

Chapter XI

CONCLUSION: LIFE IN A REFORMED HEALTH CARE SYSTEM

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CHAPTER XI — LIFE IN A REFORMED HEALTH CARE SYSTEM

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

Like Chris Reeder, David Brooks knows he can't make money seeing patients like Karen unless he can get better results for less money. So he persuaded Cheryl to use Karen's HSA money to buy a device that monitors Karen's peak air flow. He also showed Cheryl how to use the device, how to change Karen's drug regime when needed, and how to distinguish symptoms that are serious and really require an emergency room visit from those that are not.

Like Dr. Reeder, Dr. Brooks accepts phone calls and email messages from Cheryl and answers her questions promptly. He charges her for the time, and Cheryl is glad to pay — knowing that she is saving both time and money by relying on telephone and email consultations rather than the alternatives.

Under the old system, doctors feared greater malpractice liability if they consulted with patients by telephone or e-mail. But Reeder and Brooks solved that problem by signing a state-approved contract with Cheryl. Under the new arrangement, (a) a lower (liability) standard of care is applied to telephone and email consultations, (b) special computer software is employed to reduce the chance of error and (c) the parties have agreed in advance on how to compensate for unexpected adverse medical events — without the need of lawyers, judge, juries or courtrooms. Reeder and Brooks both have insurance in case patient compensation has to be paid, but the premiums are a fraction of what they used to be under the old malpractice system.

Under the old system, Karen would lose her S-CHIP coverage (and possibly also her relationship with Dr. Brooks) once her mother's income reaches a threshold level. But the state's S-CHIP program has been converted to a premium support system. Karen is now able to join any health plan, and she will enroll under her mother's Blue Cross policy. As Cheryl's income grows, the state subsidy will ebb — until eventually the Greens will

HANDBOOK ON STATE HEALTH CARE REFORM

be on their own. Karen's relationship with Dr. Brooks will continue however. The reason: Blue Cross has decided that if Brook's style of practice saves money for Medicaid, it will also save money for Blue Cross.

Bob Crosby, Cheryl's brother, is partially disabled. Bob was working as a sales manager in a department store when he fell off of a ladder and tore some ligaments in his knee. Bob is still able to do many things, but he can't endure the eight hours of standing required of most department store sales jobs. Under the old system, if Bob found a different type of employment, he would risk losing some or all of his monthly disability check. Under the new reformed Workers' Compensation system, however, once Bob's disability was verified, he began receiving checks from an insurance company. He will continue receiving them regardless of any future employment.

In the immediate aftermath of his accident, Bob was unemployed. He had self-insured to cover the first few months of his disability — paying living expenses from his personal Workers' Compensation Account. Even so, he was without a paycheck and uninsured. And like so many other uninsured people, Bob began using the hospital emergency room for free medical care for health matters unrelated to his disability. Medical cost for the disability continued to be paid by a Workers' Compensation private insurer.

All that was before Bob had a life-changing conversation with his orthopedist, Dr. Steve Shulkin. First, Shulkin pointed out that Bob's temporary unemployment and low income qualified him for a health insurance subsidy from the government. Money that used to be spent giving free care to the uninsured (usually in hospital emergency rooms) was now available to subsidize private insurance instead. Bob could use it to choose any private plan.

But that is not all. Shulkin then recommended a health insurer who would cover both Bob's leg injury and his other health care needs. Bob's initial reaction was disbelief. He had a great deal of experience with the

CHAPTER XI — LIFE IN A REFORMED HEALTH CARE SYSTEM

old insurance system, where no insurer wanted to cover someone with a preexisting illness, and where the treatment of those conditions was often excluded from coverage. Now Shulkin was telling him about an insurance company that actually wanted people just like Bob.

The arrangement works like this. The Orthopedic Insurance Company specializes in people with orthopedic injuries. It has learned through experience to produce high-quality, low-cost orthopedic care by contracting with doctors like Steve Shulkin. So Orthopedic Insurance offered to take Bob off the hands of the Workers' Comp insurer for a price well below the expected cost of conventional care. Yet because Orthopedic Insurance is so efficient at what it does, it finds that the payment from the Workers' Comp insurer plus the premium support from the state is more than enough to generate a handsome profit. The package deal is a win-win for all parties.

Shulkin, by the way, was not acting out of purely altruistic motives. In fact, he received a fee for helping put the arrangement together. Not only does the state consider Shulkin's fee ethical, it encourages and even subsidizes such fees.

While Bob is out of work, the premium subsidies may continue. When he gets a job, he will probably no longer qualify for a government subsidy. But under the state's new portable insurance system, he can stay in his new Orthopedic Insurance plan and apply the new employer's premium contributions to that plan.

Cheryl's parents, Charles and Irene, are in their sixties. They have paid off the mortgage on their home and have \$200,000 in liquid assets — in addition to the pension Charles expects to receive, plus Social Security. One would think that a couple like Charles and Irene would have little to worry about. But until recently they were worried that incapacity could land one or both in a nursing home and wipe out their entire life savings.

Their concerns have recently subsided, however, thanks to a new state law that allows them to protect their assets and have access to nursing

HANDBOOK ON STATE HEALTH CARE REFORM

home care if they need it. Specifically, the Greens have purchased a long-term care insurance plan with \$300,000 worth of coverage. If either of them enters a nursing home, insurance starts paying the bills. Should their private insurance coverage run out, they can turn to Medicaid.

They are relieved because they don't have to "spend down" all their assets. In fact, \$300,000 of their assets will be completely ignored by the state in determining eligibility for Medicaid. The Greens can have access to affordable long-term care and still leave something to their kids.

These are only a few of the changes we can imagine in a reformed health care system. Fortunately, the full extent of the potential change is not limited by our imagination. Rather, it is limited only by the range and scope of the ingenuity of 300 million Americans — all of whom would be free to use their creativity and their innovative ability to solve health care problems — unshackled by the dysfunctional, bureaucratic and regulatory obstacles of the current system.

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About the National Center for Policy Analysis

The NCPA is a nonprofit, nonpartisan organization established in 1983. Its goal is to examine the nation's most important public policy and to propose innovative, market-driven solutions.

The NCPA is probably best known for developing the concept of Health Savings Accounts (HSAs). NCPA President John C. Goodman is widely acknowledged (*Wall Street Journal*, *WebMD* and the *National Journal*) as the "Father of HSAs." In addition, a package of tax cuts designed by the NCPA and the U.S. Chamber of Commerce became the core of the Contract with America in 1994. Three of the five proposals (capital gains tax cut, Roth IRA and eliminating the Social Security earnings penalty) became law.

With a grant from the NCPA, economists at Texas A&M University developed a model to evaluate the future of Social Security and Medicare, working under the direction of Thomas R. Saving, who for years was one of two private-sector trustees of Social Security and Medicare. Pension reforms signed into law include ideas to improve 401(k)s developed and proposed by the NCPA and the Brookings Institution.

Among other initiatives, the NCPA's E-Team is one of the largest collections of energy and environmental policy experts and scientists who believe that sound science, economic prosperity and protecting the environment are compatible. Furthermore, the NCPA's Debate Central online site is the most comprehensive site for free information for 400,000 U.S. high school debaters. Debate Central received the prestigious Templeton Freedom Prize for Student Outreach.