Texas Health Care Reform:

The Best and Worst Ideas

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Executive Summary

In Texas, as in the nation, health care spending has been rising rapidly and a growing number of people are uninsured. For example:

- Total health care spending in the state grew from an estimated $30 billion in 1988 to $44 billion in 1992, an increase of nearly 50 percent in just five years.

- With about 3.8 million residents currently without health insurance, Texas is exceeded only by New Mexico among the 50 states in its percentage of population who are uninsured.

Governor Ann Richards created the Texas Health Policy Task Force late in 1991 to consider problems and recommend solutions for the state. Among the Task Force recommendations were free health care for all children and pregnant women regardless of income, health insurance available to all at the same price regardless of health status and a form of price controls for health insurance and health care services. For the long run, the Task Force recommended a state version of national health insurance.

There is considerable evidence that these recommendations will not work. The experience of Massachusetts shows that free vaccinations increase the percentage of children who are vaccinated by very little. The experience of Medicaid shows that free health care services encourage some to overuse the system while others still do not get the care they need. The experience of New York, Connecticut and other states shows that if people can wait until they are sick to purchase insurance, many will do so. And as the price of insurance rises, an increasing number of healthy people choose to be uninsured.

Despite the Task Force's glowing description of government-run health care, the experience of Canada and other developed countries shows that national health insurance causes health care rationing — with lengthy waits for such services as MRI brain scans and heart surgery. The poor, the elderly, racial minorities and rural citizens are often pushed to the rear of the waiting lines.

Although the Texas Legislature ignored most of the Texas Task Force's recommendations, it did pass a health insurance reform bill in mid-1993. Among its provisions are the following:

- Although employers will not be required to provide insurance, if they do, they must pay 75 percent of the premium and cover 90 percent of their eligible employees.

- Rate bands will limit the difference between the highest and lowest premium for the same policy.

- Employees who have been continuously insured will not be barred from obtaining insurance because of a preexisting condition after they switch jobs.

- Insurers will not be able to cancel an employer's policy because of high claims experience unless they cancel all similar businesses in the state.

- Insurers will not be able to deny insurance coverage based on health status after September 1, 1995.

- Through government-created purchasing cooperatives, smaller businesses will be able to join together when purchasing insurance in order to get lower premiums.

Some of these reforms are needed changes. But the reform package as a whole will make it more difficult and more costly for most employers to provide health insurance and will probably increase the number of uninsured Texans. Although Texas has stopped short of requiring employers to provide health insurance to their employees, other states have moved in that direction. Their experience has not been encouraging:

- Hawaii requires all employers to insure their full-time employees.

- Massachusetts and Oregon have passed "play-or-pay" proposals under which employers will be forced to provide insurance or pay a tax.

- Washington's new mandate will require all employers who do not self-insure to provide health insurance to their employees and their employees' dependents.

After nearly 20 years of employer mandates in Hawaii, 11 percent of the population is uninsured — a higher percentage than in many other states. And Massachusetts, Oregon and Washington are pushing back the date on which the mandates become effective, so today's politicians can take credit for the benefits while tomorrow's will bear the cost of implementing them. For example, Massachusetts passed its employer mandate in 1988, the year in which Michael Dukakis ran for president, and has pushed the implementation date to 1995.

This study examines the most serious health policy problems facing Texas and analyzes the best and worst proposals for state health care reform. Our recommendations include using markets to reduce costs, directly subsidizing those who need help the most, guaranteeing that people can continue their insurance coverage after they get sick, funding the Texas risk pool to cover the uninsurable, relaxing restrictions on Medicaid and rural providers and reforming the tort system.

Outline

Introduction

Comprehensive health care reform has been at the forefront of the national policy agenda since Bill Clinton made it a major issue in his presidential campaign. Over the past few years, however, the states that were unwilling to wait for a federal solution have already begun to act.[1]

- In the last two years, 23 states passed or attempted to pass health care reform legislation aimed at increasing access or containing costs.[2]
- Eight states enacted or introduced legislation to significantly alter the structure or funding of their health care system.[3]
- State governments also are seeking freedom from federal restrictions on the use of health care dollars in order to develop alternatives to federal programs.[4]

Late in 1991, Governor Ann Richards created the Texas Health Policy Task Force to consider problems and recommend solutions for the state.[5] [See the sidebar on the Texas Task Force recommendations.] And although the Texas Legislature ignored most of the Texas Task Force's recommendations, it did pass a health insurance reform bill in mid-1993. What remains unclear is whether the bill resolves existing problems or creates new ones.

"Since state governments cannot change federal law, they have more power to do harm than to do good."

Can Texas reform its own health care system? Can it adopt policies that contain costs and increase access? That too is unclear. State health care reform is limited by federal policies that largely created the very problems the states are trying to solve. Since state governments cannot change federal law, they have far more power to do harm than to do good.

This study examines the most serious health policy problems facing Texas and analyzes the best and worst reform proposals that are part of the state health care reform debate.

Problem No. 1: Rising Health Care Costs

One of the most serious problems is rising health care spending.[6] Over the past decade, national health care spending grew about twice as fast as the gross national product. If that trend were to continue — which it cannot — we would be spending 100 percent of our national income on health care by the year 2062.[7]

Like the country as a whole, Texas has experienced rapidly rising health care costs:

The Texas Health Policy Task Force Recommendations

In November of 1991, Texas Governor Ann Richards created the 29-member Texas Health Policy Task Force which, after nine months, made the following recommendations.

Free health care for children and pregnant women. A statewide system of free health care would be created for all children (up to 18 years of age) and for all pregnant women — *regardless of income or financial status.* In addition to major medical care, the plan would cover preventive care, including comprehensive reproductive health care, speech therapy, mental health care and nutritional counseling.

Medicaid expansion. More low-income people would be enrolled and more services would be covered.

Expanded services for underserved populations. Greater use of non-physician personnel (physicians' assistants, nurses, etc.) would be one of several reforms designed to increase the number of primary care providers, especially in underserved areas. In addition, networks of hospitals and primary care facilities would be created in rural and underserved areas and school-based health care facilities would be expanded. Nonprofit hospitals would be required to provide charity care — incurring a cost at least equal to the economic benefit derived from their tax-exempt status.

Regulations aimed at small group health insurance reform. Regulations would require guaranteed issue (no one could be denied health insurance because of health status), modified community rating (premium variations could reflect only age, sex and occupation) and limits on premium increases. Small businesses would be permitted to join together in purchasing pools in an attempt to gain greater purchasing power.

Regulations aimed at increasing competition and containing costs. Insurers would be required to offer a standard health benefits package with only a limited number of options from which consumers could choose. The Task Force believed that this change, along with mandatory disclosure of prices and fees and expanded use of "outcomes data" to help consumers choose the best and most efficient providers, would help consumers of health care make more prudent economic choices, thus using consumer preference to help contain health care costs. The Task Force also recommended that health care providers, employers, insurers and consumers be involved in the voluntary (at least initially) negotiation of equitable rate regulation for health care services. Standardized forms would be imposed to reduce administrative burdens and costs. The state government would study — but not necessarily do anything about — malpractice claims.

Long-term goal: A state-run health care system. The Task Force concluded that the most effective way to ensure access to health care for everyone and control health care costs in the long run would be to a establish a state-run (single-payer) system that would eliminate the role of traditional health insurance and place the health care industry in Texas under the control of the state government.

Source: "Texas Health Care: New Directions," Texas Health Policy Task Force, November 1992.

- Total health care spending in the state grew from an estimated $30 billion in 1988 to $44 billion in 1992, an increase of nearly 50 percent in just five years.[8]

- Health care spending in Texas now averages $2,600 per person, or $7,800 for a family of three.[9]

"About 120,000 small Texas businesses changed insurance carriers or dropped health insurance in 1989."

Rising health care costs also are a major financial burden for employers facing higher health insurance premiums. In 1989 (the most recent year for which statistics are available), approximately 120,000 small businesses in Texas changed their health insurance carriers in order to obtain lower premiums or canceled their policies entirely.[10]

For the longer term, the Texas Task Force recommended a "single-payer system," which is a euphemism for national health insurance at the state level. The Task Force also proposed several short-term solutions, including regulating insurance premiums, controlling pharmaceutical prices and standardizing insurance forms.[11] The latter efforts are almost certain to be futile, since the primary problem facing Texans is not rising costs but increasing spending. As long as the federal government pours extra dollars into the Texas health care market, either directly or indirectly, prices will continue to soar and Texans can do virtually nothing to contain them. [See the sidebar on how federal policies cause health care costs to rise.]

Texas can enact legislation to slow the growth rate of health care spending, but such reforms will have only marginal impact. On the other hand, any reform that leads to increased government health care spending, including those reforms recommended by the Texas Task Force, will exacerbate the problem.

Good Idea: Use Markets to Reduce Costs. Virtually the entire world has come to realize that markets are powerful tools for cutting costs and encouraging efficiency. With competitive markets, 17 million Texans would have a self-interest in eliminating waste. If buyers had the economic incentives, they would search for the best care at the lowest price, while providers would search for low-cost methods of delivering services.

Under the current system, however, normal market incentives are distorted because the health care sector is dominated by large bureaucratic institutions. These were created by unwise government policies, including the federal policy of subsidizing third-party insurance at the expense of individual self-insurance. [See the sidebar on making markets work in health care.] Although no state can control federal tax policy, Texas can make many reforms to encourage greater competition and market-based solutions to health policy problems.

How the Federal Government Causes Health Care Costs to Rise in Texas

Unwise federal policies are the chief cause of rising health care costs for three reasons: federal tax law encourages wasteful spending in the private sector, the design of federal health programs causes wasteful spending in the public sector and direct federal spending keeps upward pressure on health care costs. State governments may attack the symptoms by imposing price controls, but they cannot affect the underlying problem.

Federal tax law encourages wasteful spending in the private sector. Under current law, every dollar of health insurance premiums paid by an employer escapes, say, a 28 percent income tax, a 15.3 percent Social Security (FICA) tax and state and local income taxes. Thus government is effectively paying up to half of the premiums — a generous subsidy that encourages employees to overinsure. Most individuals and families would be much better off if they had the opportunity to choose high deductibles and place the premium savings in a bank account — to use for small medical bills. Yet while the federal government generously subsidizes third-party insurance by excluding it from taxable income, it discourages self-insurance by taxing income that individuals try to save for future medical expenses.

The design of federal health programs causes wasteful spending in the public sector. In the Medicaid and Medicare programs, the federal government has codified wasteful first-dollar coverage. For example, Medicare pays expenses that most patients could pay with their own resources — a practice that encourages overconsumption by Medicare patients who see few reasons to compare the value of diagnostic tests or physician visits with other uses of the same money. Federal regulations governing Medicaid also limit the ability to charge patients for low-cost items.

The expansion of federal programs is pushing costs up for everyone. Prior to 1960, health care spending as a percent of gross national product (GNP) increased very slowly in the United States. After the enactment of Medicare and Medicaid in 1965, however, health care spending soared — rising from 5.2 percent of GNP in 1960 to an estimated 14.1 percent in 1992. Direct government spending has increased from 24 percent of all health care spending in 1960 to 42 percent in 1990. And when federal tax subsidies for health insurance are combined with direct spending, government at all levels (federal, state and local) now spends more than half (53 percent) of all health care dollars. On the average, government spending has been growing much more rapidly than private spending. For example:

- Government spending (as a share of total consumption) in the hospital sector has been growing 2-1/2 times faster than private sector spending.
- Government spending on doctors has been growing five times faster than private spending.
- Government spending on pharmaceuticals has been growing 10 times faster than private spending.

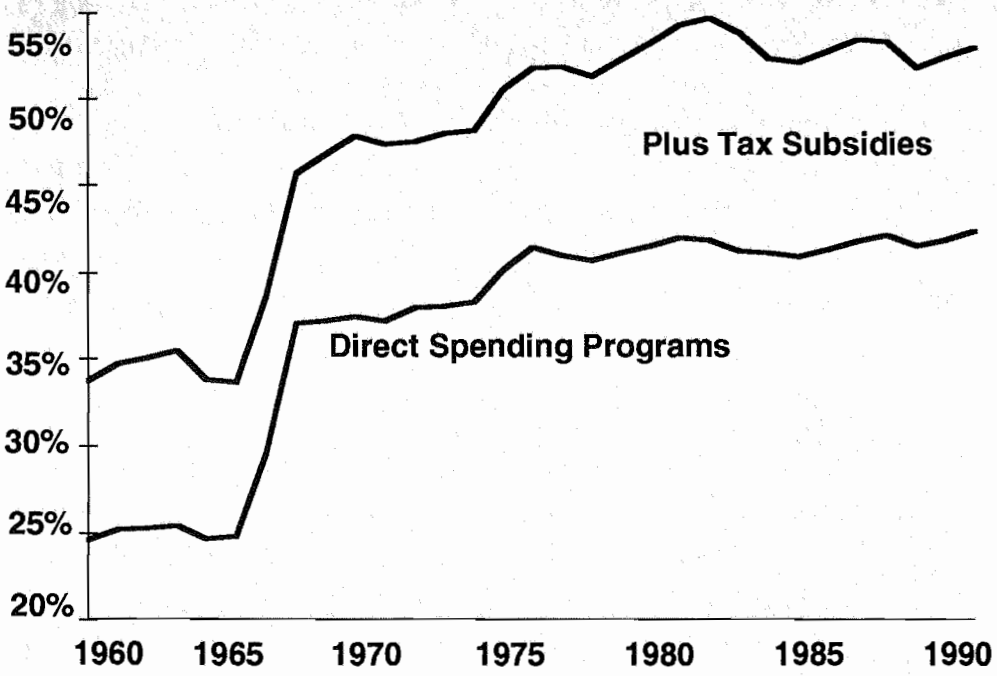
The constant influx of government money keeps upward pressure on prices for everyone. On the average, every additional dollar spent in the medical marketplace buys only 43 cents worth of real services and 57 cents worth of higher prices.

Source: Gary Robbins, Aldona Robbins and John C. Goodman, "How Our Health Care System Works," National Center for Policy Analysis, NCPA Policy Report No. 171, February 1993.

"Government at all levels now spends 53 percent of all health care dollars."

FIGURE I

Government Spending as a Share of All Health Care Spending



Source: NCPA/Fiscal Associates Health Care Model.

Good Idea: Medical Savings Accounts at the State Level. Several states have taken steps to enact or endorse some version of Medical Savings Accounts (MSAs) — also called Medical IRAs and Medisave Accounts. These tax-free, interest-bearing personal accounts permit people to set money aside for small health care expenditures while purchasing catastrophic health insurance for major medical expenses.[12] For example, Colorado allows tax-free deposits and tax-free buildup in these accounts, and the money can be withdrawn to pay medical bills during retirement. Missouri has created conventional MSAs that allow withdrawals at any time to pay medical bills.

Texas, Montana and Utah have passed resolutions calling on the federal government to adopt Medical Savings Accounts. MSA legislation is also being considered in other states, including Georgia, Indiana, Michigan, New York, Oklahoma, Oregon, Pennsylvania, South Carolina and Washington. An unsuccessful bill in Montana would have combined MSAs with workers' compensation insurance so that employers could put money in the employee's account and then provide the employees with a high-deductible workers' compensation policy.

Making Markets Work in Health Care

The medical marketplace — particularly the hospital marketplace — has none of the normal features of a competitive market. In most places, patients cannot find out the cost of even routine procedures before entering a hospital. At the time of discharge, they are presented with lengthy, line-item bills that are virtually impossible to read or understand. Small wonder that there is so much waste in our health care system! The people who make the purchasing decisions cannot discover the price before they buy and cannot understand what they were charged afterward.

Hospital prices. Patients who try to find out about hospital prices before they are admitted face a depressing surprise. A hospital can have as many as 12,000 different line-item prices. For patients doing comparison shopping among the 50 hospitals in the Chicago area, for example, there are as many as 600,000 prices to compare. To make matters worse, different hospitals use different accounting systems. The definition of a service as well as its price may differ from hospital to hospital.

Bureaucracies. The major reason why the market is not competitive is that it is dominated by large, bureaucratic institutions. Because 95 percent of hospital revenues come from third-party payers, prices charged to patients are not market-driven. Instead, they are artificial prices designed to maximize revenue against third-party reimbursement formulas. The federal government has encouraged an institutionalized, bureaucratized market by subsidizing third-party payment. Yet the evidence suggests that the market would be radically different if patients were spending their own funds.

Why empowering patients makes a difference. In a few areas of the medical marketplace, most of the generalizations made above are no longer true. For example, cosmetic surgery is not covered by private or public health insurance. Yet in every major city, it is a thriving industry. Patients pay with their own money, and they are almost always given a fixed price in advance — covering all medical services and all hospital charges. Patients also have choices about quality (e.g., surgery can be performed in a physician's office or, for a higher price, on an outpatient basis in a hospital). Overall, patients probably have more information about the price and quality of cosmetic surgery than about any other type of surgery.

Other examples. Cosmetic surgery is not an isolated case. Because of the trend toward higher deductibles, parents today can expect to pay a large portion of the bill for well-baby delivery. In response, Humana and other hospital chains are beginning to advertise package prices in competitive cities. Uninsured patients who pay in advance also sometimes get package prices — especially for day surgery. And, in England, private hospitals frequently offer package prices for routine surgery to patients who pay with their own funds.

Source: John C. Goodman and Gerald L. Musgrave, "Controlling Health Care Costs with Medical Savings Accounts," National Center for Policy Analysis, NCPA Policy Report No. 168, January 1992; and John C. Goodman and Gerald L. Musgrave, *Patient Power : Solving America's Health Care Crisis* (Washington, DC: Cato Institute, 1992).

Good Idea: Deregulate. Texas, like many other states, limits the ability of health care providers to meet patients' demands in the most cost-effective manner. In some cases, the states impose restrictions directly on providers. In other cases, they place restrictions on health care facilities. For example, state licensing laws often require hospitals to employ several individuals to perform tasks that one person could perform. Other laws prohibit physicians' assistants, nurses and other trained medical personnel from providing services for which they are qualified. [These restrictions are considered in detail in our discussion of underserved areas.]

Texas also has joined other states in limiting the ability of third-party payers to use managed care and other cost control techniques.[13] For example, Texas law requires out-of-state pharmacies to be licensed within the state, limiting consumer access to lower-cost drugs from out-of-state mail order firms.[14] Under Texas HMO statutes, "gatekeeper physicians" (who provide primary medical services and refer patients to specialists as needed) may be utilized by HMOs but not by preferred provider organizations (PPOs).[15] Managed care proponents contend that gatekeepers are essential to managed care, because they reduce the number of unnecessary tests and visits to specialists. Although there is reason to question that claim, prohibiting PPOs from using gatekeepers arbitrarily limits the PPOs' ability to hold down costs. Furthermore, Texas limits to 30 percent the amount of extra coinsurance that insurers can charge patients who see providers outside of their managed care plans.[16] Without this limitation, managed care groups might be able to charge much less, saving consumers a significant amount of money.

"Texas has joined other states in limiting the ability of third-party payers to control costs."

Mediocre Idea: Managed Competition.[17] Claiming to avoid the polar extremes of socialized medicine and free markets, the advocates of managed competition say they have found a workable middle ground — capturing the benefits of competition and solving social problems at the same time. Managed competition has been championed by Bill Clinton and is the key element in the health care reforms recently passed in Washington and Florida.

Under this approach, employees would choose from an array of health insurance plans. The employer's contribution would be a fixed sum of money, and the employee would pay the balance of the premium. So if an employee chose a more expensive plan, the extra cost would come out of that employee's pocket. This would make employees price-conscious and encourage health insurers to be more competitive by holding down the costs of their plans.[18]

However, the prices employees face would be artificial, because insurers would be forced to charge the same premium to all policyholders of the same age (modified community rating)[19] and to accept all applicants (guaran-

teed issue). The theory is that insurers should compete and try to keep their premiums low by becoming more skillful at managing care rather than at pricing and managing risk.[20] To the degree that there is a trade-off between cost and quality, insurers would compete based on their ability to manage that trade-off in ways pleasing to potential customers.

To see one problem with managed competition, imagine two competing HMOs. In the first, enrollees can see a primary care physician at the drop of a hat, but there are screening procedures and sometimes lengthy waiting periods for kidney dialysis, heart surgery and other expensive procedures. In the second, dialysis and heart surgery are available when needed, but there are few primary care physicians. Given a choice, most of us would enroll in the first HMO until we really got sick, then switch to the second. But if everyone did that, the second HMO would not survive financially.[21] As in the case of national health insurance, absent a market for real insurance the natural tendency would be to gravitate away from expensive, lifesaving medical technology.[22]

To see another problem, imagine several HMOs offering identical services. Because they must take all applicants at the same premium, each has an incentive to attract healthy people and avoid those likely to generate high health care costs. Since insurers are not allowed to discriminate on the basis of price, they will try to discriminate in other ways. In the attempt to avoid sick people — a game, like musical chairs — some will be more successful than others. The less successful will have higher costs, which will require higher premiums, which will result in fewer customers, etc.[23]

For these reasons, managed competition — and, indeed, any plan that combines community rating with competition — is inherently unstable. In order to keep the market from disintegrating, proponents invariably propose a complex government bureaucracy designed (a) to redistribute funds from profitable to unprofitable insurers or (b) to tightly regulate the content of health insurance policies, preventing insurers from offering higher deductibles on any feature likely to attract healthier subscribers.

"The problem with managed competition is that there is too much management and too little competition."

By pointing out the need for market-based reforms, the advocates of managed competition have performed a valuable service. The problem is that they promise too much management and permit too little competition. What is needed is *real* competition. We should allow individuals rather than bureaucrats to choose health insurance benefits in the face of market prices and to make their own decisions about the desirability of managed care. Competitive markets can perform quite well without the heavy hand of government.

Can managed competition slow the rise in health care costs? The existing systems that most closely resemble managed competition provide little cause for optimism, as the following case studies show.[24]

Case Study: The FEHBP. The program most often cited as an example of managed competition at work is the Federal Employees Health Benefits Program (FEHBP).[25] But almost anyone familiar with the FEHBP knows that it desperately needs reform.[26] This is the opinion of the Office of Personnel Management (OPM), which oversees the program, and of other analysts inside and outside of government. For example, a Towers, Perrin, Forster & Crosby study concluded that "fundamental legislative reform is urgently needed."[27] Nonetheless, the program is interesting for three reasons: (1) reformers keep calling for a national health insurance program based on the FEHBP;[28] (2) the FEHBP is the model for the current advocates of managed competition;[29] and (3) the FEHBP shows what can go wrong with managed competition.

"Despite the appearance of competition and the large number of HMO enrollees, the federal employees' plan has not succeeded in controlling costs."

The program has three main features: (1) federal employees in most places can choose among eight to 12 competing health insurance plans;[30] (2) government contributes a fixed amount that can be as much as 75 percent of each employee's premium; and (3) the plans are forced to community rate, charging the same premium for every enrollee. Despite the appearance of competition and the large number of HMO enrollees, the program has not succeeded in controlling costs.[31] As Figure II shows:

- During of the 1980s, the federal government's spending on employee health benefits grew at a faster rate than employer-provided health insurance generally (11.22 percent versus 10.01 percent).
- When spending is adjusted for the number of employees, the federal employees plan grew more than 25 percent faster than private sector plans.

One reason why the FEHBP has not held down costs is that deductibles in the fee-for-service plans are quite low. While most private employers are increasing their deductibles, Blue Cross's FEHBP "high-option" plan has a deductible of $200 and its "standard-option" plan has a deductible of $250. Why are the deductibles so low? Because OPM won't allow Blue Cross, or any other plan, to raise its deductibles or copayments. Again, why? Because plans with greater patient cost-sharing are cheaper and are likely to attract younger, healthier employees. OPM rigorously reviews every attempt to tailor the plans to the employees' needs to make sure it does not appeal more to good risks than to bad ones. For example, OPM will not allow a plan to include coverage for teeth cleaning but omit coverage for dentures — on the theory that such a change would make the plan more attractive to young people.

Even with this regulatory micromanagement, outside analysts say that whatever competition exists is only for good risks and is not competition in the sense managed competition advocates imagine.[32] And it is because insurers cannot price risk accurately that Aetna, the only systemwide insurer

other than Blue Cross, left the FEHBP.[33] Despite glowing descriptions by its defenders, the FEHBP has none of the desirable characteristics of a competitive system.

Case Study: CalPERS. Another example of managed competition is the California Public Employees' Retirement System (CalPERS). A recent study found that the insurance premiums for CalPERS enrollees increased more rapidly between 1982 and 1992 than the national average — 9.8 percent for CalPERS HMOs and 12.9 percent for its PPOs versus 9.4 percent for all employers nationally.[34] [See Figure III.] Furthermore, critics contend that CalPERS' ability to hold down premium increases is due primarily to cost shifting to other plans. For example, while Foundation Health Plan, which has about 10 percent of all CalPERS enrollees, did not increase premiums for CalPERS in 1993, other customers' premiums increased by 5 to 7 percent.[35]

Mediocre Idea: Managed Care. A key component of managed competition is "managed care." Although the term is applied to a wide range of activities designed to make medical care more cost-effective, in almost all of its versions it involves third-party interference with the practice of medicine.[36] Practitioners of managed care argue that they can make the health care system more efficient and more affordable, in part by promoting primary care with an emphasis on wellness and reducing the need for specialized and acute care.

Studies show that, at their outset, managed care programs such as HMOs save money by substituting less expensive for more expensive therapies.[37] For example, physician therapy and drug therapy are both less expensive than hospital therapy. However, William Schwartz (USC) and Daniel Mendelson (Lewin-VHI) argue that managed care has already achieved most of the savings that are achievable by reducing hospitalization. The only way for managed care to control the long-term rise in health care costs, they say, is to deny people access to expensive but useful technology.[38]

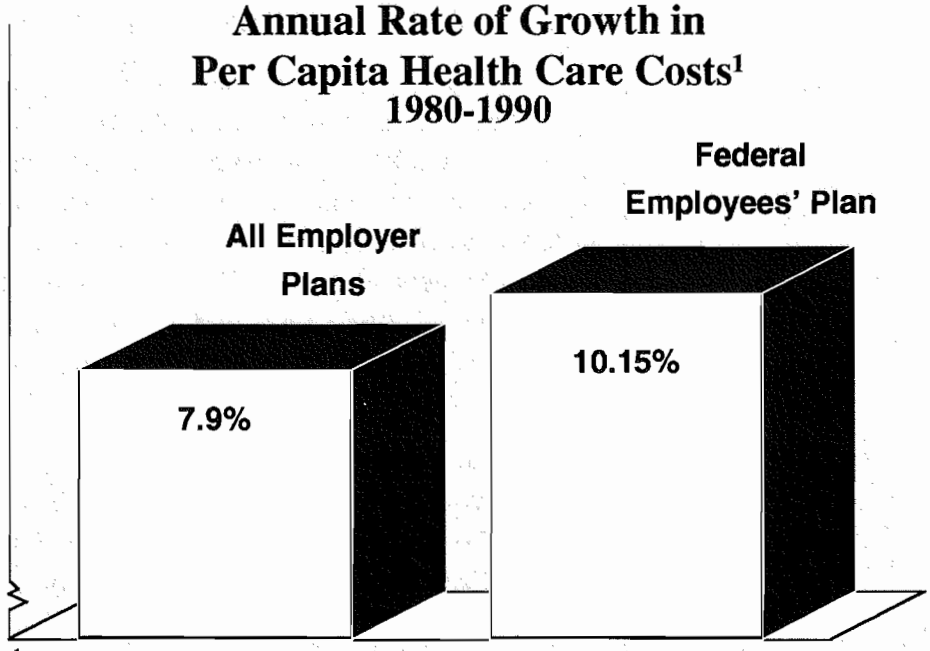
"After an initial drop, managed care costs grow at the same rate as costs in the rest of the health care system."

This observation is consistent with the evidence. Studies show that the adoption of managed care techniques should lead to a one-time reduction in costs of about 10 to 15 percent. But after that initial drop, managed care costs grow at the same rate as costs in other types of health care delivery systems — if not faster.[39] The reason managed care is not able to reduce costs significantly is that it has not come to grips with the primary problem of the health care industry: when consumers enter the medical marketplace, the vast majority are spending someone else's money. Economic studies and common sense confirm that we are less likely to be prudent shoppers if someone else is paying the bill.[40]

"The cost of the federal employees' plan has grown 25 percent faster than costs for employer plans generally."

FIGURE II

Can Managed Competition Control Costs? Annual Rate of Growth in Per Capita Health Care Costs[1] 1980-1990



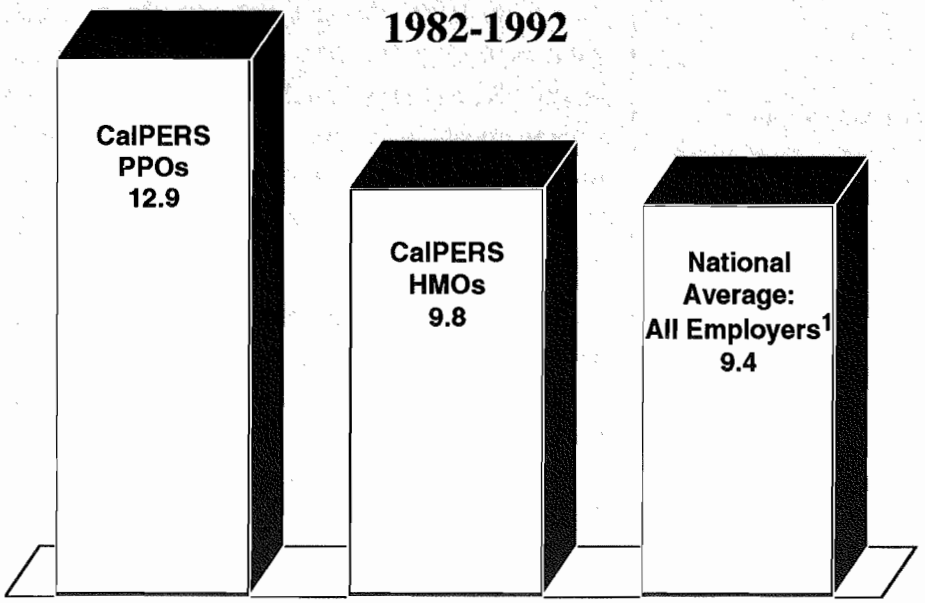
[1] Annual rate of growth in spending per full-time equivalent employee.

Source: John C. Goodman and Gerald L. Musgrave, "State Health Care Reform Under the Clinton Administration," National Center for Policy Analysis, NCPA Policy Report No. 173, November 1992.

"Insurance premiums for both CalPERS HMOs and PPOs grew faster than the national average for all employers."

FIGURE III

Can Managed Competition Control Costs? Average Annual Premium Increases 1982-1992



[1] The national average for all employers is based on data provided by Lewin-ICF (now Lewin-VHI).

Source: Service Employees International Union, "The CalPERS Experience and Managed Competition," SEIU Position Paper, March 1993.

Instead of waiting to see if managed care can outcompete the alternatives, some want government to simply declare it the winner. In other areas of economic life, we market-test ideas and allow competition to determine which ones survive. This is a good practice to follow in health care as well.

Mediocre Idea: Outcomes Research and Practice Guidelines. A natural extension of the concept of managed care is the establishment of "practice guidelines," which could be used by public and private sector bureaucracies to dictate the standard-of-care therapy for any given diagnosis. Proponents, including the Texas Task Force, want medical professionals to conduct "outcomes research" in order to determine the most effective medical treatments. They argue that such practice guidelines will help physicians deliver quality care and prevent them from ordering unnecessary tests or procedures.[41]

Currently, the American Medical Association and the Rand Corporation are working on national practice guidelines, and Congress has mandated that the Department of Health and Human Services do the same. The resultant "computerized protocols" will tell physicians what to do when confronted with certain patient symptoms and conditions.[42]

In a competitive marketplace, practice guidelines might prove useful. Clearinghouses for information on prices and quality could be valuable to patients. With greater information at their disposal, patients and physicians could make better decisions. However, if they are imposed by third-party bureaucracies, the same guidelines could discourage new and innovative therapies. They could also inhibit the use of unconventional therapies that sometimes save time, money and lives.

Bad Idea: Price Controls. Price controls — even temporary ones such as those advocated by former Senator Bob Krueger in his campaign against Kay Bailey Hutchison — often tempt politicians.[43] But price controls have failed in many countries over many centuries. Economics teaches that only under special circumstances can price controls produce beneficial results — even in theory. Those special circumstances don't apply to the market for most health care services in most places.

"Price controls tend to become a vehicle for health care rationing."

The nation's 600,000 physicians and 6,600 hospitals are not colluding to fix prices. Nor are they acting like a monopoly. And although the medical marketplace is far less competitive than it should be, price controls will not make it more competitive. They will only lead to shortages and health care rationing, much as gasoline price controls led to waiting lines in the 1970s.

The Texas Task Force hinted at price controls through its recommendation of "negotiated rate regulation," a vague proposal that would have participants from every sector of the health care industry meet and establish expenditure limits (i.e., global budgets) for each specified geographical area. [See the discussion on global budgets below.]

The Texas Task Force was especially concerned about the rising cost of pharmaceuticals and considered them prime candidates for price controls. Such price controls are attractive because their adverse consequences are not immediate. When the government grants a patent for a new drug, it is granting a monopoly that allows the drug's inventors to recoup their research and development costs. If government holds down the prices of new drugs, allowing manufacturers to receive only current production costs, patients will appear to benefit in the short run. In the long run, however, drug manufacturers will be less able to engage in research and development and will produce fewer new drugs and certainly fewer breakthrough drugs. AIDS patients, cancer patients and other victims of disease may be denied drugs that could have saved their lives.[44]

"Those most likely to be harmed by price controls are the sickest and poorest patients, who are the most expensive to treat."

Those most likely to be harmed by price controls are the sickest and poorest patients, who are the most expensive to treat.[45] Providers will try to avoid these patients if the controlled prices are too low to cover the cost of their treatment. The same principle applies to health insurance. Insurers facing price controls will tend to avoid those customers who are likely to have the highest health care costs.

For Medicare patients, the federal government already fixes prices for hospital services[46] and is in the process of doing so for physicians' services.[47] Two things can go wrong when government arbitrarily fixes reimbursement prices. If it sets the price too high, it encourages overprovision. If it sets the price too low, it encourages underprovision. The tendency is to set the price too low in order to control spending. As a result, price controls tend to become a vehicle for health care rationing. For example, consider how Medicare's payment formulas are affecting patients:

- Although hearing loss is the most prevalent chronic disability among the elderly and affects one-third of all Medicare patients, Medicare's reimbursement rate for cochlear implants is so low that only a handful of Medicare patients have received the treatment.[48]
- When Medicare reduced the reimbursement rate (in real terms) for kidney dialysis in the 1980s, many physicians reduced the treatment time, which reduced patients' chances of survival.[49]
- A survey of 21 medical conditions for which an implanted medical device is indicated found that for 18 of them the government's payment was well below hospital cost, and in more than half the cases Medicare patients did not receive the device.[50]

Even when Medicare's reimbursement equals the average cost of treatment, price fixing discriminates against above-average-cost patients. They tend to be the sickest patients and more often than not they are low-income and nonwhite. For example, blacks and Hispanics have more severe illnesses, longer hospital stays and higher hospital costs than white patients, on the average.[51]

What's Wrong with Canada's Global Budgets?

Canada attempts to control health care spending by limiting expensive medical technology and often restricting it to hospitals. In most provinces, outpatient surgery is either prohibited or discouraged. In Ontario, CAT scanners and MRI scanners are restricted to hospitals by law. Within hospitals, physicians work under the strain of severely limited budgets. The resulting health care rationing is inefficient and unfair.

Lack of access to technology. Unlike an American, a Canadian concerned about the cause of headaches cannot simply go get an MRI brain scan. Even for those patients whom doctors deem to be in great need, there are lengthy waits — for example, one year and four months in Ontario. Nor can a Canadian with high cholesterol easily get a cholesterol test. In most provinces the screening standards are much stricter than American doctors consider appropriate. One reason why gaining access to technology in Canada is difficult is that the technology is not there.

Rationing by waiting. There are 177,000 Canadians waiting for surgical procedures. Patients can wait as long as five months for a Pap smear, eight months for a mammogram and more than a year for heart surgery. The Canadian press is full of stories of heart patients dying because they did not get surgery promptly. And, as in other countries with global budgets, Canadian rationing decisions are haphazard. There is no national waiting list and no mechanism to ensure that the neediest patients receive care first.

Unequal access to care. Access to care is anything but equal. For example, among the 30 health regions of British Columbia, access to physicians varies by a factor of six to one. Access to specialists varies by a factor of 12 to 1, and access to some specialties varies by a factor of 35 to 1.

Discrimination against the poor. As in the United States, low-income families have shorter life expectancies and higher infant mortality rates.

Discrimination against racial minorities. In both the United States and Canada, Indians have shorter life expectancies than the rest of the population. Compared with their Canadian counterparts, however, American Indian life expectancy is five years longer for an male and six years longer for a female. Indian infant mortality is almost twice as high in Canada as in the United States.

Discrimination against the elderly. Health care rationing in every country tends to favor the young over the old. Canada is no exception. Per capita, the United States performs twice as many coronary artery bypass operations on elderly patients as Canada does. Among 75-year-olds, the difference between the two countries is four to one.

Discrimination based on ability to pay. If you are the 100th person waiting for heart surgery in Canada, you don't have a right to the 100th operation. Other people can and do get ahead of you. In fact, Americans can jump the Canadian queue because they are allowed to pay money for health care in Canada whereas Canadians are not. In this sense, U.S. citizens have more right to health care in Canada than do Canadians. As a result of rationing lines, more and more Canadians are coming across the border for care that they cannot get in Canada. In 1989, for example, about 100 Canadian heart patients went to the Cleveland Clinic because they could not get timely treatment in their own country. In addition to taxes, two provinces, British Columbia and Alberta, charge residents a premium to help fund their health plans. An estimated 2 to 5 percent of the population of British Columbia — 50,000 to 100,000 people — who don't pay premiums are technically uninsured. They must pay for physician care out-of-pocket or the doctors treating them must absorb the loss.

Sources: John C. Goodman and Gerald L. Musgrave, "Twenty Myths About National Health Insurance," National Center for Policy Analysis, NCPA Policy Report No. 128, December 1991; Joanna Miyake and Michael Walker, "Waiting Your Turn: Hospital Waiting Lists in Canada, Third Edition," *Fraser Forum,* Fraser Institute Critical Issues Bulletin No. 1, 1993; and Edmund F. Haislmaier, "Problems in Paradise: Canadians Complain About Their Health Care System," Heritage Foundation, Backgrounder No. 883, February 1992.

Price fixing is also a feature of the Medicaid program, under which it is not uncommon for government to pay as little as 50 cents on the dollar for services for low-income patients. One consequence is that many pregnant women on Medicaid lose access to OB/GYN physicians and turn to hospital emergency rooms for prenatal care.

Worst Idea: Global Budgets. According to the Texas Health Policy Task Force, "global budgets"[52] are necessary for cost containment and "are the single most effective tool for controlling the tendency of providers to increase the volume of services provided when the price per unit is reduced."[53]

Under global budgets, hospitals or area health authorities are given a fixed budget and required to deliver health care within that budget. Although the idea of living within a budget sounds reasonable, in practice global budgeting is a euphemism for health care rationing. By limiting what hospitals can spend, governments limit the care they can deliver.

"When health care is rationed, the principal victims are the poor, the elderly, racial minorities and rural residents."

There is considerable evidence that when health care is rationed the principal victims are the poor, the elderly, racial minorities and rural residents. [See the sidebar on global budgets.] Moreover, there is no evidence that global budgets lead to greater efficiency. To the contrary, they almost certainly encourage inefficiency. How much does it cost a hospital to perform an appendectomy? Outside of the United States, it is doubtful that any public hospital keeps records that enable them to know.

Among the indicators that government-run hospitals operating under global budgets are disastrously inefficient, consider the following:

- Currently the number of people waiting for surgery totals more than a million in Britain,[54] 60,000 in New Zealand[55] and 165,000 in Canada.[56]
- Although those waiting represent a small percent of the total population (2 percent or less), they probably represent a large portion of those who need access to expensive medical technology.[57]
- Yet in spite of the lengthy waiting lists, at any time about one-fifth of all hospital beds are empty in all three countries[58] and another one-fourth are used as expensive nursing home beds for nonacute elderly patients.[59]

In Canada, hospitalized chronic patients are known as "bed blockers," and they are apparently blocking beds with the approval of hospital administrators who believe that, because such patients use mostly "hotel" services, they are less draining to hospital budgets.[60]

If hospitals operating under global budgets were truly more efficient, American hospital administrators would be traveling to those countries to

learn about their management practices. In fact, the travel is in the opposite direction. Although U.S. hospitals certainly have room for improvement, they are already far more efficient than their international counterparts.[61]

Problem No. 2: Rising Number of Uninsured

Next to rising costs, the large number of people who lack health insurance is the nation's most important health policy problem. And in Texas, the problem is worse than in most other states.[62]

- With about 3.8 million residents currently without health insurance, Texas is exceeded only by New Mexico in its rate of uninsured individuals among the 50 states.[63]

- Although only 15 percent of the nonelderly population is uninsured nationwide, one in four nonelderly Texans has no health insurance coverage.[64]

- The city of San Antonio has the highest percentage of uninsured people (31 percent) of any U.S. metropolitan area.[65]

"One in four nonelderly Texans has no health insurance coverage."

The problem is especially acute for racial minorities. While 16 percent of nonelderly white Texans lack health insurance, 27 percent of African-Americans and 47 percent of Hispanics are uninsured.[66] [See Figure IV.] Because the number of uninsured in the state is so high, providers of indigent care (such as the publicly funded community hospitals) experience severe strains on their resources and finances.[67]

One reason for the high number of uninsured in Texas is the changing nature of the Texas economy and culture, factors over which the state government has little or no control. For instance:

- Though Texas has one of the fastest-growing service sectors in the country, with 5 million people, this sector traditionally does not provide health insurance benefits.[68]

- Texas also has one of the highest rates of preteen pregnancies, with nearly 4,700 in 1990, which are often not covered by health insurance.[69]

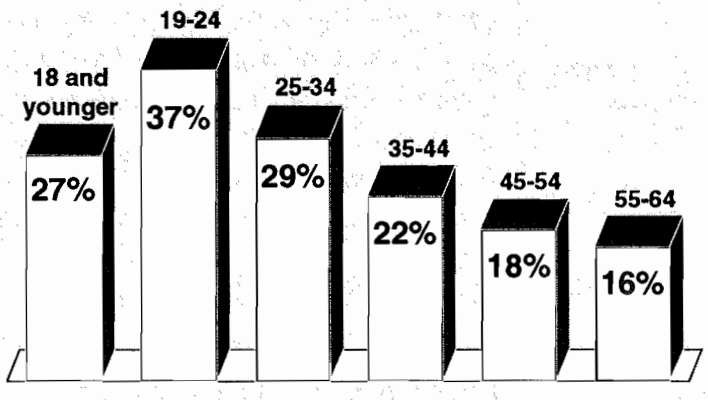
A second reason is that state regulations are pushing up the cost of health insurance and pricing the young, healthy and poor out of the market. A third reason is that federal policies are encouraging employer-based health insurance and thus increasing the number of uninsured. [See the sidebar on how the federal government causes people to be uninsured.]

"The problem of no health insurance is especially acute for racial minorities."

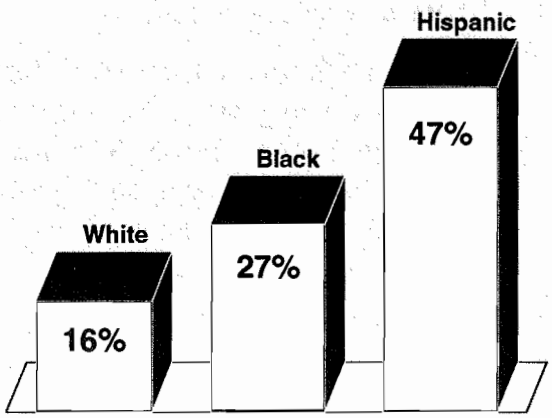
FIGURE IV

Who Are the Uninsured in Texas?

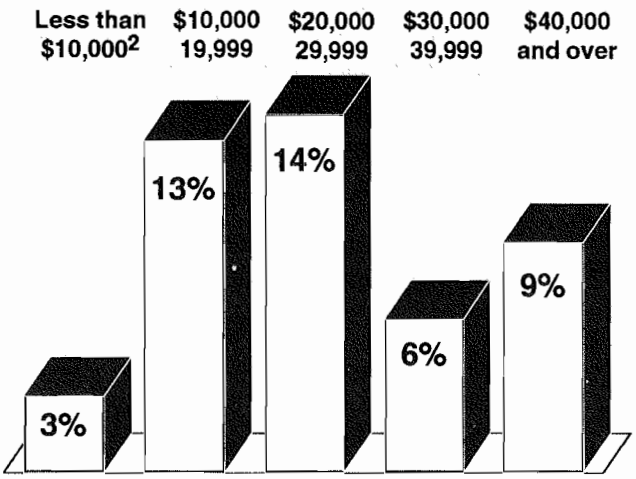
By Age[1]



By Race[1]



By Income[2]



[1] Percentage of uninsured within each group.

[2] Percentage of uninsured workers in Texas who work full-time.

Source: General Accounting Office, "Health Insurance Coverage: A Profile of the Uninsured in Selected States," Feburary 1991.

"The state's health insurance reform bill will probably increase the number of uninsured."

When the Texas Legislature passed H.B. 2055, supporters claimed the reforms would reduce the number of uninsured people in the state. [See the sidebar on Texas health insurance reform.] In fact, the bill is likely to have the opposite effect because it will force many small companies to forgo health insurance altogether. For example, the bill requires employers with 3 to 50 employees who offer health insurance to (1) pay 75 percent of their employees' health insurance premiums and (2) enroll 90 percent of their eligible employees in the plan. These reforms appear designed to force employers to pay most of their employees' health insurance costs. However, economists have demonstrated that fringe benefits such as health insurance substitute for wages — and thus are ultimately paid for by employees. And by forcing small groups to make an all-or-nothing choice, H.B. 2055 increases the likelihood that they will choose to be uninsured.

We will consider other ways in which the new reform bill encourages people to be uninsured in our analysis of health insurance reform. In what follows, we consider other alternatives that have been proposed to *decrease* the number of uninsured.

Good Idea: Direct Subsidies. One way to help lower-income families is through direct subsidies. There is an urgent need to reform the current tax system — under which $92 billion per year in federal, state and local income tax subsidies go mainly to employees of large companies and to higher-income families. Although the bulk of these subsidies ($65 billion) arise under federal tax law [see the sidebar on federal policies], there is room for state action.

Several states now exempt small business policies from state taxes levied on health insurance premiums, and at least six states extend tax credits to employers who are first-time buyers of health insurance. Iowa, for example, exempts small group policies from costly state-mandated benefits as well as from premium taxes. The state also provides a tax credit to employers who pay at least 75 percent of the premium for low-income employees and half of the premium for the employees' dependents. Nevada, New Mexico and West Virginia waive premium taxes for small businesses. Kansas, Kentucky, Montana, Oklahoma and Oregon give employers tax credits for the purchase of health insurance.[70]

Bad Idea: Employer Mandates. As noted above, virtually all economists agree that fringe benefits are earned by workers and that they substitute for wages. Requiring employers to provide health insurance, therefore, is simply a disguised attempt to force workers to take health insurance rather than wages. Two types of mandates have received considerable attention. Under the first approach, employers are required to provide health insurance for their employees.[71] Under the second, employers have a "play-or-pay" option and must either provide health insurance or pay a tax.

Hawaii, currently the only state that has a mandate in force, adopted the first type of employer mandate nearly 20 years ago. [See the sidebar on

How Federal Government Policies Increase the Number of Uninsured

Currently, the federal government "spends" about $65 billion a year subsidizing private health insurance through the tax system. These costly tax subsidies are very valuable to the people who receive them. Ostensibly, they exist to encourage private health insurance coverage. However, under the current system they may do more harm than good.

Subsidizing the rich. The current system favors high-income over low-income families in two ways. First, the ability to exclude employer-provided health insurance from taxable wages is more valuable to employees in higher tax brackets. Second, by restricting this tax subsidy to employer-provided insurance, the law favors people who work for larger firms. The result is highly regressive: families in the bottom fifth of the income distribution get an average benefit of $270 a year from federal tax subsidies for health insurance, while families in the highest fifth get an average annual benefit of $1,560. Thus the tax law benefits high-income families six times more than low-income families, giving the most help to those who are most likely to insure without subsidies.

Penalizing the nonrich. The self-employed, the unemployed and employees of small companies that do not provide health insurance must pay taxes first and buy health insurance with what's left over. This can make health insurance twice as expensive for people who pay the aftertax price as for people who have employer-provided insurance. Small wonder that almost 90 percent of the under-65 population with health insurance is insured through an employer or that 81 percent of uninsured workers are self-employed, unemployed or work for small companies.

Encouraging employer-based insurance. The kind of health insurance most of us have is determined by what the federal tax law subsidizes. This has led to an employer-based system under which people eventually lose their health insurance when they switch jobs. If they are already sick when they lose their coverage, they may become uninsurable.

Encouraging perverse employer policies. In the face of constraints imposed by federal policy, employers are trying to hold down health care costs by taking actions that have very negative social consequences. Unable to adopt a sensible approach to employee health insurance, many large firms now ask employees to pay (with aftertax dollars) a larger share of the premium. Often employers pay most of the premium for the employee, but ask employees to pay a much larger share for their dependents. These practices result in some employees opting not to buy into an employer's group health insurance plan. More frequently, employees choose coverage for themselves but not for their dependents. Three million people who lack health insurance are dependents of employees who are themselves insured.

Sources: John C. Goodman and Gerald L. Musgrave, *Patient Power: Solving America's Health Care Crisis* (Washington, DC: Cato Institute, 1992). C. Eugene Steuerle, "Finance-Based Reform: The Search for Adaptable Health Policy," paper presented at an American Enterprise Institute conference, American Health Policy, Washington, DC, October 3-4, 1991; Employee Benefit Research Institute, "Sources of Health Insurance and Characteristics of the Uninsured, Analysis of the March 1991 Current Population Survey," *EBRI Issue Brief*, No. 123, February 1992.

Texas Health Insurance Reform

Known as Governor Ann Richards' health care bill, Texas House Bill 2055 created new group health insurance regulations that apply primarily to employers with three to 50 employees. Passed into law in late spring 1993, the bill does the following basic things:

- **Imposes employer mandates.** Employers are not required to provide insurance. However, if they do, they must pay 75 percent of the premium and cover 90 percent of their eligible employees.
- **Establishes rate bands for small group policies.** Rate bands limit the difference between the highest and lowest premium for the same policy. Although they will raise the cost of insurance for the healthiest groups, they will eliminate "rate shock" for small employers by limiting increases in premiums due to high claims experience.
- **Removes preexisting conditions for previously insured employees.** Employees, either new or formerly employed, cannot be denied coverage. If they have been continuously covered, they need not pass through another preexisting condition exclusionary period when they change jobs.
- **Requires collective renewability.** Insurers cannot cancel a policy for an individual business because of high claims experience unless it cancels policies for all similar businesses in the state.
- **Conversion privilege.** Insureds under any group plan may choose a conversion plan if their employer's policy is terminated. The premium cannot exceed 200 percent of the individual's premium under the original plan.
- **Includes but postpones guaranteed issue regulations**. The legislation prohibits an insurance company from denying insurance based on health status after September 1, 1995. Specific regulations are to be proposed by a committee established to review guaranteed issue and report back to the Legislature by January 1, 1995.
- **Creates a state purchasing cooperative.** Through government-created purchasing cooperatives, smaller businesses could join together to purchase insurance at lower premiums. Employers are not required to participate, however, and the bill permits any group of employers to band together to form a private purchasing cooperative.
- **Requires standard plans and uniform claims forms**. Carriers in the small employer market will be required to offer three legislatively designed plans. Some flexibility regarding deductibles, copayments, etc., is permitted and insurers may offer other plans as well. The bill also requires the use of the standard claims forms currently used by the Health Care Financing Administration.
- **Requires a review of state-mandated benefits.** Establishes a panel to determine the impact of state-mandated benefits on the cost of health insurance.

employer mandates.] But though Hawaii has been praised by many, including the American Medical Association, for its attempt to create universal coverage, the percent of the population uninsured in Hawaii is no lower than that of many other states.[72] In fact, 16 states have uninsured populations equal to or less than Hawaii's.[73]

"Virtually all economists agree that fringe benefits are earned by workers and that they are a substitute for wages."

Massachusetts was the first state to pass a play-or-pay mandate. Though enacted in 1988, it has never been implemented. Massachusetts intended to phase in the mandate in 1992, but the date was postponed to 1995 after legislators discovered that the state's struggling economy could not support the burden. And given its history of delays, the mandate may never be implemented.

Washington and Oregon have recently passed employer mandates — a direct mandate in Washington and a pay-or-play mandate in Oregon. But like Massachusetts, these states have chosen to phase in the mandate over several years. And like Massachusetts, they are likely to discover that mandates are too costly in money and jobs and to either postpone implementation indefinitely or revoke the mandate. [See the sidebar on employer mandates.]

Mandates cause job loss by requiring that workers produce enough to finance their own health insurance (or additional payroll tax).[74] Because many low-skill, low-income workers cannot increase their productivity to compensate for the increase, they lose their jobs. According to one study:[75]

- Between 524,000 and 838,693 jobs in Texas would be at risk under a law forcing employers to purchase health insurance for their employees.
- These figures represent between 9.9 percent and 15.8 percent of total employment in the state.

Bad Idea: Individual Mandates. Almost every state requires automobile drivers to buy auto liability insurance. Many, including some who otherwise advocate free market solutions to health care problems, have argued that health insurance should be mandatory for the same reason: to protect the rest of the population against the costs incurred by those who choose to remain uninsured.[76] However, this argument overlooks the cost of politicizing health insurance, as auto liability insurance has been politicized in such states as California, Massachusetts and New Jersey.

Massachusetts, for example, has the highest automobile insurance premiums in the nation. It also has the highest rate of auto insurance claims. One reason is that Massachusetts subsidizes bad driving through artificially low insurance rates. Under Massachusetts law, insurers are forbidden to base their premiums on age, sex or marital status. Insurers must sell policies to almost any driver, and they cannot charge higher premiums for policies transferred to the state's high-risk pool. As a result, about 94 percent of young male drivers and 82 percent of young female drivers are in the risk pool. As a proportion of all premiums, policies assigned to the risk pool soared from 23 percent of the market in 1977 to 65 percent in 1989.[77]

Whereas nationally only about 8.3 percent of auto insurance premiums represent high-risk pool insurance, the Massachusetts risk pool now accounts for one-fifth of all the auto risk pool insurance in the United States. The risk pool invariably loses money, and the deficits are financed by higher premiums charged to other drivers. Overall, there is little relationship between driving behavior and insurance premiums in Massachusetts.

If individuals were forced to purchase health insurance just as they are required to purchase auto insurance, health insurance premiums would be determined in the political arena, as auto insurance premiums are. And because health insurance is a far more emotional issue, there would be constant pressure to keep premiums artificially low. Realistically, the government cannot require the purchase of health insurance and leave insurers, providers and state legislators free to increase the price without limit. Mandating health insurance is an open invitation to government regulation of the entire health care system.

"Mandating health insurance is an open invitation to government regulation of the entire health care system."

Worst Idea: A State-Run Health Care System. According to the Task Force, the best way to ensure "universality, accountability and expenditure limits" would be to adopt a universal health insurance system similar to systems in Canada and other developed countries. However, as noted above, a system that gives government complete control over the financing and delivery of health care would be unacceptable to most Americans, even if adopted at the federal level. If adopted at the state level, the results would be much worse because the best health care providers would leave the state, and higher-income patients, seeking the best health care, would likely follow.

Problem No. 3: Lack of Preventive Care

A common complaint about our current health care system is that people do not obtain sufficient preventive health services, including prenatal care, immunizations, mammograms and physical checkups. Currently:[78]

- One-third of pregnant women in Texas receive no prenatal care during the first trimester.
- Between 1988 and 1989, the number of reported measles cases in Texas rose from 300 to 3,000, with half of the counties in Texas experiencing outbreaks of the disease.

Many argue that preventive care would save health care dollars by preempting more costly acute care. For example:

- Whereas the cost of prenatal care is only a couple of hundred dollars, the average cost of medical care for a premature baby is nearly $20,000 more than the cost of a normal birth.[79]
- Whereas vaccinations for measles, mumps and rubella cost about $20 each, the average cost for hospitalization to treat those diseases runs about $21,000.[80]

Employer Mandates in Other States

There are two types of employer mandates. One requires employers to provide their employees with health insurance by paying some portion of the premium (Hawaii and Washington). The other gives employers an option of providing health insurance or paying a tax (Massachusetts and Oregon). Hawaii is the only state with a mandate currently in force.

Hawaii. Since 1974 the state has required employers to provide health insurance for all employees working over 20 hours a week. (Hawaii is the only state that can regulate the health insurance plans of self-insured companies under a special ERISA exemption granted by Congress.) Those not covered by the law — employees working fewer than 20 hours a week, government employees, small family businesses, the unemployed and seasonal workers — or not covered by Medicaid are supposed to be covered by a program established in 1989 known as the State Health Insurance Plan (SHIP). However, the reality is very different. With 11 percent of its population uninsured, Hawaii has done no better in reducing the number of uninsured than many of the mainland states.

Massachusetts. In the 1988 presidential campaign, Michael Dukakis claimed that he had provided health insurance for everyone in Massachusetts. But before the mandate for employers was to take effect in 1992, the state legislature postponed it until 1995. So the program has never been implemented and it may never be. Governor William Weld argues that it would devastate the state's economy.

This early attempt at play-or-pay legislation requires Massachusetts employers to provide health insurance for their employees or pay a tax of 12 percent on the first $14,000 of wages, or $1,680. Although the bill was intended to make health care "universal" and affordable within the state, more people might become uninsured if the program were implemented. Health insurance costs for an employee with dependents would likely be much more than the tax, and many employers would find it cheaper to pay than to play.

Washington. The state of Washington has adopted a health care reform program which some call a model for President Clinton's managed competition plan. Large employers (over 500) must cover their employees by July 1995 and the employees' dependents by July 1996. All employees and their dependents must be covered by July 1999. Employers will be required to pay at least 50 percent of their employees' premiums.

Oregon. Under Oregon's new play-or-pay plan, employers must provide health insurance coverage to employees or pay an amount equal to 75 percent of an employee's premiums and 50 percent of the dependents' premiums into a state fund that will provide coverage for the uninsured. However, the state must first find funds for the program. Like Washington, Oregon is to phase in its mandate over several years, with full implementation in 1995.

Sources: Pamela Loprest and Michael Gates, *State-Level Data Book on Health Care Access and Financing* (Washington, DC: The Urban Institute, 1993); and "Health Care Reform: State-by-State Analysis," American Legislative Exchange Council, Legislative Update, revised July 26, 1993.

- Whereas 2,175 Dallas children contracted measles in 1989 for a total cost of $3.4 million, immunizations for them would have cost only $3,700.[81]

On the theory that preventive care for all children and pregnant women would *save* money in the long run, the Texas Task Force proposed a benefits package known as the Texas Children's Health Plan, which included such services as free prenatal care, immunizations and well-baby care. But there is serious doubt that such proposals would either expand access to care or save money.

"There is serious doubt that free preventive care will either expand access or save money."

Does free care increase access? Although nationally only a little more than half of all children are immunized by the age of two, over 95 percent are fully immunized by age five so they can enter school.[82] Is the difference between the vaccination rate at ages two and five primarily due to the barrier of price? The evidence suggests otherwise.

Take Massachusetts, the state with the nation's oldest free immunization program. Vaccinations there are available to all children without charge, regardless of the parents' financial means. Are all Massachusetts children immunized? Hardly. While the national average is about 58 percent of children properly immunized by the age of two, the Massachusetts rate is 62 percent.[83] The 11 other states with free immunization programs also experience only marginally better rates of childhood immunizations.[84]

Like the Texas Task Force, President Bill Clinton has proposed a universal vaccination plan for the country.[85] There is no reason to believe that his plan would be more effective than that of Massachusetts. Over a billion dollars could be spent under Clinton's original proposal, with almost no change in outcomes. Such a program would be equally wasteful in Texas.[86]

There also is little evidence that making prenatal care free would increase check-ups by poor women. Even the Task Force recognized that two-thirds of Texas women already receive prenatal care within the first three months of pregnancy and that only 4 percent receive no prenatal counseling at all, in part because Planned Parenthood as well as community health clinics already provide free prenatal care to indigent women.

Does preventive care save money? Careful studies show that, in general, preventive medicine raises rather than lowers overall health care costs. Preventive medicine is "economical" only when special at-risk groups are targeted. Giving preventive services to the entire population usually costs more than any savings from the early detection of disease.[87] For example, if Texas provided all 17 million of its residents with an MRI scan, as many as 5,600 early-stage brain tumors or aneurysms might be detected.[88] In many of these cases, early detection would reduce the total cost of care and, in some cases, it would save lives. But at $1,000 per MRI scan, Texas could spend $17 billion — about a third of the state's current annual health care expenditures — on the procedure.

"It would be more efficient and cost-effective to target free services to the neediest mothers and children."

This does not mean that preventive care is wasteful. Diagnostic tests that show freedom from disease relieve patients' anxiety and reassure them of good health. Thus, for the most part, preventive care is like a consumer good that creates benefits in return for a cost. It is not like an investment good that promises a positive rate of economic return.

Good Idea: Target Free Services to the Neediest. If we are genuinely concerned about expanding immunizations, preventive care and basic services to children and pregnant women, we should target and directly subsidize those who cannot afford such services.[89] For example, it would be much more efficient and cost-effective to provide free care to poor mothers and children in poor urban and rural areas than in wealthier areas, where most mothers and children are covered by insurance or can pay for their care out of personal funds. Targeting services toward poor people while letting the nonpoor pay their own way frees up scarce health care dollars for those who need them most.

Bad Idea: Eliminate Deductibles for Preventive Services. One of the Texas Task Force's proposals was to outlaw private health insurance deductibles for selected health services such as Pap smears, mammograms, prostate and colon-rectal screenings.[90] But here, too, free preventive care is wasteful. First, it encourages people to consume services they do not need. For example, there is already serious doubt about the value of annual mammograms for most women under age 50 and certainly under age 40.[91] Second, free preventive services discourage people from seeking low prices, reducing the incentive for providers to compete based on price. Finally, using insurance to pay for preventive services is administratively wasteful. For example, a $25 physician's fee can easily become $50 in total costs after an insurer monitors and processes the claim — thus doubling the cost of medical care.

Although many who advocate expanding preventive care are motivated by humanitarian concerns, creating subsidized or free programs for all patients would shift scarce dollars — with little or no net benefit. A much better approach is to allow those who can afford preventive care to weigh its value against other uses of their money and to target government money to those who cannot afford the care.

Problem No. 4: Defects in the Health Insurance Market

"Most uninsured people are healthy, not sick."

Serious problems exist in the market for private health insurance. Among them: (1) many people discover that after they get sick their insurance can be canceled or they can face unreasonable premium increases; (2) employees find that when they leave employment they lose insurance cover-

age, even if they have a medical problem; and (3) people with medical problems who lose coverage may find that no other insurer will insure them.[92]

In theory, the problems in the market for private health insurance are not difficult to solve. [See the sidebar on solving the crisis in private insurance.] In practice, they have so far proved impossible. A number of proposals purporting to solve these problems — including some proposals made by the Texas Task Force and some recently enacted by the Legislature — would worsen the problems, causing more people to be uninsured and contributing to rising health care costs.

Contrary to widespread impressions, most of the 37 million Americans who are currently uninsured are healthy, not sick. Sixty percent of the uninsured are under 30 years of age and in the healthiest population age groups.[93] They have below-average incomes and few assets. The same is true in Texas. [See Figure IV.] Of the 3.9 million uninsured Texans:[94]

- The rate of uninsured is highest among those aged 19-24, and the second highest rate occurs in the 25-34 age bracket.
- 59 percent of the uninsured have incomes below $20,000.
- Only 12 percent of those individuals with incomes twice the poverty level are uninsured.

Because these individuals are healthy and have below-average incomes and few assets, they tend to be very sensitive to premium prices. Moreover, the primary reason why most of the uninsured lack health coverage is that they have judged the price of insurance too high relative to the benefits. Very few have been denied coverage. The best way to bring these young, healthy people into the insurance market is to provide health insurance at a price that reflects their minimal risk.

By contrast, the Task Force health insurance proposals included such reforms as guaranteed issue, modified community rating and the exclusion of preexisting conditions.[95] As we show below, these reforms would increase the cost of health insurance for most Texans and, therefore, increase the number of uninsured Texans.

Good Idea: Guaranteed Renewable Insurance. Most of the problems in the market for private health insurance do not exist in the market for life insurance, which can easily be taken as a model. Once a person becomes insured, health insurers should be required to continue coverage in the future at reasonable prices.[96] With this reform, the market for small group health insurance would begin to resemble the market for individual life insurance policies. In the latter, insurers cannot selectively raise prices for different policyholders based on last year's experience. The same premium increase must apply to the entire class of people who purchase a particular type of policy. Insurers cannot change the rules of the game for a single policyholder *after* an illness has occurred.[97]

"Insurers should not be able to change the rules of the game after an illness has occurred."

Solving the Crisis in Private Health Insurance

Real problems exist in the private health insurance industry. These problems have arisen because the traditional insurance philosophy has been abandoned. All too often what is called insurance is actually prepayment for the consumption of medical care. A workable solution must be one that encourages a competitive market for real insurance — one in which risk is accurately priced.

Problem: People who cannot afford to insure. Most uninsured Americans are healthy, not sick. They lack health insurance because they have been priced out of the market. Part of the solution is to encourage insurers to charge these people low premiums that reflect their low level of risk. State governments can help by repealing cost-increasing regulations and by giving low- and moderate-income families tax subsidies for the purchase of health insurance.

Problem: People who can afford to insure but choose not to. Even if tax incentives were offered, some people would choose not to buy health insurance. In that case, they should pay higher taxes. Under the current system, the higher taxes paid by the uninsured go to Washington, while free health care is delivered locally. It would be better to pool the extra taxes and make them available to the hospitals delivering charity care. That way, uninsured patients would be the payers of first resort, but funding would also be available to provide uncompensated care.

Problem: People who are uninsurable. A small number of people (less than 1 percent of the nonelderly population) cannot buy health insurance because they are sick or at high risk. Government can help by creating risk pools or subsidizing the purchase of conventional health insurance with tax dollars, rather than by artificially raising the premiums charged to healthy people. And the amount of subsidy should depend on family income. Low-income families need government help. Ross Perot does not.

Problem: Unfair cancellations and premium increases. Sensible reform is needed for people who already have insurance. Insurers should not be able to change the rules of the game after an unexpected illness has occurred. They should not be able to cancel a policy or unreasonably raise premiums. Terminally ill people who have life insurance can continue their coverage at pre-agreed premiums. There is no reason why health insurers can't follow a similar practice.

Problem: Job lock. Thirty percent of Americans say they, or others in their household, have stayed on a job they wanted to leave because they did not want to lose employer-provided insurance coverage. Even though economists are almost unanimous in the belief that health insurance costs are fully paid for by workers (as a fringe benefit that substitutes for wages), our employee benefits system treats the policy as belonging to the employer, not the employee. This might be acceptable if employees worked for the same employer for the whole of their work life. In fact, most do not. A reasonable solution is to insist that health insurance benefits be personal and portable.

Source: John C. Goodman, "Should Healthy People Pay More for Health Insurance?" National Center for Policy Analysis, NCPA Policy Backgrounder No. 115, April 1992.

Good Idea: Collectively Renewable Insurance. Even without guaranteed renewability, many of the same benefits can be obtained when insurance is collectively renewable, as the Texas Legislature recently required. [See the sidebar on H.B. 2055.] This requirement often is not a feature of policies sold to small groups. In the past, insurers in Texas could refuse to renew the policy of one employer because, for example, an employee had an expensive illness while the insurer agreed to renew another employer's identical policy. With collectively renewable insurance, insurers have to renew *all* similar policies or *none* of them. A company cannot single out the healthiest clients and discard the unhealthiest after the policies have been purchased.[98]

Good Idea: Personal and Portable Benefits. Although fringe benefits substitute for wages and are therefore "earned" by employees, today's employees have no ownership rights. Employers often can cut back coverage even after an employee gets sick.[99] And when employees with a preexisting illness leave, they may find it impossible to obtain insurance coverage elsewhere. As noted above, our system of employer-based health insurance is largely the creation of the federal tax law. Although state governments cannot change federal tax law, they can adopt policies that encourage personal and portable health insurance benefits.[100] Currently, some 40 states have passed legislation that permits individuals to continue their health insurance coverage after leaving a job. In addition, 40 states have passed legislation that permits individuals to convert their employer-based group policy to a non-group (individual) policy.[101]

H.B. 2055 requires that small group insurance contain a conversion privilege. This option permits individual employees who have their employer's coverage terminated by the insurer to continue the same coverage at a premium no more than twice what they and their employer had been paying.

Mediocre Idea: State-Run Purchasing Pools. Small businesses — those with 25 or fewer employees — face a problem not faced either by large businesses or by individuals. Under a common practice, insurers annually set each firm's premiums based on the previous year's experience. If one person in a small group has large medical expenses, the resulting premium increases may be prohibitively high, perhaps forcing the employer to cancel coverage for everyone. In response, several states have established or are considering state-administered purchasing pools that permit small employers to purchase insurance together. These purchasing pools, or health insurance purchasing cooperatives (HIPCs), will serve as middlemen between health insurers or provider networks and health insurance purchasers.[102] The recently passed H.B. 2055 establishes such a purchasing pool, known as the Texas Health Benefits Purchasing Cooperative. The bill also permits private businesses, insurance companies and other organizations to form nonprofit cooperatives.[103]

"Why buy health insurance today if you can buy it after you get sick?"

The problem with state-created cooperatives is that they impose a regulatory bureaucracy between businesses and health insurance companies, increasing administrative costs for employers and health insurers (as H.B. 2055 would do) while providing very little in return.[104] Private purchasing cooperatives are already beginning to form — but without the regulatory oversight of a state-controlled body.

Bad Idea: Guaranteed Issue. An ideal insurance market is one in which risk is priced accurately. Each person entering an insurance pool is charged a premium based on the expected cost and risk that person brings to the pool. Put another way, in an ideal insurance market people pay for what they get. Under the Task Force's proposal, however, insurers would be forced to sell policies at the same price — no matter how sick or how well the applicants are.[105] Thus people who had decided to forgo purchasing health insurance and use their money for other purposes could not be denied health insurance once they got sick. Such a policy creates a perverse incentive. Whereas guaranteed renewability would encourage people to purchase health insurance (because, once sick, they would be able to continue coverage at reasonable rates), guaranteed issue would have the opposite effect. Why buy health insurance today if you can buy it for the same price after you get sick?

"Virtually all studies of guaranteed-issue insurance have concluded that it increases premiums."

Virtually all studies of guaranteed-issue insurance have concluded that it increases premiums.[106] For example, a recent study for the Society of Actuaries compared medically underwritten policies with guaranteed-issue insurance, under which all preexisting illness limitations were waived after 12 months.[107] The study showed that:

- The cost of guaranteed-issue insurance was 23 percent higher the first year and 50 percent higher the second year.[108]
- The seven-year cost of guaranteed-issue insurance was 39 percent higher.[109]
- These numbers imply that if people who are now medically underwritten could buy only higher-priced guaranteed-issue insurance, from one-fifth to one-half of them would choose to be uninsured.[110]

According to one estimate, no more than seven-tenths of 1 percent of Americans under the age of 65 are uninsurable.[111] Yet in an attempt to make health insurance more affordable for this tiny number, guaranteed-issue regulations would impose price controls and raise premiums for the other 99 percent. The result would almost certainly be a larger number of people who are voluntarily uninsured.

Worst Idea: Community Rating. The concept of guaranteed issue is often combined with community rating. Under "pure" community rating, insurers are forced to charge the same price to every policyholder, regardless of age, sex or any other indicator of health risk. Despite the fact that health

costs for a 60-year-old male are typically three to four times as high as those for a 25-year-old male, both would pay the same premium.[112] Under "modified" community rating, as recommended by the Task Force, price differences could be based on age and sex.[113] Other than that, however, sick people could buy health insurance for the same price as healthy people. Thus:

- A person who has AIDS would be able to purchase health insurance for the same price as someone who does not.
- People in hospital cancer wards would be able to buy health insurance for the same price as people who do not have cancer. [See the sidebar on what's wrong with charging healthy people more for health insurance.]

Under community rating, healthy people must be charged more so that sick people can be charged less. Most people, therefore, would see their premiums rise. This would drive lower-income and healthy people out of the market, make the pool of insured people smaller and less healthy and drive up premiums even more.

Proponents of community rating agree that the result of permitting unhealthy people to purchase health insurance at the same price as healthy people would be to raise premiums for healthy people. But they argue those increases would be small when distributed over all of the insured. However, as Figure V shows, employees of companies that self-insure, HMOs, Medicare and Medicaid would be exempt from the price-increasing impact of community rating.[114] The full burden of the price increases would fall on a very small number of the insured — those who participate in traditional risk insurance plans.[115] As a result:

- Of the approximately 15.6 million Texans with health insurance, only 2 million have traditional risk insurance.
- Therefore, only 13 percent of the insured would be forced to cover the costs of providing community rating to the sick.

Problem No. 5: The Uninsurable

As noted above, only seven-tenths of 1 percent of Americans under the age of 65 are uninsurable.[116] Yet some reformers would force higher premiums on the other 99 percent, driving many of them out of the market. If health insurance policies were guaranteed renewable and portable, people would have strong incentives to become insured before they got sick. But what should we do about the 1 percent who are already sick and uninsured and are generally thought to be uninsurable?

"The best approach is to subsidize directly people who are uninsurable, making the subsidy highest for those with the lowest incomes."

What's Wrong with Charging Healthy People More for Health Insurance?

When people who do not have health insurance become sick and generate large medical bills, they frequently cannot pay those bills from their own resources. Yet we generally require hospitals to provide health care to people regardless of ability to pay. Who should pay the costs of uncompensated care?

The obvious answer is taxpayers, through the use of public funds. But rather than raise taxes to pay for what clearly is a social problem, many politicians want to raise the health insurance premiums of healthy people instead. These proposals require insurers to charge the same price to all buyers, whether healthy or sick. The healthy would be overcharged so that the sick could be charged a premium much lower than their expected health care costs.

Imposing a regressive, hidden tax. By forcing insurance companies to pay the medical bills of people who are already sick, politicians would be indirectly shifting the cost (through premium increases) to healthy people who buy health insurance. In so doing, they would be imposing a hidden, highly regressive tax on unsuspecting families. Whereas the income tax system is designed so that higher-income families pay higher tax rates, many health insurance reform proposals would impose the highest hidden tax rates on the lowest-income families. For example, if health insurance reform causes the premiums for family policies to rise by $1,000, that's a 10 percent tax on a family with a $10,000 annual income but only a 1 percent tax on a family with $100,000 in income. Thus the tax rate on a family with the lower annual income would be ten times as high.

Increasing the number of people without health insurance. Contrary to widespread impressions, most of the 37 million people who are currently uninsured are healthy, not sick. Sixty percent are under 30 years of age and in the healthiest population age groups. They have below-average incomes and few assets and tend to be very sensitive to premium prices.

Moreover, the primary reason why most of the uninsured lack health coverage is that they have judged the price too high relative to the benefits. Very few have been denied coverage. The artificial premium increases that would result from many health insurance reform proposals would substantially increase the number of employers who fail to provide coverage for their employees and the number of individuals who are uninsured by choice.

Subsidies versus price controls. The worst feature of one-price-for-all laws is that they cause enormous harm in order to accomplish a little good. A much better approach would be to directly tackle the problems of the less than 1 percent of the population that is uninsurable and allow the other 99 percent to buy real health insurance.

Source: John C. Goodman, "Should Healthy People Pay More for Health Insurance?" National Center for Policy Analysis, NCPA Policy Backgrounder No. 115, April 1992.

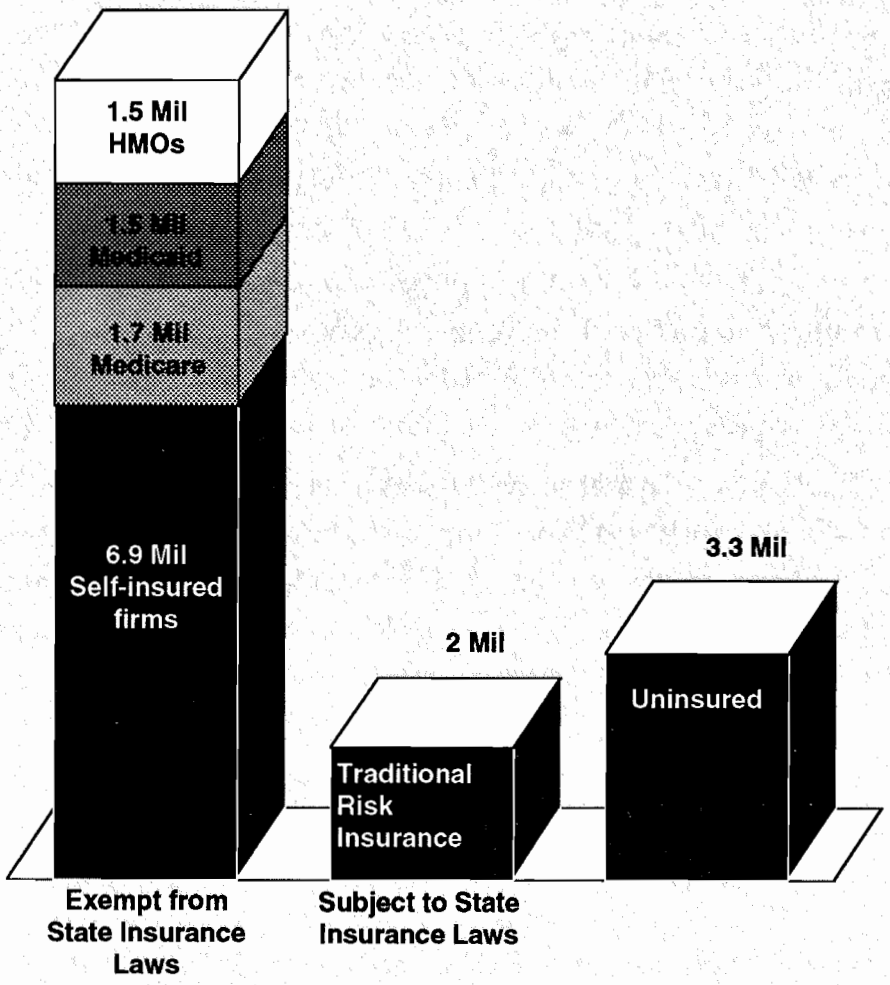
Best Idea: Direct Subsidies. The best approach is to subsidize directly people who are uninsurable, making the amount of subsidy highest for those with the lowest incomes. The subsidies should be funded by general taxes, so that the burden of solving this social problem is fairly spread over all Texas taxpayers. Government might pay a portion of their medical bills[117] — say, everything above 30 percent of income — or part of the cost of having an insurer manage their health care.[118]

Second-Best Idea: Texas Risk Pool. One way in which state governments have attempted to provide health insurance for high-risk individuals is through risk pools. Currently, 27 states have passed legislation creating risk pools,[119] which sell insurance to individuals who cannot obtain policies elsewhere. Premium prices generally are set as a percentage of the prices of similar policies sold in the marketplace. For example, in most states the

"The cost of community rating would be borne by only 13 percent of the population."

FIGURE V

Who Would Pay for Guaranteed Issue and Community Rating in Texas?



Source: Blue Cross and Blue Shield of Texas, December 1991.

premium for risk pool insurance is 50 percent higher than for comparable policies. In Florida, however, risk pool premiums may be three times as high, and in Montana they may be four times as high. In Minnesota, the most generous state, risk pool insurance is only 25 percent more expensive.[120]

Since all states cap the price of risk pool insurance, thus creating an artificially low price, risk pools almost always lose money.[121] In Maine, losses are covered by a tax on hospital revenues. In Illinois and California, the subsidies are funded by general tax revenues.[122] The most common approach, however, is to assess insurers in proportion to their share of the state health insurance market and allow them to fully or partially offset their assessment against premium taxes paid to state governments.[123]

In 1989, Texas passed legislation establishing a state risk pool, but the pool is not operational because it has never been funded.[124] As with all risk pools, the plan specifies benefits, deductibles and premiums. For example, in Texas' legislation:

- There is a lifetime maximum benefit of $500,000.
- The deductibles offered must not be greater than $250 for an individual and $500 for a family.
- Premiums must not be lower than 150 percent or higher than 200 percent of the prices of similar policies sold in the marketplace.

The enabling legislation specifies that any loss incurred by the plan is to be recouped through an assessment on each insurer authorized to write health insurance in the state. Funding the losses in this way potentially raises the cost of health insurance for everyone not in the pool. Even though insurers would be allowed to offset their assessments against state taxes, this practice creates additional pressure to maintain (or even increase) taxes on insurance premiums, which causes further distortion in the health insurance marketplace. Moreover, any excess burden for insurers would be borne by a minority of people, since uninsured people and those in self-insured plans, HMOs and federally funded programs such as Medicare and Medicaid would not be affected. [See Figure V.]

"Texas has a risk pool but no funding."

Precisely because risk pools lose money and because there is a natural resistance to the higher taxes needed to fund those losses, many states refuse to sell risk pool insurance to all who would like to buy it. In Illinois, for example, the price is kept artificially low, but there is a waiting list of potential buyers. Texas, as noted above, has a risk pool but no funding.

Worst Idea: Regulate Insurance Prices. Politicians often perceive regulating insurance premiums as an easy way to make health insurance more affordable for those who are sick. While artificially low prices are clearly a good deal for the sick, they produce two perverse results: (1) most people have to pay higher premiums, which means that many cancel their policies; and (2) insurers try to find ways other than price to discriminate against sick people.

In either case, the market for health insurance is distorted, leaving insurers reluctant to sell and many consumers reluctant to buy.

Very Worst Idea: A State-Run Health Care System. Although the Task Force asserted that a state-run health care system would be the best solution, it is in fact the worst. As noted above, health care rationing would soon follow, as it already has in Canada, and the elderly, the poor and racial minorities would suffer most. Furthermore, the state's best physicians, put under price controls, would leave Texas to practice in another state, perhaps right across the Texas border so that monied patients could travel out of state for private care.

Problem No. 6: State-Mandated Benefits

State-mandated health insurance benefits laws tell insurers what services and providers they must cover in order to sell health insurance in a state. Although they nominally restrict the behavior of insurers, these laws actually limit the freedom of choice of consumers. They force people either to purchase a Cadillac plan — bloated with extra benefits — or to remain uninsured.

Nationally, mandated benefits laws cover diseases ranging from mental illness to alcoholism and drug abuse, services ranging from acupuncture to in vitro fertilization and providers ranging from chiropractors to naturopaths. They cover everything from the serious to the trivial: heart transplants in Georgia, liver transplants in Illinois, hairpieces in Minnesota, marriage counseling in California, pastoral counseling in Vermont and deposits to a sperm bank in Massachusetts. In 1965, there were only eight mandated health insurance benefits laws in the United States. As Figure VI shows, today there are more than a thousand.[125]

"Mandated benefits raise the cost of health insurance and price millions of people out of the market."

The number of mandated health insurance benefits has increased markedly in Texas. In 1970, the state imposed only one mandate: a requirement that insurers offer optional coverage for osteopathy. By the 1990s, however, the number of Texas mandates had soared. [See Table I.]

- Only six states had a higher number of mandated benefits laws than Texas at mid-year 1991, the latest period for which national data is available.
- The number of mandates in the state *tripled* between 1980 and 1991 — rising from 9 to 27.

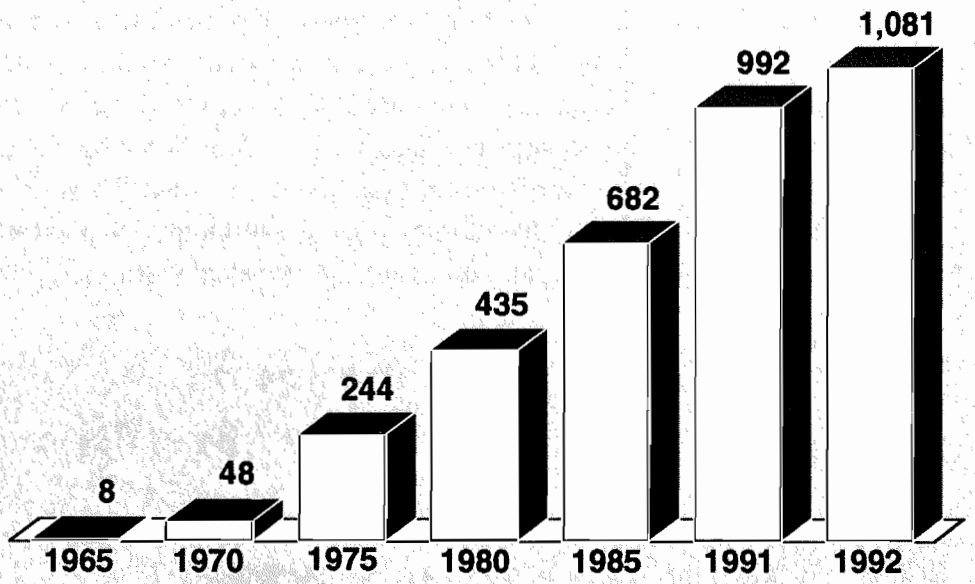
Mandated benefits raise the cost of health insurance and price millions of people out of the market. According to one study, mandated coverage increases premiums by 8.8 percent for substance abuse, 15 percent for dental services (the most expensive mandate) and nearly 13 percent for psychiatric hospital care.[126] [See Figure VII.] A study by the National Center for Policy Analysis has estimated that:[127]

"The number of state mandates soared in the 1970s and 1980s."

FIGURE VI

Number of Mandated Health Insurance Benefits Enacted by State Governments

(1965 to 1992)



Source: Greg Scandlen, *Health Benefits Letter,* Vol. 1, No. 15, August 29, 1991, and Vol. 2, No. 2, July 31, 1992.

- For the nation as a whole, as many as one out of every four uninsured people has been priced out of the market by state-mandated benefits laws.
- In Texas, between 389,000 and 701,000 are uninsured as a result of state mandates.

"As many as 701,000 Texans are uninsured as a result of state mandates."

As noted above, most large corporations are exempt from these regulations because they self-insure. As more mandated benefits laws are enacted, more companies opt to self-insure. One study found that mandating coverage of psychologists increased the probability that a firm would self-insure by 93.2 percent, while drug dependency mandates increased the probability by 58.8 percent. The collective impact of all state regulations prompted 51 percent of the sample firms to self-insure.[128]

Best Idea: Repeal All State Mandates. The most straightforward way to lift the burden of state mandates is to repeal them. As noted below, a number of states have already repealed mandates for small business in an effort to make health insurance more affordable. But mandates are bad not just for small businesses but for *all* businesses. There is no reason to substitute the judgment of politicians for the judgment of buyers and sellers in determining the extent of health insurance coverage.

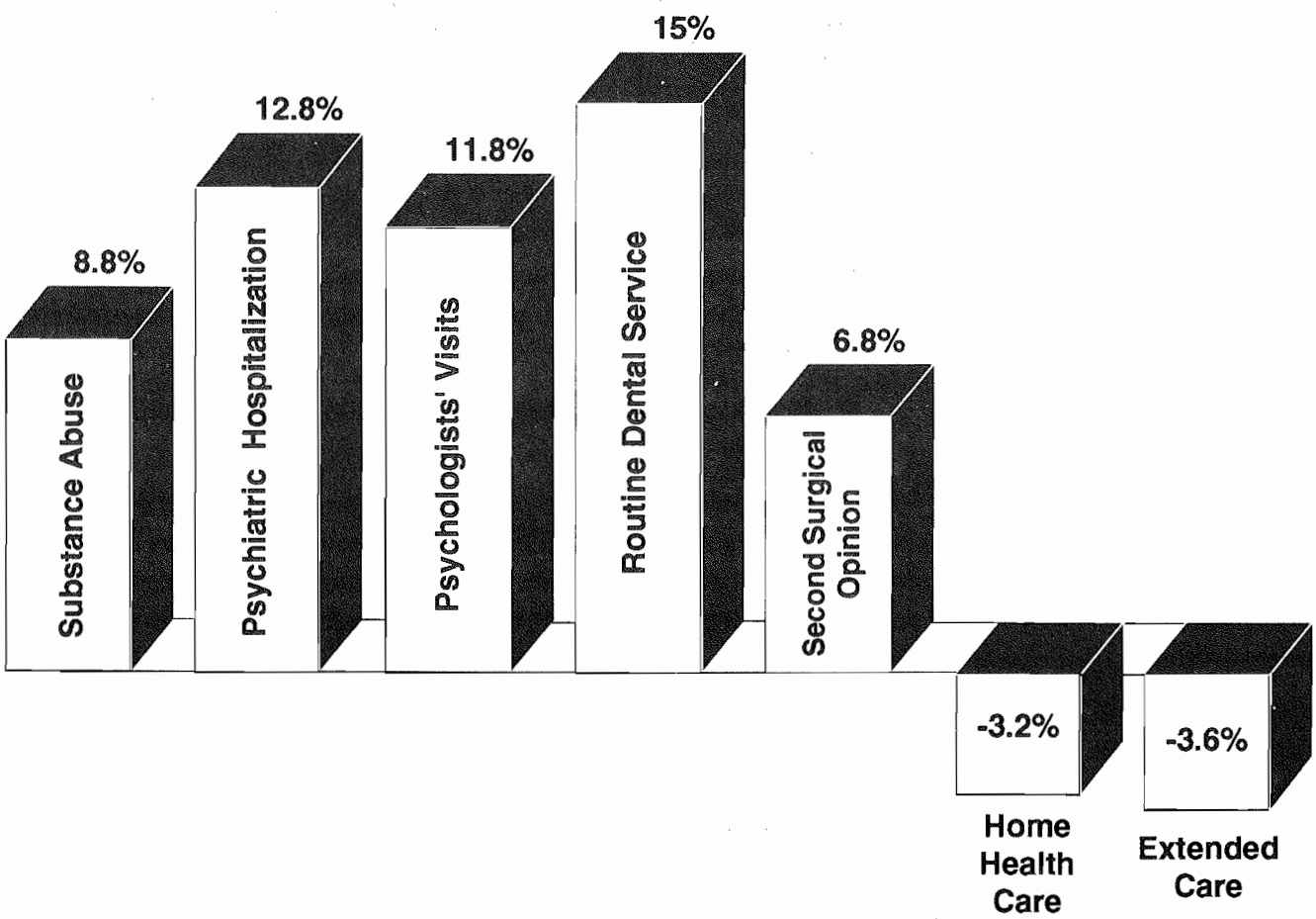
Good Idea: Allow No-Frills Alternatives. Failing total repeal of mandated benefits, state governments should allow insurers to sell a no-frills policy to any buyer within the state. Mandate-free insurance could compete side-by-side with regulated insurance. This would extend to the rest of the population a right now enjoyed only by employees of the largest corporations.

"There is no reason to substitute the judgment of politicians for the judgment of buyers and sellers in determining the extent of health insurance coverage."

Second-Best Idea: Exempt Small Businesses. At one time it was thought that significant progress could be made in exempting small businesses from mandated benefits. Over the past few years, 24 states have done so to one degree or another.[129] Take Washington state, for example. Normally, health insurance policies there would be subject to 28 mandates — covering alcohol and drug abuse, mammography and the services of chiropractors, occupational therapists, physical therapists, speech therapists, podiatrists and

FIGURE VII

How Much Do Mandated Benefits Add to Costs?



Source: Jon Gabel and Gail Jensen, "The Price of State-Mandated Benefits," Health Insurance Association of America, Research Bulletin, July 1989.

TABLE I

Texas Health Care Mandates

Providers	Benefits	Extended Coverages
Chiropractors	**Alcoholism Treatment**	**Continuation/Dependents**
Dentists	**Drug Abuse Treatment**	**Continuation/Employees**
Optometrists	**Home Health Care**	**Conversion to Non-Group**
Osteopaths	**In Vitro Fertilization**	**Handicapped Dependents**
Physical Therapists	**Mammography Screening**	**Newborns**
Podiatrists	**Maternity**	**Noncustodial Children**
Professional Counselors	**Jaw (TMJ) Disorders**	
Psychologists	**Outpatient Psychiatric**	
Public & Other Facilities		
Social Workers		
Speech Therapists		
Hearing Loss Therapists		
Dietitians		

optometrists. Under a law passed in 1990, firms with fewer than 50 employees can buy cheaper insurance with no mandated benefits.[130]

While they are a step in the right direction, most mandate-exemption laws are so narrowly constructed that the qualifying firms are few and dispersed. Unable to identify a large enough market, most insurers have simply ignored it.[131] For example, in 14 states such exemptions apply only to firms with no more than 25 employees. In addition, many states allow a small business to qualify only if it has been without insurance for some period of time: at least one year in seven states, two years in Kansas, Maryland and Rhode Island and three years in Kentucky. In these states, small employers are penalized for providing insurance coverage. All the benefits from the new legislation go to their uninsured competitors.[132]

Second-Best Idea: Require Social and Financial Impact Statements. Following the lead of Washington, Arizona and Oregon, more than a dozen state legislatures now require social and financial impact statements before they pass additional mandates.[133] For example, because of concern about costs, in 1983 Washington state began putting the burden of proof on mandate proponents to show that a mandate's benefits would exceed its costs. As a result, no new mandate was adopted by the Washington legislature for several years.[134] Clearly, impact statements slow the passage of mandated benefits,

if only because the proponents of mandates need more time and money to overcome the new legislative hurdles.

Problem No. 7: Rural and Underserved Areas

It is widely believed that certain groups of people are underserved by the U.S. health care system. They are primarily low-income families and/or people who live in rural areas. Rural health care is an especially important state issue because more than 3.1 million Texans live in rural areas.[135] Overall:

- In Texas, 224 areas and two "populations" are designated as medically underserved.[136]
- Another 34 counties have no hospital, two or fewer physicians and no nurse-practitioners or physicians' assistants.[137]

The Texas Task Force expressed particular concern about the limited number of physicians, nurses and hospitals in rural Texas. Among the reasons:

- Texas led the nation with 77 hospital closings between 1984 and 1990, more than half of them in rural counties.[138]
- In rural Texas, there is one physician for every 1,219 people — over twice as many individuals per physician as in urban areas, and in 1990, 18 counties in Texas had no physician.[139]

"The main reason there are few or no physicians in many areas is that there are too few residents to support them."

The problem, however, is easy to exaggerate. The main reason there are few or no physicians in many of these areas is that there are too few residents to support them. More importantly, almost anyone with access to a car in Texas can reach a physician. Although rural areas are often depicted as lacking health care alternatives, more than 84 percent of rural hospitals are within 30 miles of another hospital.[140]

Government policy toward rural health care is somewhat schizophrenic. On the one hand a number of bureaucratic programs are designed to subsidize rural health care. On the other hand, the government discourages the development of a healthy private sector in rural health care. The next two proposals are designed to meet the needs of these people innovatively — not by spending more money but by using current funds more effectively. Their full implementation would require waivers from the federal government, but the Clinton administration has indicated a willingness to grant waivers for innovative solutions.

Good Idea: Medical Enterprise Zones. Many people assume that the only way to meet the health care needs of rural citizens is to spend more government money on rural health care programs. In fact, government

Selected Mandated Benefits in Texas

An important principle of insurance is that the insured event must be a risky event — one which has not already occurred. Yet many mandated benefit laws require insurers to offer benefits that are more related to people's choices and lifestyles than to well-defined, risky events. Other mandates require insurers to cover a wide range of health care providers and conditions such as mental disorders.

In vitro fertilization. Absent state regulation, in vitro fertilization is not an insurable event. The expense is not one that arises from a risky event over which the insured has no control. Instead, the decision to undergo this treatment is a voluntary, personal choice. The cost can run from $4,000 to $8,000 per attempt, and many attempts are not uncommon. The cost must be borne by all of the enrollees in an insurance plan unless rejected in writing by the group policyholder.

Alcoholism and drug abuse. Texas regulations state that benefits for the necessary care and treatment of chemical dependency must be provided in group policies on the same basis as for other physical illnesses generally. The only limitation imposed is that the benefits may be limited to three separate series of treatments for each covered individual. The result is that social drinkers, teetotalers and non-drug users must pay higher premiums to cover these costs.

Outpatient mental health care. Texas requires that a group policy providing benefits for treatment of mental illness in a hospital include benefits for treatments in a psychiatric day treatment facility. The benefit must be equal to at least one-half of that provided for treatment in a hospital. Though the intent of the regulation is to encourage substitution of less expensive for more expensive services, outpatient utilization is higher, adding to total costs.

Home health care. Home health care is a mandated offering in Texas. Unless rejected in writing, group policy benefits must provide coverage for the following services: skilled nursing; physical, occupational, speech or respiratory therapy; home health aide; and medical equipment and supplies.

Extended coverage. Two laws have been passed that further extend the scope of eligibles:

- One law mandates that health insurance coverage be provided to the policyholder's dependent, even if the child is not living in the same household.
- As of 1991, if an insurance policy offers dependent coverage, the insurer must provide coverage for dependent grandchildren as well.

Mandated providers. Besides traditional physicians, mandates cover dietitians, marriage and family therapists, chiropractors, podiatrists, professional counselors, speech therapists and others.

Oral contraceptives. Though oral contraceptives are a voluntary choice that most women can afford, they must be included in plans when all other prescription drugs are included.

Alternative medicine. Legislation was introduced, but did not pass, that would have required plans to cover "alternative" medical therapies if the state licenses and oversees their practitioners.

regulations are probably a far greater obstacle to good quality care at a reasonable price than is a lack of funds.[141] Many state and federal regulations discriminate against rural areas by placing onerous, cost-increasing restrictions and regulations on health care providers and facilities. These regulations often cause existing facilities to close and prevent new facilities from opening. [See the sidebar on Medical Enterprise Zones.]

In most states, for example, medics who treated soldiers in the field in the Vietnam or Persian Gulf wars are not allowed to treat ordinary citizens, even if no doctor lives in the area. The same restrictions apply to nurses and physicians' assistants, despite studies showing that paramedical personnel can deliver certain kinds of primary care as well as licensed physicians.[142]

"Medical Enterprise Zones give underserved areas the freedom and flexibility to meet health care needs with scarce resources."

The concept behind Medical Enterprise Zones (MEZs) is that underserved areas should have the freedom to make their own decisions about the best way to meet health care needs with scarce resources. Accordingly, within MEZs, many of the normal restrictive rules and regulations would be suspended, creating new options and opportunities for the people who live there.[143]

Good Idea: Medical Enterprise Programs. Closely related to the MEZ is the concept of Medical Enterprise Programs (MEPs). Whereas an MEZ is defined in terms of a geographical area, an MEP is defined in terms of a market being served. The urban poor face many of the same problems as rural residents — not because of a lack of physicians and facilities, but because they have been priced out of the market by government regulations engendered by special interests. Accordingly, individuals and facilities providing medical services primarily to low-income families should be allowed to participate in Medical Enterprise Programs that are exempted from many government regulations in a manner similar to those in an MEZ.

Mediocre Idea: Subsidize Rural Providers. Many states have adopted policies to increase the number of primary care physicians practicing in rural and underserved areas, including tuition waivers for medical students who agree to practice in these areas and limits on medical malpractice liability if a retired physician decides to voluntarily serve poor patients. A more recent and radical proposal would redistribute income from medical specialists to primary care physicians.[144]

The implicit assumption behind these schemes is that urban politicians and bureaucrats know how best to allocate money to provide health services to rural residents. A better solution would be to send the money directly to the district so that its residents could allocate it to meet their needs. They might, for instance, use the money to provide free immunizations, to improve a clinic rather than a hospital or, if restrictions were removed, to increase their supply of nurses or physicians' assistants.

The Case for Medical Enterprise Zones

Rural areas often suffer from a shortage of health care providers and facilities. This is a result, in part, of expensive and burdensome government regulations. For example:

- Medicare rules require rural hospitals to maintain a staff of numerous professionals (whether needed or not), including a full-time director of food and dietary services.
- State licensing laws often require rural hospitals to have fully equipped operating rooms and a surgical staff — even if the hospital performs no surgery.
- Medicare requires hospitals to meet expensive fire and safety rules, including corridors of a minimum width — even if the rural hospital is greatly underused.
- State licensing laws often require hospitals to employ several individuals for tasks that one could perform.
- To qualify as a Community Health Center (CHC), a facility must have a minimum number of patient encounters per physician, and administrative costs must not exceed a certain percent of total costs — standards that many rural CHCs cannot meet.
- Medicare and Medicaid regulations prevent hospital-physician joint ventures, physician ownership of hospitals and other arrangements that might induce more physicians to practice in rural areas.

The general principle behind the concept of Medical Enterprise Zones (MEZs) is that some care is better than none. People who live where care is unavailable or difficult to obtain should have the opportunity to have their areas classified as MEZs. Within MEZs, restrictions such as those listed above would be waived.

For example, studies have shown that qualified nonphysicians can render many traditional medical services — and at a lower cost. Collectively referred to as "mid-level practitioners," they include nurse-practitioners, physicians' assistants, certified nurse-midwives, certified registered nurse-anesthetists and paramedics. State laws restrict not only these nonphysicians but also such personnel as pharmacists, optometrists and various technicians and therapists. These restrictions would be relaxed in an MEZ.

Given the poor economic conditions in many rural areas, health care professionals should be permitted to own or have a financial interest in pharmacies, laboratories, hospitals and home health services. The professionals should be required to inform patients of their financial interest and inform them of other, competing facilities or services, but should not be inhibited in their patient referrals.

Finally, Medicare and Medicaid should reimburse MEZ providers at the same rates paid in other areas. The average Medicare payment was 9 percent greater for large city hospitals than for rural hospitals in 1989, and Medicare's method of paying physicians relies on "customary, prevailing and reasonable charges" — which means that more expensive urban doctors tend to receive about 36 percent more for performing the same service.

Source: John C. Goodman and Gerald L. Musgrave, "National Health Insurance and Rural Health Care," National Center for Policy Analysis, NCPA Policy Report No. 107, October 1991.

Problem No. 8: Restrictive Medicaid Laws

Established in 1965, Medicaid is the health insurance program for the poor. But the program fails to serve many poor patients for three reasons. First, Medicaid was created to cover primarily those who qualify for Aid to Families with Dependent Children (AFDC), so less than half of the Americans whose annual income falls below the federal poverty level are eligible for Medicaid assistance.[145] Second, the states play a major role in establishing eligibility and benefits under their respective Medicaid programs, so the eligibility criteria and benefit amounts vary widely. Finally, because of low reimbursement rates and heavy administrative requirements, many physicians simply decline Medicaid patients.

In Texas, Medicaid fees are substantially below private fees and even below Medicaid reimbursement rates in other states:[146]

- While the Medicaid programs in Florida, Arkansas, Colorado and Georgia pay between $24 and $25 for an "intermediate" office visit for an established patient, Medicaid in Texas pays physicians only $19.50.
- Medicaid in Texas reimburses physicians for a normal vaginal delivery at only 53 percent of what private insurers pay for the same service.

"In Texas, Medicaid fees are substantially below private fees and even below Medicaid reimbursement rates in other states."

As already mentioned, many physicians now refuse to see Medicaid patients. According to one recent survey, 2 million adults between the age of 18 and 64 are refused care each year because they are on Medicaid.[147] Physicians who do see Medicaid patients often reduce the time allotted to those patients, which may decrease the quality of their care.

Furthermore, Medicaid's unwillingness to reimburse providers at or near market rates encourages patients to turn to more costly and inefficient alternatives. For example, because of lack of access to primary care physicians, Medicaid patients often turn to hospital emergency rooms, where care is immediate but much more expensive. Such inefficiencies have resulted in per-person Medicaid outlays that are far higher than those of private health insurers. The average annual cost of a Medicaid recipient under age 65 is $3,313, while for groups of 100 or more privately insured people it is $1,495 and for groups of less than 100 it is $1,507.[148] The difference between the annual cost of a Medicaid recipient and a non-Medicaid patient in a nursing home is even more dramatic: $7,103 versus $943, respectively — more than seven times as much.[149]

Finally, the Medicaid budget is being depleted by expenses other then direct medical care. For example, it is expected that 27 percent of the Medicaid budget will go to long-term care in 1994.[150]

These inefficiencies have led to a funding crisis in Medicaid. The program's spending increased about 10 percent annually through most of the 1980s, then soared in 1989, increasing 32 percent in 1991.[151] This spending explosion occurred in part because a loophole in 1991 Medicaid legislation permits states to expand their use of Medicaid and collect more matching funds from the federal government.[152] In fact, the Texas Task Force's primary recommendation regarding Medicaid, besides increasing the services provided, was to take better "advantage of generous federal matching funds available through Medicaid."[153]

Because Medicaid is largely under state control, states can act to address the problems in the program. In fact, many states have already begun to act. California, Kansas, Tennessee and Hawaii, for example, are transferring Medicaid patients into a managed care system. Florida is placing restrictions on physicians' fees, and Arizona's Medicaid system contracts for services from health insurance purchasing cooperatives. The key is to give states the freedom they need to respond to the Medicaid population.

"Decisions made by people far away from the problems often result in an enormous waste of resources."

Good Idea: A Federal Waiver. One of the biggest problems with the Medicaid program is that the decisionmakers who write the rules and regulations are often far removed from the problems they are attempting to solve. Politicians, pressured by special-interest groups, decide who is eligible and how health care is to be delivered. Often, their decisions result in an enormous waste of resources and prevent local communities from solving problems in a reasonable way.

President Bill Clinton has indicated a willingness to relax some Medicaid restrictions and grant Medicaid waivers to state governments, which would free up Medicaid money and permit local officials to make allocations based on community needs. Texas should take advantage of this. For example, the American Legislative Exchange Council (ALEC) has created a model "Rural Hospital Deregulation Act" that would provide regulatory relief to rural hospitals through federal waivers.[154] This would permit a wider and more efficient use of rural medical personnel, clinics and hospitals.[155]

Good Idea: Decentralize Medicaid. Absent federal and state regulations, those who provide indigent health care could find better ways of spending health care dollars. They should have the opportunity to do so. Medicaid funds should be decentralized and turned over to local communities with only one caveat: that the funds be spent on indigent health care. This would allow the providers to decide what services are most needed, and by whom.

Better Idea: Decentralize All Welfare. Given limited resources, it is not clear how much money should be spent on physicians and hospitals rather than on housing, food and other goods and services for the poor.

What's Wrong with Medicaid?

At its inception in 1965, proponents claimed that Medicaid would provide the poor with expanded access to medical care, which would in turn save on future costs. No one today believes that the program has lived up to those expectations.

Currently, Medicaid covers only about half of nonelderly people living in poverty. Even so, Medicaid spending is expected to absorb one-fourth of state budgets by 1995. On the average, about 60 percent of Medicaid expenses are paid with federal tax dollars.

The services paid for by Medicaid differ considerably from state to state. Although the federal government mandates certain services, the states add on a variety of options, including such services as chiropractors, optometry and podiatry, and such devices as dentures, prostheses and eyeglasses. However, in some states many below-poverty-level families are denied coverage for basic medical care.

In principle, people on Medicaid are entitled to virtually any services covered by the program. In practice, patient care is rationed by Medicaid reimbursement practices. In most states Medicaid payments for medical services are well below the payments made by other third-party payers. And Medicaid patients cannot add their own funds to Medicaid reimbursements. For example:

- In New York, the Medicaid payment is only 30 percent of the Medicare payment, and in West Virginia it is only 35 percent.
- As a result, many physicians who used to accept Medicaid patients no longer do so and those who do may deliver a lower quality of care.
- According to the American Hospital Association, Medicaid paid more than 90 percent of the cost of hospital care for Medicaid patients in 1980, but by 1988 the figure had dropped to 78 percent.
- One consequence is that many hospitals no longer want to accept Medicaid patients.

Things would be even worse were it not for the intervention of the federal courts, which are somewhat insulated from political pressures. In response to lawsuits filed by nursing homes in 20 states and hospitals in 21 states, the courts are ruling that Medicaid payments do not meet the standards of "reasonable and adequate" compensation and are ordering higher reimbursement levels. In principle, there is nothing wrong with paying lower prices in return for taking a hospital bed when it becomes available, rather than paying top dollar for immediate services. The trouble is that these decisions are being made not by patients but by the health care bureaucracy.

Source: Ken McDonnell, Michael Anzick and William Custer," State Initiatives in Health Care Reform," Employee Benefit Research Institute, *EBRI Issue Brief*, No. 127, June/July 1992; John Holahan and Sheila Zedlewski, "Expanding Medicaid to Cover Uninsured Americans," *Health Affairs*, Spring 1991, p. 49; Robert Pear, "Low Medicaid Fees Seen as Depriving the Poor of Care," *New York Times*, April 2, 1991; Robert Pear, " Suits Force U.S. and States to Pay More for Medicaid," *New York Times*, October 29, 1991.

"All means-tested welfare spending should be turned over to local communities."

Currently, we allow the politicians who govern what we call the welfare state to decide. But people in local communities faced with real problems are likely to make better decisions. Accordingly, we propose that all means-tested welfare spending be turned over to local communities with only one restriction: that the funds be spent helping low-income people. Under Community-Centered Welfare (CCW), the amount given by federal and state governments would not be determined by arbitrary eligibility standards devised in the political process. Instead, each community would receive an amount based on the poverty in that community.

Good Idea: Privatize Medicaid. One way to give low income people the same health care opportunities as others would be to allow them a government-funded voucher, which they could use to subscribe to an HMO or to purchase conventional health insurance. This option would be less expensive per recipient, cover the poor with private health insurance and make them full participants in the medical marketplace.

Mediocre Idea: Managed Care for Medicaid Recipients. Tennessee has passed legislation that would place all of the state's Medicaid recipients, along with all of the state's uninsured, in a private managed care system known as TennCare, financed by combining the state's Medicaid funds with other government money spent on indigent care. Because Medicaid is so loaded with inefficiencies and administrative waste, Governor Ned McWerter believes the state can use the same money to provide services for the poor and uninsured without increasing taxes.

Although this program might be better than Medicaid, it will create a two-tiered system in which most working people have options while the poor have only managed care.

Bad Idea: Ration Health Care. Oregon has openly adopted medical rationing for Medicaid recipients by creating a list of procedures and ranking medical treatments in terms of priority. The ranking takes into consideration such factors as costs, benefits to the patient, the extent to which treatment would affect the patient's quality of life and community values. Medical conditions considered "economically worthwhile" include prenatal care, several types of pneumonia, appendicitis, hernia and tuberculosis. Conditions not covered include those which individuals can treat themselves such as superficial wounds, benign conditions such as a cyst on the kidney, conditions that are untreatable such as anencephaly (a child born without a brain), and conditions that have a low success rate such as treatment for extremely low-birth-weight babies (less than 1.1 pounds and less than 23 weeks of gestation) and terminal AIDS patients.[156]

Proponents argue that the plan makes open and explicit the rationing decisions that were covert before. Critics argue that the plan unfairly reduces care for the young, the elderly and those with terminal illnesses such as

AIDS.[157] The Department of Health and Human Services (HHS) under the Bush administration rejected the Oregon Health Plan on the grounds that it might conflict with the Americans with Disabilities Act.[158] After Oregon made a few alterations, HHS under Clinton approved the program.

The Oregon plan draws our attention to the uncomfortable fact that if we tried to meet every health care need, we could easily spend the entire gross national product on health care. As a consequence, we must choose between health care and other uses of money. The plan also invites us to consider that if government controls our health care dollars, then government must make the rationing decisions. If we control our own health care dollars, we can make our own decisions.

Problem No. 9: Paying for Reforms

The Texas Task Force was long on recommendations for health care reforms but short on suggestions about how to pay for them. Even for the very expensive task of providing free health care to all children and pregnant mothers in the state, the Texas Task Force had no funding recommendation other than the observation that more matching federal funds were available through Medicaid.

Both good and bad ideas for health care reform can cost money. How should such reform be financed?

"The appropriate way to fund health care reform is through general tax revenues."

Good Idea: Use General Revenues. If there is any reason for government to subsidize health care or health insurance for low- and middle-income families, presumably it is to serve the "public good." Accordingly, the appropriate way to fund such activities is through general revenues collected from the entire public, with higher burdens for those with greater ability to pay.

Bad Idea: Tax Health Insurance. A common proposal is to fund health care reform by taxing health insurance. For example, most health insurance risk pools are funded by a tax on health insurance premiums. And many health insurance reform proposals are designed to lower premiums for high-risk (or sick) people by raising them for low-risk (or healthy) people.

If it is socially desirable for people to have health insurance, then any policy that artificially raises premiums is inconsistent with achieving that goal. As stated before, most of the uninsured are young, healthy people with low incomes who have been priced out of the market. Charging more for health insurance will only increase their ranks.

Worst Idea: Tax Sick People. A number of states are attempting to pay for health care reform by taxing hospital beds or revenues or by taxing providers. New Jersey currently imposes a 19 percent tax on all hospital bills (except those of Medicare patients), although the practice of taxing the hospital bills of employees of self-insured companies has been struck down by the courts.[159] The state uses the money to subsidize indigent hospital care and

"Taxing the sick takes funds from people at a time in their lives when they can least afford it."

hospital discounts for Blue Cross and Blue Shield patients. Minnesota's new reform plan is to be financed by a 1 percent tax on premiums paid to HMOs, a 2 percent tax on the revenues of hospitals, physicians and wholesale drug distributors and a 5 cents-per-pack cigarette tax.[160] To discourage Minnesotans from seeking untaxed hospital care outside the state, Minnesota plans to impose its tax on out-of-state hospitals that care for 20 or more Minnesotans per year — "not just in bordering states, any state, even Canada."[161]

These ideas are partly a continuation of a long-established tradition of financing charity care by shifting the cost from those who cannot pay to those who can. As a result, paying patients are overcharged, forcing their health insurance premiums up while they pay more out-of-pocket. Unfortunately, taxing the sick takes funds from people at a time in their lives when they can least afford it.

Problem No. 10: Tort Liability

According to the medical community, tort liability is one of the primary factors driving up the cost of health care. No one knows exactly how much the tort system adds to an average medical bill. Most people think the number is quite large. Apart from such measurable items as attorney fees, court costs, damage awards and settlement checks, there are thousands of unseen costs. For example, out of fear of lawsuits, physicians order extra tests, perform extra procedures and otherwise practice defensive medicine.[162]

Although estimates of the total cost of the medical malpractice system range from $20 to $45 billion, most scholars think that about 1 percent of the nation's annual health care bill is consumed by malpractice premiums and another 3 percent by defensive medicine.[163] There are, however, reasons to believe that the studies underestimate the true cost of defensive medicine. But even if the current estimates are accurate, the cost of the medical tort liability system is quite high — about $36 billion for the nation as a whole or $360 per year per household. Note that this amount is considerably more than the cost of mammograms, childhood vaccinations and other preventive services. From a financial point of view, tort reform is at least as important as a lot of other problems that concerned the Texas Task Force. Yet the Task Force had difficulty identifying any significant impact from malpractice claims, and its recommendations were generally benign.[164] However, the Task Force did recommend an extension of the Omnibus Health Care Rescue Act of 1989, which gives health care providers partial indemnification for malpractice claims arising from indigent care.[165]

The financial burden of the medical malpractice system might be worth bearing if the system's benefits exceeded its costs. But such benefits are hard to document. Studies show that one out of every 10 actual incidents of malpractice results in a lawsuit.[166] And many insurers are convinced that whether patients "like" their doctor is more important in determining legal action than actual malpractice. Moreover, many believe that once a suit has

been initiated, the outcome more resembles a lottery than the administration of justice.

Some have calculated the considerable savings from abolishing the system entirely.[167] But the tort system is not all bad. Given that third-party payers put enormous pressure on providers to make quality-reducing changes, the tort system may be the single most important protector of patient welfare. By contrast, consider Britain, where the quality-reducing pressures are much greater and the rights of plaintiffs more restricted. When British patients sue hospitals, they are actually suing the government. Unquestionably, there is far more *actual* malpractice in Britain than in the United States, even though there is far less litigation.[168]

The primary problem with the tort system is that it is another bureaucracy, replete with its own perverse incentives. Moreover, it is a bureaucracy that feeds off the health care sector with little consideration of the damage it causes. Juries do not even know and are not allowed to consider that huge damage awards set precedents affecting other patients, physicians and hospitals — not just those who are litigating the specific case.

How can the system be reformed in order to reduce costs and at the same time protect patients' rights?

Best Idea: Reduce Liability by Contract.[169] Most proposals to reform the malpractice liability system would place arbitrary limits on the rights of plaintiffs in malpractice suits. Not all of these proposals are bad. But they share the common flaw of attempting to solve problems by bureaucratic fiat rather than by voluntary, mutually beneficial exchanges. Why not allow patients to make contractual agreements in their own interests? Patients should have the same rights as buyers in other markets, including the right to waive certain tort claims in return for lower prices or other compensation.[170]

"An alternative to negligence litigation is to have the hospital take out a life insurance policy on a patient prior to surgery."

For example, one sensible way to cut down on negligence litigation is to have the hospital take out a life insurance policy on a patient prior to surgery. The hospital and the patient (or the patient's family) could agree that if the patient dies for any reason the family would accept the policy's payment as full compensation, unless there was criminal negligence. Litigation costs would be avoided, and life insurance companies would monitor the quality of care.

Second-Best Idea: Mandatory Arbitration and Limits on Awards. At least 15 states have adopted arbitration laws that encourage plaintiffs to settle their claims out of court, thereby saving court costs and occasional high jury awards. Besides arbitration, 25 states cap malpractice awards. Of these, 21 place caps on "pain and suffering." Nebraska, South Dakota and Virginia have caps of $1,000,000 on the total award and Indiana has a cap of $750,000.[171]

Some argue, however, that capping the reward limits a victim's ability to "punish" a provider for poor or negligent practice. Nebraska has passed legislation meant to address this problem. Providers can be sued for punitive damages, but the plaintiff receives only actual damages, which includes pain and suffering. The Nebraska Constitution requires that all punitive awards be earmarked for public education.

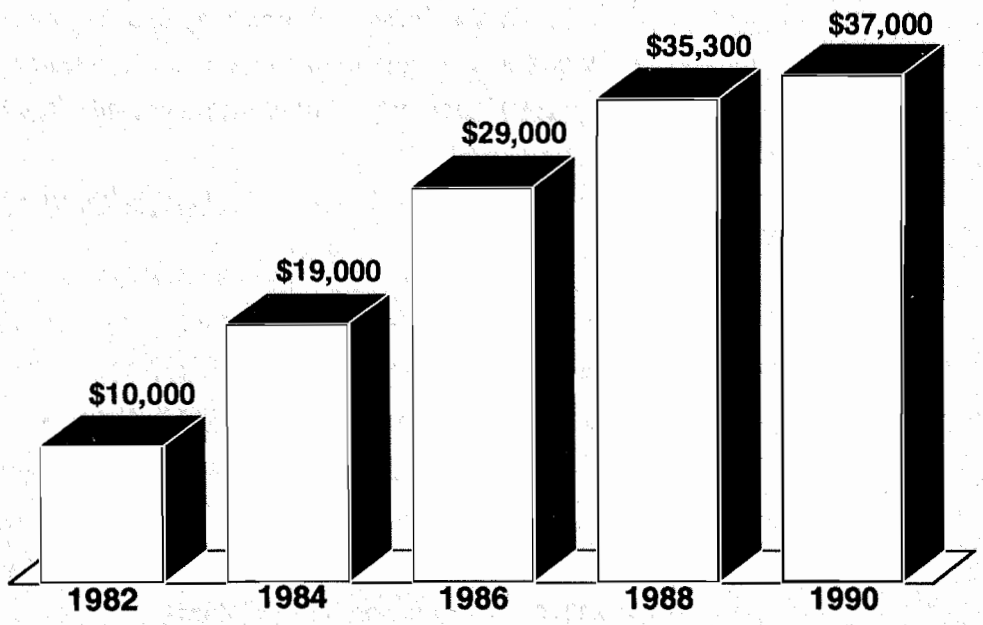
Mediocre Idea: State-Provided Practioners' Liability Coverage. The Task Force recommended providing state medical liability coverage for health care professionals who agree to serve rural or low-income populations. As noted above, this proposal does not lower the cost of the tort system — it simply shifts part of the cost to government. Nor does the proposal lower the cost of meeting the needs of underserved populations — it simply shifts the nature of the payment, from salaries to liability insurance premiums.

Mediocre Idea: Practice Guidelines. The Task Force endorsed the idea of providing medical liability immunity for physicians who follow practice guidelines for specific diagnoses. For example, Maine has established "risk management protocols" in the four specialties hardest hit by malpractice claims: anesthesiology, emergency medicine, obstetrics/gynecology and radiology. The 90 percent or more of the physicians in those specialties who have enrolled in the program cannot be sued if they stay within the established parameters.[172]

"The rise of medical malpractice suits has led to escalating malpractice premiums."

FIGURE VIII

Nationwide Average Annual Malpractice Premiums for Obstetricians



Source: *Socioeconomic Characteristics of Medical Practice* (Chicago: American Medical Association, 1990-91), Table 55, p. 147.

The primary problem with practice guidelines is that they tend to force physicians to practice "cookbook medicine." That may be fine for most instances, but for unusual cases the best treatment may not be in the cookbook. Patients may die or suffer prolonged illness if their physicians stay within the guidelines. It is in the patients' interest for health care providers to treat illness without artificial constraints.

Bad Idea: Shift Liability to Bureaucracies. One proposal suggested by Hillary Rodham Clinton's health care task force is to transfer malpractice liability from physicians and hospitals to an Accountable Health Plan (AHP), a provider organization similar to an HMO. Proponents argue that this reform, known as "enterprise liability," would permit physicians to lower their fees by removing the threat of malpractice claims, and would discourage frivolous suits. But the reassignment of liability will not reduce the costs of the tort system unless there is a reduction in (1) the number of lawsuits, (2) the size of the average award or (3) the amount spent on defensive medicine. And it is not obvious how the reform will reduce any of the three.

"On the whole, the best way to achieve efficiency and minimize costs is by voluntary agreement and contract."

In fact, the deep pockets of the AHP might actually encourage lawsuits by making them potentially more profitable. Even if physicians did reduce the amount of defensive medicine, that would not reduce total costs if the move were offset by more and higher liability awards. Physicians engage in defensive medicine in order to reduce tort liability claims. Less defensive medicine may mean more liability.

On the whole, the best way to achieve efficiency and minimize costs is by voluntary agreement and contract. Arbitrary assignments of liability by the legislative branch of government interfere with that process.

Conclusion

There are two directions we can take in health care reform: Either we can enact laws that permit patients and providers to respond to the needs and demands of the health care marketplace, or we can enact more regulations and controls and encourage more bureaucracy.

As states across the country enact health care reforms, the Clinton administration is preparing to unveil its own national plan. The Clinton plan may override many state reforms now in existence. Or it may expand the range of options open to the states.

The central problem with Ann Richards' Health Policy Task Force is that it endorsed the worst ideas among the many alternatives for reform.

"States that are emphasizing freedom of choice in health care should become models."

Fortunately, Texas legislators ignored most Task Force recommendations when they passed H.B. 2055. Unfortunately, provisions in the bill are likely to increase — rather than decrease — the number of uninsured Texans. On the positive side, the bill did include some good reforms, and Texas legislators also passed a resolution calling on Congress to enact Medical Savings Accounts.

The battle over market-based reforms versus government control in health care is just beginning. And while a number of states are turning toward government control, many others are making freedom of choice in health care central to their proposals. The latter states should become models for Texas and for the nation.

NOTE: Nothing written here should be construed as necessarily reflecting the views of the National Center for Policy Analysis or as an attempt to aid or hinder the passage of any bill before Congress.

Notes

[1] See American Legislative Exchange Council, "Health Care Reform: State-by-State Analysis," *ALEC Legislative Update*, revised July 26, 1993.

[2] Dana Priest and Dan Morgan, "Governors Hoping Clinton Won't Slow Their Health Care Changes," *Washington Post*, February 1, 1993.

[3] Ibid.

[4] B. Drummond Ayres, Jr., "States Hustle to Adopt Health-Care Overhauls," *New York Times*, April 25, 1993; and Dana Priest and Ann Devroy, "Governors Seek Right to 'Opt Out' of Federal Health Cost Controls," *Washington Post*, April 6, 1993.

[5] See Texas Health Policy Task Force Report, "Texas Health Care: New Directions," November 1992 [hereafter referred to as Task Force Report].

[6] This problem is often described as the problem of rising costs. However, it is not clear that costs in the sense of average cost of treatment are rising. More importantly, the term "costs" encourages people to focus solely on the supply side of the market, when the source of the problem is on the demand side.

[7] See John C. Goodman and Gerald L. Musgrave, *Patient Power: Solving America's Health Care Crisis* (Washington, DC: Cato Institute, 1992), p. 76.

[8] Charles E. Begley and J. Guidry, "Health Care Expenditures in Texas, 1988," a paper presented to the Texas Health Policy Task Force, February 1992, p. 12, extrapolated to develop expenditures for the period 1988-1992. Cited in Task Force Report, p. 10. Federal figures for health care spending by states have not been collected for 10 years. Texas' growth in health care spending was consistent with national growth.

[9] Texas per-person spending was a little lower than the national average of $2,868 per person. See Suzanne W. Letsch, "National Health Care Spending in 1991," *Health Affairs*, Spring 1993, p. 95.

[10] "Critical Condition: Soaring Health Care Costs Plague Texas Businesses," a report of the Comptroller's Forces of Change Project, March 1992, p. 5.

[11] Task Force Report, pp. 115-25.

[12] See John C. Goodman and Gerald L. Musgrave, "Personal Medical Savings Accounts: An Idea Whose Time Has Come," National Center for Policy Analysis, NCPA Backgrounder No. 128, July 22, 1993.

[13] In 1991, for example, 195 pieces of legislation were introduced in various states to stop or cripple managed care and other cost control techniques. See the Wyatt Co., "Cost Analysis of State Legislature Mandates on Six Managed Care Practices," produced by the Health Insurance Association of America, July 1991, and reported in *Medical Benefits*, Vol. 8, No. 17, September 15, 1991, pp. 9-10. See also "Utilization Review Law: 'Hassle Factor' Inspires Provider Push for Restrictions," *Health Benefits Letter*, Vol. 1, No. 14, August 22, 1991.

[14] Jeanne Casey, "Prescription Drug Benefits: Pharmacies Oppose Managed Care," *Health Benefits Letter* No. 47, April 5, 1993. See also Paul P. Cooper III and Kylanne Green, "The Impact of State Laws on Managed Care," *Health Affairs*, Winter 1991.

[15] Cooper and Green, "The Impact of State Laws on Managed Care." A Preferred Provider Organization (PPO) is a loose association of health care providers who charge a discounted price to patients who are part of the network.

[16] Ibid.

[17] The concept was developed by the "Jackson Hole Group" — a group of health policy analysts that meets in Jackson Hole, WY, and includes Alain Enthoven, Paul Ellwood and Lynn Etheredge. For a description of their plan, see Ellwood, Enthoven and Etheredge, "The Jackson Hole Initiatives for a Twenty-First Century American Health Care System," *Health Economics* 1, 1992, pp. 149-68. Many of these ideas were originally developed in Alain C. Enthoven, *Health Plan: The Only Practical Solution to the Soaring Cost of Medical Care* (Reading, MA: Addison-Wesley, 1980).

[18] Other reforms would extend health insurance coverage to more people and make it personal and portable so that employees would not lose coverage when they change jobs. Insurers would not be able to arbitrarily cancel policies or single out sick people for unfair premium increases.

[19] Premiums would vary by age — not because the managed competition proponents find the practice fair or desirable, but because they judge it necessary in order to induce young people to buy insurance.

[20] What is called "managed care" is also referred to as "coordinated care."

[21] The HMO would receive premiums only from people who were about to undergo expensive medical procedures. Thus the average premium would have to equal the average cost of the procedures. It is precisely because most people cannot easily bear such a financial burden that health insurance is desirable in the first place.

[22] In the absence of a competitive market, people living in countries with national health insurance may find it in their rational self-interest to vote for a policy of increased primary care services funded by a reduction in acute care services. See the analysis in John C. Goodman and Gerald L. Musgrave, "Twenty Myths About National Health Insurance," National Center for Policy Analysis, NCPA Policy Report No. 128, December 1991.

[23] Note that this problem arises only because of price controls. Insurers have no reason to avoid applicants if each person who enters an insurance pool pays a premium that reflects the expected cost and risk the person adds to the pool.

[24] A recent study by the Congressional Budget Office also is pessimistic about the ability of managed competition to save money. See "Managed Competition and Its Potential to Reduce Health Spending," Congressional Budget Office, May 1993.

[25] See Alain Enthoven, *Health Plan*. The Heritage Foundation has called the FEHBP a "prototype" for national health care reform. See Robert E. Moffit, "Consumer Choice in Health: Learning from the Federal Employees Health Benefits Program," Heritage Foundation, Backgrounder No. 878, February 6, 1992. See also Robert E. Moffit, "Surprise! A Government Plan That Works," *Wall Street Journal,* April 2, 1992.

[26] See Janet P. Lundy, "The Federal Employees Health Benefits Program," Congressional Research Service, CRS Issue Brief, updated June 11, 1992.

[27] Cited in Lundy, "The Federal Employees Health Benefits Program."

[28] See the summary in Enthoven, *Health Plan,* pp. 114-15.

[29] Ibid., pp. 82-84 and p. 119.

[30] The Blue Cross "high-option" and "standard-option" fee-for-service plans are available to all federal employees. Seven "open" fee-for-service plans sponsored by unions or employee organizations also are available to all federal employees. Health Maintenance Organizations (HMOs), which are geographically based and thus available only to those living in specific areas, make up the remaining FEHBP options.

[31] See the discussion in John C. Goodman and Gerald L. Musgrave, "State Health Care Reform Under the Clinton Administration," National Center for Policy Analysis, NCPA Policy Report No. 173, November 1992.

[32] "Statement of the Consultants of the Committee on Post Office and Civil Service before the Subcommittee on Compensation and Employee Benefits," testimony before the House Subcommittee, May 20, 1992.

[33] Lundy, "The Federal Employees Health Benefits Program," p. 7.

[34] Service Employees International Union, "The CalPERS Experience and Managed Competition," SEIU Position Paper, March 1993. See also Steven Findley, "CalPERS: A Model for Health Care Reform?" *Business & Health,* June 1993, pp. 45-54.

[35] Ibid. , p. 10. See also *"At Issue,"* National Association of Health Underwriters, April 23, 1993.

[36] For a review of the effects of HMOs, see John K. Iglehart, "The American Health Care System: Managed Care," *New England Journal of Medicine*, Vol. 327, No. 10, September 3, 1992, pp. 742-47.

[37] See, for instance, CBO Staff Memorandum, "The Effects of Managed Care on Use and Costs of Health Services," Congressional Budget Office, Washington, DC, June 1992, p. 13.

[38] William B. Schwartz and Daniel N. Mendelson, "Why Managed Care Cannot Contain Hospital Costs," *Health Affairs,* Summer 1992.

[39] Ibid. The CBO contends that staff and group model HMOs "reduce hospital use significantly," but those savings are often offset by an increased use of their services. Other types of managed care have produced up to 8 percent reductions in overall expenditures. See CBO, "The Effects of Managed Care on Use and Costs of Health Services," p. 17.

[40] See Robert Brook et al., *The Effect of Coinsurance on the Health of Adults* (Santa Monica, CA: Rand, 1984); and Willard Manning et al., "Health Insurance and the Demand for Health Care: Evidence from a Randomized Experiment," *American*

Economic Review, June 1987.

41 Proponents also argue that practice guidelines, by authorizing an "official" standard of care, will help protect physicians who follow them from the threat of malpractice suits. However, because practice guidelines are just beginning to be developed, there is little agreement on what procedures should be included or how they should be developed and utilized.

42 See the discussion in Goodman and Musgrave, *Patient Power: Solving America's Health Care Crisis.* For a critical evaluation of practice guidelines, see Jane Orient, "An Evaluation of Abdominal Pain: Clinicians' Performance Compared with Three Protocols," *Southern Medical Journal,* Vol. 79, No. 7, July 1986, pp. 793-99.

43 See "Health Care Plans of the Texas Senatorial Candidates," National Center for Policy Analysis, May 26, 1993.

44 See Murray Weidenbaum, "Restraining Medicine Prices: Controls vs. Competition," Center for the Study of American Business, Policy Study No. 116, April 1993.

45 See the analysis in Goodman and Musgrave, "State Health Care Reform Under the Clinton Administration."

46 Medicare pays hospitals a predetermined reimbursement fee for 492 diagnosis-related groups. Medicare's DRG system for reimbursing hospitals is a price-fixing scheme in which the government is attempting to create an artificial market. DRG reimbursement prices do much more than limit the amount that government will pay. Since Medicare patients cannot add their own funds to the DRG rate and hospitals cannot give rebates to patients, Medicare literally fixes the prices of services rendered, independent of supply and demand.

47 The Health Care Financing Administration (HCFA) began on January 1, 1992 to phase in the Resource Based Relative Value Scale (RBRVS), a cost control and payment program that reimburses physicians who care for Medicare patients.

48 Nancy M. Kane and Paul D. Manoukian, "The Effect of the Medicare Prospective Payment System on the Adoption of New Technology," *New England Journal of Medicine*, Vol. 321, No. 21, November 16, 1989, pp. 1378-83.

49 Edward E. Berger and Edmund G. Lowrie, editorial, *Journal of the American Medical Association*, Vol. 265, No. 7, February 20, 1991, pp. 909-10. See also Phillip J. Held et al., "Mortality and Duration of Hemodialysis Treatment," *Journal of the American Medical Association*, Vol. 265, No. 7, February 20, 1991, pp. 871-75.

50 Kane and Manoukian, "The Effect of the Medicare Prospective Payment System on the Adoption of New Technology," p. 1379.

51 Eric Muñoz et al., "Race, DRGs, and the Consumption of Hospital Resources," *Health Affairs,* Spring 1989, p.187.

52 These are also referred to as "expenditure limits" by the Texas Task Force, which envisions private sector participation in their development. Under this approach, the state would bring together representatives of health care providers, businesses, insurers and consumers to decide what the health care spending limit for a given geographic area ought to be for the next fiscal year. After the limit was established, regulators would then establish "fair and reasonable rates" (i.e., price controls) for providing health care within the spending limit. Yearly expenditure limits would be established by a negotiating team. If the expenditure limits were exceeded in any given year, the shortfall would have to be balanced in the next year's budget. See Task Force Report, pp. 116-17.

53 Task Force Report, p. 132.

54 Patricia Day and Rudolf Klein, "Britain's Health Care Experiment," *Health Affairs*, Fall 1991, p. 43.

55 For New Zealand, see Patricia Danzon and Susan Begg, *Options for Health Care in New Zealand,* CS Boston NZ Limited, April 1991.

56 For Canada, see Joanna Miyake and Michael Walker, "Waiting Your Turn: Hospital Waiting Lists in Canada, Third Edition," *Fraser Forum*, Fraser Institute, Critical Issues Bulletin No. 1, May 1993.

57 The number ranges from 1/2 percent in Canada to 2 percent in Britain. Note, however, that in the United States about 4 percent of the population accounts for about 50 percent of total population costs. These are the patients who require surgery and access to expensive technology. If the same percent holds for the other three English-speaking countries, this implies that from 1/8 to 1/2 of all patients who need access to expensive medical technology are not receiving it — at least not promptly.

58 See George J. Schieber, Jean-Pierre Poullier and Leslie M. Greenwald, "U.S. Health Expenditure Performance: An International Comparison and Data Update," *Health Care Financing Review,* Vol. 13, No. 4, Summer 1992.

59 In Canada, the latest estimate is 23 percent. See Edward Neuschler, *Canadian Health Care: The Implications of Public Health Insurance* (Washington, DC: Health Insurance Association of America, 1989), p. 18.

[60] See Rosie DiManno, "Hard Choices Facing Health Care System," *Toronto Star,* January 28, 1989; "Ceiling System Needs Radical Surgery," (Sunday) *Toronto Star,* March 27, 1988; and Robert G. Evans et al., "Controlling Health Expenditures: The Canadian Reality," *New England Journal of Medicine,* Vol. 320, No. 9, March 2, 1989, p. 574.

[61] According to one nonmonetary indicator of hospital efficiency — average length of stay — U.S. hospitals routinely outperform their international rivals. In 1990, the average length of stay in a U.S. hospital was 9.1 days. In Japan, patients stayed an average of 50.5 days — more than five times as long. The average hospital stay in Britain was 14.5 days, in Germany 16.2 days and Canada 13.9 days. See Schieber, Poullier and Greenwald, "U.S. Health Expenditure Performance: An International Comparison and Data Update," Table II. Figures for Germany and Canada are from 1989, the latest available.

[62] See "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1992 Current Population Survey," Employee Benefit Research Institute, *EBRI Issue Brief,* No. 133, January 1993.

[63] See Pamela Loprest and Michael Gates, *State-Level Data Book on Health Care Access and Financing* (Washington, DC: The Urban Institute, 1993), pp. 12-13, Table A1. See also "Health Insurance Coverage: A Profile of the Uninsured in Selected States," General Accounting Office, GAO/HRD-91-31FS, Washington, DC, February 1991, p. 41.

[64] Ibid.

[65] David McLemore, "Many Texans Uninsured," *Dallas Morning News*, January 13, 1993.

[66] General Accounting Office, "Health Insurance Coverage: A Profile of the Uninsured in Selected States," p. 41.

[67] According to Ron Anderson, M.D., president of Parkland Memorial Hospital in Dallas and chairman of the Texas Board of Health, Parkland will handle about 800,000 outpatient visits this year, with approximately 62 percent of those expenses uncompensated. See Ron Anderson, "Clinton's Health Care Reforms Are Only a First Step," *Dallas Morning News*, November 29, 1992.

[68] General Accounting Office, "Health Insurance Coverage: A Profile of the Uninsured in Selected States," p. 25.

[69] The Texas Department of Health, Statistical Services Division, Bureau of Vital Statistics 1990, cited in Task Force Report, p. 49.

[70] See "Bare Bones Health Insurance: An Emerging Consensus in the States," *Health Benefits Letter,* Vol. 1, No. 8, May 23, 1991; and "Small Group Market Reform Laws Enacted in 16 States," *Health Benefits Letter,* Vol. 1, No. 13, August 8, 1991. See also John C. Goodman, "Regulation of Health Insurance by State Governments," in Tex Lezar, ed., *Making Government Work : A Conservative Agenda for the States* (San Antonio: Texas Public Policy Foundation, 1992), p. 237.

[71] Senator Edward Kennedy (D-MA), for example, once proposed such legislation. For an analysis, see John C. Goodman, Aldona Robbins and Gary Robbins, "Mandating Health Insurance," National Center for Policy Analysis, NCPA Policy Report No. 136, February 1989.

[72] The Urban Institute found that 11 percent of Hawaii's population under age 65 is uninsured. See Loprest and Gates, *State-Level Data Book on Health Care Access and Financing*, p. 13, Table A1.

[73] Ibid.

[74] See Goodman, Robbins and Robbins, "Mandating Health Insurance"; and Attiat R. Ott and Wayne B. Gray, *The Massachusetts Health Plan: The Right Prescription?* (Boston: Pioneer Institute for Public Policy Research, 1988).

[75] CONSAD Research Corporation, "An Analysis of the Jobs-at-Risk Associated with Mandated Employer Health Insurance," prepared for the Partnership on Health Care & Employment, October 1990.

[76] Stuart Butler and Edmund F. Haislmaier, eds., *A National Health Care Plan for America* (Washington, DC: Heritage Foundation, 1989).

[77] Simon Rottenberg, *The Cost of Regulated Pricing: A Critical Analysis of Auto Insurance Premium Rate-Setting in Massachusetts* (Boston: Pioneer Institute for Policy Research, 1989).

[78] Task Force Report.

[79] Ibid.

[80] Ibid.

[81] See "No Excuses!: Legislature Funds Immunizations for Children," *Fiscal Notes*, Texas Comptroller of Public Accounts, July 1993.

[82] "White Paper: Merck Vaccine Division Principles and Immunization Enhancement Initiatives," Merck and Co., Inc., (no date). See also Mona Charen, "Do We Need A Federal Pharmacist?" *Washington Times*, February 18, 1993.

[83] Rebecca Voelker, "Universal Vaccination Plan Gives Way to Compromise," *American Medical News*, May 24-31, 1993.

[84] Ibid.

[85] President Clinton had advocated free immunizations for all children but scaled back his program to cover only poor children who are on Medicaid, are uninsured or get their shots at community health centers. The funding for the program was part of the President's budget package. See Robert Pear, "U.S. to Guarantee Free Immunization for Poor Children," *New York Times*, August 16, 1993.

[86] Texas appropriated $22.3 million dollars for immunizations in 1993, which will go up to $39.6 million in 1994. See *Fiscal Notes,* July 1993. Although the legislation covers all children, the free immunization distribution at public health clinics, which are often crowded with long waiting lines, means that most people who can afford the immunizations pay for them out-of-pocket.

[87] See Louise B. Russell, "The Role of Prevention in Health Reform," *New England Journal of Medicine,* Vol. 329, No. 5, July 29, 1993, pp. 352-54. For a more extensive examination, see Louise B. Russell, *Is Prevention Better Than Cure?* (Washington, DC: Brookings Institution, 1986).

[88] By one estimate, universal MRI scans would catch tumors in no more than 1 in every 3,000 persons examined. See Robert Wright, "The Technology Time Bomb," *The New Republic*, March 29, 1993. The source of the estimate is William F. Schwartz of the University of Southern California.

[89] This is the actual approach adopted by the U.S. Congress and the state legislature.

[90] Although large, self-insured companies operating under the Employee Retirement Income Security Act (ERISA) would be exempt from this requirement, the state could mandate that all companies using standard insurance cover these and other services with no deductible.

[91] This was the conclusion of an extensive 1992 Canadian-sponsored study on the effectiveness of mammography. The study, known as the Canadian National Breast Screening Study, was immediately challenged by some Americans. But evidence presented to a recent conference sponsored by the National Cancer Institute provided international confirmation of the study. See Charles Culhane, "Value of Mammograms in Younger Women Questioned," *American Medical News*, March 22-29, 1993. See also Charlotte Gray, "U.S. Resistance to Canadian Mammogram Study Not Only about Data," *Canadian Medical Association Journal*, Vol. 148, No. 4, February 15, 1993. See also "Mammogram Data Back Canada Study," *Dallas Morning News*, March 16, 1993.

[92] Polls show that about 30 percent of employees experience "job lock" — a condition under which they fear switching jobs because of a loss of health insurance benefits. Eric Eckholm, "Health Benefits Found to Deter Job Switching," *New York Times*, September 26, 1991.

[93] Jill D. Foley, *Uninsured in the United States: The Nonelderly Population without Health Insurance* (Washington, DC: Employee Benefit Research Institute, April 1991), p. 16.

[94] General Accounting Office, "Health Insurance Coverage: A Profile of the Uninsured in Selected States."

[95] Guaranteed issue permits anyone to purchase health insurance, regardless of their health status. Modified community rating means that everyone is charged the same price with a few variations based on such factors as age or geographic location. And the exclusion of preexisting conditions means that an insurance company cannot exclude an existing illness from an applicant's insurance coverage.

[96] See the American Legislative Exchange Council's (ALEC) model legislation, "The Health Insurance Reform Act for Small Business Coverage," in Molly M. Hering and Samuel A. Brunelli, eds., *Keeping the Promise: Making Health Care Accessible and Affordable for All Americans* (Washington, DC: American Legislative Exchange Council, January 1993).

[97] There is some evidence that state regulation is largely responsible for the absence of guaranteed renewable health insurance nationwide. Before government began to impose extensive regulations and mandates on the health insurance industry, many companies offered guaranteed renewable policies. Today, insurers are unwilling to make long-term commitments to policyholders in the face of arbitrary and unpredictable rate regulations. Currently, Texas has no rate regulation laws. Thus, if an insurer needs to increase its health insurance premiums, it notifies the state, but it does not have to wait for approval. However, an insurer that sold a guaranteed renewable policy in Texas would risk future adverse regulations.

[98] See the discussion in Edmund F. Haislmaier, "Health Care," in Tex Lezar, ed., *Making Government Work: A Conservative Agenda for the States,* pp. 201-206.

[99] In a recent and highly publicized case, H & H Music Company of Houston, TX, reduced its lifetime benefits limit from $1 million to $5,000 after learning that one of its employees had tested positive for the AIDS virus. The employee sued the company but lost the suit because the employer was self-insured and therefore not subject to federal regulations. See Jerry Giesel, "Self-Insurers Can Limit AIDS Benefits: Court," *Business Insurance*, August 6, 1990, pp. 1, 27-28.

[100] For example, the American Legislative Exchange Council has proposed model legislation that would guarantee employees a "conversion privilege," an option to continue their health insurance coverage after leaving a job. Employees would have 31 days after loss of coverage in which to accept the conversion, and premiums would not exceed 135 percent of the rate charged as an employee. See the ALEC model legislation in Hering and Brunelli, *Keeping the Promise: Making Health Care Accessible and Affordable for All Americans.*

[101] Information provided by the Council for Affordable Health Insurance, Washington, DC.

[102] Large businesses would have the option to self-insure and avoid the pool.

[103] Note that under President Clinton's version of managed competition, such pools probably would be mandated by the federal government.

[104] H.B. 2055 permits two or more employers to join together to form a purchasing cooperative.

[105] H.B. 2055 includes guaranteed issue for new hires for businesses that operate under three legislatively created plans. Whether this provision will affect small businesses that do not choose one of the three plans has yet to be determined. Meanwhile, a committee is being set up to determine if guaranteed issue would increase the price of health insurance.

[106] For small group health insurance reform (which does not include individual and family policies), here are other estimates of the likely increase in premiums:

- The Health Insurance Association of America (HIAA) estimates that its proposed small group reform would raise premiums by 2.5 percent to 4.0 percent, but this estimate makes unrealistically low assumptions about the numbers of sick people who would buy health insurance and the numbers of healthy people who would drop their coverage. See HIAA memo dated August 29, 1991.
- Community Mutual Insurance Company (a Blue Cross-Blue Shield company) estimates that the HIAA plan would increase premiums by 20 to 25 percent. See "Perspective on Small Group Market Reform," a study conducted by Community Mutual Insurance Company, September 1991.
- Tillinghast estimates that a similar plan in the state of Ohio would increase premiums by 11 to 47 percent. See Ted A. Lyle and Janet M. Carstens, "Actuarial Review of Proposed Small Group Reform Legislation in Ohio," a study conducted for Community Mutual Insurance Company, November 29, 1991.
- Golden Rule Insurance Company's actual experience was that guaranteed issue policies led to an increase in claims costs of over 50 percent in the second year and 30 to 35 percent thereafter. Golden Rule offered no-questions-asked health insurance policies to employers with 10 to 25 employees. There was a surcharge for the no-questions-asked groups that ranged from 15 to 20 percent above what the same group could get if they provided health information in their application. There were also some restrictions.

[107] Stephen D. Brink, James C. Modaff and Steven J. Sherman (Milliman & Robertson, Inc.), "Variation by Duration in Small Group Medical Insurance Claims," Society of Actuaries Research Report, September 5, 1991.

[108] These are results for groups of one to 25 persons. For smaller groups, say two to nine, the cost of guaranteed issue insurance was twice as high.

[109] This cost is adjusted for the drop-off in the number of policyholders over time.

[110] A standard industry assumption is that the elasticity of demand for health insurance is 0.5. The NCPA/Fiscal Associates Health Care model estimates the elasticity at 0.65.

[111] Karen M. Beauregard, "Persons Denied Private Health Insurance Due to Poor Health," Agency for Health Care Policy and Research, Public Health Service, AHCPR Report No. 92-0016, December 1991.

[112] Sarah Lyall, "Albany Will Pass Bill to Overhaul Health Insurance," *New York Times,* July 2, 1992. In New York, Guardian Insurance (a commercial insurer) charges a monthly premium of $149 to single people under age 30 and $349 to single people ages 60 to 64. By contrast, Blue Cross — which must community rate — charges $184, regardless of age. See Peter Passell, "What Hidden Cost in Spreading the Health Risk?" *New York Times,* July 12, 1992. In states where insurers can rate based on sex, the premium difference for males of different ages is greater than for females.

[113] Though the Task Force recommended it, H.B. 2055 did not include community rating.

[114] Companies that self-insure under the Employee Retirement Income Security Act (ERISA) are exempt from state mandates. Federally chartered HMOs, which include most HMOs, are also exempt, as is Medicare under federal law. And though Medicaid recipients often receive the benefits of state mandates, they are shielded from the increased cost because they do not have to pay premiums.

[115] Numbers provided by Blue Cross and Blue Shield of Texas, 1991.

[116] Beauregard, "Persons Denied Health Insurance Due to Poor Health."

[117] See Milton Friedman, "Input and Output in Medical Care," Hoover Institution, Essays in Public Policy No. 28, 1992.

[118] See the discussion in Goodman and Musgrave, "State Health Care Reform Under the Clinton Administration."

[119] For a state-by-state survey of risk pools, see *Comprehensive Health Insurance for High-Risk Individuals*, 6th ed. (Minneapolis: Communicating for Agriculture, 1992).

[120] Ibid.

[121] In 1990, pools paid out $77.6 million more than they took in. Ken McDonnell, Michael Anzick and William Custer, "State Initiatives in Health Care Reform," Employee Benefit Research Institute, *EBRI Issue Brief*, No. 127, June/July 1992; John Holahan and Sheila Zedlewski, "Expanding Medicaid to Cover Uninsured Americans," *Health Affairs*, Spring 1991, p. 49; Robert Pear, "Low Medicaid Fees Seen as Depriving the Poor of Care," *New York Times*, April 2, 1991; Robert Pear, "Suits Force U.S. and States to Pay More for Medicaid," *New York Times*, October 29, 1991. Among operating pools in 1991, California, Montana and Wyoming were the only states not to experience losses. California caps enrollment to ensure the risk pool can operate within its appropriated budget. Data on Wyoming is for its first four months of operation only. See *Comprehensive Health Insurance for High-Risk Individuals.*

[122] Ibid.

[123] *Comprehensive Health Insurance for High-Risk Individuals.*

[124] H.B. 2055 provides for a reinsurance pool for small employer carriers to pool their high risks. But the pool does not become operational until guaranteed issue goes into effect in 1995.

[125] "1,081 State-Mandated Benefits Identified," *Health Benefits Letter,* No. 32, Vol. 2, July 31, 1992.

[126] See Jon Gabel and Gail Jensen, "The Price of State-Mandated Benefits," Health Insurance Association of America, Research Bulletin, July 1989, p. 12.

[127] John C. Goodman and Gerald L. Musgrave, "Freedom of Choice in Health Insurance," National Center for Policy Analysis, NCPA Policy Report No. 134, November 1988.

[128] Ibid.

[129] Greg Scandlen, "State-Mandated Coverage: Mandate Evaluation Laws," Blue Cross/Blue Shield, Office of Government Relations, Washington, DC, November 1989.

[130] Greg Scandlen, "Mandate Waiver Laws for Small Group Coverage," Blue Cross/Blue Shield, Office of Government Relations, Washington, DC, August 13, 1990.

[131] Evidence that only a small number of people are purchasing bare bones insurance has been collected by the Families USA Foundation, an organization that advocates national health insurance. See Philip J. Hilts, "Bare Bones Health Insurance Found to Attract Few Buyers," *New York Times*, July 23, 1993.

[132] See John C. Goodman, "Health Insurance: States Can Help," *Wall Street Journal,* December 17, 1991.

[133] "Mandated Benefits: Mixed Signals from the States," *Health Benefits Letter*, Vol. 1, No. 3, March 13, 1991.

[134] Employee Benefit Research Institute, *Employee Benefit Notes*, Vol. 8, No. 9, September 1987, p. 7.

[135] Health Professions Resource Center, *Health Professions in Texas, 1990* (Austin, TX: Texas Department of Health, 1990).

[136] Medically underserved populations are population segments experiencing unusual local conditions that create a barrier to access to personal health services. For example, the poor of Denton and Nacogdoches counties are designated MUPs, according to a summary compiled by the Texas Department of Health, Bureau of State Health Data and Policy Analysis.

[137] Task Force Report, p. 32.

[138] "Texas Task Force Report on Rural Health," a Task Force appointed by Senator Phil Gramm, April 28, 1990, p. 3. See also Texas Bureau of State Data and Policy Analysis, *Special Task Force on Rural Health Care Delivery, A Report to the 71st Texas Legislature* (Austin, TX: February 1989).

[139] *Health Professions in Texas, 1990.*

[140] Office of Technology Assessment, *Health Care in Rural America,* September 1990, Table 5-43, p. 148.

[141] See John C. Goodman and Gerald L. Musgrave, "National Health Insurance and Rural Health Care," National Center for Policy Analysis, NCPA Policy Report No. 107, October 1991.

[142] Office of Technology Assessment, "Nurse-Practitioners, Physicians' Assistants and Certified Nurse-Midwives: A Policy Analysis," Health Technology Case Study No. 37, December 1986. See also John C. Goodman, *Regulation of Medical Care: Is the Price Too High?* (Washington, DC: Cato Institute, 1980).

[143] See Goodman and Musgrave, "National Health Insurance and Rural Health Care."

[144] Norman G. Levinsky, "Recruiting for Primary Care," *New England Journal of Medicine*, Vol. 328, No. 9, March 4, 1993.

[145] John K. Iglehart, "The American Health Care System: Medicaid," *New England Journal of Medicine*, Vol. 328, No. 12, March 25, 1993.

[146] Anne Schwartz, David C. Colby and Anne Lenhard Reisinger, "Variation in Medicaid Physician Fees," *Health Affairs*, Spring 1991, pp. 131-39.

[147] "New Survey Shows Significant Gaps in Medicaid Safety Net," Henry J. Kaiser Family Foundation, March 17, 1993.

[148] Council for Affordable Health Insurance, "The Impact of Medicaid and Medicare on National Health Care Expenditures," April 1993.

[149] Ibid.

[150] Department of Health and Human Services, "Justification of Estimates for Appropriations Committees," Health Care Financing Administration, Fiscal Year 1994.

[151] Iglehart, "The American Health Care System: Medicaid."

[152] The law permits certain bank transfers to be counted as state contributions to Medicaid. For example, in North Carolina four state-run mental hospitals transfer about $100 million a year to the state Medicaid program. Under the law, the money is counted as a state "contribution" to the program, thus entitling the state to an extra $200 million in federal matching funds. Dan Morgan, "Are Cash Starved States 'Looting' Medicaid Coffers?" *Washington Post,* April 13, 1993.

[153] The Task Force did not devote much effort to Medicaid reform, since the proposed Texas Children's Health Plan would have preempted many of Medicaid's functions. See the Task Force Report, p. 82.

[154] Hering and Brunelli, *Keeping the Promise: A Comprehensive Health Care Plan for All Americans.*

[155] States also can take action for regulatory relief. For example, Montana and California recently passed laws relaxing restrictions on rural health care facilities. See "Forgotten by the System: Rural Health Care in America," The Health Care Task Force, American Legislative Exchange Council, *The State Factor*, Vol. 18, No. 13, December 1992.

[156] For a comparison of the highest- and lowest-ranked Medicaid conditions, see Timothy Egan, "Oregon Shakes Up Pioneering Health Plan for the Poor," *New York Times*, February 22, 1991.

[157] "Oregon Rationing Plan to Apply to Private Sector Benefits," *Health Benefits Letter*, Vol. 1, No. 2, February 28, 1991.

[158] "Oregon's Bid to Boost Coverage Gets Federal Red Light," *Congressional Quarterly,* August 8, 1992, p. 2362.

[159] See Joseph F. Sullivan, "Judge Stays Ruling on Hospital Billing in New Jersey," *New York Times*, June 5, 1992.

[160] Keith J. Halleland and S. Olivia Mastry, "HealthRight's Mandate for Change," *Minnesota Medicine,* Vol. 75, June 1992.

[161] James Hyatt, "The Tax Report," *Wall Street Journal,* September 2, 1992. This provision is currently being challenged by a group of physicians in bordering states who believe that Minnesota does not have jurisdiction to tax an out-of-state provider.

[162] For a discussion, see Peter W. Huber, *Liability: The Legal Revolution and Its Consequences* (New York: Basic Books, 1988).

[163] Paul C. Weiler, *Medical Malpractice on Trial* (Cambridge, MA: Harvard University Press, 1991), pp. 4, 85. See also Patricia M. Danzon, *Medical Malpractice: Theory, Evidence and Public Policy* (Cambridge, MA: Harvard University Press,

1985); and J.E. Moser and R.A. Musacchio, "The Costs of Medical Professional Liability in the 1980s," *Medical Practice and Management,* Summer 1991.

164 The Task Force pointed to a 1992 study jointly funded by the Texas Medical Association, the Texas Hospital Association and the Texas Trial Lawyers Association, which examined the impact of medical malpractice costs on health care in Texas. The study concluded that only 1 percent of the state's total health care costs could be attributed to medical and hospital liability insurance premiums. The report also concluded that even if 15 percent of services were defensive in nature, that would only amount to 3.6 percent of the total health care bill. See Tonn and Associates, "Medical and Hospital Professional Liability: A Report Prepared for the Texas Health Policy Task Force," July 1992. This finding coincides with a 1992 study by the Congressional Budget Office, which argued that tort reform would not significantly impact total health care spending. See Congressional Budget Office, "Economic Implications of Rising Health Care Costs," Washington, DC, October 1992, p. 27.

165 Under this act, providers can participate if 10 percent or more of their patients are "qualified" poor patients. For participating, providers get a discount on their malpractice premiums. If they are sued by any patient, the state of Texas becomes the insurer of first resort. This is meant to encourage physicians to practice in underserved areas. Task Force Report, p. 123.

166 Weiler, *Medical Malpractice on Trial,* p. 12; and Danzon, *Medical Malpractice: Theory, Evidence and Public Policy,* p. 19.

167 See Robert J. Rubin and Daniel N. Mendelson, "Estimating the Costs of Defensive Medicine," Lewin-VHI, Inc., January 27, 1993. The Lewin-VHI study found that the middle range of potential savings from comprehensive malpractice reform (which included physician immunity when physicians followed established guidelines, tort reform and provisions for alternative mediation) could save $4.3 billion in 1994 and $35.8 billion between 1994 and 1998 for the nation as a whole. The study found that if a system of "no-fault" insurance were adopted, which eliminates the ability of patients to sue physicians, "virtually all costs of defensive medicine would disappear," resulting in a five-year savings that could equal $76.2 billion.

168 See Goodman, *National Health Care in Great Britain: Lessons for the USA,* pp. 121-22.

169 See Richard A. Epstein, *Medical Malpractice: The Case for Contract* (New York: Center for Libertarian Studies, Occasional Paper Series No. 9, 1979); and Paul H. Rubin, *Tort Reform by Contract* (Washington, DC: The AEI Press, 1993).

170 The current system ignores contractual waivers of tort liability claims. What is needed is a legal change requiring the courts to honor certain types of contracts under which tort claims are waived in return for compensation.

171 McDonnell et al., "State Initiatives in Health Care Reform," pp. 33-34.

172 "Maine Shields Physicians from Malpractice Charges," *State Legislatures,* July 1993.

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The National Center for Policy Analysis

The National Center for Policy Analysis is a nonprofit, nonpartisan research institute funded exclusively by private contributions. The NCPA originated the concept of the Medical IRA (which has bipartisan support in Congress) and merit pay for school districts (adopted in South Carolina and Texas). Many credit NCPA studies of the Medicare surtax as the main factor leading to the 1989 repeal of the Medicare Catastrophic Coverage Act.

NCPA forecasts show that repeal of the Social Security earnings test would cause no loss of federal revenue, that a capital gains tax cut would increase federal revenue and that the federal government gets virtually all the money back from the current child care tax credit. These forecasts are an alternative to the forecasts of the Congressional Budget Office and the Joint Committee on Taxation and are frequently used by Republicans and Democrats in Congress. The NCPA also has produced a first-of-its-kind, pro-free-enterprise health care task force report, presenting the views of 40 representatives of think tanks and research institutes.

The NCPA is the source of numerous discoveries that have been reported in the national news. According to NCPA reports:

- Blacks and other minorities are severely disadvantaged under Social Security, Medicare and other age-based entitlement programs;
- Special taxes on the elderly have destroyed the value of tax-deferred savings (IRAs, employee pensions, etc.) for a large portion of young workers; and
- Man-made food additives, pesticides and airborne pollutants are much less of a health risk than carcinogens that exist naturally in our environment.