FAIR Health Care: Free-markets, Affordability, & Individual Rights

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> Third-party payment has required the bureaucratization of medical care and, in the process, has changed the character of the relation between physicians (or other caregivers) and patients. A medical transaction is not simply between a caregiver and a patient; it has to be approved as "covered" by a bureaucrat and the appropriate payment authorized. The patient—the recipient of the medical care—has little or no incentive to be concerned about the cost since it's somebody else's money. The caregiver has become, in effect, an employee of the insurance company or, in the case of Medicare and Medicaid, of the government. The patient is no longer the one, and the only one, the caregiver has to serve. An inescapable result is that the interest of the patient is often in direct conflict with the interest of the caregiver's ultimate employer. That has been manifest in public dissatisfaction with the increasingly impersonal character of medical care. – Milton Friedman[1]

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a) Comprehensiveness
(1) What problem does this proposal address?

Measured by access, survival rates, and mortality rates, people in the Unites States have access to the best health care in the world. Yet, costs of health care covered by third parties (e.g., insurance, Medicare, and Medicaid) are exploding. In a sense, the problem with health care is inherent in the stated goal of the Blue Ribbon Commission for Health Care reform: to both "increase coverage" (third-party payment for health expenditures) and "reduce costs." Health care costs have been increasing because federal tax policy and state-level mandated benefits encourage insurance policies to offer too *much* coverage, not too little. This escalates costs such that too few people having access to adequate health care.

Tragically, many proposed solutions to increasing health care access and quality merely prescribe more of what has caused the problem in the first place: that third parties defray patient health care costs to such an extent that patients have little incentive to spend wisely. As Nobel Laureate Milton Friedman wrote, "nobody spends somebody else's money as wisely or as frugally as he spends his own" (Friedman 2001, Appendix E).[2]

Health care is so costly precisely because patients pay so little for it -- just 14% out-of-pocket. "Using health care in this country is like shopping with someone else's credit card," says Nelson Sabatini, former Maryland Secretary of Health and Mental Hygiene (Gratzer 2006, p. 37). The reason for such over-consumption is not the free-market, but federal and state legislation and social programs. They have changed how Americans think about paying for

[1] From "How to Cure Health Care," reprinted in Appendix E of this document.
[2] Appendix F lists the full citations of works cited in this document.

medical services: we expect insurance, Medicaid, or Medicaid to pay for almost everything.

The tax exempt status of employer-provided health insurance, mandated insurance benefits, and Medicaid have transformed most health insurance policies into pre-paid health care, which insulates consumers from the true costs of health care and hence increases costs for everyone.

Third-party payments also insulate doctors from their patients, which erodes the doctor-patient relationship. Ernest Truffer, a Swiss medical ethicist, echoes Milton Friedman's observation at the start of this document. Excessive third-party payment, be it by insurance companies or government, says Truffer (Goodman 1990; Cannon and Tanner 2005, p. 57),

> amounts to the rejection of the *medical* ethic—which is to care for a patient according to his specific medical requirements—in favor of a *veterinary* ethic, which consists of caring for the sick animal not in accordance with its specific medical needs, but according to the requirements of its master and owner, the person responsible for paying any costs incurred.

The tragic irony of this metaphor is that in Canada, where contracting between doctors and patients is essentially outlawed, pets may have better access to medical care than humans. Yet, Canadians *veterinarians* operate in a relatively free-market. *The New York Times* quoted Brian Day, President of the Canadian Medical Association, "dogs can get a hip replacement in under a week," while "humans can wait two to three years" (Krauss 2006). Worse yet, in 1999 *The Washington Post* reported that "in Ontario, the waiting list for MRIs is so long that one Ontario resident booked himself into a private veterinary clinic that happened to have one of the machines, listing himself as 'Fido'" (Cato 2000).

Frustrated with how third-party care interferes with the medical ethic, some doctors are moving toward fee-for-service practices where patients pay doctors directly. In 2004 the Joint Economic Committee of Congress held a hearing called "Consumer-Directed Doctoring: The Doctor Is In, Even if Insurance Is Out," where several fee-for service doctors testified. In the journal *Medical Economics*, Senior Editor Robert Lowes writes, "It might be time to consider a cash-only practice. Your income may drop, but your overhead will decrease and your job satisfaction could soar" (Scandlen 2004).

We are in a vicious cycle: a government program or mandate intended to "fix" a problem ends up causing more problems. Entrepreneurial-minded politicians propose new "products," (legislation and government programs) to remedy the problem, and the cycle continues.

State-level regulations caused insurance companies to lose customers and some companies to give up doing business in-state. This "crowding out" of private insurers increased market

share for social programs such as Medicaid, which are essentially government-run charities. Such programs crowds out private charities, unfairly compete with those remaining, and increase the cost of private insurance for tax-payers who are also forced to donate to the programs.

Regardless of any alleged benefits from mandated benefits, guaranteed issue, or Medicaid, these programs are fundamentally unethical because they violate people's right to voluntary association. Mandated benefits prohibit consumers from purchasing certain types of insurance plans. Guaranteed issue forces insurance providers to have customers they might not choose otherwise. State and federal laws force taxpayers to fund Medicaid, regardless of its effectiveness, and at the expense of a competitive non-profit marketplace that would encourage Medicaid to be innovative and efficient.

We do not need more government intrusion into the voluntary for-profit and non-profit marketplace, but less. The purpose of government is to protect individual rights so people can exchange goods and services peacefully and voluntarily.

This proposal addresses the above problems by suggesting modifications to state-level insurance mandates and guaranteed issue. It also suggests ways to convert Medicaid from a monopolistic pre-paid health entitlement program to a something closer to a real health insurance charity that has incentives to be efficient because it must compete for tax dollars.

Quality of Insurance

By several measures, patients in the United States have access to the best health care in the world. Appendix A reviews studies that show health care in the United States is superior to that in other countries in terms of (1) how long patients wait to for non-elective surgery, (2) access to high-tech treatments, (3) mortality ratios, and (4) survival of cancer.

The perception that there is a crisis of the uninsured is also inaccurate. As of 2005, the US Census Bureau (2003) reports that "spells without health insurance, measured on a monthly basis, tend to be short in duration - about three-quarters were over within 1 year." Further, the national rate of uninsured in 2006 is essentially the same as it was ten years earlier (Herrick Sept. 9 2006, see also Appendix B).

Health care costs so much because patients pay so little for it

However, the cost of medical services is increasing. Costs of medical services increased by 77%, almost twice that of the Consumer Price Index between 1992 and 2005. Yet, cosmetic surgery costs increased by just 22%, and the cost of corrective eye surgery has actually decreased. This difference in costs increases suggests that the structure our insurance system is

responsible for increasing costs (Herrick Sept. 21, 2006).

Americans pay very little out-of-pocket for their health care. Third parties pay 97% of hospital care and 90% of physician services. As a whole, patients pay only 14% of their medical bills out-of-pocket. Insurance companies and government programs such as Medicare and Medicaid pays the rest. In effect, typical employer-provided health insurance plans are not insurance at all, but pre-paid health care. The consequence is that patients over-consume because they are insulated from costs of services. While they are understandably concerned for their health, they visit the doctor and request expensive treatments more often than necessary. Since insurance pay the cost of their "playing it safe" there is little incentive not to over-consume. This drives up costs for patients who truly need services (Herrick Sept. 21, 2006).

The RAND Health Insurance Experiment illustrates this phenomenon. It tracked the health expenditures of 2000 non-elderly families over six years. The families had health insurance with different degrees of cost-sharing ranging from zero copayments ("free" pre-paid health care) and high-deductible plans with higher copayment. Linda Gorman (2006) summarizes: "The most important result was that per capita expenses on the free plan were 45% higher than those for the 95% cost-sharing plan. Savings primarily came from a reduction in the number of contacts rather than in the intensity of services. For average adults, the health of those who spent less appeared to be just as good as those who spent more." For more information on this, see Appendix C, and Gorman (2006).

Most Colorado residents do not have real health insurance. Instead they have employer-provided pre-paid health care. As described above, this encourages over-consumption, which drives up costs so as to make life-saving or health-maintaining medical procedures prohibitively expensive for some Colorado residents.

Federal tax exemption for employer-paid premiums

The federal tax exemption of employer-paid health insurance premiums distorts the insurance market to encourage such policies. The tax exemption effectively lowers the costs of employer-provided health insurance - by at least 40% when including federal, state, and FICA taxes. This gives employees an incentive buy insurance that covers as much as possible. After all, payments for medical expenses out-of-pocket are taxed. Because the tax rate increases with income, this tax exemption is a subsidy for the rich. John C. Goodman (2007) notes that "[h]ouseholds earning more than $100,000 per year receive an average subsidy of $2,780. By contrast, those earning between $20,000 and $30,000 receive only $725."

In addition to distorting the insurance market to encourage over-consumption that

increases costs, this tax exemption has other adverse effects. Increased health care costs result in lower wages and fewer insurance options, and tying health insurance to employment decreases job mobility – more so among women (Cannon & Tanner 2005) . Further, as Cannon and Tanner (2005, p. 64) note, "[by] encouraging overreliance on health coverage, the tax exclusion leads to a moral hazard. It not only encourages riskier behaviors (smoking, overeating, inactivity), it also discourages prudent behaviors (saving for future medical expenses, exercise, preventative care) by creating the expectation that one's medical expenses are another's responsibility."

Benefits Mandates Reform (BMR)

The Colorado legislature should repeal any and all benefits mandates related to health insurance. A mandated benefit, as defined by the Council for Affordable Health Insurance (2007), is legislation "requiring that a health insurance policy or health plan cover (or offer to cover) specific providers, procedures or benefits." Such mandates drive up the costs of insurance premiums, thereby causing some people to drop insurance or not purchase it. Benefits Mandate Reform, or "BMR" in this proposal, seeks to repeal benefits mandates that the state currently places on insurance policies.

Small Group Reform (SGR)

Small Group Reform, or "SGR" in this proposal, seeks to phase out the state's distinction of a "small group of one." While federal rules impose "guaranteed issue" on small-group insurance – i.e., require insurance providers to offer insurance to everyone in the category who applies – Colorado also imposes "guaranteed issue" on the "small [or business] group of one," meaning the self-employed who qualify. The state thus creates a perverse incentive that encourages some people to avoid purchasing health insurance until after they develop health problems. This drives up insurance costs for other small-group participants. Phasing out the category of the "small group of one" will encourage more of the self-employed to seek lower-cost, long-term, individual insurance in conjunction with a tax-exempt Health Savings Account.

Medicaid Reform (MCR)

In Colorado, one in ten people are on Medicaid, or nearly half a million people (Augé 2007), and its costs have risen to 20% of the state's budget. Given these figures, the Blue Ribbon Commission on Healthcare Reform should evaluate Medicaid according to its own criteria for new health care proposals. I have done this, and found empirical data for the following, which is detailed in Appendix D of this document.

Medicaid is neither efficient nor sustainable. Further, it limits consumer choice and access to health care for both enrollees and taxpayers who fund it, and increases the health care costs for those not enrolled. It provides sub-par quality care for its enrollees, and disempowers them because its means-based eligibility discourages them from saving money and seeking higher-paying jobs.

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(2) What are the objectives of your proposal?

As described above, federal tax policy and regulations have distorted the market to demand employer-provided pre-paid health care, which increases costs and limits access to those who most need health care. Medicaid encourages recipients to both over-consume, and forgo self-improvement to qualify for benefits. Fundamental reform requires removing the federal tax-subsidy for employer-provided insurance.

Yet, several state-level policies increase health care costs and reduce quality. This proposal seeks to identify existing state legislation and programs that contribute to the rising costs of health care and insurance, and suggest ways to modify them to expand coverage and lower costs.

BMR: The reform seeks to lower the costs of health insurance and increase the number of people with insurance. The reform is also a step toward restoring freedom of contract between the providers and purchasers of health insurance and is thus consonant with individual rights.

SGR: The reform seeks to encourage more self-employed Coloradans to obtain lower-cost, long-term, individual health insurance in conjunction with a tax-exempt Health Savings Account; avoid adverse impacts on those who currently obtain health insurance as a "small group of one;" and keep small-group insurance rates relatively lower and thus promote greater insurance coverage. The reform is also a step toward restoring freedom of contract.

MCR: Medicaid reform seeks to transfer more enrollees into the private insurance market (MCR1), decrease over-consumption with cost-sharing (MCR2a and b), reduce asset sheltering for long-term care (MCR2c), and increase access to home-care (MCR2d). This proposal also asks the Colorado legislature to allow Medicaid to compete for funding with voluntary charities on the private market (MCR3).

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b) General

(1) Please describe your proposal in detail.

Regulations Reform

BMR: The reform asks the Colorado legislature to repeal any and all statutorily-imposed mandates regarding benefits that insurance policies must provide. This proposal suggests that the details of specific legislation are best left to the legislature and its full-time staff.

SGR: The reform asks the Colorado legislature to phase out the statutory "small group of one" through the following two steps: 1) Those insured as a "small group of one" as of the date on which the reform is instituted may continue to obtain small-group insurance unless and until they voluntarily agree to obtain some other sort of health insurance; and 2) No person who is not insured as a "small group of one" as of the date on which the reform is instituted may thereafter obtain insurance as a "small group of one." This proposal suggests that the details of specific legislation are best left to the legislature and its full-time staff.

Medicaid Reform

Fundamental Medicaid reform must be at the federal level: replacing matching funds with a block grant and changing eligibility requirements. Appendix D (section 8) addresses this. I propose state-level Medicaid reform consisting of the following:

MCR1: Medicaid vouchers for private insurance & Health Opportunity Accounts (HOAs)

To the extent that Medicaid provides pre-paid health care to its enrollees, which promotes over-consumption and escalating prices for taxpayers who donate to it, it should provide vouchers to purchase real health insurance on the private market.

Medicaid managed care both insulates patients from costs and does not allow insurance companies to compete for their business. Since both cost-insulation and lack of competition contribute to increasing costs, Medicaid should move to a more competitive market-based system.

This defined-contribution model will benefit administrators because budgets are more stable than in the current pay-as-you-go system. As Owcharenko (2006) describes, it will "encourage greater competition and participation among private insurers, and give individuals a choice from a menu of competing insurers and plans." As described in section b4, Colorado's Consumer-Directed Attendant Support (CDAS) program illustrates the success and cost savings of empowering Medicaid enrollees to choose how to administer their health.

Health Opportunity Accounts (HOAs) can provide Medicaid recipients with incentives to spend responsibly and give insurance providers incentives to compete for these dollars by offering good prices - just as HSAs do for those insured privately. The Deficit Reduction Act (DRA) of 2005 has authorized 10 states to offer HOAs in five-year demonstration projects. The

Centers for Medicare and Medicaid Services (CMS) summarizes: "Section 6082 of the DRA allows for States to operate Medicaid demonstrations programs to test alternative systems to deliver Medicaid benefits through a Health Opportunity Account (HOA) in combination with a high deductible health plan (HDHP)" (HHS 2007, CMS 2007).

In 2006 Florida began to implement a plan along these lines. The National Center for Policy Analysis has summarized their program (Goodman, 2006):

> It is designed to cover most Medicaid enrollees, including children, parents, pregnant women and disabled persons who are not institutionalized. Under the plan,
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> * Private-sector health care provider networks will compete to enroll various Medicaid populations by offering different benefit packages to cater to their needs.
> * Participants can choose among the plans, or use their state-paid premium to purchase employer-sponsored insurance instead.
> * Florida pays the networks a monthly, risk-adjusted premium per patient and providers compete by offering innovative care, convenient networks and optional services.
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> The competition among providers is similar to private health insurance plans that offer various coverage options. Three basic packages of Medicaid benefits will be offered:
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> * Comprehensive Benefits is a basic benefit package covering all mandatory Medicaid services and needed optional services, although the amount, duration and scope of services may vary.
> * Catastrophic Care covers those who require more care than is covered by comprehensive benefits plans. These patients will be re-insured for all medically necessary services.
> * Enhanced Benefits is an incentive to Medicaid beneficiaries who engage in healthy practices. Qualified recipients may use accumulated funds in their accounts to purchase additional health care services that are not covered by their plan or use them for employer-sponsored insurance when they become ineligible for Medicaid.

South Carolina Governor Mark A. Sanford has a similar plan to bring Medicaid into a "consumer-directed market-based environment" (Sanford 2005). It consists of two parts: (1) a Personal Health Account (PHA), which is similar a Flexible Savings Account (FSA) for those with private coverage, and (2) a "catastrophic and preventive benefit coverage. This coverage will be a safety net of limited benefits for those individuals....The intent is that plans will now compete for the beneficiary's business by creating an array of attractive coverage packages or pricing."

MCR2: Utilize new state-level authority granted by the 2006 Deficit Reduction Act (DRA)

The National Center for Policy Analysis summarizes what the Deficit Reduction Act allows states to do regarding Medicaid (Goodman *et al* 2006). They include

> (**MCR2a**) Tailor benefit packages to certain eligible Medicaid populations, as long as the benefits are at least as generous as a Blue Cross Blue Shield plan currently offered to federal workers.
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> (**MCR2b**) Charge premiums and copayments for beneficiaries whose incomes are over 150 percent of

the federal poverty level; however, certain mandatory populations (pregnant women and children) will still be exempt from cost-sharing.

(**MCR2c**) Increase the "look back" period to five years to discourage seniors from transferring assets in order to quality for Medicaid.

(**MCR2d**) Allow states to offer more home care through community-based services as an alternative to costly nursing home care without requiring a waiver.

To the extent that Colorado's Medicaid program does not already do the above, incorporating these policies will decrease costs, encourage informed health care consumption, and reserve the Medicaid for those truly in need. The rest of section (b) and sections (c) through (l) will expand upon the benefits of the DRA's provisions.

Tailoring benefit packages (MCR2a) may also include, if federal law allows, duration of eligibility limits, along the lines of welfare reform (O'Neill and Hill 2001), to discourage Medicaid dependence.

MCR3: Allow Medicaid to compete with charities by establishing a dollar-for-dollar tax deduction for donations to qualified Colorado Health Charities.

The problems of Medicaid described above can be best understood if we consider Medicaid to be operating in a non-profit marketplace. Most Medicaid reforms count on fixing it from the "outside," that is by suggesting new operating procedures and policies. These have their place, but so long as Medicaid administrators lack the incentive to innovate, advocating such external proposals is an uphill battle.

Most people oppose government policies such as tax breaks, eminent domain abuse, special licenses, tariffs and subsidies that explicitly benefit specific companies. Known as "big business," it gives politically-connected companies an unfair advantage over their competitors. These "corporate fat cats" can be sluggish and inefficient, but still profitable, and drive some competitors out of business. This is certainly not a "level playing field" for fair competition.

For-profit companies are not the only ones who must compete for customers: voluntary charities must compete for donations. Consider Philanthropic Research, Inc., itself a nonprofit organization. With its GuideStar database of nonprofits, it "envisions the evolution of an increasingly efficient nonprofit marketplace where donors seek out and compare charities, monitor their performances, and give with greater confidence; nonprofit organizations pursue more effective operating practices, embrace greater accountability, and enjoy lower fund-raising costs; and society benefits from a more efficient, generous and well-targeted allocation of resources to the nonprofit sector" (GuideStar 2007).

Yet, as described in Appendix D (section D.3), government charities such as Medicaid have crowded out the non-profit organizations and for-profit insurance services to establish a virtual monopoly on providing those in need with medical care. And just as we would expect from a virtual monopoly, the costs are high and the quality is low, as summarized in Appendix D (D.4, D.7). Further, Medicaid increases costs for those not-enrolled - the very taxpayers it depends on for donations.

Like any other for-profit or non-profit institution, Medicaid will be more effective and efficient if the people who provide it revenue are free to spend their money elsewhere. That is, instead of crowding out its competition with government regulations and donations compelled by tax law, Medicaid should compete with voluntary charities for its funding. This will give administrators a strong incentive to figure out innovative ways to provide health care to those Coloradans in need of quality health care.

There may be several paths to converting Medicaid into an innovating competitive charity, but federal rules will certainly restrict their feasibility. One path is to establish a category of tax-except Colorado charities such that for every dollar a taxpayer donates to them, the taxpayer's state tax burden is reduced by one dollar. This is not only a tax deduction, where donations reduce one's taxable income, but a tax refund. This refund can be limited to the fraction of the taxpayer's state and local taxes end up funding Colorado's Medicaid program.

Admittedly, following these tax dollars and calculating this fraction may not be trivial, but the concept makes it worthwhile: Give Colorado taxpayers the choice to fund Medicaid or a health-related charity of their choice that performs similar functions as Medicaid. This program will give taxpayers incentive to become involved with their communities and helping those in need by making sure their charitable contributions are being spent wisely. This will also give charity administrators (of Medicaid and of voluntarily-funded charities) a large incentive to be efficient and to prove this to donors.

As historian David Beito described in *From Mutual Aid to the Welfare State* (Appendix D, D.3), government programs and legislation drove out private charities, fraternal society, and lodges that provided communities with a true safety net. It is time to reverse this injustice.

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(2) Who will benefit from this proposal? Who will be negatively affected by this proposal?

BMR: By decreasing the cost of insurance premiums now impacted by the mandates, the reform will benefit those who currently purchase such insurance. The reform will also benefit those without insurance by making it easier for them to afford it. Three groups will be "negatively affected:" 1) Those who consume the medical services now subject to the insurance mandates

may find that their insurance costs and/or out-of-pocket expenses increase for those services; 2) Those who produce the services now subject to the insurance mandates (and who in many cases lobbied to add their services to the list of mandates) may find that insurance does not cover their services as frequently; and 3) Those politicians who gain by delivering the "concentrated benefits" of mandates to special-interest groups will no longer be able to do so. However, while this reform is clearly a net advantage for Coloradans, this proposal urges the Commission and the legislature to bear in mind the fact that not all benefits and losses are morally comparable (as is obvious if one considers those who "benefit" and those who are "negatively affected" by, for example, the abolition of slavery). Benefits mandates are immoral because they violate individual rights and freedom of contract, and as a consequence they create economic problems.

SGR: The reform will benefit those with small-group insurance by mitigating one cause of higher small-group insurance rates: the perverse incentive that encourages some people to avoid purchasing insurance until they develop significant health problems. The reform will not otherwise impact those who currently have insurance as a "small group of one." The reform will benefit the self-employed who do not have insurance by creating incentives for them to purchase portable, lower-cost, long-term, individual insurance policies; the reform will negatively affect the same people by preventing them from entering the "small group" pool in the future.

MCR1: Medicaid vouchers for private insurance & Health Opportunity Accounts (HOAs)

Medicaid recipients will benefit from Health Opportunity Accounts because they will have greater choice of physicians and medical services. Since doctors will be competing for Medicaid customers who are now more cost-conscious, the competition will result in better quality and lower costs. Doctors will be less likely to turn away Medicaid recipients because of government-set reimbursement rates, as HOAs will allow market forces to determine prices. That HOAs make Medicaid consumers more cost conscious will also give them incentives to spend wisely, and hence avoid the over-consumption and spiraling cost increases associated with such over-consumption.

MCR2a: Tailor benefit packages to certain eligible Medicaid populations.

To my understanding, Medicaid benefits are along the lines of a one-size-fits-all package. Those who qualify receive the same benefits, regardless of income and assets. As Owcharenko (2006) writes, "there is no reason why states should not be able to distinguish between individuals with a family income at 300 percent of the FPL [federal poverty level] and individuals with a family income below 100 percent of the FPL."

Modifying benefits according to ability to pay can somewhat mitigate the negative effects of means-based entitlement programs - that is, providing a disincentive to work and promoting dependence on government. The research of Yelowitz (2000) (see also Appendix D.6), demonstrates this effect with the "income notch." Removing the disincentive to work will both empower people to become self-sufficient and save taxpayers money.

MCR2b: Charge premiums and copayments for some enrollees.

Section 1 identifies a primary reason health care costs so much: consumers pay so little for it. Medicaid is essentially a pre-paid health care program that provides no incentives for enrollees to maintain costs. Charging premiums and copayments introduces a cost-saving incentive for Medicaid enrollees. This will mitigate they extent to which Medicaid increases the costs to those not enrolled (see section b).

MCR2c: Discourage seniors from transferring assets to quality for Medicaid.

Colorado's long-term-care spending has increased 21% from 2000 to 2005, and constitutes 32% of total Medicaid spending (House 2006). Medicaid's coverage of long-term care as created an industry knows as Medicaid Estate Planning, which shows people well above the poverty line how to shelter their assets and hence qualify for Medicaid. For details on this, see Appendix D.9. Extending the look-back period will reduce this practice and free up Medicaid funds for those truly in need.

MCR2d: Offer more home care without a waiver.

This will reduce demand for nursing home care, and hence costs, which will increase access to those who could not previously afford it.

MCR3: Allow Medicaid to compete for donations

The competition that emerges from free self-regulated markets makes everyone better off. Competition improves quality, which will benefit those Medicaid and other charities are supposed to help. One might argue that the Medicaid program itself may be negatively affected, but if that's the case, it only means that other charities have convinces taxpayers that they are more effective. Yet, I expect that allowing Medicaid to compete will energize administrators to come up with innovative reforms and install a sense of pride that they have earned their source of revenue. Taxpayers will benefit by having more choice in how to spend their own money. No one wants to be forced to may for a cause they do not believe in, or worse yet, an inefficient charity that makes donors less able to afford their own health care. This must end.

(3) How will your proposal impact distinct populations (e.g. low-income, rural, immigrant, ethnic minority, disabled)?

[I interpret "low income" to include assets as well. Many well-off people can have low-income but certainly not be considered "poor."]

BMR: The reform will benefit everyone with insurance subject to benefits mandates by reducing the relative cost of such insurance. Lower-income workers currently unable to afford insurance would be especially helped.

SGR: The reform will benefit everyone with small-group insurance by reducing the relative cost of such insurance. Lower-income workers currently unable to afford insurance would be especially helped.

MCR1: Medicaid vouchers for private insurance & Health Opportunity Accounts (HOAs)

Since Medicaid eligibility is means and asset-based, this proposal will allow the above populations enrolled in Medicaid to purchase health insurance on the private market.

MCR2a: Tailor benefit packages to certain eligible Medicaid populations.

Benefit packages are likely to be income and asset based, so this proposal will certainly impact these groups to the extent that they qualify for Medicaid. Yet, as described in Appendix D.5, excluding a section of the population from Medicaid benefits resulted in increased insurance coverage.

MCR2b: Charge premiums and copayments for some Medicaid enrollees.

The cross section of this income demographic and the distinct populations above will be effected. They will become aware of health care costs and become more responsible consumers. In the case of the disabled, they already experience this with Colorado's Consumer-Directed Attendant Support (CDAS).

MCR2c: Discourage seniors from transferring assets to quality for Medicaid. This does not impact those with low-income, as its intent is to prevent people with substantial assets from sheltering them to qualify for Medicaid.

MCR2d: Offer more home care without a waiver.

This can benefit the disabled by facilitating their access to home care. CDAS may already address this.

MCR3: Allow Medicaid to compete for donations

A free and competitive non-profit marketplace can only make Medicaid and other charities more effective in providing health care and insurance assistance to those in need, including these populations.

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(4) Please provide any evidence regarding the success or failure of your approach. Please attach.

BMR: Economic analysis and robust empirical findings demonstrate that benefits mandates increase the costs of insurance premiums.

According to an analysis of benefits mandates by the Council for Affordable Health Insurance (CAHI) for 2007, Colorado imposes 46 health-insurance mandates. A CAHI document states, "Based on our analysis presented in this paper, mandated benefits currently increase the cost of basic health coverage from a little less than 20% to more than 50%, depending on the state" (Bunce 2007). Furthermore, costs of benefits mandates are considerably higher than gains. One study finds that, nationally, benefits mandates probably cost nearly double what they're worth (Conover 2004, p. 12). An older study defines "benefit" more broadly than does this proposal finds that between 20 percent and 25 percent of "uninsured Americans lacks coverage because of benefit mandates." Furthermore, the study finds, mandates drive down wages, drive up the cost of insurance premiums, and harm smaller employers particularly severely (Jenson 1999, p. *i*).

SGR: Economic analysis strongly suggests that guaranteed-issue of insurance for a "small group of one" generates the perverse incentives herein described. For example, J.P. Wieske, Director of State Affairs for the Council for Affordable Health Insurance writes, "The net result of mandating a group of one is that applicants can game the system, leading to increased administrative and claims costs for the small-group market. Individuals who do not meet health-insurer standards in the individual market will choose to purchase guaranteed-issue coverage as a group of one. This approach leads to an adverse selection, because only those with a pre-existing medical condition choose it. ...Over time, the option will make the small group market unaffordable for legitimate small groups" (Wieske 2006, p. 29). See also the 1998 study, "Uninsured Rates Rise Dramatically in States with Strictest Health Insurance Regulations" (Turner and Schriver 1998).

MCR1: Medicaid vouchers for private insurance & Health Opportunity Accounts (HOAs)

As discussed above, the Rand Health Insurance Experiment (Gorman 2006, Appendix C)

showed that consumers with HDHPs (high-deductible health plans) spent considerably less money on health care while experiencing no measurable negative impact on their health.

HOAs are not the first Medicaid programs that involve a cash allowance to recipients. Cash and Counseling Programs were first established in Arkansas, Florida, and New Jersey in 1998, and have been expanded to a dozen more states in 2004. As described on the program's website (CashandCounseling.org), the program

> provides a flexible monthly allowance to recipients of Medicaid personal care services or home and community based services. Participants use an individualized budget to make choices about the services they receive and they are able to make sure these services address their own specific needs. In the Cash & Counseling program, the participant, instead of an agency, decides who to hire and what services they would like to receive. Participants also have the option of using their budget to purchase labor saving devises or to make home modifications to help them live independently. In addition, this innovative program offers counseling and fiscal assistance to help consumers manage their allowance and responsibilities by themselves or with the aid of a representative.

James Frogue (2003) summarizes the preliminary data on Medicaid participant's satisfaction with Cash and Counseling: "Satisfaction rates among beneficiaries are extraordinarily high. Mathematica Policy Research, Inc., the evaluation contractor chosen to study Cash and Counseling, released an interim memorandum in April 2002 based on a survey of 231 of the initial participants in Florida's Consumer Directed Care. Mathematica found that 99 percent of beneficiaries were 'satisfied with their relationship with their caregivers' and that, of those that were satisfied, '96 percent described themselves as "very satisfied".' Studies of participant satisfaction rates in the Arkansas and New Jersey experiments found virtually identical results."

The success of Colorado's Consumer-Directed Attendant Support (CDAS) program also provides evidence that putting Medicaid recipients in charge of their health care spending has positive outcomes. Under CDAS, started in 2002, severely disabled Medicaid patients have the ability to choose their own caregivers and choose how to spend money on equipment to help them with their disabilities. John Andrews (2005) reports that,

> with Medicaid expenses surging faster than almost every other budget line in almost every state, such savings are welcome news to policy makers. Taxpayers in Colorado have seen their share of Medicaid--matched dollar for dollar with federal funds--increase almost 33% since 2001. Another 22% jump is predicted by 2010.
>
> Absent a tax increase here (one on the November ballot is trailing in opinion polls), the Medicaid spiral will continue squeezing all other priorities except K-12 education.
>
> The first two years of Colorado's CDAS pilot program, by contrast, showed average monthly

> spending at 21% under budget ($3,925 per client allocated, $3,131 expended). While the sample is tiny, the vector is positive for once. To Medicaid administrators like Aggie Berens and Viki Manley, that brings unaccustomed praise--and proud smiles."

MCR2a: Tailor benefit packages to certain eligible Medicaid populations.

See Yelowitz (2000) and reference to this work in Appendix D.6.

MCR2b: Charge premiums and copayments for some enrollees.

See the summary of the RAND Health Insurance Experiment (Gorman 2005) for evidence that such a measure reduces costs without affecting health outcomes.

MCR2c: Discourage seniors from transferring assets to quality for Medicaid.

Not available at this time.

MCR2d: Offer more home care without a waiver.

Since DRA was passed recently, it is unlikely that there is sufficient data to measure the effect of this provision.

MCR3: Allow Medicaid to compete for donations

People respond to incentives and that competition among or within for-profit or non-profit institutions give actors the incentive to perform better. This is a foundational idea of psychology and economics, and has been illustrated on many contexts: from our own personal experiences to the contrast between countries with relatively free economies to those with government-controlled economies. Consider the quality of life in South Korea vs. North Korea, West Germany vs. East Germany, Hong Kong vs. China, and Western Europe vs. Soviet Eastern Block Countries.

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(5) How will the program(s) included in the proposal be governed and administered?

BMR: Following the implementation of the reform, it will require no additional governing or administering.

SGR: In some cases, a person seeking continued coverage as a "small group of one" and an insurance provider may dispute the facts regarding eligibility for such insurance. Such cases can be arbitrated by existing oversight boards and/or courts. However, net administrative costs regarding eligibility are likely to decline, because currently the self-employed seeking insurance as a "small group of one" must demonstrate eligibility, and the size of that pool will decrease substantially.

MCR1: Medicaid vouchers for private insurance & Health Opportunity Accounts (HOAs)

HOAs will be administered through the Colorado Department and Health Care Policy and Financing.

MCR2a-d: The Colorado Department of Health Care Policy and Financing will govern and administer Medicaid reforms.

MCR3: Allow Medicaid to compete for donations

The Colorado Department of Revenue and related agencies will need to establish a new category of charitable organizations that can compete for Medicaid dollars.

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(6) To the best of you knowledge, will any federal or state laws or regulations need to be changed to implement this proposal (e.g. federal Medicaid waiver, worker's compensation, auto insurance, ERISA)? If known, what changes will be necessary?

BMR: The Colorado legislature will need to repeal the statutory benefits mandates.

SGR: The Colorado legislature will need to phase out the "small group of one" as described under question (b)(1): 1) Those insured as a "small group of one" as of the date on which the reform is instituted may continue to obtain small-group insurance unless and until they voluntarily agree to obtain some other sort of health insurance; and 2) No person who is not insured as a "small group of one" as of the date on which the reform in instituted may thereafter obtain insurance as a "small group of one."

MCR1: Medicaid vouchers for private insurance & Health Opportunity Accounts (HOAs)

The implementation of HOAs and allowing enrollees to purchase private insurance will require a federal Medicaid waiver. This is likely to be a Section 1115 Waiver: Research and Demonstration Projects (See http://tinyurl.com/32p9ja, a link the relevant page on the Centers for Medicare and Medicaid Services [CMS] website).

MCR2a-d: The Deficit Reduction Act allows all of these reforms.

MCR3: Allow Medicaid to compete for donations

Depending on how the tax refunds are administered, this may require a Medicaid Waiver.

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(7) How will your program be implemented? How will your proposal transition from the current system to the proposal program? Over what time period?

BMR: The reform will be implemented by statutory change. Upon implementation of the reform, insurance providers and consumers will adapt on a schedule that best fits their individual needs.

SGR: The reform will be implemented by statutory change. The reform is transitional in that it does not impact those currently insured as a "small group of one." Because no new party will be able to apply for insurance as a "small group of one," the number of people so insured will eventually decline to zero. The transition and its period raise no additional legislative or administrative issues.

MCR1: Medicaid vouchers for private insurance & Health Opportunity Accounts (HOAs)
We do not know the details on this. For more information, see http://www.cms.hhs.gov/DeficitReductionAct/04_HOA.asp.

MCR2a-d: Medicaid reforms should be implemented in a timely manner, but as necessary, be phased in to prevent interfering with decisions people have already made based on existing policy.

MCR3: Allow Medicaid to compete for donations

The process of transitioning Medicaid from its current quasi-monopoly status to that of a charitable organization competing more fairly in the non-profit marketplace should be quick, but not so much that unforeseen complications (legal, administrative, etc.) leave enrollees without the benefits they expected.

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c) Access
(1) Does this proposal expand access? If so, please explain.

BMR: The reform expands access by making health insurance more affordable.

SGR: The reform expands access by making health insurance more affordable and by encouraging the self-employed currently without health insurance to obtain it.

MCR1: Medicaid vouchers for private insurance & Health Opportunity Accounts (HOAs)

Appendix D.7 sites empirical data that Medicaid recipients have less access to physicians - partly because of reimbursement policies to doctors set by state governments. While Medicare reimburses doctors at just 60% of what private insurers do, Medicaid reimbursements are about 62% of Medicare reimbursements. This inevitably results in doctors denying new Medicaid patients, as discussed above, and increasing reimbursement rates will only exacerbate the problem of increasing health care costs.

HOAs empower Medicaid recipients to be conscious consumers of health care and introduce a market-based pricing mechanism. Doctors competing for HOA funds will price their services competitively.

MCR2a: Tailor benefit packages to certain eligible Medicaid populations.

Section b-2 and Appendix D.6 address how tailoring benefit packages can reduce the income notch, reduce Medicaid dependence, and encourage self-sufficiency. Consequently, Medicaid's crowding-out effect will diminish, as people will less often forgo private insurance for Medicaid (Cauchon 2005). This may allow Medicaid administrators to concentrate efforts on those truly in need, and hence increase access. If Medicaid were a state-level program, associated cost reductions could be returned to taxpayers, so they would have more funds for their own health care.

MCR2b: Charge premiums and copayments for some enrollees.

As described in section b-2, shifting even a small portion of the costs to some Medicaid enrollees will discourage overconsumption, which will lead to lower health care costs for all. This will improve access.

MCR2c: Discourage seniors from transferring assets to quality for Medicaid.

Proposal MCR2c is aimed at relatively well-off people who shelter assets to qualify for long-term care paid for by others. Reducing this abuse will make these seniors take responsibility for their own long-term care. Spending their own money, instead of that of taxpayers, they will be more prudent consumers, which will lower long-term care costs across the board and hence increase access. Repeating from the above section, if Medicaid were a state-level program, associated cost reductions could be returned to taxpayers, so they would have more funds for their own health care.

MCR2d: Offer more home care without a waiver.

Removing obstacles to using Medicaid funds for home-based care, which costs less than nursing homes, will increase access to this type of long-term care for those who could not afford, or simply not prefer, nursing home care.

MCR3: Allow Medicaid to compete for donations

Allowing Medicaid to compete will make it more effective at a lower price, and hence expand access to its recipients while perhaps no longer increasing costs to non-enrollees to the extend that it currently does.

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(2) How will the program affect safety net providers?

BMR: The reform will reduce the percent of people who need to rely on "safety net providers," by making health insurance more affordable.

SGR: The reform will reduce the percent of people who need to rely on "safety net providers," by making health insurance more affordable and by encouraging the self-employed currently without health insurance to obtain it. However, while the overall percent of people needing a "safety net" will likely decline; some people may need a "safety net" who would otherwise be able to gain insurance as a "small group of one." Among the self-employed, some now obtain insurance as individuals, some obtain insurance as a "small group of one," and some do not have health insurance. The reform would encourage more of the self-employed to obtain individual health insurance. However, some among the self-employed would continue to go without health insurance, and some of those people would end up developing significant health problems that might put them in need of a "safety net." Note that some people who do not have insurance and who develop significant health problems are no longer able to work, and thus they are not able to purchase small-group insurance.

MCR1: Medicaid vouchers for private insurance & Health Opportunity Accounts (HOAs)

HOAs are likely to curb Medicaid's escalating costs because it gives recipients incentive to be cost-conscious consumers of health care. Again, as illustrated by the Rand Health Insurance Experiment, HDHPs reduce costs with no measurable impact on patient health. Currently Medicaid recipients have an incentive to over-consume, which drives up costs.

MCR2a-d: In this case, the safety net provider is Medicaid, and it will decrease administrative costs.

MCR3: Allow Medicaid to compete for donations

As a safety net provider, Medicaid has suffered from lack of competition. Allowing it to compete with other Colorado health charities will, as described above, motivate administrators to formulate effective internal reforms and innovative ideas to assist those they truly care about. This will also invigorate non-government voluntary charities by leveling the Colorado's health charity playing field by allowing taxpayers to fund charities that have truly earned their dollars.

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d) Coverage
(1) Does your proposal "expand health care coverage?" (Senate Bill 06-208) How?

BMR: The reform expands coverage by making health insurance more affordable.

SGR: The reform expands coverage by making health insurance more affordable and by encouraging the self-employed currently without health insurance to obtain it.

MCR1: Medicaid vouchers for private insurance & Health Opportunity Accounts (HOAs)

and

MCR2a and b: Charging premiums and copayments, tailor benefit packages to select enrollees.

It is important to distinguish health care "coverage" from access. Currently Medicaid enrollees have 100% coverage in that they do not pay any of their health care expenses. The RAND health insurance experiment shows that such populations spend much more on health expenses, but receive no measurable health benefit. Further, Appendix D (sections 3 and 7) shows that in terms of access to quality health care, Medicaid enrollees have much less than those with private-sector insurance.

Hence, 100% coverage is equivalent to pre-paid health care, which promotes over-consumption and increased costs. Further, *extensive health care coverage actually inhibits access*. Changing Medicaid to a voucher program will decrease coverage, and that is a good thing. It will encourage enrollees to spend responsibly, which will decrease costs for all Coloradans and hence increase access.

MCR2c and d: not applicable

MCR3: Allow Medicaid to compete for donations

Medicaid and health-related voluntary charitable organizations can defray people's health care costs. Allowing Medicaid to compete with these organizations will benefit both, and allow them to more effectively defray costs.

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(2) How will outreach and enrollment be conducted?

BMR: not applicable

SGR: not applicable

MCR1: Medicaid vouchers for private insurance & Health Opportunity Accounts (HOAs)

Medicaid recipients will enroll for HOAs when demonstrating their eligibility for the program. South Carolina Governor Mark Sanford explains further:

> Critical to the success of this effort will be the agency utilizing enrollment counselors during the eligibility process. These counselors will help explain the menu of options that will be available to recipients. In fact, the agency's role will evolve from primary claims processor to more education and coordination. The agency's role will help the beneficiary become a wise shopper for health care, a real market place participant. The beneficiary will be able to define what quality health care means to him, and through his purchasing power, influence the kinds of services that are available to him (Sanford 2005).

MCR2a-d: not applicable

MCR3: Allow Medicaid to compete for donations

In this case, outreach and enrollment applies to notifying existing Colorado non-profits of the opportunity to compete for dollars previously available only to Medicaid.

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(3) If applicable, how does your proposal define "resident?" : not applicable

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e) Affordability
(1) If applicable, what will enrollee and/or employer premium-sharing requirements be?

MBR and **SGR:** not applicable.

MCR1: Medicaid vouchers for private insurance & Health Opportunity Accounts (HOAs)

Medicaid recipients with HOAs have the opportunity to purchase commercially available insurance plans. HOA proposals in Florida and South Carolina have these features. For details on these plans, see Susan Konig (2005), "Medicaid Reform: Florida, South Carolina Lead the Way." This proposal involves premium-sharing, and Florida and South Carolina's requirements may be used as guidelines.

MCR2a: Tailor benefit packages to certain eligible Medicaid populations.

Premium sharing can be determined according to the enrollee's financial status. See MCR2b, below.

MCR2b: Charge premiums and copayments for some enrollees.

Determining the details of this is beyond the scope of this proposal. The premium-sharing requirements should be determined within the goals of the program: to assist enrollees in purchasing insurance on the private market (including through their employer), but not to crowd out private insurance.

MCR2c-d: not applicable

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(2) How will co-payments and other cost-sharing be structured?

MBR and **SGR:** not applicable.

MCR1: Medicaid vouchers for private insurance & Health Opportunity Accounts (HOAs)
Co-payments and cost-sharing will depend on the type of insurance policies Medicaid recipients choose.

MCR2a and **b**: Tailor benefit packages to certain eligible Medicaid enrollees and (b) charge premiums and copayments for some enrollees.

Premium sharing can be determined according to the enrollee's financial status. From e-1, "The premium-sharing requirements should be determined within the goals of the program: to assist enrollees in purchasing insurance on the private market (including through their employer), but not to crowd out private insurance."

MCR2c-d: not applicable

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f) Portability
(1) Please describe any provisions for assuring that individuals maintain access to coverage even as life circumstances (e.g. employment, public program eligibility) and health status change.

BMR: While the reform expands coverage by making health insurance more affordable, it does not directly impact the issue of portability.

SGR: The reform expands portability by encouraging the self-employed currently without health insurance to obtain portable, lower-cost, long-term, individual health insurance.

MCR1: Medicaid vouchers for private insurance & Health Opportunity Accounts (HOAs)

While HOAs will lower health care costs by encouraging Medicaid recipients to be cost-conscious consumers, this change by itself does not change Medicaid's eligibility requirements, which, as discussed above, discourages people from seeking higher-paying jobs. However, since Medicaid recipients will own their HSAs, it would be possible for them to keep the money in them even when they are no longer eligible for Medicaid. Upon leaving Medicaid a consumer's HOA can be converted into a Health Savings Account (HSA).

MCR2a-d: not applicable

MCR3: Allow Medicaid to compete for donations: not applicable

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g) Benefits
(1) Please describe how and why you believe the benefits under your proposal are adequate, have appropriate limitations and address distinct populations.

BMR and SGR: The reform will generate insurance coverage for more people across distinct populations.

MCR1: Medicaid vouchers for private insurance & Health Opportunity Accounts (HOAs)

HOAs will remedy severe problems that plague Medicaid recipients and the burdens they impose on Colorado taxpayers who fund the program. A Health Opportunity Account combined with a HDHP replaces pre-paid health care, which encourages over-consumption, with real insurance that encourages responsible consumption. This will lower Colorado health care costs and make it affordable to those who most need it.

MCR2a-d: not applicable

MCR3: Allow Medicaid to compete for donations: not applicable

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(2) Please identify an existing Colorado benefit package that is similar to the one(s) you are proposing (e.g. Small Group Standard Plan, Medicaid, etc) and describe any differences between the existing benefit package and your benefit package.

BMR: The reform will modify some existing insurance policies by allowing insurance providers to stop covering services now mandated by legislation.

SGR: The reform will modify the scope of "small group" insurance.

MCR1: Medicaid vouchers for private insurance & Health Opportunity Accounts (HOAs)

HOAs and HDHPs (high-deductible health plans) for Medicaid recipients are equivalent to high-deductible health plans combined with HSAs for those not on Medicaid.

MCR2a-d: This is a reform proposal for Medicaid.

MCR3: Allow Medicaid to compete for donations

This will give voluntary non-profits the incentive to develop benefit packages targeted to the same population that Medicaid services. They will be similar to a degree, but since both Medicaid and the voluntary non-profits will compete for donations, the administrators will have strong incentive to innovate, and it is difficult predict what kind of creative methods they will come up with.

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h) Quality
(1) How will quality be defined, measured, and improved?

BMR and **SGR**: Following the legislative reform, quality will be defined, measured, and improved by insurance providers and consumers without state micromanagement. State agencies as well as for-profit and nonprofit groups will be able to define and measure quality at their discretion.

MCR1: Medicaid vouchers for private insurance & Health Opportunity Accounts (HOAs)

HOAs and HDHPs for Medicaid recipients will give them more choices of doctors and medical services and make them more concerned with quality and cost. Consequently, providers will improve quality and lower costs to attract these consumers.

MCR2a-d: These measures will reduce Medicaid costs by systematically encouraging responsible health care consumption through cost-sharing, reduction of abusive asset-hiding, and cost-saving home care. Since increased costs limit access to health care, reduced costs increase

it, and hence more people will have access to quality care.

MCR3: Allow Medicaid to compete for donations

In a competitive non-profit marketplace, individual donors will have the freedom to withdrawal their support of a charity they do not perceive as providing a quality service. Hence, the aggregate preferences of donors will define quality. Enrollees in these programs will also have a role in defining quality, as they will have more choices of charities to contact to assist them in becoming self-sufficient.

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(2) How, if at all, will quality of care be improved?

BMR: The reform will improve access and coverage, thereby improving the quality of health care especially for lower-income employees.

SGR: The reform will improve quality of care by encouraging some among the self-employed who do not currently have health insurance to obtain portable, lower-cost, long-term, individual health insurance, in conjunction with a Health Savings Account. Such insurance improves the relationship between medical service providers and their customers by reducing the interference of insurance agencies and government bureaucrats. Any increase in the percentage of people with individual health insurance and Health Savings Accounts will have positive "spillover" effects in that it will encourage more consumers to adopt such insurance and encourage doctors to be more responsive to the needs of their patients. (See Milton Friedman in Gratzer 2006, p. *ix-xi*). These improvements in quality will benefit all cultural groups.

MCR1: Medicaid vouchers for private insurance & Health Opportunity Accounts (HOAs)

Empowering Medicaid recipients to choose their health care and health insurance providers will certainly align provider payment with outcomes. As Dr. David Gratzer (2006) describes CDAS, "the severely disabled poor can choose a program that empowers them with health dollars; participants are able to hire and fire their own caregivers, and use moneys for life-enhancing equipment." See also h-1.

MCR2a-d: not applicable

MCR3: Allow Medicaid to compete for donations

Allowing Medicaid to compete will align provider payment with outcomes in two ways: Medicaid and competing charities will need to compete for both enrollees and donors.

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i) Efficiency

(1) Does your proposal decrease or contain health care costs? How?

BMR: The reform reduces the costs of health insurance that is currently subjected to legislative benefits mandates.

SGR: The reform contains health care costs in at least three ways: 1) The reform reduces the (costs of small-group health insurance; 2) The reform encourages the self-employed currently without insurance to purchase portable, lower-cost, long-term, individual health insurance, thereby reducing their risks; and 3) The reform fosters the adoption of the sort of insurance that reduces the costs of health "insulation" (see Kling, 2007).

MCR1: Medicaid vouchers for private insurance & Health Opportunity Accounts (HOAs)

As discussed in the introduction, pre-paid health care leads to over-consumption and increased costs. HDHPs combined with HSAs and HOAs (for Medicaid recipients) eliminates the incentive to splurge on health care with no consideration of the costs. See also g-1.

MCR2a-d: These measures will reduce Medicaid costs by systematically encouraging responsible health care consumption through cost-sharing, reduction of abusive asset-hiding, and cost-saving home care. Since increased costs limit access to health care, reduced costs increase it, and hence more people will have access to quality care.

MCR3: Allow Medicaid to compete for donations

Given the evidence that Medicaid increases health care costs (along with other undesirable consequences catalogued above), very few taxpayers would choose to donate to such a charity if they had the choice. Making Medicaid compete for funds will give administrators incentive to support those in need in a cost-effective manner. However, federal matching funds for Medicaid will still discourage frugal spending. This may be offset if the matching funds can be used for the tax refund to those who choose to donate to non-government charities.

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(2) To what extent does your proposal use incentives for providers, consumers, plans or others to reward behavior that minimizes costs and maximizes access and quality in the health care services?

BMR: Removing mandates gives insurance companies the incentive to offer plans with benefits determined by consumer preferences rather than those mandated by law. With this new freedom, more consumers will want lower-cost health plans most appropriate to their specific needs. Removing mandated benefits may also strengthen the market for HSAs and high-deductible plans, which as shown in the RAND Health Insurance Experiment (Appendix C), promote frugality with no measure effect on health.

SGR: The reform increases the incentive for some people to purchase health insurance. Because it encourages the adoption of portable, lower-cost, long-term, individual health insurance in conjunction with Health Savings Accounts, the reform increases the incentive of health-care consumers to seek the best value in obtaining medical care, and it increases the incentive of health-care providers to be more responsive to the needs of their customers.

MCR1: Medicaid vouchers for private insurance & Health Opportunity Accounts (HOAs)

As it stands, Medicaid recipients have no incentive to consider costs when requesting health care, and hence over-consume which increases costs for everyone. Replacing this "free" health care entitlement with a HOA and a HDHP will make Medicaid recipients aware of costs, and as suggested by the RAND Health Insurance experiment (Appendix C), they will consume less with no measurable effect on their health.

MCR2a: Tailor benefit packages to certain eligible Medicaid populations.

As discussed in sections b and c, this can potentially reduce incentives for enrollees to forgo employment to maintain eligibility.

MCR2b: Charge premiums and copayments for some enrollees.

The RAND Health Insurance Experiment (Appendix C) showed that consumers with high-deductible health plans spent significantly less on health care than those with low or zero deductibles - with no measurable effect on their health. Charging premiums and copayments provides incentives for Medicaid enrollees to reduce unnecessary expenditures.

MCR2c-d: not applicable

MCR3: Allow Medicaid to compete for donations

Given the evidence that Medicaid increases health care costs (along with other undesirable consequences catalogued above), very few taxpayers would choose to donate to such a charity if they had the choice. Making Medicaid compete for funds will give administrators incentive to support those in need in a cost-effective manner. However, federal matching funds for Medicaid will still discourage frugal spending. This may be offset if the matching funds can be used for the tax refund to those who choose to donate to non-government charities.

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(3) Does this proposal address transparency of costs and quality? If so, please explain.

BMR: Benefits mandates force some in the insurance pool to subsidize others. Repealing such mandates will increase transparency of the costs of insurance, with and without various benefits, as well as the costs of the services now included in the list of mandates.

SGR: Phasing out the "small group of one" will make the resulting relatively lower costs of small-group insurance, and thus the true net benefits of such insurance, transparent to those in the market. The reform will also make more transparent to the self-employed the risks of remaining without insurance. In addition, by encouraging the adoption of portable, lower-cost, long-term, individual health insurance in conjunction with Health Savings Accounts, the reform will encourage health-care consumers and providers to seek and convey with greater transparency information about medical costs, benefits, options, desires, and needs.

MCR1: Medicaid vouchers for private insurance & Health Opportunity Accounts (HOAs)

This has been addressed in previous questions. In short, HOAs increase out-of-pocket spending and encourage health care consumers to be cost-conscious and to get the most quality for their dollar. Consequently, this will motivate providers to lower costs and enhance quality.

MCR2a,c,d: not applicable

MCR2b: Charge premiums and copayments for some enrollees.

Eliminating the "pre-paid health buffet" aspect of Medicaid's fee-for-service and/or managed care will make enrollees aware of health care costs to the extent that they pay premiums and copayments.

MCR3: Allow Medicaid to compete for donations

A dollar-for-dollar tax reduction for donations to health-related charities will make tax-payers aware of how much the tax law compels them to fund Medicaid, and motivate them to monitor how effective the program is. Hence, the costs to them will become more transparent, and they will have good reason to seek a better return on their investment in contributing to a health charity.

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(4) How would your proposal impact administrative costs?

BMR: The reform will have no significant impacts on net administrative costs.

SGR: The reform will reduce costs to insurance providers of administering small-group insurance.

MCR1: Medicaid vouchers for private insurance & Health Opportunity Accounts (HOAs)

Since Medicaid in Colorado is operating in the traditional fee-for-service model as opposed to outsourcing to managed care partners (Fletcher 2006), the state is probably bearing the administrative costs. Since the federal government matches every dollar spent on Medicaid, this provides incentives to spend more, rather than less.

Converting from a defined-benefit system to a defined-contribution system will make costs more predictable. To the extent that Medicaid acts to subsidize enrollee purchase of private insurance, administrative costs will decrease, as these for-profit companies have a stronger incentive to be cost conscious than does a government agency.

MCR2a-d: These proposals change how Medicaid is administered, which will require initial administration costs. No changes in recurring costs are anticipated.

MCR3: Allow Medicaid to compete for donations

Again, competition encourages innovation and cost-cutting. Making Medicaid compete will provide incentives to reduce administrative costs. Yet, there will be a cost to establishing the new tax category for Colorado Health Charities.

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j) Consumer choice and empowerment
(1) Does your proposal address consumer choice? If so, how?

BMR: The reform will increase the number of cost-effective insurance choices for many Coloradans who currently lack health insurance.

SGR: The reform will increase the number of cost-effective insurance choices for many Coloradans who currently lack health insurance. By eliminating the perverse incentive that encourages some among the self-employed to avoid obtaining health insurance until they develop significant medical problems, the reform tightens the link between choice and responsibility. In addition, by encouraging the adoption of portable, lower-cost, long-term, individual health insurance in conjunction with Health Savings Accounts, the reform will foster more meaningful choice regarding medical costs, benefits, options, desires, and needs.

MCR1: Medicaid vouchers for private insurance & Health Opportunity Accounts (HOAs)
This will give Medicaid enrollees more choice in their providers and insurance companies. The current fee-for-service system and consequent state-defined limited reimbursement discourages doctors from seeing Medicaid patients, which I document in Appendix D.7. In the defined-contribution model, enrollees will be empowered to purchase both insurance and coverage in the private market, and hence have more choice.

MCR2a: Tailor benefit packages to certain eligible Medicaid populations.

One of the goals of this measure is to reduce incentives for Medicaid dependence and encourage enrollees to be proactive in increasing their income and employability so they are no longer on the public dole. Nothing is more empowering than becoming independent and self-sufficient through one's own efforts.

MCR2b: Charge premiums and copayments for some enrollees.

The cost savings associated with this measure will increase access for both enrollees and taxpayers who fund Medicaid. Increased access translates into more choices in health care providers, and hence the empowerment associated with making such choices.

MCR2c: not applicable

MCR2d: Offer more home care without a waiver.

Owcharenko (2006) points out that "this new change enables states to give eligible enrollees greater choice of the setting in which they receive care, keeping them from leaving their homes and entering institutional facilities."

MCR3: Allow Medicaid to compete for donations

This will give more choices to both Medicaid enrollees - in terms of available charities that can assist them in getting back on their feet - and the taxpayers who fund Medicaid, who will now be able to use these dollars to fund competing charities.

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(2) How, if at all, would your proposal help consumers to be more informed about and better equipped to engage in health care decisions?

BMR: Benefits mandates force some in the insurance pool to subsidize others. Repealing such mandates will increase information about the costs of insurance, with and without various benefits, as well as the costs of the services now included in the list of mandates.

SGR: Phasing out the "small group of one" will make more information about the resulting relatively lower costs of small-group insurance, and thus the true net benefits of such insurance, available to those in the market. The reform will also indirectly make more information available about the risks of not purchasing health insurance. In addition, by encouraging the adoption of portable, lower-cost, long-term, individual health insurance in conjunction with Health Savings Accounts, the reform will encourage health-care consumers and providers to seek and convey more information about medical costs, benefits, options, desires, and needs.

MCR1: Medicaid vouchers for private insurance & Health Opportunity Accounts (HOAs)

As Nobel Laureate Milton Friedman wrote, "nobody spends somebody else's money as wisely or as frugally as he spends his own" (Friedman 2001, Appendix E). Health Opportunity Accounts empower Medicaid enrollees to make wise health decisions, and giving them more choice in insurance providers will make them conscious consumers.

MCR2a-b: Giving people more choices as consumers provides incentives to be more informed about their consequences. As in MCR1, Medicaid enrollees will be more informed to the extent that they are spending their own money compared to spending other people's money.
MCR2c-d: not applicable

MCR3: Allow Medicaid to compete for donations

Making Medicaid compete will create a non-profit marketplace for health care charities. Effective health care charities, because they will compete for donations by demonstrating their effectiveness, will function to encourage those they assist to make their own decisions and take responsibility for their own health.

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k) Wellness and prevention
(1) How does your proposal address wellness and prevention?

BMR: The reform will enable more people to purchase health insurance, which fosters wellness of those who develop significant health problems and prevention of problems associated with non-insured risks.

SGR: The reform offers the same benefits as BMR (though probably to a different degree), and in addition it encourages the adoption of portable, lower-cost, long-term, individual health insurance in conjunction with Health Savings Accounts, which encourages health-care customers to take greater responsibility for their own wellness and prevention of health problems.

MCR1: Medicaid vouchers for private insurance & Health Opportunity Accounts (HOAs)

Putting Medicaid enrollees in charge of their own health care dollars will discourage the over-consumption associated with pre-paid health care plans, as shown by the RAND Health Insurance Experiment (Appendix C). Above I describe how this program will empower enrollees to be conscious consumers of health care. Since one's healthy behaviors and preventive care can operate as a financial investment, that is, they save the person money in the long run, this proposal encourages such behavior by placing a financial cost on risky activities.

MCR2b: The answer for MCR1, directly above, also applies to charging Medicaid enrollees

premiums and copayments.

MCR2a, c, d: not applicable

MCR3: Allow Medicaid to compete for donations

Encouraging wellness and prevention can be a significant part of how a health care charity assists people in need, and making Medicaid compete will give Medicaid administrators and those of competing charities incentives to promote this behavior.

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l) Sustainability
(1) How is your proposal sustainable over the long-term?

BMR: The reform will foster sustainability by increasing the percent of people with health insurance. In addition, the reform will disrupt the cycle of special-interest lobbying to obtain the "concentrated benefits" of mandates that disperse costs among the broader population.

SGR: The reform encourages the adoption of portable, lower-cost, long-term, individual health insurance in conjunction with Health Savings Accounts, and such insurance is inherently more portable and thus more sustainable than is employer-paid insurance. In addition, individual insurance mitigates the problems of "insulation" that push up the costs of medical care.

MCR1: Medicaid vouchers for private insurance & Health Opportunity Accounts (HOAs)

and

MCR2a-d: Cost-saving measures which contribute to increasing Medicaid's sustainability.

Medicaid is currently unsustainable because, in part, its recipients have no incentive to curb their health care consumption. Changing Medicaid to a defined contribution system (with vouchers for private insurance and Health Opportunity Accounts) makes budgeting more predictable and promotes enrollees to spend their subsidy wisely. Reducing incentives of enrollees' overconsuming, and hence straining the system, promotes sustainability.

MCR3: Allow Medicaid to compete for donations

Appendix D describes how Medicaid is not sustainable. Allowing Medicaid to compete for funds with non-government charities will provide administrators financial incentives to remedy this.

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(2) (Optional) How much do you estimate this proposal will cost? How much do you estimate this proposal will save?

BMR: The reform will clearly save purchasers of insurance now subject to benefits mandates significant sums of money, but this proposal does not offer a precise estimate. The Council for

Affordable Health Insurance estimates that benefits mandates increase the costs of insurance premiums by around 20 to 50 percent (Bunce, 2007). In addition to reducing overall costs, this reform helps to align costs and savings more fairly among particular purchasers of medical services and insurance, according to use.

SGR: The reform will help to contain overall costs and align costs and savings more fairly among particular consumers of medical services and insurance, according to use.
MCR1,2,3: These Medicaid reforms will save the program money.

---

(3) Who will pay for any new costs under your proposal?

BMR: The reform will reduce costs on net, and it will shift some costs from those now forced to subsidize mandated services to those who use the services.

SGR: As with BMR, this reform does not create "new costs" on net, but it does shift some costs. Currently, the self-employed who delay purchasing health insurance because of the perverse incentive arising from the "small group of one" often shift the cost of their health risks to others in the small-group insurance market. With the reform, the self-employed without insurance will be encouraged to purchase insurance, and they will properly bear these insurance costs.

MCR1: Medicaid vouchers for private insurance & Health Opportunity Accounts (HOAs)
By replacing pre-paid health care with true health insurance, this proposal should save money.
MCR2a-d: These proposals are intended to decrease Medicaid costs.
MCR3: Allow Medicaid to compete for donations

Administrative costs associated with converting Medicaid from government-subsidized charity to one that fairly competes with other charities will come out of current Medicaid funds.

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(4) How will distribution of costs for individuals, employees, employers, government, or others be affected by this proposal? Will each experience increased or decreased costs? Please explain.

BMR: The reform will encourage additional people to gain insurance. The additional insurance coverage will be paid by individuals and, in some cases, their employers. Those with private insurance generally rely less on government-funded services.

SGR: The reform will encourage more of the self-employed to purchase health-insurance, and they will pay the costs. The costs to employers and employees in the small-group market, as well as to the government, will be reduced.

MCR1: Medicaid vouchers for private insurance & Health Opportunity Accounts (HOAs)

As described in section (i), this will decrease costs for everyone by reducing incentives for over-consumption associated with pre-paid health care.

MCR2a-b: Tailor benefit packages to certain eligible Medicaid populations.

These measures transfer costs from taxpayers and government to select Medicaid enrollees who are able to pay for a portion (even a nominal sum) of their health care and health insurance.

MCR2c: Discourage seniors from transferring assets to quality for Medicaid.

Allowing well-off people to shelter assets to qualify for Medicaid increases costs for long-term care services for other consumers and government.

MCR2d: Offer more home care without a waiver.

This will decrease Medicaid budgets. Decreased demand for high-cost nursing homes will decrease their prices, which will hence lower costs of all consumers of this product.

MCR3: Allow Medicaid to compete for donations

Medicaid will face a potential loss in tax revenue to competing charities. To avoid this, administrators will need to engage in effective fund-raising just as other charities must.

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(5) Are there new mandates that put specific requirements on payers in your proposal? Are any existing mandates on payers eliminated under your proposal? Please explain.

BMR: The reform eliminates benefits mandates for insurance.

SGR: The reform phases out the "small group of one."

MCR1: Change Medicaid to a defined-contribution system, offer HOAs: No.

MCR2a-d: not applicable

MCR3: Allow Medicaid to compete for donations: No.

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(6) (Optional) How will your proposal impact cost-shifting? Please explain.

BMR, SGR, MCR2c,d, MCR3: not applicable

MCR1 and MCR2 (a & b): These three Medicaid proposals involve shifting a fraction of health care costs to Medicaid enrollees.

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(7) Are new public funds required for your proposal?

BMR and **SGR:** No.
MCR1 (vouchers & HOAs) and **MCR2** (Deficit Reduction cost-savings): No.

MCR3: Allow Medicaid to compete for donations. No new public funds. See section l-3.

3. This is a comprehensive proposal that (1) "expands coverage," (2) "increases access to quality care," (3) "decreases costs broadly for all Coloradans," & (4) "improves health." [3]

Expanding Coverage: Medicaid crowds out health insurance and long-term care providers (see Appendix D). Medicaid's providing essentially pre-paid health care encourages overconsumption, which drives up health care costs for those not enrolled. Replacing the Medicaid fee-for-service plan with vouchers for private insurance & Health Opportunity Accounts[4] empowers enrollees to choose health insurance plans and spend wisely. Introducing cost-sharing (allowed by the 2006 Deficit Reduction Act) will also partly achieve this end. The decreased incentive to overconsume will mitigate the crowding out effects and cost increases that reduce coverage for the taxpayers who fund Medicaid.

In the private market, this proposal asks the Colorado legislature to eliminate benefits mandates and phasing out guaranteed issue for the "small [or business] group of one." Both regulations increase the number of uninsured.

Increase Access to quality care: The Medicaid reforms mentioned in the above sections will also increase access to quality health care. Appendix D (D.7) shows that while Medicaid provides "coverage," access is lacking compared to the private market. Both making Medicaid compete with voluntary charities, and converting it from a welfare entitlement program to a voucher program for private health insurance and HOAs will increase enrollee access to quality care. Since, as described above, this will expand coverage for those in the private market, it will also increase their access to quality care.

Similarly, since benefits mandates and guaranteed issue for the "small group of one" increase the number of uninsured, eliminating the mandates and phasing out guaranteed issue will increase access to health insurance, and hence quality care.

Decreasing costs broadly for all Coloradans: The Medicaid reforms mentioned above, making it compete with other medical care charities, and the other two reforms allowed by the Deficit Reduction Act (long term care and home care) will reduce costs. Eliminating mandated benefits will significantly reduce premium costs. Since guaranteed issue can encourage people to wait until they are sick to purchase insurance, phasing out the "small group of one" will discourage such waiting, and hence spread the risk in a more cost-effective way.

Improved Health: To the extent that improved health is correlated with increased coverage, access to quality care, and decreasing the cost to this care, this proposal promotes improved health. Independently of these causes, this proposal provides incentives for individuals to make healthy choices by promoting real insurance policies instead of pre-paid health care. Such policies involve more cost-sharing, and hence provide policy holders with financial incentives to develop healthy lifestyles and avoid taking irresponsible risks.

[3] "Comprehensive" defined according to the Proposal Solicitation.

Appendix A: Health Care in the United States vs. Other Countries

Patients in the United States have access to the best health care in the world. First consider access. According to a Commonwealth Fund report, only one in twenty patients (5%) in the United States had to wait more than four months for elective (non-emergency surgery). Yet, this happens at least four times more often in the Australia, New Zealand, Canada, and Britain (23%, 26%, 27%, and 36% respectively). Physicians in the United States see only about two-thirds the number of patients than those in Canada or the United Kingdom, but they more likely to spend over 20 minutes with a patient (30%) than in the above-mentioned countries (12%, 15%, 20%, 5% respectively) (Goodman 2005)

Compared to the United Kingdom and Canada, patients in the United States are significantly more likely to receive high-tech treatment. John C. Goodman (2005), cites studies showing that "the use of coronary bypass surgery in the United States is slightly more than three times higher per capita than in Canada and almost five times higher than in Britain. The rate of coronary angioplasty in the United States is almost five times higher than in Canada and almost eight times higher than in Britain. The rate of renal dialysis in the United States is almost double that of Canada and almost three times that of Britain. Britain was the co-developer with the United States of kidney dialysis in the 1960s, yet Britain consistently has had one of the lowest dialysis rates in Europe." The United States also has significantly more, more than twice as many in all but one case, per-capita CT scanners, MRI units, and lithotripsy units.[5]

One method to measure the quality of health care is the mortality ratio: the percentage of those diagnosed with the disease who die from it. This ratio is lower in the United States for breast cancer (25%) than in other industrialized countries, where the mortality ratio ranges from 28% (Australia) to 46% (New Zealand and the United Kingdom). The same applied for prostate cancer (19%), whereas the mortality rate ranges from 25% (Canada) to 57% (United Kingdom) (Goodman 2005).

In 2000, the American Cancer Society (2000) reported similar results: "U.S. patients have better survival rates than European patients for most types of cancer, according to a new study….The results show Americans have significantly better five-year relative survival rates for cancers including: prostate (81 percent vs. 56 percent), melanoma (86 percent vs. 76 percent), colon (60 percent vs. 47 percent), rectum (57 percent vs. 43 percent), breast (82 percent vs. 73 percent), uterine cancer (83 percent vs. 73 percent)."

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[4] Along the lines of Florida and South Carolina

[5] *Lithotripsy* is a medical procedure that uses shock waves to break up stones formed in the kidney, bladder, ureters, or gallbladder.

Appendix B: Insurance Coverage

According to the National Center for Policy Analysis (Herrick Sept. 9 2006), drawing in Census Data:

- More than 84 percent (247.3 million) of the 293 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 (SCHIP).
- 10 million to 14 million adults and children qualified for government programs but have not enrolled.
- 17 million live in households with annual incomes above $50,000 & could likely afford health insurance.
- The proportion of people without health insurance was only slightly higher in 2005 (15.9 percent) than it was a decade earlier (15.6 percent in 1996).

The Colorado Health Institute (CHI 2006a) reports that Colorado's uninsured rate increased from 15% to 17% between 199 and 2005. The uninsured rate for those younger than 18 remained constant during this period. This document did not specify the average duration of lacking health insurance.

Appendix C: The RAND Health Insurance Experiment

Excerpted from Gorman (2006):

> Gorman, Linda, The History of Health Care Costs and Health Insurance, Wisconsin Policy Institute Research Report, Vol. 19, No. 10, www.wpri.org/Reports/Volume19/Vol19no10.pdf, October 2006.

"The RAND Health Insurance Experiment studied the health and health expenditures of approximately 2,000 non-elderly families from six areas of the United States. Participants were followed for three to five years between 1974 and 1982.

"Participating families were assigned either to a prepaid group practice or one of 14 fee-for-service insurance plans. The fee-for-service plans varied only in the fraction of charges billed to the participant and the maximum dollar expenditure cap. There were four coinsurance percentages: 0 (free care), 25%, 50%, and 95%. The coinsurance rate referred to the fraction of billed charges paid by the insured. There were also three levels of maximum dollar expenditures, caps on the amount that any family was expected to pay during each 12 month accounting period. The maximum dollar expenditures were 5%, 10%, or 15% of family income or $1,000 whichever was less. As a result, the highest maximum dollar expenditure was roughly equivalent to $3,000 in today's dollars.

"...The most important result was that per capita expenses on the free plan were 45% higher than those for the 95% cost-sharing plan. Savings primarily came from a reduction in the number of contacts rather than in the intensity of services. For average adults, the health of those who spent less appeared to be just as good as those who spent more....

"In all, the RAND Health Insurance Experiment showed that the average consumer spent far less on medical care when he was spending his own money, and that he chose reductions that were not harmful to health in any measurable fashion. [E]mergency room visits responded robustly to cost sharing. People who were paying for their own care reduced visits for conditions that can safely be endured while waiting to see a physician during normal business hours. Cost sharing had little effect on visits for serious problems likely to require immediate attention-head injuries, abdominal disease, chest pain/acute heart disease, and acute eye injuries."

See also:

Newhouse, Joseph P., *Free for All? Lessons from the RAND Health Insurance Experiment*, (Harvard University Press, 1993)

Appendix D: How Medicaid measures up to the Blue Ribbon Commission's Criteria

D.1 Is Medicaid Efficient? (Criterion 8)

Medicaid recipients comprise a large segment of the population that has pre-paid health care, but not health insurance. Medicaid enrollees need not meet a deductible or pay co-payments, so there is little to discourage over-consumption. Eligibility depends on income level and the number of children in the family, as well as family assets (Colorado Health Initiative 2007). As noted above, what most people consider to be "health insurance" really functions as pre-paid health care. It encourages over-consumption with no evidence that it results in better patient health. In this sense, Medicaid does not satisfy the efficiency criterion of Senate Bill 06-208 that emphasizes "cost-effective" health care costs and decreasing health care costs for Colorado residents.

D.2 Is Medicaid Sustainable? (Criterion 11)

Senate Bill 208 also emphasizes sustainability, and Medicaid's increasing costs suggest that it needs major reform. Medicaid costs have more than doubled in the past ten years, grew almost 8% in 2004, and accounts for 22% of state expenditures (Owcharenko, 2006). According to the *Denver Business Journal* (Fletcher 2006), Medicaid "comprises a growing share -- now about 20 percent -- of the state's budget. It's not an optional program, so when care isn't provided efficiently, less money is available for other state-funded projects and services, including transportation and higher education....Worse, when hospitals, doctors and other providers are under-reimbursed, they frequently shift those costs to paying patients, most of whom receive their health insurance through their employer. That increases insurance rates."

According to the Kaiser Family Foundation, 95% of Colorado Medicaid recipients were enrolled in managed care as of 2004 (Kaiser 2007). A study by the National Bureau of Economic Research concluded that "empirical results demonstrate that the resulting switch from fee-for-service to managed care was associated with a substantial increase in government spending but no observable improvement in health outcomes" (Duggan, 2002).

Further, in September 2006, *The Denver Business Journal* reported that a "year after the state said it wanted more managed health plans to care for state Medicaid patients, there isn't an HMO in the state that wants to participate in the program. That, critics say, is leaving taxpayers paying more than necessary to care for the poor, and Medicaid patients with less preventative care. The state's last Medicaid HMO, Colorado Access, quit the program in August after state officials estimated they would impose a 15 percent rate decrease in the company's

reimbursement for insuring Medicaid patients. As a result, nearly all the doctors and hospitals who care for the 400,000 Coloradans receiving care under Medicaid are getting paid under a financial system called "fee for service" that critics argue provides no incentive to limit services or improve patients' health" (Fletcher 2006).

As John Adams Hurson of the Maryland House of Delegates and president of the National Conference of State Legislatures, as said, "I am a Democrat, a liberal Democrat, but we can't sustain the current Medicaid program. It's fiscal madness. It doesn't guarantee good care, and it's a budget buster. We need to instill a greater sense of personal responsibility so people understand that this care is not free" (Pear 2005).

D.3 Medicaid Inhibits Consumer Choice (Criterion 9)

Medicaid has several downsides. First, by crowding out private charities, it cripples non-government institutions that have historically provided health care for the poor. Medicaid also decreases demand for and increases the costs of private insurance. In addition, Medicaid's means and asset-based eligibility discourages recipients from both seeking higher paid jobs and saving money.

In his book, From *Mutual Aid to the Welfare State: Fraternal Societies and Social Services*, 1890-1967, historian David Beito documents how mutual aid societies (also known as fraternal organizations) played a significant role in providing health care and insurance to the poor before the introduction of Medicaid in 1965 and the New Deal Social Programs years earlier. These organizations "dominated the field of health insurance. They offered two basic varieties of protection: cash payments to compensate for income from working days lost and the care of a doctor. Some societies…founded tuberculosis sanitariums, specialist clinics, and hospitals." Beito continues, "A conservative estimate would be that one of three adult males was a member [of such organizations] in 1920, including a large segment of the working class." Moreover, these organizations "achieved a formidable presence among blacks and immigrant groups" (Cannon 2005).

Beito documents how government programs crowd out voluntary programs. An example of such a voluntary program was Mississippi's Knights and Daughters of Tabor. Writes Beito: "For twenty-five years before 1967, thousands of low-income blacks in the Mississippi Delta obtained affordable hospital care through fraternal societies. Although there were clear deficiencies, the quality was reasonably good, especially given the limited resources. Most importantly, the Taborian Hospital and the Friendship Clinic excelled in providing benefits to

patients that were not easily quantifiable, including personal attention, comfortable surroundings, and community pride. Both societies accomplished these feats with little outside help. The Knights and Daughters of Tabor and the United Order of Friendship of America forged extensive networks of mutual aid and self-help for thousands of low-income blacks" (Cannon 2005).

Federal programs introduced government-funded competition to these non-profits, and drove them out of operation. "In 1966 the federal Office of Economic Opportunity (OEO), the major front-line agency in the War on Poverty, entered the scene with subsidized health care," Beito writes. "The next year witnessed the end of fraternal hospitalization in the Delta." 'Since 90% of our membership is composed of people who are classified in the poverty category-they are eligible for free care at the Mound Bayou Community Hospital. Therefore, we are losing their membership in the order,' wrote the leaders of the Knights and Daughters of Tabor, 'This puts the Order in a declining position in membership and financial income.'" Beito continues: "The rapid inflow of federal money dampened the community's old habits of medical mutual aid and self-help. According to Dr. Louis Bernard of Meharry Medical College, 'The dollars available from the so-called antipoverty program ruined the International Order of the Knights and Daughters of Tabor'" (Cannon 2005).

Government-run charities and pre-paid health programs also crowd out for-profit insurance companies and discourage employers of low-income workers from providing coverage. Cannon (2005) summarizes research by the Robert Wood Johnson Foundation (Davidson 2004):

> Medicaid encourages employers of low-income workers not to offer coverage and encourages low-income workers not to enroll in private coverage. Researchers at the Robert Wood Johnson Foundation surveyed 22 leading studies on whether "free" government coverage crowds out private coverage and concluded that such crowd-out "seems inevitable." More than half of those studies found that expansions of public coverage were accompanied by reductions in private coverage. Some even found that enrollment growth in public programs was completely offset by reductions in private coverage.

Medicaid also crowds out long-term care. A National Bureau of Economic Research study by Jeffrey Brown and Amy Finkelstein found that "the provision of even incomplete public insurance can substantially crowd out private insurance demand. We examine the interaction of the public Medicaid program with the private market for long-term care insurance and estimate that Medicaid can explain the lack of private insurance purchases for at least two-thirds and as much as 90 percent of the wealth distribution, even if comprehensive, actuarially fair private policies were available" (Brown 2004).

D.4 Medicaid inhibits affordable health care (Criterion 4)

Further, Medicaid increases health care costs for those not enrolled. *The Puget Sound Business Journal* reports that "employers pay hundreds of dollars more for each employee because Medicaid and Medicare underpay hospitals and doctors. In 2004, according to the study, Washington employers together paid more than $1 billion in health care costs to cover government payment shortfalls incurred by hospitals and physicians. The study, by the actuarial firm Milliman Inc., concluded that nearly 9 percent of what employers pay in insurance premiums a year goes to subsidizing Medicaid and Medicare rather than to covering employee medical expenses" (Neurath 2006).

Medicaid also increases drug prices for those with private insurance. A study by the National Bureau of Economic Research (Duggan and Morton 2004) found that "a ten percentage-point increase in the MMS [Medicaid Market Share] is associated with a ten percent increase in the average price of a prescription. This result is robust to the inclusion of controls for a drug's therapeutic class, the existence of generic competition, the number of brand competitors, and the years since the drug entered the market. We also demonstrate that the Medicaid rules increase a firm's incentive to introduce new versions of a drug at higher prices and find empirical evidence in support of this for drugs that do not face generic competition. Taken together, our findings suggest that government procurement can have an important effect on equilibrium prices in the private sector."

D.5 Medicaid disempowers its recipients (Criterion 9)

Results of recent studies call into question whether Medicaid is functioning as a safety net or as competition to private insurance companies. For example, the *USA Today* reports that "many workers choose Medicaid over insurance offered by their employers because it is less expensive" (Cauchon 2005). The effect of a 1996 law limiting Medicaid eligibility for immigrants further illustrates how Medicaid discourages consumers from seeking private insurance. Economist George Borjas of Harvard writes that "as the Medicaid cutbacks took effect, the proportion of those immigrants covered by some type of health insurance should have declined." However, Borjas found that "the expected decline in health insurance coverage rates did not materialize. If anything, health insurance coverage rates actually rose slightly in this group."

Borjas explains that immigrants affected by the cutbacks "increased their labor supply, thereby raising their probability of being covered by employer-sponsored insurance. In fact, this increase in the probability of coverage through employer-sponsored insurance was large enough

to completely offset the Medicaid cutbacks. The empirical analysis, therefore, provides strong evidence of a sizable crowd-out effect of publicly provided health insurance among immigrants. In an important sense, the state programs were unnecessary. In the absence of these programs, the targeted immigrants themselves would have taken actions to reduce the probability that they would be left without health insurance coverage" (Cannon 2005).

Medicaid also introduces perverse incentives for long-term care. As Arnold Kling (2005) points out, "Medicaid's eligibility rules for long-term care reimbursement need to be restructured. As it stands today, two people who enjoy healthy working lives and make different choices concerning consumption and saving receive perverse rewards. The spendthrift obtains Medicaid coverage for a nursing home, and the saver must pay entirely out of pocket."

According the Colorado Senate Bill 06-208, one of the Commission's objectives is "personal health responsibility." As shown above, Medicaid keeps people in poverty and discourages such personal responsibility.

D.6 Medicaid encourages unhealthy behaviors (Criterion 10)

Borjas's findings illustrate one of the most pernicious effects of Medicaid: it makes recipients dependent on the state and hence lack the pride and self-esteem essential to psychological health.

Medicaid's means and asset-based eligibility criteria rewards behaviors that keep people poor, and discourages people from taking initiative to become self-sufficient through seeking better employment and saving money. Put simply, Medicaid recipients will not increase their income or assets in a way that will disqualify them from benefits, as doing so results in a net loss of income. Economist Aaron S. Yelowitz of UCLA showed this empirically in a study for the Employment Policies Institute, "Evaluating the Effects of Medicaid on Welfare and Work: Evidence from the Past Decade." Yelowitz's data shows that income-based Medicaid eligibility creates a "Medicaid notch" in income distribution, which illustrates the incentive for people to forgo increasing their own income because of the income provided by Medicaid. In some instances the income notch was so wide that Medicaid recipients would need to double their earnings to see a net increase in their income (Yelowitz 2000).

Asset eligibility also has negative consequences. According to the Colorado Consumer Health Initiative, "Colorado eligibility for low-income families is at the minimum level required by the federal government. Colorado is also one of six states to impose asset tests to determine children’s eligibility, rendering children in families with assets of more than $2500, including a

car worth up to $1500 in value, ineligible (pregnant women excluded)." Cannon (2005) summarizes the findings of Yelowitz and Jonathan Gruber of MIT: "Medicaid eligibility was associated with reduced asset holdings among non-elderly households. Rather than accumulate assets, recipients shifted income to consumption. Increased consumption does not jeopardize eligibility, but substituting consumption for asset accumulation...decreases the likelihood of escaping poverty. Yelowitz and Gruber estimate that in 1993 Medicaid reduced asset holdings among eligible households by the equivalent of $1,600 to $2,000 in today's dollars."

D.7 Does Medicaid improve access to and quality of health care? (Criteria 2, 6, 7)

The quality of any product or service depends largely on the number of competitors providing it, and how easy it is for consumers to change providers if their current provider does not satisfy them. Health care is no exception. In 2004, J.A. Sakowski *et al* reported in *The American Journal of Managed Care*, "The largest predictors of unwillingness to recommend a plan were dissatisfaction with choice of providers and preventive services coverage. ...Enrollee dissatisfaction with the choice of providers and preventive services coverage are major predictors of health plan dissatisfaction." In "Medicaid's Unseen Costs," Michael Cannon (2005) summarizes

> Medicaid patients often see their physician choices narrow even when payments to physicians rise. From 1998 to 2003 states increased physician payments by twice the rate of inflation. Yet Medicaid patients still saw their choice of providers drop. The share of doctors accepting all new Medicaid patients fell from 48.1 percent to 39.4 percent from 1999 to 2002. In contrast, far more doctors accepted all new private fee-for-service (FFS) and preferred provider organization (PPO) patients, Medicare patients, non-Medicaid health maintenance organization (HMO) patients, and uninsured, self-pay, and charity patients (see Figure 2). The share of doctors accepting no new Medicaid patients increased from 26.4 percent to 30.5 percent over the same period, yet far fewer doctors refused to see patients with the other types of coverage. As Oregon's Medicaid bureaucracy acknowledged in 2001, "Having coverage does not always guarantee access."...[A]dults who are eligible for Medicaid but have private coverage have fewer unmet medical needs than eligible adults who are enrolled in the program.

In some cases uninsured women had better access to health care than those on Medicaid. Salganicoff (2002) reports that more often than uninsured women, women on Medicaid attributed "difficulty getting care to lack of doctors or clinics" (14%) and could not see a new doctor because the doctor was not taking new patients (23%).

Doctors are not accepting new Medicaid patients because reimbursement costs are too low and paperwork is too high. John S. O'Shea, M.D (2007) summarizes:

> About one-fifth of physicians (21 percent) reported accepting no new Medicaid patients in 2004-05, a rate six times higher than for Medicare patients and five times higher than for privately insured patients. Low physician participation in Medicaid has been shown to reduce enrollees' access to medical care (Cunningham 2005). The most important reasons given by physicians for not accepting Medicaid patients are inadequate or delayed reimbursement and the growing burden of Medicaid administration and paperwork (Cunningham 2006).

Dr. O'Shea (2007) also reports that "Medicaid patients with NSTSE ACS [a form of heart attack] were less likely to receive evidence-based therapies and had worse outcomes (including increased mortality rates) than patients who had private insurance as the primary payer."

A study of more than 400 health clinics further shows that Medicaid enrollees are being short-changed: "Private insurance gives patients a far better chance of getting appointments within a week of treatment than does Medicaid or no insurance, according to the study of 430 clinics in nine U.S. cities. Most clinics inquired about patients' insurance status but not their conditions, the researchers found" (Tanner 2005)

D.8 Medicaid reform at the federal level

Despite largely increasing costs, states have little incentive to cut or limit Medicaid spending because they receive one dollar in matching funds for every dollar spent. Hence, any cut in Medicaid spending would be viewed a "costing Colorado money," even though the state would be spending fewer of our tax dollars. One way to remedy this disincentive to spend wisely would be for the federal government to replace matching funds with a block grant. Yet, since this is a change in federal policy, it is beyond the scope of the Commission's purpose.

Since Medicaid is not simply a state-level program, but a joint federal and state program, any reform is constrained to operate within federal rules. For example, the Aid for Families with Dependent Children was a federal means-based entitlement program that, like Medicaid, was accused of fostering dependency on government and discouraging enrollees from working. Welfare reform in 1996 replaced AFDC with Temporary Assistance for Needy Families (TANF), which removed the federal entitlement, included a time-limit on benefits and work requirements for recipients. It also block granted federal funding to states and gave states increased control over spending, eligibility, and benefits.

A study by economist June O'Neill, former director of the Congressional Budget Office, and Anne Hill, both Economics Professors at Baruch University, found that TANF "accounts for more than half of the decline in welfare participation and more than 60 percent of the rise in employment among single mothers....TANF accounts for 40 percent of the increase in work

participation among single mothers who are high school dropouts; 71 percent of the increase in work participation among 18-29 year old single mothers; and 83 percent of the increase in work participation among black single mothers" (O'Neill 2001).

D.9: Medicaid Long-Term Care Abuse

In *The Wall Street Journal*, Stephen Moses (2005), President of the Center for Long-Term Care Reform, writes:

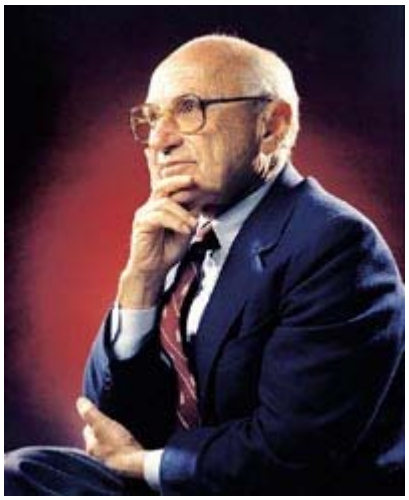
> According to the National Council on the Aging, 81% of America's 13.2 million householders aged 62 and over own their own homes, and 74% own their homes free and clear. Altogether, seniors possess nearly $2 trillion worth of home equity. Yet, by the time they apply for Medicaid, few own their homes. Are they giving the homes away to their grown-up children or other relatives? Such a transfer of assets carries no legal penalty as long as it is done at least three years and a day before applying for Medicaid.
>
> That's just one of hundreds of eligibility "loopholes" that allow individuals, especially those advised by Medicaid planning attorneys, to qualify for Medicaid long-term care benefits without spending down their own wealth for care. If you doubt this, try an Internet search for "Medicaid planning" and read some of the sales pitches on the more than six million hits. You'll learn how to purchase non-countable assets, buy and give away a string of luxury cars without penalty, hide wealth in exempt annuities, sell your ailing parent a "life-care contract," even buy a farm or business -- all for the express purpose of "impoverishing" yourself or a loved one artificially and qualifying for Medicaid long-term care benefits.

Appendix E

How to Cure Health Care [6]

By Milton Friedman

The United States spends a mind-boggling percentage of its GDP on a health care system that virtually everyone agrees is a disaster. Is there any way out of this mess? There is—and Hoover fellow ***Milton Friedman*** *has found it.*



Since the end of World War II, the provision of medical care in the United States and other advanced countries has displayed three major features: first, rapid advances in the science of medicine; second, large increases in spending, both in terms of inflation-adjusted dollars per person and the fraction of national income spent on medical care; and third, rising dissatisfaction with the delivery of medical care, on the part of both consumers of medical care and physicians and other suppliers of medical care.

Rapid technological advances have occurred repeatedly since the Industrial Revolution—in agriculture, steam engines, railroads, telephones, electricity, automobiles, radio, television, and, most recently, computers and telecommunication. The other two features seem unique to medicine. It is true that spending initially increased after non-medical technical advances, but the fraction of national income spent did not increase dramatically after the initial phase of widespread acceptance. On the contrary, technological development *lowered* cost, so that the fraction of national income spent on food, transportation, communication, and much more has gone down, releasing resources to produce new products or services. Similarly, there seems no counterpart in these other areas to the rising dissatisfaction with the delivery of medical care.

International Comparison

These developments in medicine have been worldwide. By their very nature, scientific advances know no geographic boundaries. Data on spending are readily available for 29 Organization for Economic Cooperation and Development (OECD) countries. In every one, medical spending has gone up significantly both in inflation-adjusted dollars per person and as a fraction of national income. In 1997, the United States spent 14 percent of gross domestic product on medical care, the highest of any OECD country. Germany was a distant second at 11 percent; Turkey was the lowest at 4 percent.

A key difference between medical care and the other technological revolutions is the role of government. In other technological revolutions, the initiative, financing, production, and distribution were primarily private, though government sometimes played a supporting or

[6] This version of "How to Cure Health Care" was originally published in Hoover Digest, 2001, No. 3 by the Hoover Institution, and has been reprinted its permission.

regulatory role. In medical care, government has come to play a leading role in financing, producing, and delivering medical service. Direct government spending on health care exceeds 75 percent of total health spending for 15 OECD countries. The United States is next to the lowest of the 29 countries, at 46 percent. In addition, some governments indirectly subsidize medical care through favorable tax treatment. For the United States, such subsidization raises the fraction of health spending financed directly or indirectly by government to more than 50 percent.

What are countries getting for the money they are spending on medical care? What is the relation between input and output? Spending on medical care provides a reasonably good measure of input, but, unfortunately, there is no remotely satisfactory objective measure of output.

Ultimately, the purpose of this article is to examine the situation in the United States. I have mentioned the data on the OECD countries primarily to document the two (related?) respects in which the United States is exceptional: we spend a higher percentage of national income on medical care (and more per capita) than any other OECD country, and our government finances a smaller fraction of that spending than all countries except Korea.

Why Third-Party Payment?

Two simple observations are key to explaining both the high level of spending on medical care and the dissatisfaction with that spending. The first is that most payments to physicians or hospitals or other caregivers for medical care are made not by the patient but by a third party—an insurance company or employer or governmental body. The second is that nobody spends somebody else's money as wisely or as frugally as he spends his own. These statements apply equally to other OECD countries. They do not by themselves explain why the United States spends so much more than other countries.

No third party is involved when we shop at a supermarket. We pay the supermarket clerk directly: the same for gasoline for our car, clothes for our back, and so on down the line. Why, by contrast, are most medical payments made by third parties? The answer for the United States begins with the fact that medical care expenditures are exempt from the income tax if, and only if, medical care is provided by the employer. If an employee pays directly for medical care, the expenditure comes out of the employee's after-tax income. If the employer pays for the employee's medical care, the expenditure is treated as a tax-deductible expense for the employer and is not included as part of the employee's income subject to income tax. That strong incentive explains why most consumers get their medical care through their employers or their spouses' or their parents' employer. In the next place, the enactment of Medicare and Medicaid in 1965 made the government a third-party payer for persons and medical care covered by those measures.

> We are headed toward completely socialized medicine—and, if we take indirect tax subsidies into account, we're already halfway there.

We have become so accustomed to employer-provided medical care that we regard it as part of the natural order. Yet it is thoroughly illogical. Why single out medical care? Food is more essential to life than medical care. Why not exempt the cost of food from taxes if provided by the employer? Why not return to the much-reviled company store when workers were in effect paid in kind rather than in cash?

The revival of the company store for medicine has less to do with logic than pure chance. It is a wonderful example of how one bad government policy leads to another. During World War II, the government financed much wartime spending by printing money while, at the same time, imposing wage and price controls. The resulting repressed inflation produced shortages of many goods and services, including labor. Firms competing to acquire labor at government-controlled wages started to offer medical care as a fringe benefit. That benefit proved particularly attractive to workers and spread rapidly.

Initially, employers did not report the value of the fringe benefit to the Internal Revenue Service as part of their workers' wages. It took some time before the IRS realized what was going on. When it did, it issued regulations requiring employers to include the value of medical care as part of reported employees' wages. By this time, workers had become accustomed to the tax exemption of that particular fringe benefit and made a big fuss. Congress responded by legislating that medical care provided by employers should be tax-exempt.

Effect of Third-Party Payment on Medical Costs

The tax exemption of employer-provided medical care has two different effects, both of which raise health costs. First, it leads employees to rely on their employer, rather than themselves, to make arrangements for medical care. Yet employees are likely to do a better job of monitoring medical care providers—because it is in their own interest—than is the employer or the insurance company or companies designated by the employer. Second, it leads employees to take a larger fraction of their total remuneration in the form of medical care than they would if spending on medical care had the same tax status as other expenditures.

If the tax exemption were removed, employees could bargain with their employers for higher take-home pay in lieu of medical care and provide for their own medical care either by dealing directly with medical care providers or by purchasing medical insurance. Removal of the tax exemption would enable governments to reduce the tax rate on income while raising the same total revenue. This hidden subsidy for medical care, currently more than $100 billion a year, is not included in reported figures on government health spending.

Extending the tax exemption to all medical care—as in the current limited provision for medical savings accounts and the proposals to make such accounts more widely available—would reduce reliance on third-party payment. But, by extending the hidden subsidy to all medical care expenditures, it would increase the tendency of employees to take a larger portion of their remuneration in the form of medical care. (I discuss medical savings accounts more fully in the conclusion.)

Expressed as a fraction of national income, Americans spent a mind-boggling 17 percent of the national income on medical care in 1997. No other country in the world approaches that level of spending as a fraction of national income, no matter how its medical care is organized.

Enactment of Medicare and Medicaid provided a direct subsidy for medical care. The cost grew much more rapidly than originally estimated—as the cost of any handout invariably does. Legislation cannot repeal the nonlegislated law of demand and supply: the lower the price, the greater the quantity demanded; at a zero price, the quantity demanded becomes infinite. Some method of rationing must be substituted for price, which invariably means administrative rationing.

A look at the data is instructive. The effect of tax exemption and the enactment of Medicare and Medicaid on rising medical costs from 1946 to now is clear. According to my estimates, the two together accounted for nearly 60 percent of the total increase in cost. Tax exemption alone accounted for one-third of the increase in cost; Medicare and Medicaid, one-quarter.

Now consider a different breakdown of the cost of medical care: between the part paid directly by the government and the part paid privately. Government's share went from an eighth of the total in 1919 to a quarter in 1965 to nearly half in 1997. The rise in the government's share has been accompanied by centralization of spending—away from state and local governments to the federal government. We are headed toward completely socialized medicine and are already halfway there, if, in addition to direct costs, we include indirect tax subsidies.

Expressed as a fraction of national income, spending on medical care went from 3 percent of the national income in 1919 to 4.5 percent in 1946 to 7 percent in 1965 to a mind-boggling 17 percent in 1997. No other country in the world approaches that level of spending as a fraction of national income no matter how its medical care is organized. The changing role of medical care in the U.S. economy is truly breathtaking. To illustrate, in 1946, seven times as much was spent on food, beverages, and tobacco as on medical care; in 1996, 50 years later, more was spent on medical care than on food, beverages, and tobacco.

The Changing Meaning of Insurance

Employer financing of medical care has caused the term *insurance* to acquire a rather different meaning in medicine than in most other contexts. We generally rely on insurance to protect us against events that are highly unlikely to occur but that involve large losses if they do occur—major catastrophes, not minor, regularly recurring expenses. We insure our houses against loss from fire, not against the cost of having to cut the lawn. We insure our cars against liability to others or major damage, not against having to pay for gasoline. Yet in medicine, it has become common to rely on insurance to pay for regular medical examinations and often for prescriptions.

This is partly a question of the size of the deductible and the copayment, but it goes beyond that. "Without medical insurance" and "without access to medical care" have come to be treated as nearly synonymous. Moreover, the states and the federal government have increasingly specified the coverage of insurance for medical care to a detail not common in other areas. The effect has been to raise the cost of insurance and to limit the options open to individuals. Many, if not most, of the "medically uninsured" are persons who for one reason or another do not have access to employer-provided medical care and are unable or unwilling to pay the cost of the only kinds of insurance contracts available to them.

If the tax exemption for employer-provided medical care and Medicare and Medicaid had never been enacted, the insurance market for medical care would probably have developed as other insurance markets have. The typical form of medical insurance would have been catastrophic insurance (i.e., insurance with a very high deductible).

The Black Hole of Bureaucratization

Third-party payment has required the bureaucratization of medical care and, in the process, has changed the character of the relation between physicians (or other caregivers) and patients. A medical transaction is not simply between a caregiver and a patient; it has to be approved as "covered" by a bureaucrat and the appropriate payment authorized. The patient—the recipient of the medical care—has little or no incentive to be concerned about the cost since it's somebody else's money. The caregiver has become, in effect, an employee of the insurance company or, in

the case of Medicare and Medicaid, of the government. The patient is no longer the one, and the only one, the caregiver has to serve. An inescapable result is that the interest of the patient is often in direct conflict with the interest of the caregiver's ultimate employer. That has been manifest in public dissatisfaction with the increasingly impersonal character of medical care.

Some years ago, the British physician Max Gammon, after an extensive study of the British system of socialized medicine, formulated what he called "the theory of bureaucratic displacement." He observed that in "a bureaucratic system . . . *increase in expenditure* will be matched by *fall in production.* . . . Such systems will act rather like 'black holes,' in the economic universe, simultaneously sucking in resources, and shrinking in terms of 'emitted production.'" Gammon's observations for the British system have their exact parallel in the partly socialized U.S. medical system. Here, too, input has been going up sharply relative to output. This tendency can be documented particularly clearly for hospitals, thanks to the availability of high-quality data for a long period.

The data document a drastic decline in output over the past half century. From 1946 to 1996, the number of beds per 1,000 population fell by more than 60 percent; the fraction of beds occupied, by more than 20 percent. In sharp contrast, *input skyrocketed.* Hospital personnel per occupied bed multiplied ninefold, and cost per patient day, adjusted for inflation, an astounding fortyfold, from $30 in 1946 to $1,200 in 1996. A major engine of these changes was the enactment of Medicare and Medicaid in 1965. A mild rise in input was turned into a meteoric rise; a mild fall in output, into a rapid decline. Hospital days per person per year were cut by two-thirds, from three days in 1946 to an average of less than a day by 1996.

Taken by itself, the decline in hospital days is evidence of progress in medical science. A healthy population needs less hospitalization, and advances in science and medical technology have reduced the length of hospital stays and increased outpatient surgery. Progress in medical science may well explain most of the decline in output; it does not explain much, if any, of the rise in input per unit of output. True, medical machines have become more complex. However, in other areas where there has been great technical progress—whether it be agriculture or telephones or steel or automobiles or aviation or, most recently, computers and the Internet—progress has led to a reduction, not an increase, in cost per unit of output. Why is medicine an exception? Gammon's law, not medical miracles, was clearly at work. The provision of medical care as an untaxed fringe benefit by employers, and then the federal government's assumption of responsibility for hospital and medical care of the elderly and the poor, provided a fresh pool of money. And there was no shortage of takers. Growing costs, in turn, led to more regulation of hospitals and medical care, further increasing administrative costs and leading to the bureaucratization that is so prominent a feature of medical care today.

So much for input. What about output? What have we gotten in return for quadrupling the share of the nation's income spent on medical care?

I have already referred to one component of output—days of hospital care per person per year. That has gone down from three days in 1946 to less than one in 1996. Insofar as the reduction reflects the improvements in medicine, it clearly is a good thing. However, it also reflects the pressure to keep hospital stays short in order to keep down cost. That this is not a good thing is clear from protests by patients, widespread enough to have led Congress to mandate minimum stays for some medical procedures.

The output of the medical care industry that we are interested in is its contribution to better health. How can we measure better health in a reasonably objective way that is not greatly influenced by other factors?

The least bad measure that I have been able to come up with is length of life, though that too is seriously contaminated by other factors—improvements in diet, housing, clothing, and so on generated by greater affluence, better garbage collection and disposal, the provision of purer water, and other governmental public health measures.

Expected longevity went from 47 years in 1900 to 68 years in 1950, a truly remarkable rise. From 1950 on, expected longevity continued to increase but at a much slower rate, reaching 76 years in 1997. For our purposes, it is of fundamental importance that, whatever its source, *the increase in longevity did not have any systematic relation to spending on medical care as a fraction of income.*

On the evidence to date, it is hard to see that we have gotten much for quadrupling the share of the nation's income spent on medical care other than bureaucratization and widespread dissatisfaction with the economic organization of medical care.

The United States versus Other Countries

Our steady movement toward reliance on third-party payment no doubt explains the extraordinary rise in spending on medical care in the United States. However, other advanced countries also rely on third-party payment, many or most of them to an even greater extent than we do. What explains our higher level of spending?

I must confess that despite much thought and scouring of the literature, I have no satisfactory answer. One clue is my estimate that if the pre–World War II system had continued—that is, if tax exemption and Medicare and Medicaid had never been enacted—expenditures on medical care would have amounted to less than half the current level, which would have put us near the bottom of the OECD list rather than at the top.

In terms of holding down cost, one-payer directly administered government systems, such as exist in Canada and Great Britain, have a real advantage over our mixed system. As the direct purchaser of all or nearly all medical services, they are in a monopoly position in hiring physicians and can hold down their remuneration, so that physicians earn much less in those countries than in the United States. In addition, they can ration care more directly—at the cost of long waiting lists and much dissatisfaction.

In addition, once the whole population is covered, there is little political incentive to increase spending on medical care. Once the bulk of costs have been taken over by government, as they have in most of the other OECD countries, the politician does not have the carrot of increased services with which to attract new voters, so attention turns to holding down costs.

An additional factor is the tax treatment of private expenditures on medical care. In most countries, any private expenditure comes out of after-tax income. It does in the United States also, unless the medical care is provided by the employer. For this reason, the bulk of medical care is provided through employers, and private expenditures on medical care are decidedly higher than they would be if medical care, like food, clothing, and other consumer goods, had to be financed out of post-tax income. It is consistent with this view that Germany, the country second to the United States in the fraction of income spent on medical care, has a system in which the employer plays a central role in the provision of medical care and in which, so far as I

have been able to determine, half of the cost comes out of pretax income and half out of post-tax income.

Our mixed system has many advantages in accessibility and quality of medical care, but it has produced a higher level of cost than would result from either wholly individual choice or wholly collective choice.

Conclusion: Medical Savings Accounts and Beyond

The high cost and inequitable character of our medical care system are the direct result of our steady movement toward reliance on third-party payment. A cure requires reversing course, reprivatizing medical care by eliminating most third-party payment, and restoring the role of insurance to providing protection against major medical catastrophes.

The ideal way to do that would be to reverse past actions: repeal the tax exemption of employer-provided medical care; terminate Medicare and Medicaid; deregulate most insurance; and restrict the role of the government, preferably state and local rather than federal, to financing care for the hard cases. However, the vested interests that have grown up around the existing system, and the tyranny of the status quo, clearly make that solution not feasible politically. Yet it is worth stating the ideal as a guide to judging whether proposed incremental changes are in the right direction.

Most changes made in the final decade of the twentieth century were in the wrong direction. Despite rejection of the sweeping socialization of medicine proposed by Hillary Clinton, subsequent incremental changes have expanded the role of government, increased regulation of medical practice, and further constrained the terms of medical insurance, thereby raising its cost and increasing the fraction of individuals who choose or are forced to go without insurance.

There is one exception, which, though minor in current scope, is pregnant of future possibilities. The Kassebaum-Kennedy Bill, passed in 1996 after lengthy and acrimonious debate, included a narrowly limited four-year pilot program authorizing medical savings accounts. A medical savings account enables individuals to deposit tax-free funds in an account usable only for medical expense, provided they have a high-deductible insurance policy that limits the maximum out-of-pocket expense. As noted earlier, it eliminates third-party payment except for major medical expenses and is thus a movement very much in the right direction. By extending tax exemption to all medical expenses whether paid by the employer or not, it eliminates the present bias in favor of employer-provided medical care. That too is a move in the right direction. However, the extension of tax exemption increases the bias in favor of medical care compared to other household expenditures. This effect would tend to increase the implicit government subsidy for medical care, which would be a step in the wrong direction.

Before this pilot project, a number of large companies (e.g., Quaker Oats, Forbes, Golden Rule Insurance Company) had offered their employees the choice of a medical savings account instead of the usual low-deductible employer-provided insurance policy. In each case, the employer purchased a high-deductible major medical insurance policy for the employee and deposited a stated sum, generally about half of the deductible, in a medical savings account for the employee. That sum could be used by the employee for medical care. Any part not used during the year was the property of the employee and had to be included in taxable income. Despite the loss of the tax exemption, this alternative has generally been very popular with both employers and employees. It has reduced costs for the employer and empowered the employee, eliminating much third-party payment.

Medical savings accounts offer one way to resolve the growing financial and administrative problems of Medicare and Medicaid. It seems clear from private experience that a program along these lines would be less expensive and bureaucratic than the current system and more satisfactory to the participants. In effect, it would be a way to voucherize Medicare and Medicaid. It would enable participants to spend their own money on themselves for routine medical care and medical problems, rather than having to go through HMOs and insurance companies, while at the same time providing protection against medical catastrophes.

A more radical reform would, first, end both Medicare and Medicaid, at least for new entrants, and replace them by providing every family in the United States with catastrophic insurance (i.e., a major medical policy with a high deductible). Second, it would end tax exemption of employer-provided medical care. And, third, it would remove the restrictive regulations that are now imposed on medical insurance—hard to justify with universal catastrophic insurance.

This reform would solve the problem of the currently medically uninsured, eliminate most of the bureaucratic structure, free medical practitioners from an increasingly heavy burden of paperwork and regulation, and lead many employers and employees to convert employer-provided medical care into a higher cash wage. The taxpayer would save money because total government costs would plummet. The family would be relieved of one of its major concerns—the possibility of being impoverished by a major medical catastrophe—and most could readily finance the remaining medical costs. Families would once again have an incentive to monitor the providers of medical care and to establish the kind of personal relations with them that were once customary. The demonstrated efficiency of private enterprise would have a chance to improve the quality and lower the cost of medical care. The first question asked of a patient entering a hospital might once again become "What's wrong?" not "What's your insurance?"

A longer version of this essay appeared in Public Interest, winter 2001. Available from the Hoover Press is To America's Health: A Proposal to Reform the Food and Drug Administration, by Henry I. Miller. Also available is *The Essence of Friedman*, edited by Kurt R. Leube. To order, call 800-935-2882.

Milton Friedman, recipient of the 1976 Nobel Memorial Prize for economic science, was a senior research fellow at the Hoover Institution from 1977 to 2006. He passed away on Nov. 16, 2006. He was also the Paul Snowden Russell Distinguished Service Professor Emeritus of Economics at the University of Chicago, where he taught from 1946 to 1976, and a member of the research staff of the National Bureau of Economic Research from 1937 to 1981.

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