

LEGISLATIVE
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SERIES

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One in a series of brief guides to the most important public policy issues of the day, written especially for elected officials and other opinion leaders.

Ten Principles *of* Health Care Policy

BY JOSEPH L. BAST

Series Preface

The purpose of this series of booklets called *Legislative Principles* is two-fold: To compile and express concisely legislative principles based upon research evidence too voluminous for most legislators, policy analysts, and interested citizens to read; and to complement the news reporting in The Heartland Institute's five monthly public policy newspapers, *Budget & Tax News*, *Environment & Climate News*, *Health Care News*, *IT&T News*, and *School Reform News*.

Each booklet in this series presents a set of fundamental principles central to the debates about a major public policy issue. Each principle, in turn, is carefully documented to enable readers to find the original sources, many of which are on The Heartland Institute's Web site (www.heartland.org). An electronic version of this booklet, also posted on Heartland's Web site, has links to the URLs of many of the sources cited.

By design, Heartland's public policy newspapers focus on news and contain factual accounts about current events, policies, and legislation. The booklets in the *Legislative Principles* series, on the other hand, set forth enduring principles that are likely to remain valid and relevant to legislative policy in the next decade. They can help busy legislators rapidly prepare themselves to discuss and even propose new legislation in areas they may not ordinarily follow closely.

We hope the series forms a mini-library for elected officials, their staff, and concerned citizens. Kept on a desk or in a drawer, the booklets can form a ready reference on major legislative issues and policies. We also hope you will distribute copies to friends and colleagues who share your interest.

This booklet can be downloaded for free from The Heartland Institute's Web site at www.heartland.org. Permission is granted to make additional copies. Additional copies also may be ordered from Heartland by following the instructions on page 33.

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Herbert J. Walberg
Series Editor and
Chairman, The Heartland Institute

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About The Heartland Institute

The Heartland Institute is a genuinely independent source of research and commentary. Founded in Chicago, Illinois in 1984, Heartland's mission is to discover, develop, and promote free-market solutions to social and economic problems. Such solutions include parental choice in education, choice and personal responsibility in health care, and market-based approaches to environmental protection. Its activities are tax-exempt under Section 501(c)(3) of the Internal Revenue Code.

The Heartland Institute
19 South LaSalle Street #903
Chicago, Illinois 60603
phone 312/377-4000, fax 312/377-5000
www.heartland.org

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Introduction

Why do we need principles of health care policy?

The proper role of government in financing and the delivery of health care is one of the hottest public policy issues of our time. Some experts call for more regulation and more subsidies, while others call for less. All levels of government in the U.S. are coping with rising spending on health care for their own workforces and rapidly rising spending on programs for the poor and elderly.

This booklet is designed to help state legislators find solutions to health care problems by first identifying their causes and true extent – which often are not as they are reported in newspaper stories or touted by special interest groups – and then by presenting ten principles that ought to guide reform efforts.

Do we really spend too much?

It often is assumed at the outset that “we spend too much” on health care in the U.S., but who is “we” and what is the “right” amount? Individuals, not nations, earn income and choose how to spend it.

When adjusted for inflation, per-capita health care spending in the U.S. today is about 10 times what it was in 1950. By itself, this statistic is not evidence of a problem. Data from around the world show that people tend to spend a bigger part of their incomes on health care as they grow wealthier (OECD 2004). Health is what economists call a “superior good,” which means spending rises faster than income.

Spending on health care in the U.S. totaled \$1.9 trillion in 2004 – an average of \$6,430 per person, almost one-sixth of the nation’s gross domestic product (NCHS 2006). No doubt some of this increased spending has produced good results. Higher spending on health care is responsible for some part of the significant increases in lifespan and reduced disability during the past half century. Most spending today is on treatments that were unavailable at any cost in the not-so-distant past (Cutler 2004, Gratzner 2006). Health care providers in the U.S. provide a higher level of care than is available in most, and perhaps all, other countries (Brase 2000).

Reasons we spend so much

Spending on health care in the U.S. often is compared unfavorably to spending levels in other countries, but there are some good reasons having little or nothing to do with public policies that help explain why health care in the United States costs more than it does in other countries. Among them:

- We invest much more in saving prematurely born infants and extending the life of our elderly. Other countries withhold care and stop treatment (Wesbury 1990, Wennberg 2006).
- Pregnancy, birth, and abortion rates among girls aged 15 to 19 are higher in the U.S. than in other developed countries (Singh and Darroch 2000).
- The portion of the U.S. population aged 15 and older that is obese is nearly double that of Canada and substantially higher than in other wealthy countries (Anderson and Hussey 2000).

The need for health care reform

Even knowing that a high level of spending on health care is not necessarily a bad thing, and that there are reasons why we spend more than consumers in other countries, we might still conclude that we still spend too much on health care in the U.S. In fact, we should come to this conclusion.

Waste and inefficiency are easily identified in our hospitals, government programs, and private insurance markets (Meier 2001). We see it in the number of people who lack health insurance, the lack of price transparency in much of the health care system, the high rate of medical mistakes in hospitals, and the massive transfers of income – often from the poor and uninsured to the well-to-do and insured – that the current system generates.

A “good health care system” wouldn’t employ armies of “gatekeepers” to intrude in the relationship between doctors and patients, wouldn’t require lawsuits to ensure that victims of malpractice get adequate compensation or that incompetent providers lose their licenses, and wouldn’t ration access to life-saving drugs.

These are the real problems facing health care in America today, and they each can be traced back to bad public policies. The rest of this booklet examines these policies and describes the most promising reforms.

Suggested readings: Bast, J., Rue, R., and Wesbury, S., 1993, *Why We Spend Too Much on Health Care*, Chicago: The Heartland Institute; Cutler, D.M., 2006, *Your Money or Your Life: Strong Medicine for America’s Health Care System*, New York: Oxford University Press; Gratzner, D., 2006, *The Cure: How Capitalism Can Save American Health Care*, New York: Encounter Books.

1. Health care is a service, not a right

Health care is best delivered by the market, just like other important goods and services.

Much of the debate over health care policy begins with two mistaken notions, first that health care is different than other goods and services and therefore does not respond to normal economic rules, and second that it is “too important” to be entrusted to the anonymous forces of markets.

Health care services are delivered by markets

Markets exist wherever consumers are allowed to seek the greatest value for their money and producers are allowed to seek profits by providing what consumers want. The interaction of demand and supply creates prices, generates investment, and leads to innovation and progress. Even with current policies and regulations that distort the market for health care, we find normal economic forces working in the same manner as they do in other markets:

- *Price controls lead to shortages.* Medicaid programs set fees for doctor visits below market prices and often below the cost of the visit. As a result, there is a shortage of doctors willing to treat Medicaid patients (Medicare Payment Advisory Commission 2003).
- *Competition reduces prices.* Lasik eye surgery and cosmetic surgery are two areas where providers compete directly and consumers spend their own money. While health care costs overall have risen dramatically in recent years, prices for Lasik and cosmetic surgery have fallen (Cannon and Tanner 2005).
- *Consumers respond to price signals.* Many experiments and other studies have found that consumption of health care changes when prices change. Health plans with increased cost-sharing reduce discretionary spending and unnecessary visits to emergency rooms (Wharam et al. 2007).

Health care is not too important for markets

The claim that health care is too important to be left to the market can be turned on its head: Health care is too important to be left in the hands of government bureaucracies that often are unaccountable and unreliable. We need *greater* reliance on markets and normal economic forces, not less, because health care is so

important to so many people (Wilson 1989).

Access to and the provision of many important goods and services are generally left to markets, with charitable assistance limited to those who need it. Producers of food, for example, are free to supply whatever they want and sell it at whatever price the market will bear. Regulations help to ensure food safety and some subsidies are offered for a few crops, but beyond that the market for food is generally free from government interference. Food stamps, income subsidies, and private charity allow the poor to purchase what they need in the same markets as everyone else.

Problems with a “right to health care”

The alternative to viewing health care as a service is to view it as an entitlement or right. This view resonates with some health care providers and political and legal philosophers, but it is a deeply problematic idea.

A right is a claim to be treated in a certain way by others, which places an obligation on others to act in certain ways. Negative rights – such as the rights to “life, liberty, and the pursuit of happiness” proclaimed in the Declaration of Independence – are rights to be free from interference and coercion by others, and generally do not contradict the exercise of the same freedom rights of others. Positive rights – such as a claim to free or subsidized health care – are claims to the service, involuntary if necessary, of others. Positive rights therefore bring the risk of contradicting the freedom rights of others (Epstein 1997).

A “right to health care” does not appear in the U.S. Constitution or its Bill of Rights, or in any state constitution, or in the writings of the Founding Fathers or the British intellectual tradition they drew their inspiration from. This was not an oversight. Positive rights may require that goods and services be produced involuntarily, under the penalty of law. Historically, this has not been an efficient or just way to produce goods and services.

Reformers looking to improve access to quality health care must start by understanding that health care services should be delivered by markets. The policymaker’s task is to enable normal economic forces to perform their tasks just as they do in markets for other goods and services.

Suggested readings: Epstein, R., 1997, *Mortal Peril: Our Inalienable Right to Health Care?* Addison-Wesley Publishing Company; Goodman, J.C. and Musgrave, G.L., 1992, *Patient Power: Solving America’s Health Care Crisis*, Washington, DC: Cato Institute.

2. Repeal existing regulations first

Benefit mandates, “guaranteed issue,” and “community rating” are among the regulations that unnecessarily increase health care spending.

Policymakers often are anxious to pass new laws and create new programs to “solve” the nation’s health care finance problems. But they first should repeal laws and programs that cause those problems or make them worse.

Mandated benefits

In the U.S. there are 1,843 laws mandating that insurers cover specific providers, procedures, or benefits (Bunce, Wieske, and Prikazsky 2006). These laws often are billed as being pro-consumer but they mostly are pro-producer, needlessly adding to the cost of health insurance and health care services by requiring insurers to cover seldom-used or easily abused services. Higher insurance premiums due to state-mandated benefits are responsible for about 25 percent of the number of uninsured (Jensen and Morrissey 1999).

Mandated benefit laws disproportionately affect those who are self-employed, unemployed, or who work for companies that are too small to afford insurance benefits for their employees. Big businesses typically self-insure and are exempt from state regulations.

“Guaranteed issue” laws

Guaranteed issue laws require insurance companies to provide insurance to anyone who seeks it. The Health Insurance Portability and Accountability Act of 1996 requires insurers to offer guaranteed issue policies in the small group (2-50 insured persons) market. Some states also try to impose guaranteed issue on their small group and individual markets, with disastrous effects.

Guaranteed issue drives up the price of health insurance by creating an incentive for people to wait until they are sick before buying insurance. Insurance companies raise premiums to guard against the larger claims of the insured population that tends to be less healthy at any given time. Each round of premium increases causes a new group of healthy people to drop its coverage, causing the insured population to become still more expensive to insure. The result is soaring premiums and rising numbers of uninsured (Meier 2005, Bast 2004).

“Community rating” laws

Community rating requires insurers to charge similar rates to all members of a community regardless of age, lifestyle, health, or gender. Because an insurer cannot adjust its premiums to reflect the individual health risks of consumers, the majority who are healthy see their premiums rise.

Community rating means insurance premiums paid by young and healthy individuals are higher than the benefits they are likely to receive, encouraging them to drop their coverage. Like guaranteed issue, this results in an insured population with higher health care expenses than the average population, requiring higher insurance premiums. Once again, premium increases cause more people to choose to go without health insurance.

States that have adopted guaranteed issue and community rating have higher premiums and fewer insurers competing for customers than states that have not. Guaranteed issue and community rating laws have been especially harmful in states where they have been applied to the individual insurance market (Meier 2005, NAHU 2005).

Other regulations

Mandated benefits, guaranteed issue, and community rating are the three most destructive regulations states impose on health insurance companies. Other regulations on insurers and health care providers that limit competition and consumer choices include:

- *Individual and employer mandates.* Maine, Massachusetts, and Vermont are planning to impose mandates on individuals and employers to purchase health insurance. These mandates are unlikely to raise enough money in new premiums or penalties to justify the cost of investigating employers, determining eligibility, overseeing premium collection, and identifying and collecting penalties from the uninsured (Tanner 2006).
- *Certificate of Need.* Many states require health care providers to obtain certificates of need before expanding facilities or opening new centers. Existing hospitals and clinics are allowed to testify against new competitors, and naturally they do. Extensive research demonstrates that certificate of need laws reduce competition and result in higher prices (Barnes 2006, Conover 1998, Cordato 2005).
- *Rate reviews and bands.* Most states regulate the rates insurers charge for insurance products in the small group market either by requiring pre-approval of rates or by prohibiting insurers from offering rates more than 25 percent above or below a base rate. Sometimes rate review is also imposed on the individual market, and sometimes rate bands of less than 25 percent are proposed. Rate reviews and narrow bands stifle innovation and

competition (Wieske 2007).

- *Clean claims and prompt pay laws.* Some states mandate that health insurers pay 95 percent or more of all claims within a certain amount of time after receipt of the claim by the insurer. Such laws can be reasonable, but if the percentage of claims is set too high or the time period too short, compliance costs can soar, causing profit margins to shrink and insurers to stop writing policies (Bunce 2002).
- *Prohibitions on exclusionary waivers.* Some states prohibit insurers in the individual health insurance market from offering policies with either temporary or permanent medical waivers for preexisting conditions. Such waivers enable insurers to offer affordable coverage for all but one or two known conditions, such as allergies, that would otherwise require much higher premiums (Wieske and Matthews 2007).
- *Regulations on PPOs.* Preferred Provider Organizations (PPOs) are groups of providers who agree to offer discounts to insurers, employers, and other plan members. Some states are considering legislation, supported by the American Medical Association, that would limit the ability of insurers and employers to negotiate terms with physician groups. This is likely to lead to higher prices for consumers.
- *Impediments to interstate competition.* Consumers are unable to purchase insurance from out-of-state companies because the McCarran-Ferguson Act (1945), which grants states the right to regulate health plans within their borders. The patchwork of 50 different sets of state regulations makes it costly and time-consuming for insurers to enter new states (Bast, D. 2005a, Flowers 2007).

States that want to increase the availability of health insurance and make health care more affordable should begin by eliminating or at least reducing the many regulations that currently raise the price of insurance and health care services and limit competition and choice.

Suggested readings: Meier, C., 2005, *Destroying Insurance Markets: How Guaranteed Issue and Community Rating Destroyed the Individual Health Insurance Market in Eight States*, Council for Affordable Health Insurance and The Heartland Institute; Wieske, J.P., 2007, *State Legislators' Guide to Health Insurance Solutions*, Council for Affordable Health Insurance.

3. Reduce reliance on third-party payers

Over-reliance on third-party payers is at the root of many health care problems.

Government policies that reward reliance on third parties to pay for routine medical expenses encourage Americans to overuse health care services and reduce the rewards to providers who would otherwise compete on price.

Growing reliance on third-party payers

Federal tax policies have long encouraged third-party, prepaid medical care over individual insurance or direct payment. Under current tax law, employers can deduct the cost of health insurance premiums from their employees' pre-tax income, so one dollar of earned income buys one dollar's worth of health insurance.

People without employer-provided health insurance and people with insurance but paying out-of-pocket for expenses below the deductible or for required copayments, typically must use after-tax dollars. This means one dollar of earned income may buy only \$0.50 to \$0.75 (depending on a person's tax bracket) of health insurance or medical services. This encourages over-reliance on employer-provided insurance with low deductibles and copayments (Goodman and Musgrave 1992).

Government health care programs for the poor and elderly add greatly to the number of people who depend on third parties to pay for their health care. Government programs for the elderly (Medicare) cost \$265 billion and for the poor (Medicaid) cost another \$305 billion in 2004. (Kaiser 2005, Kaiser 2007b). A recent study found that about half of the increase in health expenditures nationwide since 1965 was caused by the creation of Medicare and Medicaid (Finkelstein 2006).

As a result of tax policy and the expansion of Medicaid and Medicare, the amount Americans pay out-of-pocket for health care has fallen precipitously. In 1960 Americans paid about one-half (47 percent) of their medical bills out-of-pocket. By 2004, only 13 cents of every dollar was paid out-of-pocket. The remainder was paid by third parties—employers, insurance companies, and government agencies (CMS 2006).

Consequences of over-reliance on third parties

Because the party receiving service is not the one paying the bill, reliance on third-party payers reduces the financial incentive for patients to shop for the best deal and to limit their discretionary use of health services. This be seen in the absence of comparative

information about the quality and price of medical procedures now available to consumers. Prices for hospital procedures are rarely posted and bills bear little relationship to actual costs. Consumers seldom seek out such information because they aren't paying the bill, and producers have little reason to provide it because it won't affect whether a patient will choose them over other providers.

Managed care plans emerged in an effort by governments and businesses to combat the rising cost of health care due to these perverse incentives. Government regulations and Health Maintenance Organization (HMO) pre-authorization were substituted for market discipline, the privacy of patients and freedom of doctors were compromised, and a new layer of insurance bureaucracy was created. Since the underlying incentives to over-consume and over-spend were left unchanged, however, spending soon started to rise again.

The direct payment alternative

If consumers paid a larger part of the cost of their care, consumption would fall significantly. The RAND Health Insurance Experiment, conducted during the 1970s, showed that when patients were exposed to greater cost-sharing their medical expenditures fell by about 30 percent with negligible health effects (Newhouse 1993). More recent research on consumers choosing high-deductible insurance and Health Savings Accounts shows significant reductions in spending without negative effects on health (Wharam et al. 2007).

While insurance is necessary and appropriate for expensive and unexpected care, nearly half of all health care spending is for relatively routine and inexpensive treatments best paid directly by patients. Recognizing this, hundreds of doctors have already arranged their practices to reduce their reliance on insurers by encouraging direct payment for services (Cherewatenko 2002, Meier 2001). These practices accept only cash, checks, credit cards, or debit cards for Health Savings Accounts (see Principle 7 for more on HSAs). Because they no longer require large staffs to process complex insurance claims or comply with price controls imposed by government programs, they are able to offer prices that are between 25 percent and 50 percent less than the reimbursement paid by Medicare and other insurers.

Direct payment for health care services also reduces the need for claims reviewers and "gatekeepers" who make up the bureaucracy created by managed care programs. Doctors and patients are once again allowed to determine appropriate care without interference.

Direct payment also ends the injustice present in the current system whereby households with the highest incomes, and therefore in higher tax brackets, get the largest tax benefits for

employer-provided health insurance. John Goodman estimates that families in the wealthiest quintile of taxpayers get an annual tax subsidy of \$1,560 a year, while families in the poorest quintile get only \$250 (Thorpe and Goodman 2005).

Policies to promote direct payment

Elected officials can promote the movement away from over-reliance on third-party payers by adopting the following policies:

- End the tax preference for employer-provided health care by replacing it with a tax credit or standard deduction for health care that can be used to purchase individual insurance and make deposits into Health Savings Accounts (Bast, J. 2005);
- Make price information for hospital services more accessible and transparent (Kreit 2006);
- Repeal policies that slow the adoption of high-deductible plans with an HSA, such as mandated first-dollar coverage and state taxes on HSA deposits; and
- Include HSA-like accounts in government programs for the poor and elderly to ensure they have funds for direct payment of health care (Raniszewski Herrera 2006, Konig 2005).

By promoting direct payment, policymakers can reduce unnecessary health care spending, strengthen the doctor-patient relationship, end tax injustice, and reward the most efficient health care providers.

Suggested readings: Cannon, M., and Tanner, M., 2005, *Healthy Competition: What's Holding Back Health Care and How to Free It*, Washington DC: Cato Institute; Herrick, D., 2003, "Why Are Health Costs Rising?" National Center for Policy Analysis, *Brief Analysis* No. 437; Newhouse, J., 1993, *Free for All?* Cambridge, MA: Harvard University Press.

4. Help only those who need help

Universal coverage is not the appropriate goal of health care reform.

Despite saturation media coverage of the “crisis” of rising numbers of people without health insurance, the proportion of Americans who lack health coverage has increased little over the past decade: 15.6 percent of the population lacked coverage in 1996, compared to 15.9 percent in 2005 (Census Bureau 2007). The uninsured are a heterogeneous population with diverse needs, priorities, and opportunities.

Being uninsured is not always harmful

Being uninsured is similar to losing employment in that most periods without insurance last only for a short time. For example, three-fourths of uninsured individuals regain coverage within 12 months (Census Bureau 2007). We do not assume that everyone who is between jobs needs a government program to provide them with work. Why assume that all of the uninsured need or want government’s help to find health insurance?

Brief periods without insurance do not pose either a financial or health threat to the vast majority of individuals who experience them. Access to care can still be obtained through direct payment, many medical services can be postponed until insurance is found or other payment arrangements are made, and hundreds of programs provide drugs and access to insurance for those who want them but believe they cannot afford regular commercial rates (Foundation for Health Coverage Education 2007). Emergency room care cannot legally be denied to the uninsured by hospitals, and hospitals and doctors provide billions of dollars a year in uncompensated care to the needy.

In short, being uninsured does not mean having to go without quality health care. Health insurance is only one way to pay for health care.

Lack of insurance often is voluntary

Millions of Americans who can afford to purchase health insurance choose to remain uninsured. This should not surprise us since the perverse incentives created by tax policies and regulations have turned health insurance into an expensive way to prepay for routine care, including services most people will never use or would not choose to use if they had to pay for them directly.

The actual “insurance” component of health insurance is small and quite affordable, as revealed by premiums for high-deductible

policies in the individual insurance marketplace (Bast, D.C. 2005b). Public health insurance programs that fail to target the needy offer taxpayer-subsidized insurance coverage in direct competition with private insurers, while other welfare programs reduce the risk of going without insurance.

Of the 46 million individuals identified as uninsured in 2005, as many as 14 million already qualify for public coverage but have not enrolled (Blue Cross and Blue Shield Association 2005a). They don't bother because they can always enroll after they become sick. Yet these individuals are included in estimates of the uninsured population.

At the other end of the income spectrum, upper-income families are the fastest-growing segment of the uninsured, yet they plainly can afford to buy private health insurance. The probability of being uninsured in households earning more than \$75,000 rose 117 percent from 1996 to 2005 (Herrick 2006e). Approximately 19 percent of the uninsured are in families with income greater than 300 percent of the federal poverty level – \$61,950 for a family of four in 2007 (Kaiser 2007a).

Forty-two percent of the uninsured (18.8 million) are between the ages of 18 and 34 (Census Bureau 2006). These young people realize they probably will not incur any medical expenses in the coming year, making health insurance (especially at prices inflated by government regulations) a poor investment.

The uninsured typically get good health care

The uninsured receive care at a level similar to patients insured by Medicare, managed care, and fee-for-service (Asch et al. 2006). They receive only about 50 percent of the care received by those covered by low-deductible employer-provided health insurance, but this is testimony to the over-use of routine health care services by the latter rather than denial of service experienced by the former (Hadley and Holahan 2003).

Federal and state governments spend more than \$300 billion annually on public health insurance such as Medicaid and state children's health insurance programs (SCHIP). Government and private charity care spending on the uninsured totals about \$1,000 per full-time uninsured individual (Thorpe and Goodman 2005).

Focus efforts on the needy

Many states are offering subsidized health insurance to middle- and even upper-income families, even though these are not the people who need or merit public assistance. Many previously insured people switch to new state programs simply to take advantage of public subsidies, leaving the uninsured rate unchanged yet costing taxpayers tens or hundreds of millions of dollars.

Government efforts to reduce the number of uninsured should

focus on that relatively small group of individuals and families that have low incomes but do not qualify for public aid, can't get employer-provided coverage, and are uninsured for relatively long periods of time (HPCG 2007). Reforms that target their needs include:

- High-risk pools which provide subsidized comprehensive health insurance to those with serious medical conditions. Such pools are typically funded by a combination of state subsidies and tax credits for insurer assessments. Thirty-four states had high-risk pools in 2006 (Wieske 2007).
- Replace the tax exemption for employer-provided health insurance with a tax credit or personal deduction that can be used to purchase health insurance and make deposits into Health Savings Accounts;
- Repeal community rating and guaranteed issue laws, particularly in the individual market, that force the healthy to subsidize the unhealthy, driving many people out of the private insurance market.
- Restrict eligibility for government health insurance programs, such as Medicaid and SCHIP, so that private insurers can sell affordable insurance products to middle-income families that can afford to pay the premiums without public aid.
- Expand Health Savings Accounts, which give those who are uninsured for short periods of time the funds needed to pay directly for health care.

The public policy challenge is not to persuade people to do what is not in their best interest, and certainly not to *force* them to make such a choice. Rather, it is to allow people to buy real health insurance without mandated coverage for seldom-used and less-valued services, and to hold accountable those who decide not to purchase insurance for whatever costs they impose on others.

Suggested readings: Wieske, J.P., and Matthews, M., 2007, *Understanding the Uninsured and What to Do about Them*, Council for Affordable Health Insurance; Bunce, V.C., Wieske, J.P., and Prikazsky, V., 2006, *Health Insurance Mandates in the States 2006*, Council for Affordable Health Insurance; Hadley, J. and Holahan, J., 2003, "How Much Medical Care do the Uninsured Use, and Who Pays for It?" *Health Affairs*, February.

5. Single payer is not the answer

Single payer health systems provide inferior care and fail to provide universal access.

Some nations have substituted central planning for markets for the delivery of health care services. Such programs cause long delays in the provision of care (rationing by queue), low rates of investment and innovation, and inferior health outcomes. They are not a model for the U.S.

Waiting lines

Single-payer systems use long delays in receiving treatment to ration health care. In Canada, the median average wait for treatment after referral to a specialist was nearly 18 weeks in 2006. Patients in New Brunswick waited on average 31.9 weeks. Patients waited an average of 16.2 weeks to see an orthopedic surgeon, and another 24.2 weeks for treatment to be performed after the initial visit (Esmail, Walker, and Wrona 2006).

Britain's National Health System (NHS) has more than one million people on waiting lists for care. Multiplied by the time spent waiting for care "produces an astounding fact: Britons already in the queue for medical treatment will wait a total of *one million years* for care" (Young and Butler 2002).

Lack of investment

The number of physicians per capita is nearly 50 percent higher in the U.S. than in Britain and Canada, resulting in smaller case loads and more individualized attention in the U.S. (Anderson et al. 2003). Whereas only a little more than 11 percent of U.S. physicians are general practitioners, in Canada and Britain nearly half are. This means patients in the U.S. have greater access to specialists than those in other countries (Goodman, Musgrave, and Herrick 2004).

Only a handful of PET scanners, the best tool for diagnosing cancer, are available for use in Canada, compared to more than 1,000 in the U.S. The U.S. has nearly 80 percent more CT scanners per capita than Canada and nearly twice as many as Britain. The U.S. has nearly three times as many MRI scanners per capita as Canada, and more than twice as many as Britain (Goodman, Musgrave, and Herrick 2004; Anderson and Hussey 2000).

Inferior health outcomes

Long queues and limited access to specialists and the latest medical equipment mean countries with single-payer health systems have

health outcomes that are inferior to those of the U.S. For example, only one-quarter of those diagnosed with breast cancer in the U.S. die of it. The comparable figure is 35 percent in France and 46 percent in Britain and New Zealand. About 19 percent of American men die from prostate cancer once diagnosed. The figures are 30 percent and 35 percent in New Zealand and Australia, respectively, and 49 percent and 57 percent in France and Britain, respectively (Goodman, Musgrave, and Herrick 2004).

The shortcomings of single-payer systems are likely to get worse as populations age and the pace of medical innovation accelerates. A British medical think tank called “Reform” reported in 2005 that despite a massive investment in a new National Cancer Plan, the NHS’s response to the rising demand for cancer treatments is characterized by “a huge delay in obtaining scans and pathology before a decision can be made on the best treatment to offer an individual,” and the system is “operating in a top down confused bureaucracy.” According to the authors, “real improvement will not be achieved by simply giving more dollars to a burgeoning bureaucracy. It requires a serious commitment to reform” (Sikora, K., Slevin, M., and Bosanquet, N. 2005).

Violation of patients’ and physicians’ rights

Inherent in single-payer health care plans is allowing a relatively small number of elected officials and unelected bureaucrats to make life-and-death decisions affecting others, substituting their judgment for the voluntary and better-informed choices of millions of patients and their doctors. When government agencies replace markets, those with the most political clout are rewarded with the best and most timely treatment. Everyone else must wait in lines for treatment and are more likely to die from denial of services.

These findings should give pause to proponents of single-payer health care and other proposals, such as expanding Medicaid and imposing insurance mandates on individuals and employers, that are likely to destabilize private health care markets and lead to single-payer programs (Tanner 2006).

Suggested readings: Goodman, J., Musgrave, G., and Herrick, D., 2004, *Lives at Risk: Single Payer National Health Insurance around the World*, Lanham, MD: Rowman & Littlefield; Esmail, N., Walker, M., and Wrona, D., 2006, *Waiting Your Turn: Hospital Waiting Lists in Canada*, 16th Edition, Vancouver: Fraser Institute; Meier, C., 2002, *Britain’s Deadly Mistake: A First-Hand Report on England’s Disastrous Experience with Nationalized Health Care*, Chicago: The Heartland Institute.

6. Encourage entrepreneurship

Specialty hospitals, retail clinics, and other innovations can lower costs and improve access to quality health care services.

Entrepreneurs and innovators are developing new ways to deliver health care that are more convenient, higher in quality, and cost less than currently available services. Unfortunately, public policies often stand in their way.

Retail health clinics

Retail health clinics, located in shopping malls or inside big-box retail outlets, are increasingly popular because of their convenience, minimal waiting, low prices, and high quality of care. They typically are staffed by a nurse practitioner (NP) with a masters degree in nursing who focuses on diagnosing and treating relatively common and minor illnesses. Prices are posted and typically are lower than a visit to a doctor's office (Martin 2007).

Retail health clinics free up better-trained physicians to focus on more seriously ill patients. Because they often are open on evenings and weekends, these clinics serve patients who might otherwise go to expensive emergency rooms (Parnell 2005a).

These clinics can be hindered by legislation restricting the number of NPs a physician can supervise or limiting the scope of practice for NPs. Some states have even considered legislation that would prevent NPs from staffing clinics inside pharmacies, which is an indirect attempt to ban these clinics (LoBuono 2006).

Specialty hospitals

Specialty hospitals, typically owned at least in part by the doctors who practice in them, focus on providing on a few areas of care, enabling them to increase efficiency and provide higher levels of care than are provided by general hospitals (Parnell 2005b).

Critics of speciality hospitals, such as the American Hospital Association (AHA), cite concerns about physician self-referral and the loss by general hospitals of the most profitable medical procedures to these more efficient rivals. But specialization and competition lead to better quality and lower prices even in health care. Specialty hospitals have shown how innovations such as redesigned hospital layouts can reduce labor costs, reduce waiting times for patients, and improve patient outcomes.

Medical tourism

Patients are increasingly traveling outside the U.S. for surgery, often at prices that are one-fifth to one-third as high as in the U.S. Countries with highly advanced medical facilities specifically built or equipped for medical tourists include Belgium, Brazil, Costa Rica, India, Malaysia, Mexico, Poland, Singapore, and Thailand (Herrick 2006f).

Patients looking for surgery outside the U.S. can use a Web site, PlanetHospital.com, for expert assistance. Some insurers are beginning to understand how global competition improves quality and lowers cost, and they may start to reimburse patients for this choice (Cannon and Tanner 2005).

Telemedicine

The Internet and the spread of high-speed broadband services hold enormous potential for improving the quality and lowering the cost of health care. Patients can contact their doctors by email and get quick answers to questions, schedule meetings, and exchange test results. Doctors can monitor their patients' conditions remotely, store and access medical records more quickly, and minimize the amount of time spent on paperwork (Kleba 2007).

Similarly, greater use of electronic medical records could produce huge savings – \$81 billion a year according to a report published in *Health Affairs* in fall 2005, or \$77 billion according to a 2005 report by RAND. Firms such as SafetySend and eMedicalfiles offer physicians and hospitals ways to create, send, and store confidential medical files that are safe from theft and fraud (Herrick 2006c).

Public policy implications

Entrepreneurship in health care, as in other markets, requires that consumers be free to choose and producers be free to compete with one another. Policymakers should avoid regulations that stifle innovation with red tape, and price controls that don't allow reimbursement for new services. Regulations that serve to protect incumbent businesses from new competition should be rejected.

Suggested readings: Cannon, M., and Tanner, M., 2005, *Healthy Competition: What's Holding Back Health Care and How to Free It*, Washington DC: Cato Institute; Herrick, D., and Goodman, J., 2007, "Price and Quality in Health Care: The Coming Revolution in the Medical Marketplace," National Center for Policy Analysis, *Policy Report*.

7. Expand Health Savings Accounts

Health Savings Accounts are a key part of empowering consumers and restoring market discipline to health care providers.

Health Savings Accounts (HSAs) are the key to reducing reliance on third-party payers. They level the tax treatment of dollars used to pay directly for health care and dollars used by purchase health insurance. They also can (but don't yet) level the tax treatment of dollars spent by businesses on health insurance for their employees and dollars spent by individuals for their own health insurance.

What are HSAs?

Health Savings Accounts (HSAs) are privately owned savings accounts funded with pretax dollars. Created by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, HSAs are similar to 401(k) retirement plans, but rather than allow people to save for their retirement, HSAs allow people to save for future medical expenses.

By law, HSAs must be paired with high-deductible health insurance plans. Since such insurance costs much less than the usual comprehensive insurance provided by employers, the premium savings can be deposited into the account and used to pay routine medical bills up to the deductible. Any money left in the account at the end of each year "rolls over" to the next year.

Popular and inexpensive

The number of HSA accounts in the U.S. tripled between March 2005 and January 2006. Approximately 3.2 million HSAs are now in use (AHIP 2006a). The Treasury Department predicts 14 million people will own HSAs by 2010 if no changes are made to existing law, and as many as 21 million by 2010 if changes were made to encourage their adoption (Clay Trueman 2006).

In 2006, HSAs were approaching 10 percent of the private benefits market and held more than \$1 billion, with the average balance being about \$1,000. Surveys, including one conducted in 2005 by McKinsey & Company, find very high levels of consumer satisfaction with HSAs as well as sophisticated understanding of how to manage spending (Agrawal 2005).

HSAs cost less and reduce spending

The average annual premium for HSA high-deductible health plans in 2005 was \$2,772 (single coverage) and \$6,955 (family) (AHIP 2006b). This is substantially less than the average annual premium

for all health insurance plans, \$4,024 (single) and \$10,880 (family) (Kaiser 2005a).

Because they spend their own money, patients with HSAs shop more wisely for medical care than do people with conventional low-deductible insurance coverage. Two surveys have found people with HSA plans are about twice as likely to ask about drug costs, and 50 percent more likely to inquire about the overall cost of care. Patients were 20 percent more likely to manage chronic conditions and 25 percent more likely to use preventive care and engage in health and wellness programs (McKinsey and Co. 2005; Blue Cross Blue Shield Association 2005b).

Health care providers are responding to HSAs with innovative services including retail walk-in clinics, greater price transparency, discounts for cash payment, and easier access to physicians by phone and email (Herrick 2006a).

A real solution to the uninsured problem

Whereas government-subsidized health insurance programs often attract people who were previously insured, HSAs are popular with people who were previously uninsured. Between 30 percent and 40 percent of HSA enrollees were previously uninsured (AHIP 2006b, eHealthInsurance 2006).

Between 30 percent and 40 percent of HSA enrollees have annual incomes below \$50,000 (EBRI 2005). If HSAs were supplemented with federal tax credits, the program would provide coverage to currently uninsured individuals at an annual cost to the government of \$2,761, much less than other proposals, and would cause minimum disruption of the private group insurance marketplace. At least 40 percent of the newly covered would come from the bottom 25 percent of income brackets and 75 percent from the bottom half (Feldman, R., et al. 2005).

National reforms

HSAs would be even more successful if Congress allowed unlimited contributions to HSAs and permitted such accounts to wrap around third-party insurance – paying for any expense the insurance plan does not pay. Short of that, four reforms at the national level that would improve HSAs are:

- Provide tax credits or a personal deduction for those who currently do not have employer-provided health coverage;
- Allow people who do not have employer-sponsored health insurance to pay for health insurance with funds from their HSAs;
- Allow insurers to offer a portable, nationally regulated HSA high-deductible health plan; and

- Allow insurers to design their plans so different deductibles and copayments apply to different medical services, with high deductibles for services where patient discretion is possible and low or no deductibles where patient discretion is more difficult or inappropriate.

State reforms

States can help expand HSAs by adopting the following policies recommended by the Council for Affordable Health Insurance (CAHI 2007):

- Ensure that the state's definition of income conforms to the Internal Revenue Code for HSA purposes. Four states in 2007 did not accept or follow the federal tax treatment for HSAs: Alabama, California, New Jersey, and Wisconsin.
- Adopt laws that exempt HSA high-deductible health plans from state mandated benefit requirements. States with mandated benefits that conflict with HSAs include California, Illinois, Maine, Missouri, New York, and Ohio.
- Add an HSA option for persons who buy insurance through the state's high-risk pool. Twelve states have done so already.
- Add an HSA option for state and municipal employees. Eleven states have done so already.
- Add an HSA option for people enrolled in Medicaid. Four states (Florida, Iowa, New York, and South Carolina) have pilot programs that do so already.

Suggested readings: America's Health Insurance Plans, 2006, "HSAs and Account-Based Plans: An Overview of Preliminary Research"; Goodman, J., 2005, "Making HSAs Better," National Center for Policy Analysis, *Brief Analysis* No. 518, June; CAHI 2007, "A State Implementation Report," Council for Affordable Health Insurance, <http://www.cahi.org> (accessed on April 15, 2007).

8. Expand access to prescription drugs

Prescription drugs cure diseases and reduce hospital costs, but they often are the target of price controls and rationing.

Prescription drugs play a major and growing role in the nation's health care system as biotechnology and genetic engineering expand the range of treatment possibilities. Prescription drugs are extending life, reducing suffering, and making surgery less necessary, yet they are heavily regulated and often rationed.

Prescription drugs are a good value

Drugs represent only about 11 percent of total U.S. health care spending. Drug therapy is often the most efficient method of caring for patients. A dollar of drug expenditure reduces hospital costs by more than \$3.50 (Lichtenberg 1996).

Newer drugs work even better than older ones. Patients diagnosed with conditions that have the greatest number of new prescriptions see larger declines in the number of hospital days. For every 100 new prescriptions, hospital days decline by 16 days (Lichtenberg 2003).

Drug importation is no answer

Importing drugs from other countries is not a solution to high drug prices. Countries with pharmaceutical price controls produce too few drugs to provide more than a small fraction of what the U.S. market needs (Goodman 2005a). Imported drugs usually enter the U.S. via channels that are outside the chain of custody that ensures the quality of drugs sold in the U.S., making them vulnerable to counterfeiting, contamination, and improper handling (Giuliani Partners 2005, Meier 2005b, Pitts 2006).

Because other countries impose price controls on prescription drugs, importing drugs amounts to importing price controls on drugs purchased in the U.S. By making it more difficult for drug companies to charge prices high enough to cover the cost of research and development, large-scale drug importation would lead to less investment in new drugs in the U.S., and soon the number of new drugs would fall as well (Turner and Meier 2004).

Drug rationing is no answer

State Medicaid programs and the U.S. Veterans Benefits Administration ration access to drugs by using drug formularies, lists of pre-approved drugs. In order to appear on the list, drug companies must offer discounts or pay rebates to the states.

Drug formularies are a crude and ineffective form of price controls. To extract price concessions, plan administrators may refuse to cover new or expensive drugs requested by doctors and substitute older or generic ones. For example, the Veterans Benefits Administration formulary covers fewer than 1,300 drugs compared to more than 4,000 available for Medicare Part D drug plans (Enthoven and Fong 2006). Such restrictive formularies greatly reduce patients' and doctors' choices and endanger lives.

Need for Food and Drug Administration(FDA) reform

A major reason new drugs are so expensive is the costly and time-consuming approval process used by the Food and Drug Administration (FDA). Since 1962, the FDA has required new drugs to pass effectiveness as well as safety trials, causing the new drug approval process to take approximately eight years. Many drug developers cannot afford the substantial fees or the nearly decade-long wait for revenue from drug sales to begin.

A promising way to reform FDA regulation of new drugs is to create a dual tracking system whereby patients and their doctors could choose either to wait for FDA-approved drugs or use new drugs that have passed Phase I safety trials but still are undergoing clinical trials for effectiveness. Patients choosing early access to new drugs could get complete information about the new drug from a Tradeoff Evaluation Database (Madden 2007).

Ways to reduce drug costs

Policymakers can help their constituents reduce their spending on prescription drugs without new legislation (Herrick 2006g):

- Since much of the cost of prescription drugs is the result of retail mark-ups, comparison shopping often saves consumers 30 percent to 50 percent and sometimes more.
- Requesting a generic substitute for an expensive branded drug can reduce prices as much as 90 percent.
- With a physician's permission, buying larger-dose tablets and an inexpensive pill splitter can cut drug cost in half.
- Buying drugs online from reputable Web sites is often less expensive than buying them from a neighborhood pharmacy.

Suggested readings: Lichtenberg, F.R., 2003, "The Value of New Drugs," *Milken Institute Review*, Fourth Quarter; Herrick, D., 2006, "Shopping for Drugs: 2007," National Center for Policy Analysis, *Policy Report* No. 293; Epstein, R., 2006, "How Safe and Effective Is the FDA?" *Medical Progress Today*, June 30.

9. Reduce malpractice litigation expenses

Malpractice litigation is costly and often fails to reimburse victims and change the behavior of medical providers.

Malpractice insurance, litigation, and the practice of defensive medicine are responsible for part of the unnecessary high cost of health care in the U.S. Some of this expense is caused by over-reliance on third party payers, making it difficult for patients to hold providers accountable for their mistakes without resorting to lawsuits.

The high cost of malpractice litigation

In real terms, malpractice claims grew 10-fold and malpractice premiums tripled during the past 30 years (Frank and Grace 2006). In 2001, 52 percent of malpractice awards were for amounts in excess of \$1 million, compared to a median award of less than \$500,000 just five years earlier (Manhattan Institute 2003).

Even though doctors win an overwhelming majority of medical malpractice cases, these claims still impose huge costs on doctors and insurers. The average legal cost exceeds \$93,000 in cases where the doctor successfully defends against a malpractice case and are nearly \$19,000 in cases where a claim is dismissed or dropped (AMA 2006).

Lawsuit abuse leads to “defensive medicine,” the practice of physicians, hospital administrators, and other providers to order tests and file reports solely for the sake of reducing the possibility of litigation in the event a patient doesn’t get well. The annual cost of defensive medicine has been estimated by the Department of Health and Human Services as being between \$60 billion and \$108 billion (HHS 2002).

Issues regarding legal reform

The plaintiff’s bar and its apologists claim rising malpractice insurance premiums are the result of poor investment decisions and price gouging by insurance companies, not frivolous lawsuits or giant awards (Hunter 2004). These claims are unpersuasive.

Many malpractice insurers are physician-owned nonprofit mutual companies and their rates are similar to those offered by commercial insurers. It is unlikely doctors are over-charging themselves for insurance. If insurers were making excessive profits there would be new firms entering the market, but the market has seen more exits than entries. Poor investment strategies seem unlikely to be the culprit given that 80 percent of medical-

malpractice insurer investments are in bonds rather than stocks. And investment losses should be unrelated to an insurer's decision to sell a profitable product (Frank and Grace 2006).

The plaintiff's bar and even some reform advocates say caps on awards discourage attorneys from taking on risky cases, deny appropriate compensation to victims of medical malpractice, and send a signal to hospitals and doctors that life-threatening mistakes are tolerable (Hyman and Silver 2007). While these concerns are legitimate, caps may be a necessary part of an overall legal reform strategy because the plaintiff's bar opposes other reforms that would reduce their financial windfalls while ensuring that victims receive fair and speedy compensation.

Legal Reforms

States that have passed legislation to reduce the cost of malpractice litigation include Alaska, California, Colorado, Maine, Michigan, and Utah. The Oklahoma legislature passed legislation (SB 507) in April 2007 that is a good model for other states. Specific reforms state and national elected officials should consider include:

- Cap non-economic damages for pain and suffering, which are difficult to quantify and subject to abuse (Pruitt and Schwartz 2003). Approximately 30 states have imposed caps.
- Create special medical courts to deal exclusively with complex medical malpractice cases requiring specialized knowledge (McCaughey 2003).
- State licensing boards and hospitals should be required to conduct quality audits of physicians who are repeat offenders, publicize the results, and report them to the National Practitioner Databank (Hyman and Silver 2007).
- Require malpractice claimants who reject reasonable settlement offers to meet a "beyond any reasonable doubt" standard to win pain-and-suffering damages (Horowitz 1999).

Suggested readings: Frank, T. and Grace, M.F., 2006, "Faulty Studies from Center for Justice & Democracy are Stunting the Medical-Malpractice Debate," American Enterprise Institute, *Policy Outlook*; Manhattan Institute, 2003, *Trial Lawyers, Inc.: A Report on the Lawsuit Industry in America 2003*, Manhattan Institute Center for Legal Policy.

10. Encourage long-term care insurance

Middle- and upper-income families should privately insure for their long-term care needs.

Many members of America's "baby boomer" generation face a financial crisis as they enter retirement without having made adequate arrangements for retirement income or health care expenses (Goodman and Cordell 1998). Encouraging the purchase of long-term care insurance and saving Medicaid for the truly needy are two ways policymakers can help their constituents and control Medicaid spending.

Long-term care and Medicaid

Long-term care (LTC) – commonly defined as nursing home care or home health care for individuals above the age of 65 or with a chronic condition requiring constant supervision – is a growing part of the nation's health care system. LTC expenditures account for about 8.5 percent of total health expenditures in the U.S., or 1.2 percent of gross domestic product. Real expenditures (adjusted for inflation) are expected to triple over the next 35 years (Brown and Finklestein 2004).

LTC can be very expensive, with the average nursing home providing skilled care charging between \$150 and \$300 per day, or as much as \$100,000 a year. Custodial home care costs less, but just three visits per week can cost more than \$9,000 a year.

Medicaid was designed to help meet the health care needs, including LTC, of the indigent, but over the years it has become the principal source of payment for nursing home and home health care costs for all Americans. Medicaid paid 44.3 percent of nursing home costs in 2004, while private health insurance paid for only 7.8 percent of nursing home bills and 12 percent of home health care costs (Moses 2007a).

Reducing reliance on Medicaid

"Medicaid's LTC benefit has become 'inheritance insurance' for baby boomers," explains Stephen Moses, "lulling them into a false sense of security regarding their own future LTC needs. Medicaid's loose eligibility rules for LTC create perverse incentives that invite abuse and discourage responsible LTC planning" (Moses 2005).

A cottage industry has emerged to counsel middle- and upper-income retirees on how to shelter their wealth in order to qualify for Medicaid. Most elderly people needing nursing home care can easily qualify for Medicaid-financed LTC, even those with middle-

and upper-incomes and substantial assets (Moffit and Moses 2000).

Private insurance for long-term care is available, but only about 15 percent of seniors and 5 percent of baby boomers own such policies. The greatest challenge faced by insurers is the easy availability of Medicaid. Medicaid imposes an implicit tax of 60 to 75 percent on the benefits paid from private LTC insurance plans, explaining at least two-thirds and as much as 90 percent of the lack of private insurance (Brown and Finklestein 2004).

Unless Medicaid policies are changed, it is unlikely the number of people buying private LTC insurance will grow fast enough to prevent a financial crisis in the coming years.

Policy Reforms

States will not be able to fund all the health needs of tens of millions of retiring middle-income baby boomers in the years ahead. The cost would simply be too enormous. To the extent possible under federal law, states should target Medicaid LTC benefits to people truly in need and prevent Medicaid from being free “inheritance insurance” for middle- and upper-income families (Moses 2004, Moses 2007b). Specifically:

- Estimate the savings that could accrue by tightening Medicaid eligibility rules and expanding Medicaid estate recoveries.
- Set up programs to divert applicants for Medicaid to home equity conversion and private insurance.
- Close Medicaid eligibility loopholes such as those related to annuities, trusts, asset transfers, and life care contracts.
- Make Medicaid a loan, not a grant, for middle-income recipients and implement a strong estate recovery program to ensure loans are repaid.
- Use some of the savings to educate and incentivize the younger and healthier population to plan, save, invest, and privately insure for long-term care.

Suggested readings: Moses, S.A., 2004, *The Long-Term Care Dilemma: What States are Doing Right - and Wrong*, Council for Affordable Health Insurance and American Legislative Exchange Council, September; Moses, S.A., 2005, “Aging America’s Achilles’ Heel: Medicaid Long-Term Care,” Cato Institute, *Policy Analysis* No. 549, September.

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