Chapter I

THE GOALS OF REFORM

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

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

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

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

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

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

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

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

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

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

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

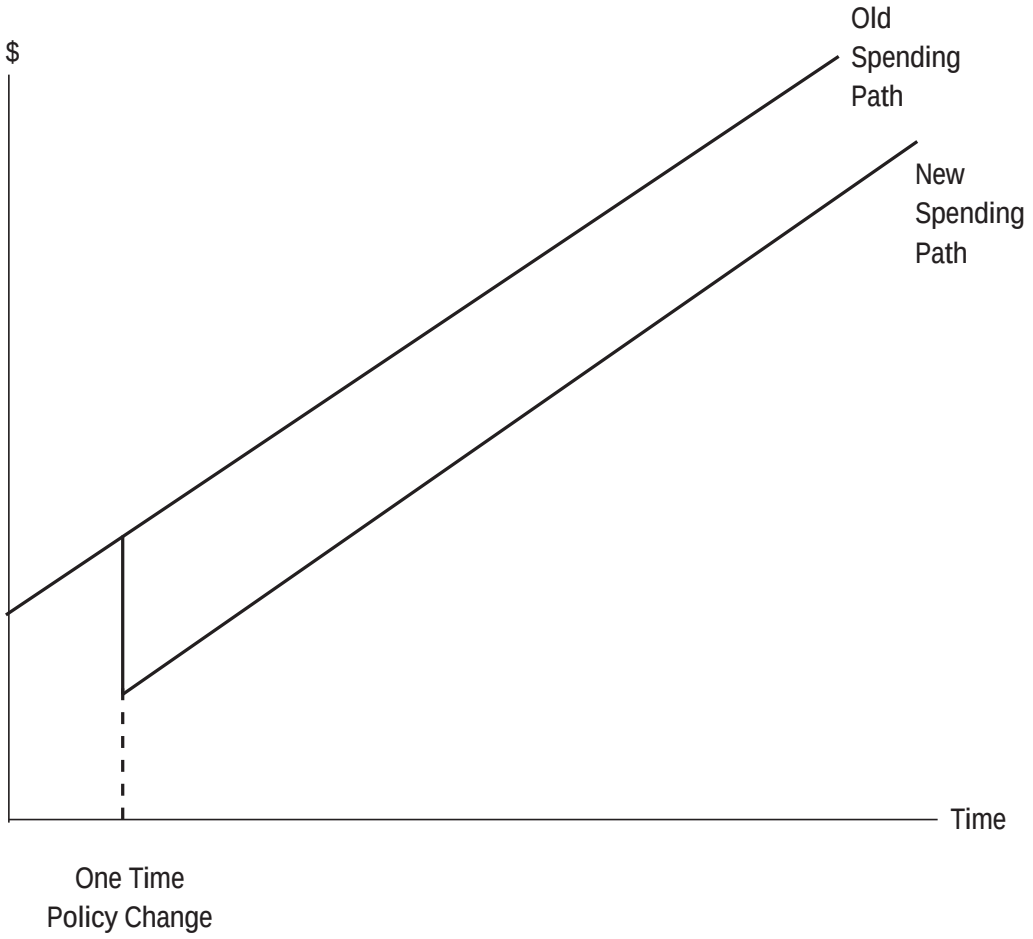
Illusory Solution: Shifting Costs. Another set of proposals would shift costs from one group to another. For example, Physicians for a National Health Program, an advocacy group, argues that if government were the sole (monopolistic) buyer of health services, it could force reductions in fees paid to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

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

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

FIGURE I

Health Care Spending



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

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

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

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

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

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

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

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

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

Too Many Errors?

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

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

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

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

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

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

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

[3] G. Ross Baker et al., "The Canadian Adverse Events Study: the Incidence of Adverse Events Among Hospital Patients in Canada," *Canadian Medical Association Journal*, Vol. 170, No. 11, pages 1,678-86.

Source: Linda Gorman, Independence Institute.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

State Health Insurance Mandates

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

[1] As a percent of total premiums.

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

Saving Health Insurance from the Minimum Wage

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

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

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

1. Allow employers to count health insurance expenses against the minimum wage increase (so up to $4,200 of the mandated increase for a full-time worker could go to health insurance).

2. Allow employers who do not provide health insurance to use the increase to purchase non-taxed, individually owned insurance instead of paying taxable wages.

3. Allow employees to choose between taxable wages and non-taxed, individually owned health insurance.

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

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

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

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

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

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

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

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

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

Notes

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