NATIONAL CENTER FOR POLICY ANALYSIS

Applying the Lessons of State Health Reform

Policy Report No. 323 by Michael Bond September 2009

Lack of health insurance is a significant, persistent problem in New Jersey. In 2007, more than 1.3 million residents were uninsured — three-fourths were working-age adults 19 to 64 years old. About 15.6 percent of New Jersey residents are uninsured, which is close to the national average, and the U.S. Census Bureau recently ranked New Jersey 34th among states in the percentage of residents with insurance coverage.

Dallas Headquarters:
12770 Coit Road, Suite 800
Dallas, TX 75251
972.386.6272
Fax: 972.386.0924
www.ncpa.org

Washington Office:
601 Pennsylvania Avenue NW,
Suite 900, South Building
Washington, DC 20004
202.220.3082
Fax: 202.220.3096

ISBN #1-56808-200-2
www.ncpa.org/pub/st/st323/st323.pdf

NCPA
NATIONAL CENTER FOR POLICY ANALYSIS

Executive Summary

In 2007, more than 1.3 million New Jersey residents were uninsured. Although many of the uninsured are eligible for Medicaid and the State Children's Health Insurance Plan (S-CHIP), the majority of the uninsured are employees of small firms and individuals who have to obtain coverage on their own. A primary reason people cite for lack of health insurance is the inability to pay premiums. In the market for individually purchased insurance, premium costs in New Jersey are nearly twice the national average and among the highest of any state.

Why are health insurance premiums so high in New Jersey? One reason is that state regulations require insurers to sell policies to all applicants, including people who wait until they become sick to buy coverage (so-called guaranteed issue). Another reason is that the state keeps insurers from adjusting their premiums to reflect the health risks of individual consumers (called community rating). As a result, the young and healthy are charged more for insurance than they would be otherwise in order to subsidize the premiums of others. For example:

- A healthy 25-year-old male could purchase a policy for $960 a year in Kentucky, according to a 2005 study, but would pay about $5,880 in New Jersey.
- A family in Texas paid $5,501 a year, on the average, for coverage in 2006-2007, whereas a family in New Jersey paid $10,398.

Thus, for many New Jersey residents, health insurance is too costly, and not a very good value.

Massachusetts has faced similar problems and, in 2006, it enacted reforms to achieve near-universal coverage. These reforms have been considered a model for other states to follow — however, there are problems with the Massachusetts model that New Jersey can avoid.

The Massachusetts reforms include an individual mandate to obtain insurance and small penalties for employers that don't offer group coverage. However, most of the newly insured have obtained coverage through

the Commonwealth Connector — an insurance exchange where individuals and small groups were supposed to be able to buy health insurance from competing providers. Unfortunately, there is little competition because the plans sold through the Connector must have community rating and guaranteed issue — adding significantly to premium costs for many people. Since 2006, the state government's health care costs have skyrocketed, due in large part to heavily subsidized coverage. In 2009, the cost of Commonwealth Care, the state's insurance subsidy program, reached $1.3 billion — more than $650 million higher than initially projected.

New Jersey could avoid the mistake of Massachusetts' Connector by creating a marketplace exchange for small groups and individuals. In this less-regulated system, private insurance carriers could offer a range of plans, allowing consumer choice to drive the offerings. The state would be able to operate the system with no more overhead than a major corporation (5 percent), significantly lowering premiums for small groups and individuals. To truly foster competition, however, it is imperative that New Jersey's exchange be: 1) voluntary, 2) allow for underwriting and exclusion of preexisting conditions and 3) adjust state subsidies for each enrollee's health status.

Utah is implementing a market exchange that shares some characteristics with the proposal for New Jersey. Employers participating in the Utah Health Exchange will contribute toward personal and portable insurance selected by individual workers.

Additionally, a number of states have introduced Medicaid reforms that provide incentives for patients to become better consumers of health care and providers to compete on quality and cost. New Jersey should consider adopting some of these reforms.

In 2006, for example, Florida reformed its Medicaid system to foster competition among private insurance carriers and health care provider networks. Three benefit packages are available for recipients, and payments are risk-adjusted, meaning insurers receive greater subsidies for enrollees with significant health problems. South Carolina reformed its program in a similar fashion, giving participants a choice of plans as well as personal health accounts to pay for part of their medical expenses.

In late 2008, Louisiana Gov. Bobby Jindal proposed moving the state's Medicaid enrollees into Coordinated Care Networks administered by private managed care plans. Instead of fee-for-service payments, providers would be given lump-sum payments per patient, adjusted for risk. The reforms center on choice, health literacy, incentives for healthy behavior and medical homes.

New Jersey should reform its system with the successes of states like Florida and South Carolina in mind, while also remembering the lesson from Massachusetts. To significantly reduce the number of uninsured, New Jersey should foster competition and choice, and increase incentives to reduce costs and improve quality in both public and private insurance programs.

About the Author

Michael Bond is a senior fellow with the National Center for Policy Analysis, a senior fellow in Health Care Policy at the James Madison Institute, and a senior lecturer at the University of Arizona. His work on health care policy reform has received national attention and appeared in a wide range of professional and popular publications. Bond co-authored a guide to reforming Medicaid using a market-based plan, which served as the framework for Florida's path breaking Medicaid reform waiver. He also has authored reports on Medicaid reform in Texas, Pennsylvania, New York, Ohio, and Kansas.

Bond has assisted a number of public policy institutes and government leaders on the topic of Medicaid Reform, including the Texas Public Policy Institute and South Carolina Governor Mark Sanford. Bond earned his Ph.D., M.A. and B.A. in economics from Case Western Reserve University.

Introduction

Lack of health insurance is a significant, persistent problem in New Jersey. In 2007, more than 1.3 million residents were uninsured — three-fourths were working-age adults 19 to 64 years old.[1] About 15.6 percent of New Jersey residents are uninsured, which is close to the national average, and the U.S. Census Bureau recently ranked New Jersey 34th among states in the percentage of residents with insurance coverage.[2]

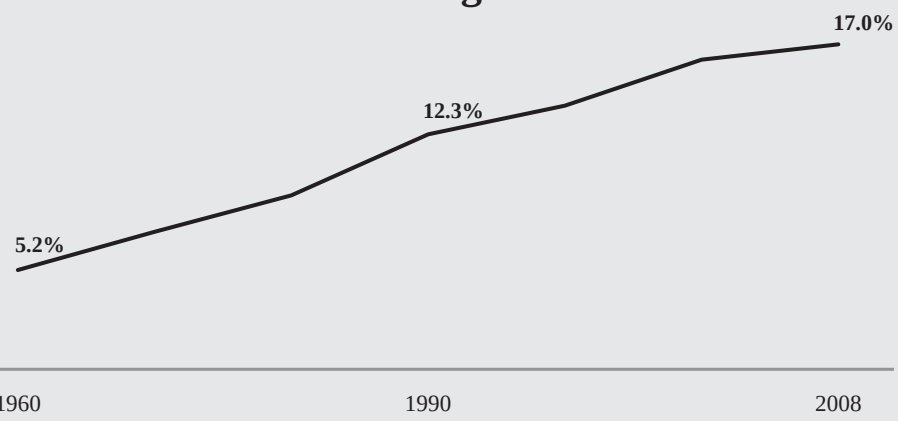
A primary reason people cite for lack of health insurance is the inability to pay premiums. About a third of uninsured New Jersey residents live in poverty, one-quarter have incomes 100 percent to 200 percent of the poverty level, and the remaining 40 percent earn more than twice the poverty threshold.[3]

Why is being uninsured a problem? Every state has a large uninsured population, and the uninsured often receive health care comparable to individuals enrolled in public programs like Medicaid. However, people who lack insurance frequently face difficulties accessing care, and the care they receive is often delivered in an expensive setting, such as a hospital emergency room.

This study examines some of the reasons why individuals in New Jersey are uninsured and analyzes proposed solutions — some of which would make the problem worse. Drawing on the experiences of other states, it recommends comprehensive reforms for New Jersey that would significantly reduce the uninsured population. Implementing these reforms would require reversing current government policies that contribute to the problem, freeing the private marketplace to provide low-cost health insurance products and giving the uninsured incentives to enroll in health plans.

Figure I

National Health Expenditures as a Percentage of GDP



Source: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group; U.S. Department of Commerce, Bureau of Economic Analysis; and U.S. Bureau of the Census.

Health Insurance and U.S. Health Care Costs

Nationally, there is evidence that around two-thirds of the increase in the uninsured population in the last decade is related to the increased cost of private health insurance.[4] Insurance costs reflect rising health care spending and the structure of the health insurance market, which has evolved over time. Today, there is little price or quality competition in health care, resulting in rising costs, lack of innovation and low quality.

The Evolution of Health Insurance. Employer-based health insurance increased dramatically during World War II when employers began to offer it as nonwage compensation due to wartime wage controls. After the war, the IRS ruled that employer-paid health insurance premiums were not taxable, encouraging employees to accept part of their pay in the form of health insurance.[5]

Under the new employer-based insurance system, an employee could see any doctor or enter any hospital and insurance paid all or most of the bills. Deductibles — minimum expenses paid by the insured before drawing on insurance — were high. As a result, more than half of health expenditures were paid for out-of-pocket, rather than by third parties like employers, insurers or government. In today's dollars, deductibles were as high as $15,000.[6] Since patients paid for routine medical care themselves, they had an incentive to be cost-conscious health care consumers.

This, in turn, gave providers motivation to compete on the basis of price, convenience and quality. As a result, health care spending was limited to about 5 percent of Gross Domestic Product (GDP) in 1965.

However, the 1965 enactment of Medicaid and Medicare fundamentally altered the U.S. health care system. These programs reimbursed doctors and hospitals for any covered procedures or services they provided — a system called cost-based reimbursement — with little or no out-of-pocket spending (cost sharing) by patients. In the private sector, many insurers marketed health plans with limited cost sharing, and unions negotiated contracts that specified low- or no-deductible health plans. Consequently, health care demand soared and the cost and quantity of medical services increased dramatically.

> *"Third-party payment — by government, insurers or employers — raised demand for health care."*

Many private insurers practiced "community rating," basing premiums on average expenses in a particular area, rather than on the likelihood of high medical expenses each covered individual or family brought to the insurance pool. Employers with healthier or younger employees often dropped out of the risk pool and self-insured because it was less expensive to pay employees' medical bills directly (or through a third-party health plan administrator). This trend accelerated following passage of the Employee Retirement Income Security Act (ERISA) in 1974.[7]

Large-Group versus Small-Group and Individual Market. Over time, two markets for private health insurance have developed: a large-group market for firms with more than 50 employees and a small-group and individual market for those purchasing health insurance on their own. In the small-group and individual market health insurers rate the specific risk of high health care costs for each firm or individual (called underwriting), making expenses less predictable than in the large-group market. Insurers often exclude higher-risk individuals by charging them extraordinarily high premiums, eliminating coverage for preexisting conditions or by simply refusing to sell them policies. As larger firms have dropped out of the insurance pool, the difficulty of obtaining insurance in the small-group and individual market has grown worse.[8] For example, according to the Congressional Budget Office (CBO):

- In 2008, among employees of firms with less than 25 employees, the uninsured rate for families with incomes 100 percent to 200 percent of the federal poverty level was almost 60 percent.
- Among employees with incomes 200 percent to 400 percent of the poverty level, the uninsured rate was much lower, around 30 percent, and was less than 10 percent for those with incomes above 400 percent of poverty.
- By contrast, in firms employing more than 1,000 workers, the uninsured rate among employees earning 100 percent to 200 percent of the poverty level was less than 30 percent, and it was dramatically lower for higher income groups.

Thus, after accounting for Medicaid and State Children's Health Insurance Plan (S-CHIP) eligible individuals, the majority of the uninsured are employees of small firms and individuals who have to obtain coverage on their own.

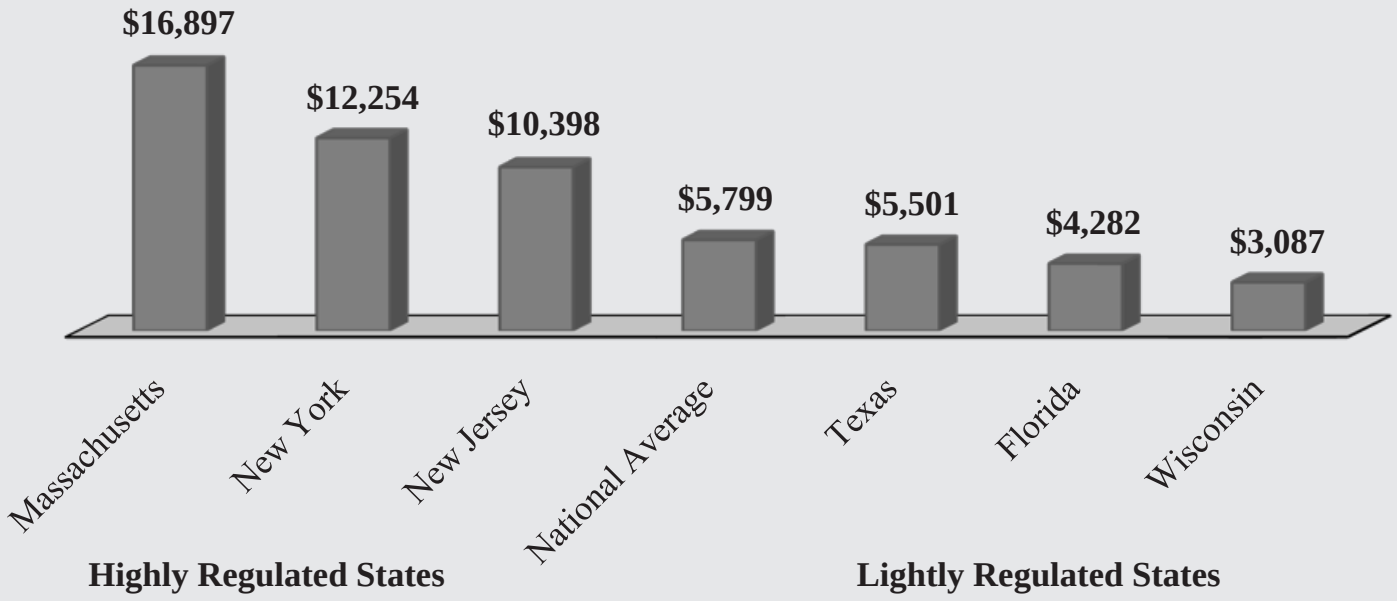
Reasons for Rising Health Care Spending. Over the past four decades, health care spending has grown 9.8 percent annually versus 7.5 percent annually for the economy as a whole. As a result, health insurance premiums more than doubled in real terms. For instance, a family health insurance policy that cost $5,000 in 1979 would cost $10,500 in 2005, in real dollars.[9] As a percentage of GDP, health spending rose from 5 percent in the 1960s to 17 percent in 2008. Following are some of the most notable factors behind the increased cost.

Cost-Increasing Factor: Low Out-of-Pocket Costs. Low-deductible public and private health insurance has made health care consumers increasingly indifferent to real medical costs.[10] Today, consumers pay only about 12 cents out of every health dollar.[11]

In the 1970s, the groundbreaking Rand Health Insurance Experiment found that individuals with coverage that required no out-of-pocket spending used 30 percent more

Figure II

Annual Family Policy Premiums (2006–2007)



Source: "Individual Health Insurance 2006-2007: A Comprehensive Survey of Premiums, Availability, and Benefits," America's Health Insurance Plans, AHIP Center for Policy and Research, December 2007.

medical services (by dollar value) than those with high-deductible plans. Among those in the Rand study with similar incomes, there was virtually no difference in health outcomes between individuals with no out-of-pocket spending and those with high-deductible plans. The inescapable conclusion is that third-party payment dramatically drives up medical demand, and it does so without improving health.[12]

Cost-Increasing Factor: Rising Incomes. As real income rises, people spend a higher proportion of their earnings on medical care. Even after adjusting for inflation, wages have grown significantly since World War II, contributing to rising health care demand.[13]

Cost-Increasing Factor: New Drugs and Procedures. Dramatic increases in the availability and effectiveness of health services and products, such as expensive new drugs, drive up demand. Indeed, there is evidence that programs like Medicare play a major role in encouraging the research and development necessary to create these new products. Consequently, the level of medical technology has evolved beyond what it would have had consumers been faced with the discipline of the market place.[14]

Cost-Increasing Factor: Defensive Medicine. For a time in the 1990s, health care costs rose less than inflation as health plans adopted managed care techniques designed to contain costs and reduce unnecessary use of services. However, fear of litigation eliminated most reasonable efforts to limit care, and many insurers returned to fee-for-service coverage. Potential litigation has also encouraged physicians to avoid certain specialties and practice locations, reducing supply and increasing prices in those areas.

Cost-Increasing Factor: Lack of Health Plan Competition. Many people would choose cheaper health care plans if they could benefit financially without losing quality. However, around 85 percent of employers provide employees with no

choice of insurance carrier.[15] These "one-size-fits-all" packages cannot possibly meet the diverse health needs of all employees. Even when employers provide choice among plans, detailed cost comparisons may not be available, making it difficult for beneficiaries to economize if they so desire.

Little choice of coverage within employer-provided plans dramatically limits real competition. For example, employers have been extremely slow in offering Health Savings Account (HSA) plans, which allow employees to contribute part of their income to a savings account that they can use to pay for qualified medical expenses. HSA plans allow employees to manage more of their own health care dollars. HSAs give individuals incentives to be prudent consumers of health care by allowing them to make tradeoffs between current health care consumption and saving for future needs.[16]

Cost-Increasing Factor: Guaranteed Issue. Guaranteed issue requires health insurance companies offering individual policies to sell coverage to all applicants. Since insurers are compelled to issue coverage regardless of a person's health status, people often wait until they become sick to buy coverage. This practice drives up prices for consumers because insurers must raise premiums to guard against potential losses due to insuring unhealthy individuals. As a result, healthy people leave the risk pool due to high premium costs, and insurance becomes a poor value for everyone except those with serious health conditions. This causes insurance companies to lose business and leave the market, resulting in rates going up further as competition diminishes. This has happened in all six states that require guaranteed issue.[17]

Cost Increasing Factor: Community Rating. Community rating, usually mandated in conjunction with guaranteed issue, keeps insurers from adjusting their premiums to reflect the health risks of individual consumers. Healthy people, therefore, are charged more than they otherwise would be in order to subsidize other, less healthy, consumers. A 2005 study by the Commonwealth Fund illustrates how insurance rates for young people are far higher in states with guaranteed

Problems with Insurance Mandates

Mandates are difficult to enforce. For example, all but two states (New Hampshire and Wisconsin) mandate auto insurance for drivers, but in 2007 an average of 13.8 percent of drivers nationwide were still uninsured. Uninsured rates were as high as 29 percent and 28 percent in New Mexico and Alabama, respectively.[23] Enacting a nominal penalty, such as the loss of a standard tax deduction on a state income tax return, is as unlikely to persuade uninsured motorists to purchase car insurance as a similar penalty is to persuade young, healthy people to buy expensive health care coverage.

Tax on Employees. In a workers' compensation package, health benefits substitute for cash wages. Firms are not likely to offer coverage if their workers prefer wages over health insurance. Thus, requiring employers to provide health benefits for workers who would prefer cash wages is tantamount to a tax on labor.[24]

Vulnerable to Special Interests. In Massachusetts, an oversight board comprised of public health advocates, union officials and representatives from medical societies and hospital associations decides what kind of coverage fulfills the state's insurance mandate. These special interest representatives are apt to prefer expensive, comprehensive plans with lavish benefits, low deductibles and high lifetime payment caps over lower-cost plans with cost sharing and self-insurance.

Special interests also lobby state boards and legislatures to mandate coverage of their industry's services as part of the minimum coverage requirement — more than 2,000 benefits and providers must be covered by health insurers across the 50 states.[25]

issue and community rating.[18] For instance:

- A healthy 25-year-old male could purchase a policy for $960 a year in Kentucky but would pay about $5,880 in New Jersey.
- A similar policy, available for about $1,548 in Kansas, cost $5,172 in New York.
- A policy priced at $1,692 in Iowa cost $2,664 in Washington state and $4,032 in Massachusetts.[19]

Premiums for family plans are also higher — often more than double the national average [see Figure II].

Cost Increasing Factor: State-Mandated Providers and Services. Most mandates add less than 1 percent each to the cost of insurance but in total can add 20 percent to 50 percent to the cost of basic coverage. New Jersey had 45 health insurance mandates in 2009 — slightly above the national average — adding significantly to the cost of individual and small-group plans.[20] Some estimates indicate that a 10 percent price increase leads to around a 5 percent to 6 percent decrease in the number of people who purchase insurance (either on their own or through their small-group employer). The CBO estimates that a 10 percent rise in plan cost will increase the number of uninsured by more than 10 percent.[21]

Health Care Reform in Massachusetts

In 2006, Massachusetts enacted an ambitious plan to achieve near-universal health insurance coverage.[22] The most prominent aspect of Massachusetts' reform, requiring individuals to purchase insurance, is also the most problematic.

Individual Mandate. The cornerstone of the Massachusetts plan is mandatory health insurance. Individuals who do not receive insurance through their employer and are not eligible for a government program, such as Medicaid, must purchase insurance in the individual market; otherwise, they lose a state tax deduction. An employer mandate is also in place, which requires firms with more than 10 employees to offer a qualifying health plan or pay a per-worker contribution to the state. [See the side bar, "Problems with Insurance Mandates."]

The Commonwealth Connector. The Commonwealth Connector is an insurance exchange where individuals and small groups (firms with less than 50 workers) can buy health insurance from competing providers. However, plans sold through the Connector must include community rating and guaranteed issue. As a result, premiums are high and healthy individuals are overcharged.[26]

Once an employer designates the Connector as its insurance carrier, individual employees select a plan that best meets their needs, moving the choice from employer to worker. This allows providers to design plans for the diverse needs of various groups. Ideally, competition and innovation resulting from employees' ability to choose will reduce medical inflation and produce higher quality care.

After enrolling in a Connector plan, employees can switch coverage during the annual enrollment period without fear that their insurance premiums will be individually risk-rated. Furthermore, employees may retain their existing coverage even if they change employers, making the plans portable. However, those who purchase coverage through the exchange do not receive the federal tax break available to workers with employer-based coverage.

> *"Massachusetts requires individuals to purchase insurance."*

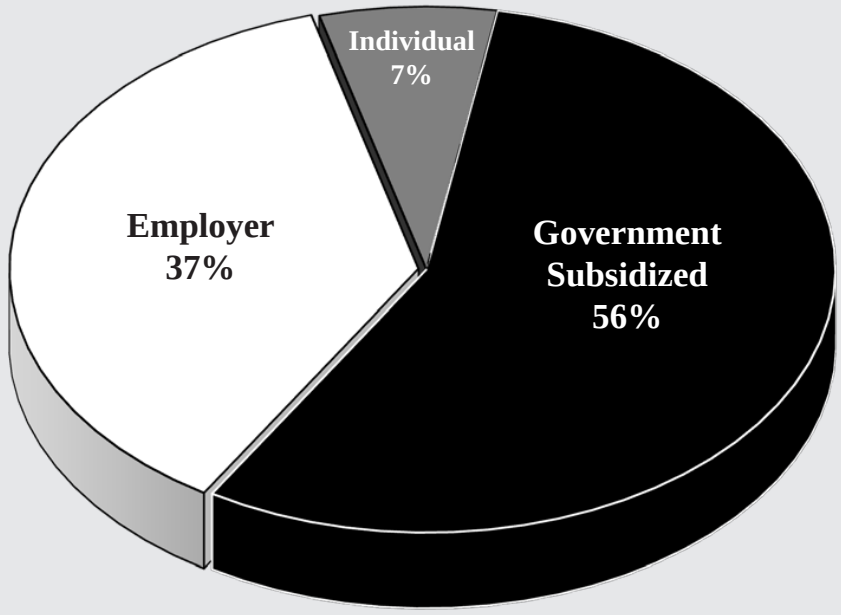
The Connector also allows two-income couples to combine the contributions from their employers to buy coverage. Thus, couples with two part-time jobs are able to buy coverage that otherwise may have been unaffordable.

Problems with Reform. Massachusetts' goal of universal coverage has become increasingly elusive. First, the state has done little to reduce extensive mandated benefits that increase the cost of insurance. Second, firms that do not provide their own health plans or make payments to the Connector are penalized only $295 per worker per year.[27] The penalty is not enough to encourage employers to offer their own health insurance nor is it sufficient to fund state-subsidized plans.

Third, the plan uses funds from the state's uncompensated care plan, which reimburses hospitals and doctors for nonpaying patients, to

Figure III

Source of Insurance for the Newly Insured in Massachusetts



Source: Debra A. Draper et al., "Massachusetts Health Reform: High Costs and Expanding Expectations May Weaken Employer Support," Center for Studying Health System Change, Issue Brief No. 124. Available at http://www.hschange.com/CONTENT/1021/.

subsidize coverage provided by the Connector. However, despite the fact that payments for uncompensated care have been cut, hospitals are still treating people without health insurance. As a result, some hospitals are threatening bankruptcy.

Perhaps the most pressing issue facing Massachusetts is runaway costs.[28] In early 2008 it was projected that the state's cost for the insurance subsidy program, Commonwealth Care, would double to $1.35 billion by 2011.[29] But only a year later, in 2009, the cost of Commonwealth Care had already reached $1.3 billion — more than $650 million higher than initially projected.[30] The increased cost to the state will probably be made up with increased taxes or higher employer contributions to the Connector.

Yet, despite increasing costs, several hundred thousand people still have no health insurance.[31] The majority of those still uninsured do not qualify for subsidies, making it difficult to convince them to buy insurance.[32] Of those newly insured, only about 7 percent are not receiving state subsidized coverage or insurance through their jobs, and nearly 56 percent of the 439,000 newly enrolled are receiving free or heavily subsidized coverage [see Figure III].[33]

Furthermore, increased demand for primary care doctors is making it difficult in some parts of the state for the newly insured to find doctors who will take new patients.[34] For example, the wait time to see a family physician in Boston has risen to more than two months — among the longest waits of major cities in the nation.[35] Long delays are causing people to rely on the emergency room (ER) for nonemergency care; more than half of the patients visiting a Massachusetts ER in the last two years could have been treated in a doctor's office.[36] Nonemergency use of the ER presents an expensive problem: The cost of caring for people in the emergency room has increased 17 percent over the same two-year period.[37]

Reforms in Other States

Although they are less ambitious than Massachusetts, a number of states have undertaken more promising reforms. Following are a few of the most noteworthy efforts.

Florida. In 2006 Florida reformed its Medicaid program to foster competition among private insurance carriers and health care provider networks. Medicaid recipients can choose from several private sector health care providers offering a variety of benefit packages. Three basic benefit packages are offered: 1) Comprehensive Benefits, which covers all mandatory Medicaid services and necessary optional services (scope, amount and duration of services vary), 2) Catastrophic Care, which covers those who require more care than is available under the Comprehensive Benefits plan, and 3) Enhanced Benefits, which encourages healthy

behavior by rewarding participants with spendable dollars. Recipients can also opt out of the program and use state-paid premiums to purchase employer-sponsored insurance.[38]

Payments are risk-adjusted, meaning insurers receive greater subsidies for enrollees with significant health problems. This gives "special needs" plans a financial incentive to reduce costs for sicker enrollees by providing innovative care.

Problems with the Florida plan include: 1) less than 1 percent of beneficiaries use the subsidy to buy into an employer-sponsored plan, 2) about one in five enrollees are not aware they have a choice among health plans, 3) more than half of those who are aware they must choose have difficulty making a choice, and 4) four in 10 enrollees appear to have been assigned to a plan by the state rather than choosing one on their own.[39]

South Carolina. South Carolina Medicaid Choice is similar to Florida's reform program.[40] It seeks to make the process of enrolling in Medicaid resemble purchasing a plan in the private market. Participants are given personal health accounts to pay for part of their medical expenses and can choose any one of a variety of plans, from high-deductible insurance to full-service programs.

The state contribution varies according to the age, sex and physical condition of the participant but is sufficient to purchase an approved health plan equivalent to the enrollee's previous coverage. On average, it is about the same amount the state pays for traditional fee-for-service plans.

Coverage options under the program include: 1) private insurance through a managed care organization or preferred provider organization, 2) medical home networks, 3) group insurance opt-out, which allows a recipient who is employed to use their health account to purchase coverage from their employer, and 4) self-directed care for those with chronic illnesses. If participants are dissatisfied with these plans, they can opt to return to the traditional Medicaid program.

> *"Florida pays insurers more to cover those with chronic health conditions."*

Rhode Island. Rhode Island was the first state to cap overall spending on Medicaid (at 23 percent of the state budget) in order to implement a more flexible program.[41]

Lower insurance premiums are provided for people who agree to see specific providers and participate in such programs as weight and disease management and smoking cessation. The deductible is about $500 per individual with out-of-pocket costs capped at $3,000. People who do not sign the agreement can still buy the plan, but have a $3,000 deductible and out-of-pocket costs of up to $6,000 a year.[42]

Texas. Rather than expand Medicaid, the Texas state legislature recently approved a new program that seeks to give Medicaid-eligible residents more control over their health care while containing costs. The program provides subsidies for families earning up to 200 percent of the poverty level to purchase health insurance.[43] Premiums will be charged on a sliding scale based on recipients' incomes, and participants will pay low deductibles and copayments for health care services. Low-income recipients will also be eligible to receive subsidies that can be used to fund an HSA or pay deductibles and copayments. The goal is to customize Medicaid benefit packages to allow the state to better meet the needs of a diverse population.

Along with the other reforms, Texas also approved the Three-Share plan. Under Three-Share, the cost of health insurance is split among the state, participating employers and employees, with each paying about one-third. The state estimates the cost of premiums will average $150 to $180 a month. The Three-Share plan has a less-generous benefit package than traditional health insurance, instead focusing on primary care coverage, specialty care, prescription drugs and limited in-patient services. In addition to Medicaid beneficiaries, the program also includes small employers with 25 or fewer employees.

Tennessee. In an attempt to cut costs under Tennessee's Medicaid program, TennCare, the state offers a limited benefit plan called CoverTN aimed at eligible individuals who are self-employed or work for a small business. The cost, $150 per month, is split between the compa-

ny, the individual and the state. Savings are achieved by setting relatively low limits on hospital stays and a $25,000 benefit maximum per year. The program includes 12 free checkups, free mammograms and $15 doctor visits with no deductibles. It has also expanded to include a prescription drug program.[44]

In the first nine months of 2008, only four out of the 15,000 individuals enrolled in CoverTN hit their benefit limit. Only three beneficiaries exceeded in-patient hospital limits and less than 4 percent exceeded the pharmacy limits.

"Tennessee offers limited benefit insurance plans for healthy young people."

Louisiana. In late 2008 Louisiana Governor Bobby Jindal proposed reforms to the state's Medicaid program that would move enrollees into Coordinated Care Networks administered by private managed care plans. Currently, Louisiana reimburses Medicaid health care providers on a fee-for-service basis, but under the proposed reforms providers would be paid a lump sum per patient, adjusted for health risk.[45]

A medical home will be designated as an enrollee's usual source of primary care — coordinating the care of any other providers treating chronic conditions. The reforms will start as pilot programs in New Orleans, Baton Rouge, Lake Charles and Shreveport, expanding statewide within five years.[46]

Utah.[47] The Utah Health Exchange unveiled in September 2009 allows employers to make fixed-dollar contributions to employees who purchase portable individual coverage. Initially open only to individuals and a limited number of small businesses, the exchange will expand to include large businesses in 2012.

This Web-based market exchange is not overly burdened by excessive regulations. It will provide information on cost and quality of plans. Workers will be able to shop for individual or family coverage. They can choose from more than a dozen different plans offered by private insurers. More plans are expected to follow as enrollment rises. Employers will benefit from a predictable defined contribution. Employers will also be able to send one check to the exchange administrator each month to cover all the employer contributions.

The minimum benefit package insurers will be able to offer are high-deductible plans. Premiums for each small group that enters the exchange will be adjusted for the group's health risks, with workers picking up the difference between the premium and the employer contribution.[48] Individuals in the group cannot be turned down for coverage. Carriers in the exchange who benefit from favorable risk selection will compensate carriers that have a high concentration of high-risk enrollees.

Steps to Reduce the Number of Uninsured in New Jersey

New Jersey can take several steps that will significantly reduce the number of uninsured. These reforms, drawn from successes in other states, would improve competition and choice, and increase incentives to reduce costs and improve quality in both public and private insurance programs.

Step No. 1: Create a Small-Group and Individual Insurance Exchange. New Jersey can begin to reduce its uninsured population by creating a state-sponsored market where small employers and individuals can purchase health insurance. This system, hereinafter called the Small-Group and Individual Health Insurance Exchange (SGIX), would have considerable advantages over the current small-group market, where overhead costs — ranging from 5 percent to more than 30 percent — have a significant impact on premium prices.

The state would be able to operate the system with the overhead of no more than a major corporation (5 percent). This reform alone would significantly lower the premiums small groups and individuals face, which is crucial in reducing the number of uninsured.

It is imperative, however, that New Jersey's SGIX avoid the mistakes of the Massachusetts Plan. At a minimum, it must be: 1) voluntary, 2) allow for underwriting and exclusion of preexisting conditions,

and 3) properly adjust subsidies for each enrollee's health status.

A Central Market for Health Insurance. The SGIX would have significant economies of scale and act as a central shopping place for health insurance for small businesses and individuals. Using traditional marketing techniques to advertise to the public, it would present the products being offered in an easy-to-understand format that allows for comparison between cost and coverage.

The SGIX would be a marketplace where insurance can be purchased, not a regulatory agency — the insurance industry would operate and staff it. Prices and benefit packages (with the exception of requiring providers to offer a set minimum coverage amount) would not be set by the SGIX, but it would have the power to reject carriers that fail to meet minimum capitalization, benefit and quality criteria. Carriers could offer managed care plans, such as Health Maintenance Organizations (HMOs) and provider networks. They could also offer point-of-service plans where enrollees select a primary care physician who coordinates all care received. Other delivery systems could also be offered through the SGIX, including comprehensive coverage, extensive copays and HSAs. Consumer choice would drive the product offerings. For example, sicker individuals may be less likely to enroll in HSA plans so the SGIX premium payment for HSAs would probably be lower, making it an attractive option for healthy individuals.

No Guaranteed Issue or Community Rating. Guaranteed issue would seriously hamper the workings of the SGIX. It would allow individuals and small firms to enroll after someone becomes sick, causing premiums to soar and driving healthy members out of the risk pool. Therefore, guaranteed issue would not be allowed, nor would community rating.

> *"State insurance exchanges should not set health insurance prices or coverage."*

Economies of Scale. Economies of scale are created when an increase in a firm's size results in a decrease in the long-run average cost for the firm.[49] By functioning as a large insurance pool, the SGIX would create economies of scale and give carriers access to populations of sufficient size (5,000 or more) to make health care expenses predictable. This would help both providers and potential purchasers in adjusting premiums for risk, reducing insurance overhead.

Market Manager, not Regulator. It is important that the duties of the SGIX are clearly defined and limited by state legislation. The SGIX would exist to spread risk, achieve economies of scale, assist in risk adjustment and allow for vigorous competition among providers. Under no circumstances should the SGIX have the power to set plan costs either initially or over time.[50]

Step No. 2: Give People Choice. As discussed earlier, most employees get insurance through their job but have little freedom to choose their plan. This has created a system with limited competition, manifesting itself as deadweight loss to consumers and inelastic (less price-sensitive) demand for health insurance.

Instead of a one-size-fits-all plan, individuals in the SGIX would select among competing plans with different benefit packages at different prices. Furthermore, the SGIX would provide employees clear cost and benefit comparisons among plans. This information would empower consumers to make cost-conscious decisions about their health insurance.

Advantages of Consumer Choice and Competition. Allowing employees rather than companies to select their own plan would increase the quality of care in three ways. First, individuals would be able to purchase insurance packages that provide the coverage that best match their various health needs. Second, the significant increase in competition would induce providers to offer better care or face the loss of customers, as employees could easily switch plans if they felt they were not being treated properly.

Finally, in order to keep existing enrollees and increase profits, competing plans would have powerful bottom-line incentives to innovate. Acceleration in the rate of innovation would initially be reflected in higher premiums; however, competition among providers would eventually slow the rate of medical inflation. This productivity gain

would make health care financially sustainable within individual and employer budgets over time.

Risk Adjusting Premiums. The exchange would assist small firms in assessing the health risks of their employees. For example, take a small firm with 10 employees. Nine of the employees are young with good health histories while the remaining person is older and has some medical issues. Normally, a carrier examining this group would either overcharge the younger individuals or exclude the sick employee. However, using the SGIX, the insurance carrier would offer a total premium amount to these 10 employees and risk-adjust the premiums and subsidies for each beneficiary according to the plans they ultimately chose. This would significantly reduce the risk that older or sicker applicants would be excluded from coverage and that younger employees would be overcharged.

Portability. The SGIX would allow an individual to retain the same coverage if he or she lost a job or moved to a new job, solving the portability problem in employer-based health insurance. The employee would use the employer premium provision from the new firm to pay for his or her existing coverage, allowing more flexibility in job movement. Also, as with the Massachusetts Connector, a husband and wife could combine their separate employer insurance contributions to purchase a plan in the SGIX. Further, an employee with two jobs would have their premium contributions combined to help purchase the plan of their choice.

High-Risk Individuals. The use of actuarially fair premiums would draw numerous competing health plans to the SGIX and reduce the number of applicants who are rejected on the basis of pre-existing conditions. There would, however, be a small number of individuals who would not qualify for insurance even with risk-based premiums. The SGIX would attempt to enroll as many of these individuals in Medicaid as are eligible and would try to expand private coverage by coordinating coverage with other sources of care for which they are eligible. The SGIX could also operate a "high-risk pool."

> *"Insurance subsidies should be based on individuals' health risks and income."*

If coverage was unavailable through the above mechanisms, high-risk, high-cost individuals could be enrolled in selectively contracted prepaid "special needs plans." Academic evidence suggests that chronic high-cost individuals have a multitude of medical problems and are best served in an integrated health plan.[51] Premiums would be established as a percentage discount from the average health costs of individuals in the pool. Several sources of funding would be available, including existing premium taxes on private sector health plans, subsidies to enrollees (discussed below) and sliding scale beneficiary contributions based on income levels.

Step No. 3: Provide Subsidies to Purchase Health Insurance. A subsidy plan should take into account two factors: the risk of enrolling a particular individual and the income of the person or family in question. Given the voluntary nature of enrollment at the SGIX, subsidies should be provided on a "use it or lose it" basis.

It would be preferable to provide subsidies for the uninsured to purchase insurance, adjusted for health status, rather than reimbursing hospitals and other providers for uncompensated care. This way, the uninsured could use the subsidy to obtain the type of coverage that best serves their needs.

Health Insurance Tax Reform. Current federal law heavily discriminates against individual insurance; therefore to level the playing field, employer-based insurance should become taxable income. The resulting funds could be used to fund subsidies and refundable credits for non-Medicare individuals. Employees could use the credit to offset their taxes. Benefits would remain tax-free at the state level unless the state offered a similar credit arrangement. Credits would also be available to Medicaid recipients as an incentive to enroll in private plans.[52]

The biggest gainers would be low-income families with children, while single, high-income individuals with no children would lose the most. Additionally, employees would have an incentive to shop around for better coverage because they would not lose the tax subsidy

by walking away from their company's plan.

Step No. 4: Eliminate State Mandates on Exchange Plans. As mentioned earlier, state mandates on health care are a significant factor in driving up the cost of health care — estimates of the gross cost of mandates nationwide range from a low of $68 billion to a high of $172 billion. In some areas mandates add 45 percent to the cost of health insurance.[53]

To control the cost of mandates, the SGIX should set a minimum package of basic benefits that each plan must provide to enrollees. The SGIX could establish this based on the lowest coverage plan offered by the state minus non-physician services, such as dental and eyeglass coverage. Consumers could choose to purchase these basic plans or other, more extensive plans based on their needs and the price. The SGIX should provide an easy-to-compare benefit list for consumers as it is essential that the option of a no-frills plan be readily transparent.

How Many of the Uninsured Will Be Covered?

A major goal of the SGIX would be to reduce the number of uninsured in New Jersey. Nationwide, it has been estimated that around 20 percent of the uninsured are eligible for Medicaid and other government-funded programs.[54] Thus, by identifying and automatically enrolling eligible individuals, the uninsured population could quickly be reduced by 10 percent to 20 percent.

Another 20 percent or so of the uninsured are middle class workers with incomes of more than $50,000 per year. Of this group, around one-half earns in excess of $75,000 annually. These individuals can afford health coverage but choose not to buy it. The reduction in premium cost anticipated from the efficiency gains of the SGIX — as well as the actuarially fair premiums it would require — would likely reduce the cost of enrollment significantly for much of this group.

The remaining 50 percent or so of the uninsured earning less than $50,000 per year are not currently eligible for public coverage. More than half of this group earns less than $20,000 per year and is employed by a small firm (less than 50 workers). Therefore, reducing premiums for those earning under $50,000 is crucial.

> *"Individuals and businesses should be allowed to purchase insurance across state lines."*

Of the 70 percent of the uninsured who aren't eligible for public coverage, how many would actually sign up under the SGIX? Research on the demand for health insurance indicates price elasticity in the range of –0.5. That is, a 10 percent reduction in real premiums would increase enrollment by 5 percent. This figure is even higher for those below the poverty level, with elasticities in the –0.8 to –0.9 range, and the CBO suggests it may even be above –1.0. The combination of enrolling those eligible for public coverage in government plans, along with enrolling those not eligible for government programs in the SGIX, suggests a short-term reduction in the number of uninsured by 30 percent to 40 percent is possible.

Conclusion

In late 2008, two radically different solutions to make health insurance more affordable were proposed by New Jersey state legislators. One proposal, the New Jersey Healthcare Choice Act, would allow residents to purchase low-cost coverage from insurers licensed in other states. This would make coverage affordable by injecting competition into the local market and by allowing individuals to buy insurance without New Jersey's expensive mandates. The other proposal would mandate New Jersey residents purchase insurance and create a comprehensive, state-sponsored plan for those with incomes too high to qualify for Medicaid.[55] However, this proposal fails to recognize the contribution of mandated benefits and costly regulations to the high cost of insurance. Both plans are still pending final action.

Further mandating health insurance would likely lead to a rise in the number of uninsured and an increase in the cost taxpayers must pay to subsidize coverage. Conversely, deregulating the market and creating a competitive marketplace, like the SGIX, would make affordable coverage available to more people.

Endnotes

1. Kaiser State Health Facts, "Health Coverage & Uninsured – New Jersey," Undated. Available at http://www.statehealthfacts.org/profileind.jsp?ind=134&cat=3&rgn=32.

2. Carmen DeNavas-Walt, Bernadette D. Proctor and Jessica C. Smith, U.S. Census Bureau, Current Population Reports, P60-235, *Income, Poverty, and Health Insurance Coverage in the United States: 2007*, U.S. Government Printing Office, Washington, DC, 2008.

3. Kaiser State Health Facts, "New Jersey: Distribution of the Nonelderly Uninsured by Federal Poverty Level (FPL), states (2006-2007), U.S. (2007)," Undated. Available at http://www.statehealthfacts.org/profileind.jsp?ind=136&cat=3&rgn=32.

4. Michael Chernow, David Cutler and Patricia Seliger Keenan, "Increasing Health Insurance Costs and the Decline in Insurance Coverage," *Health Services Research*, Vol. 40, No. 4, September 2006, pages 1,021-39.

5. By 2007, the employer-provided health insurance benefit was worth more than $250 billion to employees in reduced income and/or payroll taxes. However, the tax savings are regressive. For example, an employee in the 35 percent income bracket saves $3,500 in taxes on a $10,000 employer-provided health plan while an employee in the 10 percent bracket would save just $1,000. See "Tax Expenditures for Health Care," Joint Committee on Taxation, Publication No. JCX-66-08, July 31, 2008. Available at http://www.house.gov/jct/x-66-08.pdf.

6. Personal conversation with the late Nobel Laureate Milton Friedman.

7. For an excellent summary of how U.S. health care developed see John C. Goodman and Gerald L. Musgrave, *Patient Power: Solving America's Health Care Crisis* (Washington, D.C.: Cato Institute, 1994).

8. M. Susan Marquis and Stephen H. Long, "Recent Trends In Self-Insured Employer Health Plans," Health Affairs, Vol. 18, No. 3, May/June 1999; Oscar Pedro Musibay, "For Larger Firms, Self-Insurance Health Plans Increase in Popularity," *South Florida Business Journal*, March 6, 2009.

9. Data from Bureau of Economic Analysis, author's calculations.

10. See, for example, "The Price Sensitivity of Demand for Nongroup Health Insurance," Congressional Budget Office, August 2005. Available at http://www.cbo.gov/ftpdocs/66xx/doc6620/08-24-HealthInsurance.pdf.

11. California Health Care Foundation, "Snapshot: Health Care Spending 101," 2007. Available athttp://www.chcf.org/documents/insurance/HealthCareCosts07.pdf.

12. See Joseph P. Newhouse, *Free For All? Lessons from The Rand Health Insurance Experiment* (Cambridge, Mass.: Harvard University Press, 1994), pages 339-40.

13. See George J. Scheiber and Jean-Pierre Poullier, "Overview of International Comparisons of Health Care Expenditures," *Health Care Financing Review*, Annual Supplement, December 1989, page 23. Also, Milton Friedman, "How to Cure Health Care," The Hoover Institute, Hoover Digest 2001 No. 3. Available at http://www.hoover.org/publications/digest/3459466.html.

14. Amy Finkelstein, "The Aggregate Effects of Health Insurance: Evidence from the Introduction of Medicare," National Bureau of Economic Research, Working Paper No. 11619, September 2005.

15. Kaiser Family Foundation, "Employer Health Benefits Survey 2008, Section 4," Kaiser Family Foundation, September 2008. Available at http://ehbs.kff.org/pdf/7790.pdf.

16. John C. Goodman, "Health Savings Accounts Will Revolutionize American Health Care," National Center for Policy Analysis, Brief Analysis No. 464, January 15, 2004.

17. Laura Trueman, "Health Care Tax Credits for the Uninsured," National Center for Policy Analysis, Brief Analysis No. 498, January 14, 2005. Available at http://www.ncpa.org/pub/ba498.

18. Nancy C. Turnbull et al., "Insuring the Healthy or Insuring the Sick? The Dilemma of Regulating the Individual Health Insurance Market," February 2005. Available at http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2005/Feb/Insuring%20the%20Healthy%20or%20Insuring%20the%20Sick%20%20The%20Dilemma%20of%20Regulating%20the%20Individual%20Health%20Insurance/790_Turnbull_insuring_healthy_or_sick_case_studies%20pdf.pdf.

19. Ibid.

20. Victoria Craig Bunce and JP Wieske, "Health Insurance Mandates in the States 2009," Council for Affordable Health Insurance, May 2009. Available at http://www.cahi.org/cahi_contents/resources/pdf/HealthInsuranceMandates2009.pdf.

21. Bradley Herring, "The Effect of the Availability of Charity Care to the Uninsured on the Demand for Private Health Insurance," *Journal of Health Economics*, Vol. 24, No. 2, March 2005, pages 225-252.

22. Michael D. Tanner, "No Miracle in Massachusetts: Why Governor Romney's Health Care Reform Won't Work," Cato Institute, Briefing Paper No. 97, June 6, 2006. Available at http://www.cato.org/pubs/bp/bp97.pdf.

23. Insurance Research Council, "Economic Downturn May Push Percentage of Uninsured Motorists to All-Time High," January 2009. Available at http://www.ircweb.org/News/IRC_UM_012109.pdf.

24. Devon Herrick, "The Folly of Health Insurance Mandates," National Center for Policy Analysis, Brief Analysis No. 652, April 9, 2009. Available at http://www.ncpa.org/pub/ba652.

25. Victoria Craig Bunce and JP Wieske, "Health Insurance Mandates in the States 2009."

26. For a discussion of how community rating drives up the cost of health insurance, see Devon Herrick and Ariel House, "How to Make Health Insurance Affordable: 2008," National Center for Policy Analysis, Brief Analysis No. 630, September 9, 2008. Available at http://www.ncpa.org/pub/ba630/.

27. Ibid.

28. Greg Scandlen, "Three Lessons from Massachusetts," National Center for Policy Analysis, Brief Analysis No. 667, July 28, 2009. Available at http://www.ncpa.org/pub/ba667.

29. Alice Dembner, "Subsidized Care Plan's Cost to Double," *Boston Globe*, February 3, 2008.

30. Susanne L. King, "Mass. Healthcare Reform is Failing Us," *Boston Globe*, March 2, 2009.

31. Debra A. Draper et al., "Massachusetts Health Reform: High Costs and Expanding Expectations May Weaken Employer Support," Center for Studying Health System Change, Issue Brief No. 124, October 2008. Available at http://www.hschange.com/CONTENT/1021/.

32. Robert Steinbrook, "Health Care Reform in Massachusetts — Expanding Coverage, Escalating Costs," *New England Journal of Medicine*, Vol. 358, No. 26, pages 2,757-2,760.

33. Debra A. Draper et al., "Massachusetts Health Reform: High Costs and Expanding Expectations May Weaken Employer Support."

34. Grace-Marie Turner, "States Should Exercise Caution Before Following Massachusetts," Heartland Institute, *Health Care News*, July 2008. Available at http://www.heartland.org/publications/health%20care/article/23424/States_Should_Exercise_Caution_Before_Following_Massachusetts.html.

35. Merritt Hawkins & Associates, "2009 Survey of Physician Appointment Wait Times," May 2009. Available at http://www.merritthawkins.com/pdf/mha2009waittimesurvey.pdf.

36. Liz Kowalczyk, "ER Visits, Costs in Mass. Climb," *Boston Globe*, April 24, 2009.

37. Ibid.

38. Susan Konig, "Medicaid Reform: Florida, South Carolina Lead the Way," *Health Care News*, Heartland Institute, August 2005. Available at http://www.heartland.org/policybot/results/17496/Medicaid_Reform_Florida_South_Carolina_Lead_the_Way.html.

39. Kaiser Family Foundation, "Summary of Florida Medicaid Reform Waiver: Early Findings and Current Status," Kaiser Commission on Medicaid and the Uninsured, October 2008. Available at http://www.kff.org/medicaid/upload/7823.pdf.

40. Devon Herrick, "South Carolina Plans Tailored to Medicaid," *Health Care News*, Heartland Institute, October 2005. Available at http://www.heartland.org/policybot/results/17756/South_Carolina_Plans_Tailored_Medicaid.html.

41. Judith Solomon, "Rhode Island's Medicaid Proposal Would Put Beneficiaries at Risk and Undermine the Federal-State Partnership: Could Set Dangerous Precedent for Other States," Center for Budget and Policy Priorities, September 4, 2008. Available at http://www.cbpp.org/cms/?fa=view&id=704. Also see Krystle Russin, "Rhode Island Governor Offers Proposal for Consumer-Driven Medicaid Overhaul," *Health Care News*, Heartland Institute, August 2008. Available at http://www.heartland.org/publications/health%20care/article/23581/Rhode_Island_Governor_Offers_Proposal_for_ConsumerDriven_Medicaid_Overhaul.html.

42. Felice J. Freyer, "Rhode Island to Mandate Lower-Cost Health Plan," *Health Care News*, Heartland Institute, March 2007. Available at http://www.heartland.org/publications/health%20care/article/20608/Rhode_Island_to_Mandate_LowerCost_Health_Plan.html.

43. Devon Herrick, "Texas Governor Wants Medicaid Reforms, More Private Insurance," *Budget & Tax News*, Heartland Institute, June 2007. Available at http://www.heartland.org/publications/budget%20tax/article/21140/Texas_Governor_Wants_Medicaid_Reforms_More_Private_Insurance.html.

44. Phil Bredesen, "What Tennessee Is Doing About Health Insurance," *Wall Street Journal*, November 22, 2008. Also see John Goodman, "Three Share Works in Tennessee," National Center for Policy Analysis, John Goodman's Health Policy Blog, December 1, 2008. Available at http://www.john-goodman-blog.com/three-share-works-in-tennessee/.

45. "Jindal's Medicine," *Wall Street Journal*, November 24, 2008.

46. Louisiana Academy of Physicians, "Louisiana Health First FAQs." Also see, "Health Care Transformation Concept," Louisiana Health First, November 14, 2008.

47. Jeremy Smerd, "Utah Exchange May Offer New U.S. Health Care Insurance Model," *Workforce Management*, September 17, 2009.

48. Heidi Toth, "Utah Health Exchange launches amid reform questions," *Daily Herald*, August 20, 2009.

49. For a brief explanation of how economies of scale function, see "Economies of scale and scope," the *Economist*, October 20, 2008. Available at http://www.economist.com/daily/news/displaystory.cfm?story_id=12446567.

50. The exchanges that were envisioned under the proposed Clinton Plan in 1993 (called "Health Alliances") were a misuse of the insurance exchange concept. The Alliances would have been allowed to exclude providers from offering plans if the premium was an arbitrary percentage above the average plan offered. Consumers, not government bureaucrats, should determine whether a plan's cost

is appropriate. Furthermore, the Alliances would have provided many incentives for large employers to join the government pool. But the SGIX focuses on the biggest problem area in health insurance, the small-group and individual market. In addition, the Clinton plan required that the Alliances reduce the real rate of medical inflation by two-thirds. If competition did not achieve this effect, the plan's fallback approach was price controls.

51. Kenneth E. Thorpe, Curtis S. Florence and Peter Joski, "Which Medical Conditions Account For The Rise In Health Care Spending," *Health Affairs*, Web Exclusive, August 2004, pages W4-437-W4-445.

52. Mark V. Pauly and John C. Goodman, "Tax Credits for Health Insurance and Medical Savings Accounts," *Health Affairs*, Vol. 14, No.1, Spring 1995, pages 126-139.

53. Victoria Craig Bunce and JP Wieske, "Health Insurance Mandates in the States 2004," Council for Affordable Health Insurance, July 2004. Available at http://www.cahi.org/cahi_contents/resources/pdf/Mandatepub2004Electronic.pdf.

54. See the Current Population Survey, Bureau of Labor Statistics.

55. Devon Herrick and John O'Keefe, "Insuring New Jersey's Uninsured," National Center for Policy Analysis, Brief Analysis No. 618, May 20, 2008.

The NCPA is a nonprofit, nonpartisan organization established in 1983. Its aim is to examine public policies in areas that have a significant impact on the lives of all Americans — retirement, health care, education, taxes, the economy, the environment — and to propose innovative, market-driven solutions. The NCPA seeks to unleash the power of ideas for positive change by identifying, encouraging and aggressively marketing the best scholarly research.

Health Care Policy.

The NCPA is probably best known for developing the concept of Health Savings Accounts (HSAs), previously known as Medical Savings Accounts (MSAs). NCPA President John C. Goodman is widely acknowledged (*Wall Street Journal*, WebMD and the *National Journal*) as the "Father of HSAs." NCPA research, public education and briefings for members of Congress and the White House staff helped lead Congress to approve a pilot MSA program for small businesses and the self-employed in 1996 and to vote in 1997 to allow Medicare beneficiaries to have MSAs. In 2003, as part of Medicare reform, Congress and the President made HSAs available to all nonseniors, potentially revolutionizing the entire health care industry. HSAs now are potentially available to 250 million nonelderly Americans.

The NCPA outlined the concept of using federal tax credits to encourage private health insurance and helped formulate bipartisan proposals in both the Senate and the House. The NCPA and BlueCross BlueShield of Texas developed a plan to use money that federal, state and local governments now spend on indigent health care to help the poor purchase health insurance. The SPN Medicaid Exchange, an initiative of the NCPA for the State Policy Network, is identifying and sharing the best ideas for health care reform with researchers and policymakers in every state.

NCPA President John C. Goodman is called the "Father of HSAs" by *The Wall Street Journal*, WebMD and the *National Journal*.

Taxes & Economic Growth.

The NCPA helped shape the pro-growth approach to tax policy during the 1990s. A package of tax cuts designed by the NCPA and the U.S. Chamber of Commerce in 1991 became the core of the Contract with America in 1994. Three of the five proposals (capital gains tax cut, Roth IRA and eliminating the Social Security earnings penalty) became law. A fourth proposal — rolling back the tax on Social Security benefits — passed the House of Representatives in summer 2002. The NCPA's proposal for an across-the-board tax cut became the centerpiece of President Bush's tax cut proposals.

NCPA research demonstrates the benefits of shifting the tax burden on work and productive investment to consumption. An NCPA study by Boston University economist Laurence Kotlikoff analyzed three versions of a consumption tax: a flat tax, a value-added tax and a national sales tax. Based on this work, Dr. Goodman wrote a full-page editorial for *Forbes* ("A Kinder, Gentler Flat Tax") advocating a version of the flat tax that is both progressive and fair.

A major NCPA study, "Wealth, Inheritance and the Estate Tax," completely undermines the claim by proponents of the estate tax that it prevents the concentration of wealth in the hands of financial dynasties. Actually, the contribution of inheritances to the distribution of wealth in the United States is surprisingly small. Senate Majority Leader Bill Frist (R-TN) and Senator Jon Kyl (R-AZ) distributed a letter to their colleagues about the study. In his letter, Sen. Frist said, "I hope this report will offer you a fresh perspective on the merits of this issue. Now is the time for us to do something about the death tax."

Retirement Reform.

With a grant from the NCPA, economists at Texas A&M University developed a model to evaluate the future of Social Security and Medicare, working under the direction of Thomas R. Saving, who for years was one of two private-sector trustees of Social Security and Medicare.

The NCPA study, "Ten Steps to Baby Boomer Retirement," shows that as 77 million baby boomers begin to retire, the nation's institutions are totally unprepared. Promises made under Social Security, Medicare and Medicaid are completely unfunded. Private sector institutions are not doing better — millions of workers are discovering that their defined benefit pensions are unfunded and that employers are retrenching on post-retirement health care promises.

Pension Reform.

Pension reforms signed into law include ideas to improve 401(k)s developed and proposed by the NCPA and the Brookings Institution. Among the NCPA/Brookings 401(k) reforms are automatic enrollment of employees into companies' 401(k) plans, automatic contribution rate increases so that workers' contributions grow with their wages, and better default investment options for workers who do not make an investment choice.

The NCPA's online Social Security calculator allows visitors to discover their expected taxes and benefits and how much they would have accumulated had their taxes been invested privately.

Environment & Energy.

The NCPA's E-Team is one of the largest collections of energy and environmental policy experts and scientists who believe that sound science, economic prosperity and protecting the environment are compatible. The team seeks to correct misinformation and promote sensible solutions to energy and environment problems. A pathbreaking 2001 NCPA study showed that the costs of the Kyoto agreement to reduce carbon emissions in developed countries would far exceed any benefits.

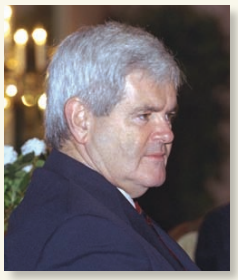
Educating the next generation.

The NCPA's Debate Central is the most comprehensive online site for free information for 400,000 U.S. high school debaters. In 2006, the site drew more than one million hits per month. Debate Central received the prestigious Templeton Freedom Prize for Student Outreach.

Promoting Ideas.

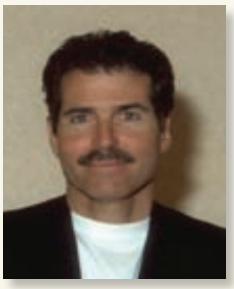
NCPA studies, ideas and experts are quoted frequently in news stories nationwide. Columns written by NCPA scholars appear regularly in national publications such as the *Wall Street Journal*, the *Washington Times*, *USA Today* and many other major-market daily newspapers, as well as on radio talk shows, on television public affairs programs, and in public policy newsletters. According to media figures from Burrelle's, more than 900,000 people daily read or hear about NCPA ideas and activities somewhere in the United States.

What Others Say About the NCPA



"The NCPA generates more analysis per dollar than any think tank in the country. It does an amazingly good job of going out and finding the right things and talking about them in intelligent ways."

Newt Gingrich,
former Speaker of the U.S. House of Representatives



"We know what works. It's what the NCPA talks about: limited government, economic freedom; things like health savings accounts. These things work, allowing people choices.We've seen how this created America."

John Stossel,
co-anchor ABC-TV's *20/20*

"I don't know of any organization in America that produces better ideas with less money than the NCPA."

Phil Gramm,
former U.S. Senator

"Thank you . . . for advocating such radical causes as balanced budgets, limited government and tax reform, and to be able to try and bring power back to the people."

Tommy Thompson,
former Secretary of Health and Human Services

The NCPA is a 501(c)(3) nonprofit public policy organization. We depend entirely on the financial support of individuals, corporations and foundations that believe in private sector solutions to public policy problems. You can contribute to our effort by mailing your donation to our Dallas headquarters or logging onto our Web site at www.ncpa.org and clicking "Donate."