Chapter III

IMPLEMENTING THE PRINCIPLES OF REFORM

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

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

Implementing Principle No. 1: Health Care versus Health Insurance

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

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

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

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

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

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

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

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

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

Who Are the Uninsured?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Case Study: Dental Care without Health Insurance in Dallas.[23] One of the more remarkable studies in health economics in recent years is economist Amy Finkelstein's finding that Medicare did not really improve the quality of care seniors received; instead it merely added to health care inflation for the county as a whole.[24]

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

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

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

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

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

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

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

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

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

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

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

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

Implementing Principle No. 2: Entrepreneurship versus Bureaucracy

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

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

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

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

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

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

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

opportunity to offer a different bundle of services for a different price. As a result, very little entrepreneurship is possible.[30]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

There are three empirical questions to ask about health insurance:

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

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

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

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

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

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

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

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

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

Utah's Limited Benefits Health Insurance

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

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

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

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

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

[1] This more limited benefit package is also the package made available under Utah's S-CHIP.

[2] Susan Konig, "Medicaid Reform: Florida, South Carolina Lead the Way," Heartland Institute, August 1, 2005.

[3] "2005 Performance Report for Utah Commercial HMOs and Medicaid and S-CHIP Health Plans," Utah Department of Health, November 2005.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

government could implement such a system, as could individual states.[64] (See the discussion below in Chapter VII.)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Massachusetts Health Plan

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

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

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

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

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

[1] Summary, "Health Care Access and Affordability Conference Committee Report," Masachusetts Legislature, April 3, 2006. Available at: http://www.mass.gov/legis/summary.pdf. Accessed September 6, 2007.

Making the Massachusetts Plan Better

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The California Health Care Plan

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

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

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

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

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

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

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

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

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

[1]"Governor's Health Care Proposal," January 8, 2007. Available at http://gov.ca.gov/pdf/press/Governors_HC_Proposal.pdf.

Do Mandates Work?
Auto Liability Insurance versus Health Insurance

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

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

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

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

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

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

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

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

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

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

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

FIGURE IIa

Government Subsidy

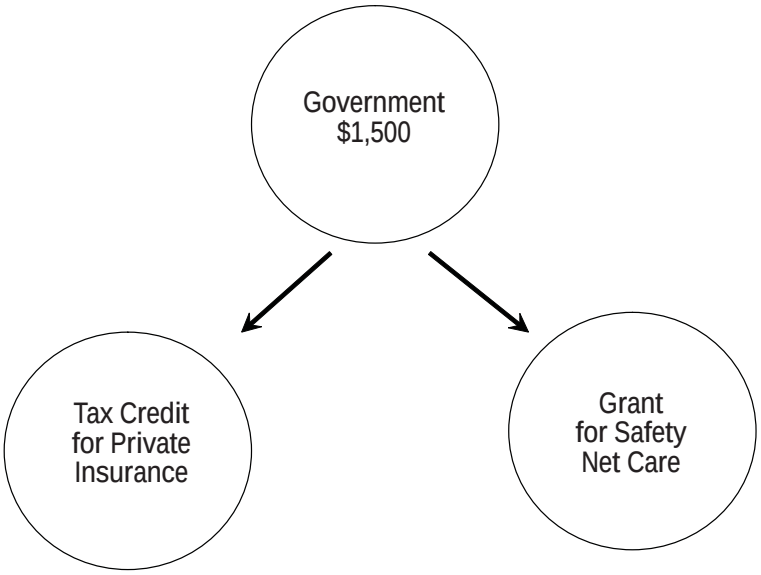
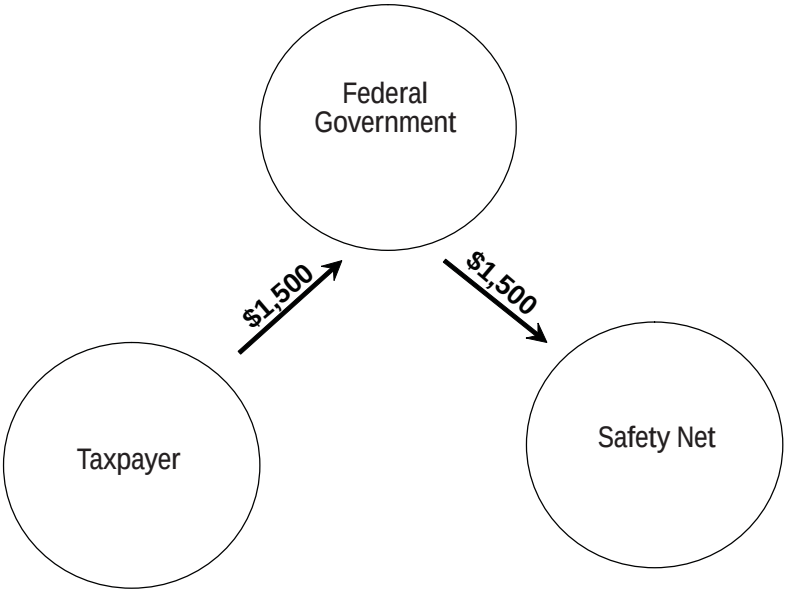


FIGURE IIb

The Marginal Effect of Choosing to be Uninsured



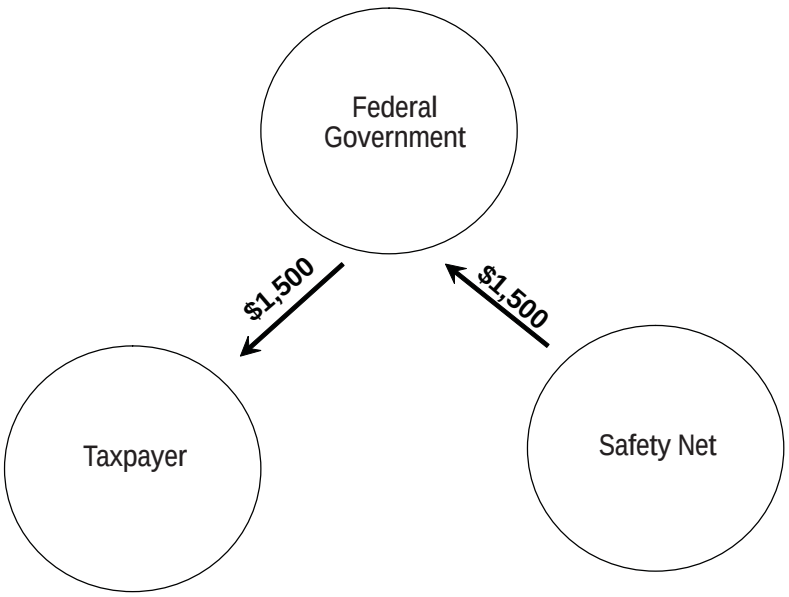
ing on a refundable $1,500 income tax credit to pay the premiums. As a result, Dallas County no longer would need to spend $1,500 per person on the uninsured. Thus, all of the money that previously funded safety net medical care could be used to fund private insurance premiums. [See Figure IIc.]

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

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

FIGURE IIc

The Marginal Effect of Choosing to be Insured



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

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

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

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

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

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

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

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

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

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

How the Federal Government Can Help: The "Do No Harm" Approach to Health Policy

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

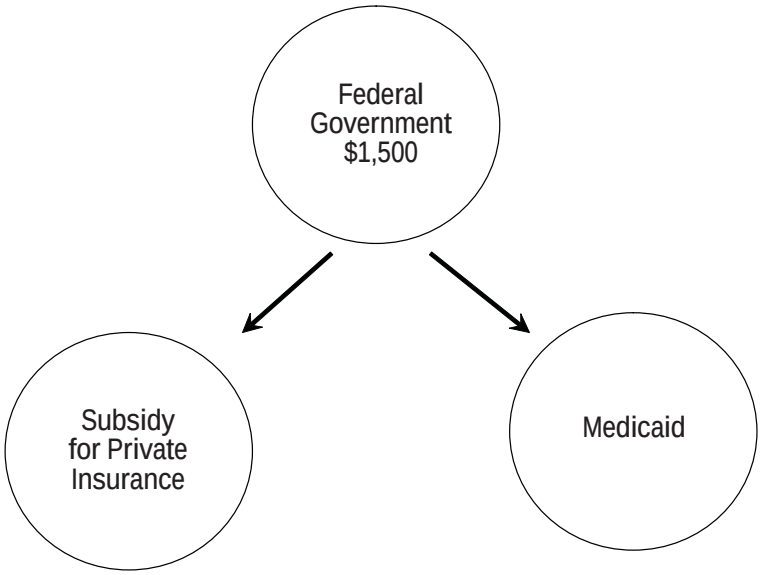
The solution here is very similar to the solution to the previous problem. If government is spending $1,500 a year per person enrolled in Medicaid, it ought to be willing to spend an identical sum on private insurance instead. [See Figure III.] Florida's Medicaid reform, whereby the state uses federal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

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

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

FIGURE III

A Level Playing Field for Private and Public Insurance



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

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

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

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76 Ibid. Cutler and Gruber found that most of the reduction came from workers deciding to drop private coverage (particularly for dependents) rather than because their employers stopped insurance coverage.

77 "The State Children's Health Insurance Program," Congressional Budget Office, Congress of the United States, May 2007.

78 However, Jonathan Gruber supports S-CHIP as the least expensive method to expand coverage. See Jonathan Gruber and Kosali Simon, "Crowd-Out Ten Years Later: Have Recent Public Insurance Expansions Crowded Out Private Health Insurance?" National Bureau of Economic Research, Working Paper No. 12858, January 2007.

79 Ibid.

80 NCPA calculations were based on HSC Community Tracking Surveys, 1997 to 2003, Center for Studying Health System Change.

81 Michael Bond, "Expanding Opportunities For Health Insurance in Florida."

82 Pam Belluck, "Maine Learns Expensive Lesson As Universal Health Plan Stalls," *New York Times*, April 30, 2007.

83 Dirigo Health Web site, at http://www.dirigohealth.maine.gov.

84 Pam Belluck, "Maine Learns Expensive Lesson As Universal Health Plan Stalls."