

Answers to Commissioner Questions Regarding FAIR Health Care
Free-markets, Affordability, and Individual Rights

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The answers to Commission questions refer to specific reforms in the [proposal](#). For completeness of this document, their definitions and acronyms are reproduced below:

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.

According to the Council for Affordable Health Insurance, Colorado currently has 37 mandated benefits. For the list, see their "[Trends in State Mandated Benefits, 2006](http://www.cahi.org/cahi_contents/resources/pdf/TrendsEndsMay2006.pdf)," on-line at http://www.cahi.org/cahi_contents/resources/pdf/TrendsEndsMay2006.pdf.

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)

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

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.

(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 qualify 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.

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

1. Please describe how this program promotes efficiency and addresses the problems of the under insured.

My proposal addresses efficiency in Section (i), starting on page 25, and answers the following:

1. Does your proposal decrease or contain health care costs?
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?
3. Does this proposal address transparency of costs and quality? If so, please explain.
4. How would your proposal impact administrative costs?

To summarize; benefits mandates, guaranteed issue for the "business group of one," the lack of cost-sharing in Medicaid, Medicaid long-term care abuse, and Medicaid's status as a monopoly charity all increase the costs of health care. My proposals address these issues and will decrease costs of health insurance and health care. The decreased costs will make health insurance more affordable to the under insured. I will further address how my proposal specifically promotes efficiency in the following sections on Benefits Mandates Reform (BMR), Small Group Reform (SGR), and Medicaid reform.

Benefits Mandates Reform (BMR)

Mandated benefits increase the cost of insurance from between 20 to 50%, and have been shown to be responsible for 20% to 25% of the uninsured. Current mandates prohibit insurance companies from selling low-cost plans, which hence discourages them to minimize costs. Mandates force consumers to purchase more expensive policies than they would freely choose – this increases premium costs.

Mandated benefits also distort the insurance market toward prepaid health care plans, which discourage consumers from being frugal and thoughtful consumers because someone else is paying the bill. Without benefits mandates, consumers will be more likely to purchase less comprehensive plans and use the cost-savings to self-insure, perhaps with a tax deductible Health Savings Account. As the [RAND Health Insurance Experiment](#) shows, cost-sharing increases transparency of costs hence significantly reduces consumer spending at negligible impact on their health.

In a large-scale, multiyear experiment, participants who paid for a share of their health care used fewer health services than a comparison group given free care.

- Cost sharing reduced the use of both highly effective and less effective services in roughly equal proportions. Cost sharing did not significantly affect the quality of care received by participants.
- Cost sharing in general had no adverse effects on participant health, but there were exceptions [just 4 out of 30 conditions]: free care led to improvements in hypertension, dental health [seeing a dentist], vision ["marginal"], and selected serious symptoms. These improvements were concentrated among the sickest and poorest patients.
- Cost sharing also had some beneficial effects. Participants in cost sharing plans (higher deductible) worried less about their health and had fewer restricted-activity days (including time spent in seeking medical care).
(source: http://www.rand.org/pubs/research_briefs/RB9174/index1.html)

Small Group Reform (SGR)

Guaranteed issue for the "business group of one" creates a moral hazard by allowing qualified individuals to wait until they are sick to purchase insurance. This increases costs by keeping healthy individuals out of the risk pool.

Medicaid Reform:

Excerpt from Appendix D of the FAIR proposal:

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."

References:

Neurath, Peter, "Study: Medicare, Medicaid payments drive up employee insurance costs," *Puget Sound Business Journal*, <http://tinyurl.com/2vzvzr>, May 31, 2006

Duggan, Mark, and Fiona Scott Morton, "The Distortionary Effects of Government Procurement: Evidence from Medicaid Prescription Drug Purchasing," NBER Working Paper no. 10930, <http://www.nber.org/papers/10930>, November 2004.

Increasing cost-sharing for Medicaid enrollees can mitigate how Medicaid increases health care costs. Parts of my proposal that increase cost sharing include:

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

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, <http://www.ncpa.org/pub/st/st288>). 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.

(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.

Medicaid's fee-for-service plan is effectively prepaid health care, which encourages thoughtless over-consumption and increases costs of private insurance plans. The FAIR proposal suggests that Colorado emulate South Carolina and Florida by converting Medicaid to a voucher-based program for private insurance with Health Opportunity Accounts that enrollees can use for out-of-pocket health care expenditures. As I mentioned above, cost-sharing increases efficiency by reducing expenditures with negligible effect on health outcomes.

Converting Medicaid to a voucher-based program for private insurance can reduce the number of frequent emergency room users. Empirical studies have shown cost-sharing to reduce emergency room use. In *Covering America: Real Remedies for the Uninsured*, Tom Miller notes that "that increased cost sharing could discourage patients from inappropriately using hospitals' emergency departments" Miller sites a study in the *New England Journal of Medicine* (O'Grady, Manning, Newhouse, and Brook. "The Impact of Cost Sharing on Emergency Department Use."

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August 22, 1985, p 484–90) finding that a "25-percent level of cost sharing deterred emergency department utilization for less serious conditions but did not deter utilization for more serious conditions." A more recent study in the same journal (Selby, Fireman, and Swain. "Effect of Copayments on Use of the Emergency Department in a Health Maintenance Organization," March 7, 1996) concluded that "a small co-payment resulted in a 15 percent reduction in emergency department utilization but did not affect conditions classified as 'always an emergency'." (source: <http://www.cato.org/research/articles/miller-coveringamerica.pdf>)

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 satisfies enrollees and contains costs. 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 (*Wall Street Journal*, 2005) reports that,

CDAS, our state's experiment with Consumer-Directed Attendant Support for the severely disabled, got started in 2002. The wheelchair-bound Linda Storey was one of its first four clients. The program now has 146 participants, each newly empowered to hire and fire their own caregivers. Quality of care and patient satisfaction are up, costs are down, and legislators approved offering the option for 33,000 Medicaid recipients statewide in 2006.

If there is more alleluia and less blues in the Storeys' music these days, CDAS is a big reason. "It gives you your life back," Mrs. Storey told me. "I'm in control of my health now." Under a federal waiver obtained by Colorado officials, she selects the health aides who come to her house, bypassing the provider agencies otherwise required under Medicaid rules for home- and community-based services.

...[W]ith 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."

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

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.

Extending the look back period can discourage such abuse and reduce Medicaid costs because, as I wrote in Appendix D of the FAIR proposal,

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" (<http://www.nber.org/papers/w10989>).

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

John Goodman and his colleagues at the National Center for Policy analysis explain how this measure can reduce costs and better serve Medicaid enrollees"

Medicaid encourages institutional care over home care. Although many state programs are changing, they could increase their use of less-expensive home care.[1] Home care often costs only half as much as a nursing home. [2] In some high-cost areas, the cost savings from home care may be even greater. For instance, home care in Washington, D.C., costs less than one-third as much as nursing home care. In Manhattan, a year of home care costs only about one-fifth as much as a year-long stay in a nursing home. [2] Home providers offer a range of medical services, including occupational or physical therapy.

Ohio, Oregon, Washington and Wisconsin expanded home- and community-based care to help control rapidly increasing institutional care expenditures. These states were able to serve more people while

controlling the growth in overall long-term care spending. Between 1982 and 1992 the combined total of nursing home beds in the three states declined 1.3 percent, while total nursing facility beds nationwide increased 20.5 percent. [3]

Ohio's Commission to Reform Medicaid has proposed rewarding families who choose lower-cost options that save the state money, such as care in the home or community. This would allow an elderly parent living with family members to receive a few hours of home or personal care per week that could delay their entry into a nursing home. The financial incentive could be to exclude some assets from eligibility tests or shield them from cost recovery. [4]

Sources

"Opportunities for State Medicaid Reform," <http://www.ncpa.org/pub/st/st288/st288i.html>

- [1] Enid Kassner, "Medicaid and Long-Term Services and Supports for Older People Fact Sheet," AARP Public Policy Institute, http://assets.aarp.org/rgcenter/il/fs90r_hcbltc.pdf, February 2005.
- [2] For a pamphlet comparing the annual cost of home care and nursing home care across the country, see "Can You Afford the Cost of Long-Term Care?" U.S. Office of Personnel Management. Available at <http://arc.publicdebt.treas.gov/files/pdf/fscombined.pdf>. Access verified June 19, 2006.
- [3] "Medicaid Long-Term Care: Successful State Efforts to Expand Home Services While Limiting Costs," U.S. Government Accountability Office, Report No. 152298, <http://archive.gao.gov/t2pbat2/152298.pdf>, August 1994.
- [4] Ohio Commission to Reform Medicaid, "Transforming Ohio Medicaid: Improving Health Quality and Value," State of Ohio, January 2005.

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

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.

2. Over 50% of health care in Colorado is now provided through a “free market” model. Why are so many Coloradoans uninsured and unable to afford coverage?

This question reflects two important distinctions that need to be made before productive discourse on health care policy may take place. The first distinction is the difference between the provision of "health care" and the provision of "health insurance." The second distinction is between types of markets: markets for goods and services can have varying degrees of freedom determined by the amount of legislation that prohibits voluntary exchanges between buyers and sellers.

Distinction I: Health care vs. Health Insurance

The 50% figure mentioned in the question prompted me to look up some figures about health insurance and the uninsured. According to the Kaiser Family Foundation, [Colorado's Distribution of Insurance Status](#) is as follows:

Medicaid: 9.5% Medicare: 8.5%
Employer: 58.6% Individual: 7.1% Uninsured: 16.4%

(source: <http://www.kff.org/mfs/medicaid.jsp?r1=CO&r2=US>)

In 2002, the US Census Bureau noted that "Spells without health insurance, measured on a monthly basis, tend to be short in duration -- about three-quarters (74.7 percent) were over within one year." <http://www.census.gov/hhes/www/hlthins/hlthin02/hlth02asc.html>. In 2003 the Congressional Budget Office issued a report, available on-line, "[How many people lack health insurance and for how long?](#)" According to this report, 45% of spells without insurance end within four months, 26% are between five and twelve months, 13% endure between thirteen months and two years, and only 16% last more than two years.

Also noteworthy is that a recent study concluded that a significant percentage of the uninsured can in fact afford insurance. In "Is Health Insurance Affordable for the Uninsured," a 2002 paper for the National Bureau of Economic Research, the authors find that "depending on the definition, health insurance was affordable to between one-quarter and three-quarters of the uninsured in 2000." (<http://www.nber.org/papers/W9281>) In "The Uninsured and the Affordability of Health Insurance Coverage," a 2007 article in the peer-reviewed journal *Health Affairs*, the authors found that "twenty-five percent of uninsured Americans are eligible for public coverage" and that "20 percent can afford coverage."

In Appendix D of my proposal (p. 39), I show that in the case of Medicaid, having this type of health *insurance* does not guarantee that enrollees receive adequate health *care*. Here is a relevant excerpt:

* * *

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).

* * *

Having health insurance does not guarantee access to medical care in other countries as well. Consider this excerpt from Appendix A (p. 36) of the FAIR proposal:

* * *

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."

* * *

Distinction II: the not-so-free market in health care.

While there is a *market* for health care and health insurance, it is certainly not a "free market." That is, government legislation significantly sets rules concerning who can legally provide medical services or insurance, and what kind of products and services can be legally sold. Also, the examples of crowd-out below show Medicaid operates as a competitor to private health insurance -- and an unfair one because it is funded through compulsory taxes rather than voluntary donations or purchases.

For example, in his article, "Health Care Regulation: A \$169 Billion Hidden Tax," Chris Conover of Duke University's Center for Health Policy, Law and Management writes that " that health services regulation imposes an annual cost of \$256 billion per year (with a range of \$28

billion to \$657 billion), suggesting that health services regulations could increase estimates of overall regulatory costs by more than 25 percent.... The high cost of health services regulation is responsible for more than seven million Americans lacking health insurance, or one in six of the average daily uninsured."

The following examples show how Colorado and the United States lacks a free-market in health care:

[1] Consider again the section of my proposal (p. 14) that I quoted in section 1:

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*).

References:

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

http://www.cahi.org/cahi_contents/resources/pdf/MandatesInTheStates2007.pdf, 2007.

Conover, Christopher J., "Health Care Regulation: A \$169 Billion Hidden Tax," Policy Analysis, No. 527, The Cato Institute, <http://www.cato.org/pubs/pas/pa527.pdf>, October 4, 2004.

Jenson, Gail A., and Michael A. Morrissey, "Mandated Benefit Laws and Employer-Sponsored Health Insurance," Health Insurance Association of America, <http://membership.hiaa.org/pdfs/jensenrpt.pdf>, 1999.

Turner, Grace-Marie and Melinda L. Schriver, "Uninsured Rates Rise Dramatically in States With Strictest Health Insurance Regulations," Galen Institute, <http://www.galen.org/statehealth.asp?docID=179>, 1998.

[2] The tax-exempt status of employer-provided insurance reduces competition and has converted true insurance into pre-paid health care. Insulated from costs, patients over-consume and drive up prices - while costs of uninsured procedures such as cosmetic surgery and

corrective eye surgery have decreases compared to the Consumer Price Index. (Google “NCPA - Brief Analysis 437, Why Are Health Costs Rising?” and “Insulation vs. Insurance”)

[3] Nearly 9 percent of what employers pay in annual insurance premiums subsidizes Medicaid and Medicare instead of covering employee medical expenses. (Google “Medicare, Medicaid payments drive up employee insurance costs”).

[4] Medicaid crowds out the free-market: (from page 41 of the FAIR proposal)

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).

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."

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 societies, and lodges that provided communities with a true safety net. It is time to reverse this injustice.

[5] Medicaid increases costs for those not enrolled (from FAIR proposal, p. 42)

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."

[6] Amy Finkelstein of the National Bureau of Economic Research found that "Medicare was associated with a 23 percent increase in total hospital expenditures (for all ages) between 1965 and 1970, with even larger effects if her analysis is extended through 1975" (Google "Medicare and Its Impact").

3. "This proposal requires a much higher educational level regarding managing one's health care coverage than the vast majority of people possess. How would a transition be managed to make this sort of system feasible or practical?"

I thought this question pertained to Medicaid vouchers for private insurance & Health Opportunity Accounts (HOAs). My proposal cited Medicaid's Cash and Counseling programs, South Carolina's Medicaid counseling program, and Colorado's Consumer-Directed Attendant Support (CDAS) as examples of how to smoothly transition from a program that discourages consumers from being knowledgeable to a consumer-driven system that promotes and fosters wise health care choices.

Converting Medicaid to a voucher-based program for private insurance and, if applicable, Health Savings Accounts, may be phased in as an option for Medicaid recipients. That is, the new program would not be a mandatory assignment. For details, see Tom Miller, "Medicaid Opt-Out for Other Private Insurance Coverage" in *Covering America: Real Remedies for the Uninsured*, p. 55. (<http://www.cato.org/research/articles/miller-coveringamerica.pdf>)

However, the Commissioner who asked the question elaborated: "No - my observation wasn't specifically tied to Medicaid. The proposal requires a great deal more understanding of personal health matters than is possessed by the general public. In order for the public to handle health care coverage that requires more financial involvement and personal responsibility they will need a much higher degree of understanding. If the public was just thrown into the structure described in the proposal, there would be chaos. As a practical matter, how to we get there from here."

The Commissioner's concern is true to the extent that people currently lack choice and responsibility in providing for their own health care, which includes self-insuring, purchasing insurance, and making wise life-style choices. I am happy to see this question, as Section 2 of [Senate Bill 06-208](#) identifies as one of the Commission's "personal health responsibility" as one of its "goals and objectives." (see <http://tinyurl.com/yxlhb2>)

A segment of Colorado's population that clearly lacks the understanding of personal health matters required to taking responsibility for their own health care: children. Generally speaking, their parents choose their insurance plan and doctors, and schedule appointments. They also provide food, shelter, and clothing. As the children mature to adolescents and adults, parents (we hope) gradually shift these responsibilities to their children so they too can become

self-responsible adults.

Yet, we all have met "adults" whose parents could not let go. For example, the college student whose mother still helps her with homework, pays all of her bills and manages her finances. Or the 30-something bachelor whose mother brings over dinner and does his laundry, and his father manages his retirement account. These are codependent relationships, where parents do not let the child grow up because their sense of worth and importance derives only from being a parent. To the extent that their parents keep making choices for them, these adults never have an incentive to take responsibility for their own lives. But it is this personal responsibility, ability to choose, and self-determination gives each of us identity, values, and makes possible a meaningful life.

In many cases government policies have the same effect on citizens that over-protective parents do on their children. The largely government-run education system drastically limits school choice to all but those who can afford non-government schools. We have, for the most part, a "single payer" education system. The implicit message in the lack of school choice is that parents are not responsible for educating their children, or even to budget for it when choosing to become parents. Yet, parents are generally more satisfied when able to choose their schools.

University of Wisconsin professor John Witte, the official evaluator of the Milwaukee choice program, commented on school choice research: "There's one very consistent finding: Parental involvement is very positive, and parental satisfaction is very positive...parents are happier. The people using vouchers are mostly black and Hispanic and very poor...they deserve the same kind of options that middle-class white people have."

References:

Parental Satisfaction with School Choice, Institute for Justice,
www.ij.org/pdf_folder/school_choice/parental_satisfaction.pdf, 2004
School Choice: 2006 Progress Report, <http://www.heritage.org/Research/Education/bg1970.cfm>

Consumers already have choices in life insurance and car insurance, and there are on-line services that compare plans. To the extent that Coloradans are not informed health care consumers, their ignorance can be attributed to existing government policies. For example, the federal tax-exemption for employer-paid premiums limits consumer choice by providing a large incentive for consumers to be insured through their employer. Consider my case: I am an engineer at a small company. Except for a Flexible Spending Account, could make no choices about my health insurance policy. If there were no tax exemption, I'd choose to accept a higher salary and purchase insurance on my own, as I do for my car. As it is, I do not even know – and

have little incentive to find out – how much my premiums cost.

In health care, Health Savings Accounts, Medicaid Cash and Counseling programs, and Colorado's Consumer-Driven Attendant Support (CDAS) programs empower consumers to make responsible and informed decisions about their medical care. As Milton Friedman says, "Nobody spends somebody else's money as wisely or as frugally as he spends his own." The FAIR proposal describes the success of both Cash and Counseling and CDAS on page 15. Both have a counseling component to assist Medicaid enrollees in making informed health care choices, and I return to these below.

The Commissioner's writes that if "the public was just thrown into the structure described in the proposal, there would be chaos." This implies that my proposal suggests radical changes from the current system, whereas these changes are meant to be incremental and are modeled on existing policies. Below I address each suggestion of my proposal.

BMR: Benefits Mandates Reform:

Eliminating benefits mandates will make it legal for insurance companies to offer lower-cost policies, and hence give consumers more choices. Yet, there is little reason to fear that consumers lack the ability to make correct choices.

In 2004 the Colorado legislature lifted the prohibition of selling "mandate-lite" policies to small businesses. According to the Colorado Commission on Mandated Insurance Benefits (Feb. 2, 2007, <http://www.dora.state.co.us/insurance/meet/MHB/SB07-78.pdf>), this allowed consumers to purchase insurance with coverage of "mammography and prostate cancer screenings, services for non-biologically based mental illness, general anesthesia for children undergoing dental procedures, and...alcoholism treatment." I have yet to see reports of problems related to mandate-lite policies that can be attributed to consumer ignorance.

The RAND Health Insurance Experiment, which I describe in Appendix C of my proposal, also demonstrates that individuals with high-deductible low-premium plans (such as those that qualify for Health Savings Accounts) are both wise and frugal consumers. RAND [summarizes](#) the key findings:

In a large-scale, multiyear experiment, participants who paid for a share of their health care used fewer health services than a comparison group given free care.

- Cost sharing reduced the use of both highly effective and less effective services in roughly equal proportions. Cost sharing did not significantly affect the quality of care received by participants.

- Cost sharing in general had no adverse effects on participant health, but there were exceptions [just 4 out of 30 conditions]: free care led to improvements in hypertension, dental health [seeing a dentist], vision ["marginal"], and selected serious symptoms. These improvements were concentrated among the sickest and poorest patients.
- Cost sharing also had some beneficial effects. Participants in cost sharing plans (higher deductible) worried less about their health and had fewer restricted-activity days (including time spent in seeking medical care).
(source: http://www.rand.org/pubs/research_briefs/RB9174/index1.html)

Eliminating mandated benefits will allow insurance companies to offer a broader range of insurance policies to customers in the individual and employer-based markets. Without mandated benefits, for example, an insurance company can offer one or more lower-cost plans that lack some or all of the previously mandated-benefits. This gives consumers more choices, and as the Commissioner's question points out, choosing the best plan for them will require them to become more familiar with their health care needs. For example, some consumers would be better off purchasing a lower-cost policy and, if applicable, saving the money saved on premiums in a Health Savings Account.

To envision how consumers will become more education, it is useful to look at what resources are currently available for assistance in choosing the best plan. The market has provided services to help consumers become educated about health care decisions. In his book, *The Cure*, Dr. David Gratzner explains

Many insurance companies aren't just selling health savings accounts, they're offering companion services, like information websites. At the Cigna site, for example, members can estimate annual costs, compare drug prices, and get comparisons of hospitals (showing quality ratings for certain procedures as well as the cost and length of the stay). Other companies offer "health coaches," so that a health professional can guide patients along, helping them navigate the choppy waters of health care. Companies outside the insurance industry are also getting involved. Websites such as DestinationRx.com and PharmacyChecker.com let patients search for their medication and compare prices as different online pharmacies. (p. 71)

For people with health insurance through their employer, their most accessible source for guidance may be in the Human Resources department, or with whoever it is in the company that works with the insurance company. They can provide pamphlets for available policies, contact information for customer service, and on-line resources such as those mentioned in the quote above.

For example, my insurance is through United Health Care, and I can access information about my plan at myUHC.com. The site includes a section called "Check Your Symptoms, a "Treatment Cost Estimator" section, a section titled "How to Choose Your Health Care," and a Spanish language option. A web search on "how to choose a health insurance policy" returns

several useful pages, including:

- <http://www.ahrq.gov/consumer/insuranc.htm>
The United States Department of Health and Human Services: Checkup on Health Insurance Choices

Today, there are more types of health insurance, and more choices, than ever before. The information presented here will help you choose a plan that is right for you. You may be buying health insurance for the first time, or you may already have health insurance but want to consider changing plans. Married or single, children or no children, this information will help you to find out how to choose a health insurance plan that best meets your needs and your pocketbook.

- ColoHealth.com:

Choose the Health Insurance Plan That's Right For You:

<http://www.colohealth.com/choose-plan.htm>

Consumer's Guide to Buying Health Insurance:

<http://www.colohealth.com/consumer-guide.htm>

- How to Choose a Health Insurance Plan,
http://www.ehow.com/how_138961_choose-health-insurance.html,
- Assurant Health's Buyers' Guide: allows you to compare plans for individual and small businesses
<http://www.assuranthealth.com/corp/ah/HealthPlans/BGComparePlans.htm>

With the above employer-based and on-line services already in place, the expanded range of options created by eliminating benefits mandates are incremental changes that these information providers can easily accommodate.

Small Group Reform (SGR)

Small Group Reform seeks to phase out the state's distinction of a "small group of one."... 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. (From FAIR, page 5.)

This reform would encourage would-be free-riders to purchase insurance before they need it, just as individuals do when not insured through their employer.

Medicaid Reform

Converting Medicaid to a voucher-based program for private insurance and self-insurance through Health Opportunity Accounts (HOAs) will give Medicaid enrollees more choice and responsibility for their own medical care. Enrollees will certainly want to learn how to make wise decisions, and a responsible way to transition Medicaid to this type of system is to provide counseling on these matters - as South Carolina has done. On page 21 of the FAIR proposal I quote South Carolina Governor Mark Sanford.

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 (<http://www.heartland.org/Article.cfm?artId=17762>).

Similar programs include Cash and Counseling and Colorado's Consumer-Directed Attendant Support (CDAS). I described these on page 15 of the FAIR proposal:

* * *

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 devices 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 [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." (<http://www.heritage.org/Research/HealthCare/BG1618.cfm>)

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 (*Wall Street Journal*, 2005) reports that,

CDAS, our state's experiment with Consumer-Directed Attendant Support for the severely disabled, got started in 2002. The wheelchair-bound Linda Storey was one of its first four clients. The program now has 146 participants, each newly empowered to hire and fire their own caregivers. Quality of care and patient satisfaction are up, costs are down, and legislators approved offering the option for 33,000 Medicaid recipients statewide in 2006.

If there is more alleluia and less blues in the Storeys' music these days, CDAS is a big reason. "It gives you your life back," Mrs. Storey told me. "I'm in control of my health now." Under a federal waiver obtained by Colorado officials, she selects the health aides who come to her house, bypassing the provider agencies otherwise required under Medicaid rules for home- and community-based services.

...[W]ith 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."

* * *

Empowering consumers to spend their own money on health care provides incentives for wise and thoughtful spending. This gives health care providers incentives to lower costs and improve the quality of their services.

4. Your proposal addresses expanding access by making it more affordable with a Medicaid voucher plan but how would your proposal address the access issue pertaining to rural Coloradoans? How will access be addressed in his proposal with respects to lack of providers in rural areas which is a part of reforming healthcare for rural Colorado?

My proposal primarily addresses insurance regulations and Medicaid reform. If implemented, these reforms will decrease the cost of insurance policies and encourage responsible health care consumption. This will result in more people having access to affordable insurance and medical care. However, it does not address your concern with providers in rural areas.

My understanding is that medical licensing requirements limits competition among doctors and nurse practitioners, and hence their supply. It is conceivable that easing these requirements would increase the number of providers in rural areas. For example, on April 1, 2007, the Associated Press reported that "In one of the most far-reaching attempts at the state level to make health care more accessible and affordable to everyone, Gov. Ed Rendell is seeking to lower barriers in Pennsylvania laws and regulations that prevent a wide range of nonphysician health professionals from providing basic types of care. From nurse practitioners and nurse midwives to dental hygienists and pharmacists, the Rendell administration wants to reshape health care practices in Pennsylvania to help provide lower-cost preventive care."

I also found this 2004 a study in the journal *Medical Care Research and Review* (Vol. 61, No. 3, 332-351) that

reports results of the 2-year follow-up phase of a randomized study comparing outcomes of patients assigned to a nurse practitioner or a physician primary care practice. In the sample of 406 adults, no differences were found between the groups in health status, disease-specific physiologic measures, satisfaction or use of specialist, emergency room or inpatient services. Physician patients averaged more primary care visits than nurse practitioner patients. The results are consistent with the 6-month findings and with a growing body of evidence that the quality of primary care delivered by nurse practitioners is equivalent to that by physicians.

In 2004, the United States Department of Justice and Federal Trade Commission wrote in *Improving Health Care: A Dose of Competition*:

State licensing boards composed primarily of physicians determine, apply, and enforce the requirements for physicians to practice within a particular state. Various state licensing boards have taken steps to restrict allied health professionals and telemedicine. Some states have limited or no reciprocity for licensing physicians and allied health professionals already licensed by another state. The Report discusses the anticompetitive potential of such restrictions, as well as their rationales. (see http://www.usdoj.gov/atr/public/health_care/204694.htm)

I considered including this in the proposal, but since I became aware of the issue just a few days before the due date, I did not have time to adequately research the ways in which the current state of CO licensing laws impact rural Coloradoans.

Zoning laws may be another impediment to attracting doctors and other providers to rural areas. For example, on April 20 of this year the *Steamboat Pilot* [reported](#) that "linkage policies" can restrict hospital expansion: "Linkage would require residential and commercial developers to compensate the city, either by a fee or by construction of affordable homes, for a percentage of the market-rate housing units or employees created by their new development." The article begins "Yampa Valley Medical Center's top executive said Thursday that city policies intended to fund affordable housing, if approved in their current form, would significantly limit future expansion and services at the hospital."

(http://www2.steamboatpilot.com/news/2007/apr/20/hospital_questions_housing_fees)

Some cities have prohibited the large stores such as Wal-Mart from opening, either through zoning laws or outright refusal. Regardless of one's feelings about Wal-Mart, they are providing low-cost health care. MSNBC [reported](#) in April that

Wal-Mart Stores Inc. plans to open as many as 400 in-store health clinics over two to three years and could raise the total to 2,000 within seven years...Wal-Mart said it would contract with local hospitals and other organizations to operate the walk-in clinics, which lease space from Wal-Mart and are run as separate businesses. It currently has 76 such clinics, which typically provide a limited number of basic health services at a lower cost than hospital emergency rooms or doctor's offices and do not require an appointment." (<http://www.msnbc.msn.com/id/18292564>)

If results of government-run health care in other countries are any indication, such programs will not alleviate the problems in rural areas. This is documented in *Twenty Myths about Single-Payer Health Insurance: International Evidence on the Effects of National Health Insurance in Countries around the World* by John C. Goodman and Devon M. Herrick (<http://www.debate-central.org/topics/2002/book2.pdf>). Myth #17 (p. 76 - 80) provides evidence against the notion that "Single-payer health insurance would benefit residents of rural areas" by citing studies in Canada, Britain, New Zealand, and Australia that compare access to health care in rural and urban areas.

5. How would your proposal address individuals who can afford insurance but choose not to obtain it knowing that they can access medical care in an emergency through the emergency room and generate cost-shift of those expenses to other people?

This is a common and legitimate concern in health care policy. A coworker asked me the same question just a couple of days before receiving this one, and researching it was on my list of aspects of health care policy I wanted to learn.

Central to this issue is federal legislation known as EMTALA, the Emergency Medical Treatment and Active Labor Act, passed in 1986. Details of the legislation can be found at <http://www.emtala.com/law/index.html>. It states that in

the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this subchapter) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition ... exists.

It is reasonable to predict that some people might abuse this law as suggested in the question. That is, they forgo purchasing insurance because federal regulations require hospitals to treat them. As I noted in question 2, a significant percentage of the uninsured can in fact afford insurance. In "Is Health Insurance Affordable for the Uninsured," a [2002 paper](#) for the National Bureau of Economic Research, M. Kate Bundorf and Mark V. Pauly find that "depending on the definition, health insurance was affordable to between one-quarter and three-quarters of the uninsured in 2000." (<http://www.nber.org/papers/W9281>)

In [*Covering America: Real Remedies for the Uninsured*](#), Tom Miller summarizes EMTALA's effect:

As an unfunded federal mandate imposed on hospitals, EMTALA has created free-rider problems. First, managed care organizations cut back on emergency care coverage, and then their insured patients bypassed their health plans' contractual restrictions on access to emergency departments and arrived there for "free treatment" anyway. By the late-1990s, EMTALA essentially mandated access to 24-hour, just-in-time, emergency care at levels well above what many insured individuals were willing to pay for in their managed care plan contracts. With hospital emergency departments already disproportionately serving patients covered by Medicaid and those who are uninsured, increasingly unable to "make up their losses on volume," and finding their proportion of paying insured patients declining, EMTALA's unrestricted entitlement for utilization up to ER capacity provided strong incentives for hospitals to constrain, rather than expand, their emergency department capabilities. As too many patients lined up for federal free lunches in the ER, overcrowding, queuing, and declining quality of care hurt the uninsured most.

However, I was surprised to find a study concluding that those in this population are not

frequent users of emergency facilities. In a 2004 study, "Characteristics of Occasional and Frequent Emergency Department Users: Do Insurance Coverage and Access to Care Matter?" in the peer-reviewed journal *Medical Care*, authors Zuckerman and Shen [concluded](#):

The uninsured do not use more ED visits than the insured population as is sometimes argued. Instead, the publicly insured are overrepresented among ED users. Frequent ED users do not appear to use the ED as a substitute for their primary care but, in fact, are a less healthy population who need and use more care overall.

They summarized their results:

People in fair/poor health are 3.64 times more likely than others to be frequent ED users as compared with nonusers. The uninsured and the privately insured adults have the same risk of being frequent users, but publicly insured adults are 2.08 times more likely to be frequent users. Adults who made 3 or more visits to doctors are 5.29 times more likely to be frequent ED users than those who made no such visits.

If these results are accurate, the high rates of emergency facility use by "publicly insured adults" suggest that converting Medicaid to a voucher-based program for private insurance can reduce the number of frequent emergency room users. Empirical studies have shown cost-sharing to reduce emergency room use. In [Covering America: Real Remedies for the Uninsured](#), Tom Miller notes that "that increased cost sharing could discourage patients from inappropriately using hospitals' emergency departments" Miller sites a study in the *New England Journal of Medicine* (O'Grady, Manning, Newhouse, and Brook. "The Impact of Cost Sharing on Emergency Department Use." August 22, 1985, p 484–90) finding that a "25-percent level of cost sharing deterred emergency department utilization for less serious conditions but did not deter utilization for more serious conditions." A more recent study in the same journal (Selby, Fireman, and Swain. "Effect of Copayments on Use of the Emergency Department in a Health Maintenance Organization," March 7, 1996) concluded that "a small co-payment resulted in a 15 percent reduction in emergency department utilization but did not affect conditions classified as 'always an emergency'." (source: <http://www.cato.org/research/articles/miller-coveringamerica.pdf>)

Other research suggests that cost-shifting caused by the uninsured is not a crisis. In a recent [piece](#) in the *Los Angeles Times*, Michael Tanner and Michael Cannon of the Cato Institute write that "some suggest that when people without health insurance receive treatment, the cost of their care is passed along to the rest of us. This is undeniably true. Yet, it is a manageable problem. According to Jack Hadley and John Holahan of the left-leaning Urban Institute, uncompensated care for the uninsured amounts to less than 3% of total healthcare spending — a

real cost, no doubt, but hardly a crisis." (*LA Times*: <http://tinyurl.com/3cyftx>, study: <http://tinyurl.com/395lh5>)

In any case, the implementation of the FAIR proposals will reduce the costs of insurance, as described in section (i), p. 25-29 of the proposal:

- Eliminating mandates would make it legal to sell low-cost policies.
- Phasing out guaranteed issue for the business group of one will encourage this population to purchase insurance before they need it, and hence reduce the odds that they abuse the EMTALA law.
- Converting Medicaid to a voucher-based system allows insurance companies to compete for Medicaid enrollees while Health Opportunity Accounts encourage responsible consumption.
- Enacting the Medicaid reforms allowed by the 2006 Deficit Reduction Act will also reduce costs.
- Allowing Medicaid to compete for tax-dollars will provide administrators incentives to transform Medicaid into an efficient charitable organization that no longer imposes costs on those who fund it (as described in Appendix D of the FAIR proposal and in the answer to question 2, above.)

All of these will make insurance more affordable and contribute to decreasing the number of uninsured, and hence, the number of free-riders.

Some may suggest mandatory health insurance as a solution to this problem. Yet, as shown above, the uninsured do not abuse emergency room access, and they do not impose a large cost. To the extent that they do impose costs, requiring that everyone purchases insurance does not eliminate this unfair cost-shifting imposed by free-riders, it just obscures it.

This occurs for two reasons. First, requiring everyone to purchase insurance increases demand for it, and hence increases prices. Second, it somewhat eliminates the option of self-insurance in so far as the previously uninsured who are compelled to purchase insurance by a comprehensive plan as opposed to a high-deductible plan that qualifies for a Health Savings Account. As the RAND Health Insurance Experiment showed, consumers with such prepaid plans utilize significantly more medical resources than those with high-deductible plans, with negligible benefit for the large costs imposed. Lastly, such a policy would punish the innocent instead of the free-riders. Resources would be better spent on tracking down those who do not pay by, for example, garnishing their wages, instead of reducing the liberties of those who end up paying the bill.

6. Did you mean to get rid of insurance pricing regulation, plan regulations and issue regulation as well as just the benefit mandates? Would the state still be able to audit companies for financial stability? Would it be able to require people to restrict their purchases to only those companies that pass state vetting or would it operate more on the Underwriters Lab model?

My proposal concerns the elimination of benefits mandates and phasing out guaranteed issue for the "business group of one." I suppose the former can be classified as a plan regulation, while latter change concerns a type of "issue regulation."

I considered addressing community rating and rate banding, which are types of pricing regulations. I found a few studies* showing adverse effects of these regulations on insurance markets and increasing the number of uninsured. Yet, due to constraints of time, the length of the proposal, and that the problems these state-level regulations are aimed to solve may be rooted in federal policies, I chose not to pursue this path.

As for auditing companies for financial stability and state vetting, I did not consider this aspect of reform. However, I have researched the role of non-government certification agencies such as Underwriters Laboratories (electronics), AAA (hotel and restaurant ratings), Good Housekeeping, Morningstar Inc. (investment ratings), Dun & Bradstreet (business credit), the American Dental Association, and Consumer Reports.

If I were to look further, I'd start with a paper by economist Daniel Klein at George Mason University, "Trust for Hire: Voluntary Remedies for Quality and Safety," and the references therein (<http://lsb.scu.edu/~dklein/papers/trust.html>). I would also look at private companies such as [A.M. Best](#), which track insurance companies' ability to pay claims.

* Studies:

Meier, Conrad F., "How Eight States Destroyed Their Individual Insurance Markets," Heartland Institute, <http://tinyurl.com/23xwad>, 2004.

Park, Edwin, "Lessons From New Hampshire: Senate Health Bill Could Drive Up Health Insurance Premiums For Many Small Businesses," Center on Budget and Policy Priorities, <http://www.cbpp.org/4-26-06health.pdf>, 2006.

Turner, Grace-Marie and Melinda L. Schriver, "Uninsured Rates Rise Dramatically in States With Strictest Health Insurance Regulations," Galen Institute, <http://www.galen.org/statehealth.asp?docID=179>, 1998.