts? One answer is for the legislature

(or a body designated by the legislature) to decide in advance what will constitute an enforceable contract. Patients would not be required to agree to such contracts as a condition of treatment; however, if they voluntarily signed the agreement, it would be binding.

Here are some provisions that should be considered for inclusion in such contracts.

**Compensation without Fault.** This provision obligates the provider to compensate the patient (or family of the patient) in the case of unexpected death or disability. In the case of an unexpected death, the amount could be set in advance and generally known to all patients. In the case of an unexpected disability, the contract might use the provisions of the state Worker's Compensation system — reformed along the lines outlined in Chapter VIII.

How much compensation should be paid in the case of an unexpected death? Any number would be somewhat arbitrary. The amount could be varied by patient characteristics, including the patient's age, the age of any surviving spouse and children, the patient's income and so forth. In other words, the amount could be based on some of the same criteria the current malpractice system uses — but without judges, jurors, lawyers and courtroom costs.

Other factors the current system ignores could be considered. For example, the existence of social insurance programs is relevant here — including workers' compensation, Social Security retirement and survivor's insurance. For disabilities, the existence of Social Security disability insurance, as well as Medicaid and Medicare, would be considered. Either the amount of compensation should be reduced by the existence of collateral social insurance benefits, or part of the compensation should go to government agencies to defray the added costs to them of the unexpected death or injury.

**Adjustments for Risk.** Not all medical cases are the same. Even if the probability of an unexpected death is low, complications in one patient

may create risks twice as high as for another. There must be a way of adjusting for this, or providers would try to avoid all the harder cases. One possibility is to reduce the amount of compensation for the riskier patient. A more attractive alternative is to ask the patient (or the patient's health insurer) to pay the extra premium needed to insure the event. (See the discussion below.)

**Full Disclosure.** As a condition of waiving the patient's legal rights to pursue liability claims under traditional tort law, providers should be required to make certain quality information public. For routine surgeries, for example, hospitals and doctors should post (case-adjusted) mortality rates, readmission rates, hospital acquired infection rates and so forth. Providers should also be required to disclose the use of safety measures, including electronic medical records, computer software designed to reduce errors and procedures designed to prevent hospital acquired infections. Additionally, in the case of unexpected death or disability, providers should be required to fully disclose all facts to appropriate investigative bodies so that steps can be taken to prevent future recurrences.

The patient should also be required to provide full disclosure. Even such routine information as when the last meal was consumed or what other drugs are being taken, if undisclosed, can lead to adverse medical outcomes.

**Patient Compliance.** Even for simple surgery, patients must comply with certain provider directives, including diet restrictions, full disclosure of medications being taken and so forth. For maternity cases, compliance in the form of prenatal care is more involved and extends over a longer period of time. Failure to comply in all these cases would result in a reduction in the amount of compensation and perhaps no compensation at all.

**Additional Insurance Options.** As explained above, legislatures will set minimum requirements for liability contracts. In most cases, insurance companies will then insure those contracts. However, once premiums for a doctor, patient and procedure are set, patients could increase the coverage

by paying an additional out-of-pocket premium. For example, if the legislature requires a minimum payout of \$500,000 for an unexpected death, and the providers have to pay \$X of premium for the insurance, patients should be able to pay an additional \$X to obtain \$1 million of insurance coverage (or any other multiple).

These are only a few provisions that seem reasonable. Other people will no doubt think of additional items. The list should not be long, however. If too many burdens are placed on the contract, there will be no contracts. The reason for the restrictions is to promote good social policy and avoid unconscionable outcomes.

**Advantages.** A liability-by-contract system along these lines would have a number of compelling advantages, including the following:

*Advantage No. 1: Insurers rather than patients would become the primary monitors of health care quality.*

Under this proposal, a great deal of quality information would be available to patients that is currently unavailable. However, patients would not be the primary monitors of quality. That role would fall to insurers. If doctors could escape the costs and burdens of the liability system by compensating patients for unexpected outcomes, they would naturally want to insure against such payments. So instead of buying malpractice insurance, they would be purchasing what amounts to short-term life insurance on all patients, say, undergoing surgery.

In the current system, there are no life and disability insurance products specifically tied to episodes of medical care. However, if the contract system becomes widely used, such products are likely to emerge.

As noted above, under the current system there is very little relationship between actual malpractice and malpractice lawsuits. As a result, malpractice premiums do not reflect the likelihood that doctors will commit malpractice. Instead, premiums reflect the likelihood that doctors will be sued. Under the liability-by-contract system, however, compensation

would be based on objective phenomenon, that is, death and disability. In pricing these policies, insurers would have a strong interest in monitoring how doctors practice medicine. The market, rather than bureaucratic bodies, would determine who is a good surgeon and who is a bad one, and those determinations would be reflected in insurance premiums.

*Advantage No. 2: Medical providers would face strong financial incentives to improve quality.*

In addition to the fact that malpractice premiums are not closely related to the actual incidence of malpractice, premiums charged to doctors rarely reflect the quality of medicine being practiced.<sup>3</sup> In the reformed system, insurance premiums should be closely related to actual outcomes. Surgeons with high mortality rates will pay higher premiums to insure against unexpected outcomes, other things being equal. These higher premiums, in turn, will constitute a strong financial incentive to find safer ways to perform surgery.

*Advantage No. 3: Multiple parties on the medical side would have strong incentives to cooperate in improving quality.*

Under the current system, a patient undergoing surgery typically is not dealing with a single doctor who is responsible for the entire procedure. Instead, the patient is (implicitly) contracting with several doctors, each as an independent contractor. For example, there is the surgeon, the anesthesiologist, the radiologist, the pathologist and the hospital itself. Because each of these entities is independent of the other, none bears the full cost of his or her bad behavior and none reaps the full benefits of good behavior.

Some have proposed making the hospital fully responsible for all malpractice claims. But that doesn't work very well when none of the other parties to the medical incident are hospital employees. Under the proposal envisioned here, all parties to a surgical event, for instance, would have strong incentives to contract with each other and cooperate with each other on error-reducing, quality improving changes (including electronic medi-

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cal records and hospital infection reduction procedures). The incentives would be to avoid the current tort system, to offer the patient a contract insured by a single insurer and to minimize the cost of that insurance.

*Advantage No. 4: Patients will receive cash compensation for unexpected outcomes without the stress or expense of a lawsuit.*

The loss of a loved one is a traumatic event. The prospect of filing a malpractice lawsuit is also inherently stressful and traumatic. A better way of facing grief is to be given a check, without the need to talk to doctors or lawyers and endure unpleasant confrontations with an opposing party in litigation. The compensation system envisioned here would put doctors and patients on the same side, with only one obligation — completing the paperwork needed to collect from an insurance company.

*Advantage No. 5: Patients and their families could self-insure for additional compensation.*

How much should a surviving spouse receive for the death of a loved one? The decision will, to a certain extent, be arbitrary — especially if made by a legislative body. However, if the amount is publicized in advance and broadly known, families can make adjustments to meet their expected needs. If the amount is too low, for example, families could buy additional life or disability insurance on their own — including (as described above) insurance under the provider's insurance contract.

*Advantage No. 6: The social cost of a liability-by-contract system is likely to be much lower than the cost of the current system.*

As noted above, according to the Institute of Medicine, as many as 98,000 people die each year because of errors and mistakes in our health care system — primarily in hospitals.<sup>4</sup> We also acknowledged that the estimate is probably excessively high. But suppose, for the sake of argument, we accept it; and suppose that the surviving family members of these patients each received a check for \$500,000.<sup>5</sup> The total cost would be less than \$50 billion. To put that number in perspective, note that the total cost of the

current malpractice system is estimated to be as much as \$200 billion, or four times as much.<sup>6</sup> If the average compensation were \$250,000, the total cost would equal one-eighth the cost of the current system.

Moreover, the current system involves a huge use of real resources — lawyers, judges, court rooms and so forth. By contrast, the check-writing solution involves very few real resources — other than monitoring and administration costs; it primarily involves moving money from some people to others, leaving real resources to be used in more productive ways.

Further, if hospitals were required to pay \$500,000 per unexpected death, on the average, the health care system would not continue to sustain 98,000 deaths from medical errors each year. Hospitals would quickly find ways of reducing their error rates.

*Advantage No. 7: Health care costs for patients would likely be reduced.*

Ultimately, the cost of any compensation system primarily will be paid by patients and potential patients. Just as the cost of malpractice premiums is embedded in the patients' cost of care, the cost of a liability-by-contract system will also be passed on to patients (and their insurers) in the form of higher prices. However, if the proposed system is socially more efficient, patients will see an overall reduction in health care costs (as well as an increase in quality and better personal protection against untoward events).

*Advantage No. 8: Liability by contract is a socially better way of handling sympathetic cases.*

Some of the most heart-wrenching cases in malpractice law involve newborns facing the prospect of a lifetime of care. Even if the doctors and hospital personnel committed no error, the parents are confronted with an enormous burden — in terms of both time and money. The tendency on the part of jurors, therefore, is to have great sympathy for the plaintiffs. One reason OBGYN malpractice premiums are so high is that the system is inching ever closer to a system of liability without fault. But if this is the

case, why not move there directly and dispense with the lawyers, judges and juries? The reformed system would take care of the sympathetic cases in an efficient, responsible way.

### Step No. 3: Free the Doctors.

A system of liability by contract will not work in all cases. Many patients have a high probability of death or disability. Doctors are unlikely to want to pay the cost of those adverse outcomes, and it would be unreasonable to expect them to do so. Further, when patients seek care at emergency rooms, no one has time to evaluate the likelihood of death or permanent injury prior to the delivery of care. Even in these cases, however, an alternative to the current system would seem to be desirable.

Accordingly, medical providers who offer their patients the opportunity to escape the current malpractice system by contract should have the chance to escape the system themselves in cases where contracts are impossible or impractical. In particular, these providers would be able to insist as a condition of treatment that all malpractice claims must be submitted to binding, unappealable arbitration. (The exception would be cases of gross negligence, discussed below.)

Two questions immediately arise: Who would the arbitrators be? What criteria would they use to make decisions?

Many people already serve as arbitrators, including former judges. They are selected and agreed upon by plaintiff lawyers and defense lawyers in cases where the parties want to avoid the costs, burdens and risks of trial by subjecting their cases to a respected, impartial third party. Since these arbitrators are already in the business and have reputations for integrity and good judgment, they are an ideal source for malpractice arbitration.

If there is a shortage of suitable arbitrators, other options exist. For example, a case could have two arbitrators — one with a history of representing plaintiffs, the other with a history of representing defendants.

The two arbitrators must agree on a final resolution; if they cannot agree, neither gets paid and two more arbitrators replace them.

What criteria should arbitrators use in deciding cases? Basically, it is the same criteria that would be relevant in a reformed tort system. However, unlike the liability-by-contract system, here the paramount issue is one of fault. Doctors (and their insurers) pay nothing unless they are found to be at fault, and the amount they would pay would be based on the degree to which they are at fault.

As in the case of liability by contract, doctors would be freed from the burden of the traditional malpractice system, provided they do certain things. For example, they must make their quality data available to all patients; they must cooperate with all safety bodies; and they must (in arbitration cases) make all relevant data available to the patient without costly discovery.

#### **Step No. 4: Free the Experts.**

All too often, expert witnesses in tort cases are “hired guns.” The same witnesses appear time and again for one side or the other. They are selected as witnesses precisely because their testimony can be counted upon to be overly generous to one of the two sides. Further, these witnesses are often handsomely paid, which gives them an incentive to continue the practice and become “professional witnesses.”

These witnesses would have no role in a properly run system of arbitration. The arbitrators would be free to call on real experts who would be agents of the arbitrator rather than agents of one of the two parties.

A model for the arbitrators is the so-called “vaccine court,” a branch of the U.S. Court of Federal Claims in Washington. The vaccine court was created in 1986 as Congress’ response to a liability crisis. In rare cases, vaccines were being blamed for catastrophic injuries and even death. Manufacturers were threatening to quit the business, which in turn threat-

ened the vaccine supply. The National Vaccine Injury Compensation Act shielded the industry from civil litigation by instituting a system of no-fault compensation. Under the law, aggrieved families file petitions, which are heard by special masters in the vaccine court. Successful claims are paid from a trust fund fed by a 75-cent surcharge per vaccine dose. The U.S. Department of Health and Human Services oversees the fund, with the Justice Department acting as its lawyer.<sup>7</sup>

### Step No. 5: Free the Courts.

The reformed system described above should be available in all cases except gross negligence. Medical practitioners should be able to contract away responsibility for mistakes. They should also be able to insure against the consequences of their mistakes. There seems to be no socially defensible reason, however, to allow them to contract out of the consequences of gross negligence.

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### Notes

- 1 Richard Epstein, "Medical Malpractice, Imperfect Information, and the Contractual Foundation for Medical Services," *Law and Contemporary Problems*, Vol. 49, No. 2, spring 1986, pages 201-212.
- 2 Paul H. Rubin, *Tort Reform by Contract* (Washington, D.C.: American Enterprise Institute, 1993).
- 3 Malpractice insurance premiums are commonly community rated, meaning all physicians in a particular specialty or geographic area pay the same rate. Community rating shifts the cost of errors (higher premiums) and the financial reward of avoiding errors from the individual to the group. This reduces the financial incentive of doctors to invest in quality-improving measures (such as electronic medical recordkeeping).
- 4 Linda T. Kohn, Janet M. Corrigan and Molla S. Donaldson, *To Err is Human: Building a Safer Health System* (Washington, D.C.: National Academy Press, 1999).
- 5 As noted above, not every patient should receive the same amount of money.
- 6 In making this comparison, we are temporarily ignoring the cost of nonfatal malpractice injuries.
- 7 The vaccine compensation law requires that petitions be filed within three years of the first sign of injury. Under the law, petitioners who have gone more than 240 days without a ruling in the vaccine court can opt out and file a civil suit. More than three dozen families who've waited long enough have opted out, and more are sure to follow.

## *Chapter XI*

# CONCLUSION: LIFE IN A REFORMED HEALTH CARE SYSTEM

What would life be like in the U.S. health care system with the reforms we have proposed? Remember, ours is a bottom up approach. We don't tell people what to do. We change incentives and let people pursue their own interests. So we can only speculate on what would happen. What follows are some reasonable speculations.

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Cheryl Green is a diabetic. Dealing with her diabetes is not easy. Her daily routine consists of testing her blood glucose four times and taking appropriate action when needed. For hard to control blood sugar spikes, she has to inject herself with a combination of two different formulations of insulin, usually four times a day. In addition, she takes oral doses of Actos and Metformin twice a day to control Type-2 diabetes, daily aspirin, in addition to Lipitor, to control cholesterol and a beta blocker to control

blood pressure. In the old days Cheryl made many trips to see her endocrinologist, Dr. Chris Reeder, and when he was not available, to the hospital emergency room. These days, trips to either place are rare.

If Cheryl wants to ask Dr. Reeder a question today, she picks up the telephone or sends an e-mail. She almost always gets a prompt response. Even if she didn't care about the time involved, Cheryl has financial reasons to guide her use of the health care system. She pays for doctor visits, emergency room visits, phone calls and e-mails from her Health Savings Account (HSA), and phone calls and e-mails are the cheapest alternatives.

Cheryl didn't exactly find Dr. Reeder. He found her, in a diabetic patient chat room on the Internet. In the past, most endocrinologists avoided patients like Cheryl (too many problems, too little money), but Reeder actively solicited her business. Although she was skeptical at first, she took a chance. It was the best decision she ever made.

At the outset, Dr. Reeder encouraged Cheryl to buy a device to monitor her own blood glucose level. She bought it with her HSA funds, and Reeder showed her how to use it. (If her condition worsens, her blood glucose readings can be transmitted to a monitor in Reeder's office.) Dr. Reeder also taught her how to shop for drugs on the Internet and cut her medication costs in half. Since drugs are also paid from her HSA, she was delighted with the savings.

Cheryl learned early on that none of Dr. Reeder's services are free. She pays for his time. But he has saved her more money than she has paid him by teaching her how to manage her own diabetic care and lower her prescription drug costs. Other doctors are also soliciting Cheryl's business. In fact, she's never been more popular with doctors. But she's happy where she is with Dr. Reeder.

Dr. Reeder wasn't always able to treat diabetic patients the way he treats Cheryl. Everything changed when he made an offer to Medicaid and the agency accepted it. In a nutshell, Reeder receives a monthly fixed fee from Medicaid; plus, Cheryl and patients like her pay him based on his time.

But the only way to make the arrangement profitable is for Dr. Reeder to teach patients how to manage their own care.

As part of the overall arrangement, Reeder acts as a care coordinator for Cheryl — a sort of a personal guide to the rest of the health care system. If she experiences high blood pressure, develops heart disease or experiences vision problems, it is Reeder's job to help Cheryl find the appropriate specialists and get the appropriate treatment. Reeder is the one individual responsible for all diabetic care and all collateral services for Cheryl Green. He is also responsible for the overall results. The initial arrangement with Medicaid required Reeder to show that the state was saving money and that the quality of care (as measured by objective criteria) had improved. Further, the burden of proof was on him, not on the state.

One of the biggest problems with chronic care (in fact, it is probably *the* single biggest problem) is patient compliance with treatment protocols. AIDS patients, cancer patients, heart patients, diabetics, asthmatics — all have persistent compliance issues. It is not hard to understand why. Complying with a treatment regime is expensive, time consuming and no fun.

So Reeder does a number of things that encourage patients like Cheryl to do what they are supposed to do. For one thing, he carefully monitors their prescription drug use, blood glucose levels and other indicators of care. He uses moral suasion. He also helps patients understand that compliance saves them money. Reeder knows he hasn't found all the answers, and every day he experiments with new techniques. But he also understands that the more successful he is, the more patients he will attract and the more money he will make.

Under the old system, a patient like Cheryl would have been on Medicaid only temporarily. If she found a new job or got a raise, her new income level would disqualify her. So it would not have been worthwhile for a doctor like Reeder to form a long-term relationship with her. However, under the new system, Medicaid provides Cheryl with "premium support." As her income rises, Medicaid's support diminishes but it doesn't abruptly

vanish. Also, Cheryl is able to apply her “premium support” to any private plan. She chose Blue Cross.

These days, Cheryl makes so much money that she no longer gets assistance from Medicaid. But she is still enrolled in her Blue Cross plan. Under the state’s small group reform system, Cheryl can take her Blue Cross plan with her to any new employer. During a job interview, she learns not only what salary is being offered, but also how much the prospective employer pays toward health insurance premiums. If the amount isn’t enough, she knows she will have to pay the balance from her paycheck.

Of course, even under the new system, Reeder was taking a risk investing in a long term relationship with Cheryl. And even though Medicaid liked the arrangement, there was no guarantee that Blue Cross would. But Reeder has found that private insurers are far more receptive than they once were. The reason: If Medicaid has determined that Reeder’s arrangement lowers cost and raises quality, the relationship is likely to benefit Blue Cross as well.

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Cheryl’s daughter, Karen, has asthma. Back in the days when Cheryl was uninsured, severe asthma attacks prompted many trips to hospital emergency rooms. Then Cheryl discovered S-CHIP, which was supposed to be better than Medicaid. But very few specialists in her neighborhood wanted to see patients like Karen because of the low payment rates. So Karen continued to go to an emergency room for most of her care.

All of this changed when Cheryl met Dr. David Brooks. Like Chris Reeder, Brooks has a relationship with S-CHIP that is different from other doctors. He gets paid more money in return for providing higher quality care that costs the state less money. Instead of the mountain of paperwork most doctors deal with, Brooks doesn’t ask for payment from anyone. Nor does he have to shuffle any papers. In Karen’s case, he receives a money payment from S-CHIP that is automatically deposited to his bank account,

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and he receives payments from Karen's HSA (managed by Cheryl) in the form of automatic debits, based on his time.

Like Chris Reeder, David Brooks knows he can't make money seeing patients like Karen unless he can get better results for less money. So he persuaded Cheryl to use Karen's HSA money to buy a device that monitors Karen's peak air flow. He also showed Cheryl how to use the device, how to change Karen's drug regime when needed, and how to distinguish symptoms that are serious and really require an emergency room visit from those that are not.

Like Dr. Reeder, Dr. Brooks accepts phone calls and email messages from Cheryl and answers her questions promptly. He charges her for the time, and Cheryl is glad to pay — knowing that she is saving both time and money by relying on telephone and email consultations rather than the alternatives.

Under the old system, doctors feared greater malpractice liability if they consulted with patients by telephone or e-mail. But Reeder and Brooks solved that problem by signing a state-approved contract with Cheryl. Under the new arrangement, (a) a lower (liability) standard of care is applied to telephone and email consultations, (b) special computer software is employed to reduce the chance of error and (c) the parties have agreed in advance on how to compensate for unexpected adverse medical events — without the need of lawyers, judge, juries or courtrooms. Reeder and Brooks both have insurance in case patient compensation has to be paid, but the premiums are a fraction of what they used to be under the old malpractice system.

Under the old system, Karen would lose her S-CHIP coverage (and possibly also her relationship with Dr. Brooks) once her mother's income reaches a threshold level. But the state's S-CHIP program has been converted to a premium support system. Karen is now able to join any health plan, and she will enroll under her mother's Blue Cross policy. As Cheryl's income grows, the state subsidy will ebb — until eventually the Greens will

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be on their own. Karen's relationship with Dr. Brooks will continue however. The reason: Blue Cross has decided that if Brook's style of practice saves money for Medicaid, it will also save money for Blue Cross.

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Bob Crosby, Cheryl's brother, is partially disabled. Bob was working as a sales manager in a department store when he fell off of a ladder and tore some ligaments in his knee. Bob is still able to do many things, but he can't endure the eight hours of standing required of most department store sales jobs. Under the old system, if Bob found a different type of employment, he would risk losing some or all of his monthly disability check. Under the new reformed Workers' Compensation system, however, once Bob's disability was verified, he began receiving checks from an insurance company. He will continue receiving them regardless of any future employment.

In the immediate aftermath of his accident, Bob was unemployed. He had self-insured to cover the first few months of his disability — paying living expenses from his personal Workers' Compensation Account. Even so, he was without a paycheck and uninsured. And like so many other uninsured people, Bob began using the hospital emergency room for free medical care for health matters unrelated to his disability. Medical cost for the disability continued to be paid by a Workers' Compensation private insurer.

All that was before Bob had a life-changing conversation with his orthopedist, Dr. Steve Shulkin. First, Shulkin pointed out that Bob's temporary unemployment and low income qualified him for a health insurance subsidy from the government. Money that used to be spent giving free care to the uninsured (usually in hospital emergency rooms) was now available to subsidize private insurance instead. Bob could use it to choose any private plan.

But that is not all. Shulkin then recommended a health insurer who would cover both Bob's leg injury and his other health care needs. Bob's initial reaction was disbelief. He had a great deal of experience with the

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old insurance system, where no insurer wanted to cover someone with a preexisting illness, and where the treatment of those conditions was often excluded from coverage. Now Shulkin was telling him about an insurance company that actually wanted people just like Bob.

The arrangement works like this. The Orthopedic Insurance Company specializes in people with orthopedic injuries. It has learned through experience to produce high-quality, low-cost orthopedic care by contracting with doctors like Steve Shulkin. So Orthopedic Insurance offered to take Bob off the hands of the Workers' Comp insurer for a price well below the expected cost of conventional care. Yet because Orthopedic Insurance is so efficient at what it does, it finds that the payment from the Workers' Comp insurer plus the premium support from the state is more than enough to generate a handsome profit. The package deal is a win-win for all parties.

Shulkin, by the way, was not acting out of purely altruistic motives. In fact, he received a fee for helping put the arrangement together. Not only does the state consider Shulkin's fee ethical, it encourages and even subsidizes such fees.

While Bob is out of work, the premium subsidies may continue. When he gets a job, he will probably no longer qualify for a government subsidy. But under the state's new portable insurance system, he can stay in his new Orthopedic Insurance plan and apply the new employer's premium contributions to that plan.

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Cheryl's parents, Charles and Irene, are in their sixties. They have paid off the mortgage on their home and have \$200,000 in liquid assets — in addition to the pension Charles expects to receive, plus Social Security. One would think that a couple like Charles and Irene would have little to worry about. But until recently they were worried that incapacity could land one or both in a nursing home and wipe out their entire life savings.

Their concerns have recently subsided, however, thanks to a new state law that allows them to protect their assets and have access to nursing

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home care if they need it. Specifically, the Greens have purchased a long-term care insurance plan with \$300,000 worth of coverage. If either of them enters a nursing home, insurance starts paying the bills. Should their private insurance coverage run out, they can turn to Medicaid.

They are relieved because they don't have to "spend down" all their assets. In fact, \$300,000 of their assets will be completely ignored by the state in determining eligibility for Medicaid. The Greens can have access to affordable long-term care and still leave something to their kids.

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These are only a few of the changes we can imagine in a reformed health care system. Fortunately, the full extent of the potential change is not limited by our imagination. Rather, it is limited only by the range and scope of the ingenuity of 300 million Americans — all of whom would be free to use their creativity and their innovative ability to solve health care problems — unshackled by the dysfunctional, bureaucratic and regulatory obstacles of the current system.

## About the Authors

**John C. Goodman** is the founder and president of the National Center for Policy Analysis. The *National Journal*, the *Wall Street Journal* and other publications have called him the “Father of Health Savings Accounts,” and he has pioneered research in consumer-driven health care. Dr. Goodman is the author/coauthor of eight books including *Patient Power*, *Lives at Risk* and more than 50 published studies on health care policy and other topics. He received a Doctor of Philosophy degree in economics from Columbia University. He has taught and done research at several colleges and universities including Columbia University, Stanford University, Dartmouth University, Southern Methodist University and the University of Dallas.

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## About the National Center for Policy Analysis

The NCPA is a nonprofit, nonpartisan organization established in 1983. Its goal is to examine the nation's most important public policy and to propose innovative, market-driven solutions.

The NCPA is probably best known for developing the concept of Health Savings Accounts (HSAs). NCPA President John C. Goodman is widely acknowledged (*Wall Street Journal*, *WebMD* and the *National Journal*) as the "Father of HSAs." In addition, a package of tax cuts designed by the NCPA and the U.S. Chamber of Commerce became the core of the Contract with America in 1994. Three of the five proposals (capital gains tax cut, Roth IRA and eliminating the Social Security earnings penalty) became law.

With a grant from the NCPA, economists at Texas A&M University developed a model to evaluate the future of Social Security and Medicare, working under the direction of Thomas R. Saving, who for years was one of two private-sector trustees of Social Security and Medicare. Pension reforms signed into law include ideas to improve 401(k)s developed and proposed by the NCPA and the Brookings Institution.

Among other initiatives, the NCPA's E-Team is one of the largest collections of energy and environmental policy experts and scientists who believe that sound science, economic prosperity and protecting the environment are compatible. Furthermore, the NCPA's Debate Central online site is the most comprehensive site for free information for 400,000 U.S. high school debaters. Debate Central received the prestigious Templeton Freedom Prize for Student Outreach.