

DISCONNECT

**Why Healthcare Costs Keep Rising In America
and
What You Can Do To Protect Yourself and Your Future**

**A Consumer's Guide to Understanding and Escaping
the Bureaucracy of Healthcare**

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September 2004

CONTENTS

<i>Acknowledgements</i>	<i>ii</i>
<i>Introduction</i>	<i>iii</i>
<i>Chapter 1</i> Just How Much Are We Spending, Anyway?	<i>1</i>
<i>Chapter 2</i> Historical Catalysts - How Did We Manage To Eliminate All Normal Economic Forces In Healthcare?	<i>7</i>
<i>Chapter 3</i> How Federal Policy Continues To Create Huge Distortions In The Healthcare Marketplace	<i>11</i>
<i>Chapter 4</i> The Huge Medicare Program Impact - Why Immediate Steps For Reform Are Critical	<i>19</i>
<i>Chapter 5</i> The Rise And Fall Of HMOs And Managed Care	<i>31</i>
<i>Chapter 6</i> A Quick Review Of Why A National Single Payer System Is Not A Viable Alternative	<i>43</i>
<i>Chapter 7</i> Market Driven Healthcare Possibilities	<i>51</i>
<i>Chapter 8</i> Finding A Model For A More Effective Healthcare System - The Singapore Experience	<i>57</i>
<i>Chapter 9</i> Fixing The Financing And Returning To A Health Insurance Concept - Criteria For Structuring An Ideal Plan	<i>61</i>
<i>Chapter 10</i> Identifying Where You Fit In The Current Scheme Of Things	<i>75</i>
<i>Chapter 11</i> Influencing The Outcome - Voice Your Concerns and Vote With Your Feet	<i>81</i>
<i>Chapter 12</i> Conclusion	<i>87</i>
<i>Endnotes</i>	<i>89</i>
<i>Additional Resources</i>	<i>95</i>

ACKNOWLEDGEMENTS

Disconnect became a product of my search to understand the numerous complexities and challenges of our healthcare system. In an effort to fashion a message that can be fairly easily digested by most people in one sitting, I have brought forth what I feel are the key “take-aways” from a variety of distinguished sources that are acknowledged throughout.

For the past two years, I have participated on a “Health Benefits Reform” listserv, an Internet discussion group of doctors, economists, insurance sales people, underwriters, administrators and others who all experience daily one part or another of our dysfunctional healthcare system. Like me, all of them seem to have a passion for wanting to fix what’s broken, and a variety of discussion threads continue simultaneously. This group has provided a wide range of perspectives, has often steered me to material I otherwise would not have been exposed to, and has prompted me to selectively collect many pearls of wisdom that seem to frequently drop into the discussions. Several of these “pearls” have been incorporated into sidebars and scattered throughout the text to shed a little more light on the topics from yet another perspective. I want to thank the members of the Health Benefits Reform discussion group for both the contributions I have included herein, and for the continuing expansion of my own knowledge base through my association with them.

My initial quest began with exposure to *Patient Power* and the National Center For Policy Analysis, The Galen Institute, CATO and a number of other public policy think tanks. I came across volumes of excellent research, commentary and proposals that had been developed throughout the past decade, but my concern was that these people just seemed to share among themselves. This stuff just wasn’t hitting the general public’s radar, and I became convinced that the only way anything was going to change significantly is to capture the attention of healthcare consumers. Much of what I found valuable has become the basis for the “Consumer Directed Healthcare” movement, but it is just barely launched with a long way to go. Consumer education with respect to healthcare and how it should be delivered and paid for is by far the most significant hurdle in accelerating progress to effective reform.

So finally, I would like to acknowledge and thank you, the reader, for picking up *Disconnect*, absorbing its message, and passing it along to others.

INTRODUCTION

I was in my early 30's when I entered the managed healthcare field in 1985. I had begun a career in retail quite by default when I started dusting shelves in the local store of a large department store chain to pay for my first car and to put myself through college. By then I had worked myself up through the ranks in retail, ultimately running my own store. After 17 years with the same employer, I decided it was time for a change. When I answered a blind ad in the newspaper recruiting "hotel, restaurant and retail management", I was surprised to learn it was placed by a healthcare company and intrigued by the business model they presented.

A Health Maintenance Organization based in California was extensively recruiting to fill its management ranks with people from the service industry. This particular HMO had just completed a successful demonstration project with the Health Care Financing Administration to provide care to Medicare recipients on a prepaid basis. They were able to expand benefits for seniors, while also reducing overall costs by effectively coordinating the patients' care and ensuring compliance with preventive measures and prescribed medications. I joined this organization, and its growth over the next 10 years from both government contracts and the expansion of its business with employer groups was phenomenal.

Again I was entering a profession by a fluke. Never in a million years would it have occurred to me to seek a job in healthcare. I had obtained an undergraduate degree in economics and a masters degree in business. Although I had consistently been covered by health insurance throughout my lifetime, through my parents insurance growing up, then with Kaiser through the Teamsters Union during my early days in retailing, and then always with some type of employer coverage, I had paid little attention to what "HMO" even meant. Having recently gotten married for the first time, my brush with the healthcare system over the years had consisted mainly of birth control and periodic routine exams. I had never had a major accident or illness, and had not spent any time in the hospital since the day I was born.

When I began to pay attention to what was happening in the healthcare industry, I realized that it was fraught with challenges and great opportunity. Like today, the cost of providing

healthcare was increasing at a pace much faster than overall inflation. The answer seemed to be managing healthcare costs by offering comprehensive prepaid healthplans, and coordinating all necessary care through carefully managed networks of healthcare providers. And for a number of years, this approach proliferated and did have a profound effect on curbing rising costs.

But now we are again facing the worst healthcare inflation ever, and not only has managed care run out of new tricks to manage it, there has been a huge consumer backlash which has led to increasing regulation and government mandates. Mandates not only limit a health plan's ability to control costs, but add additional layers of cost into the equation. We have reached the point where employers, the main source of funding for healthcare benefits other than the government, can no longer afford to provide the comprehensive coverage that has been offered in the past. The number of uninsured in this country continues to grow, exceeding 43 million.

We spend more on healthcare in the United States than any other country in the world, and while the innovation and technology we have access to is second to none, we have a whole lot of folks experiencing barriers to obtaining care. We have created a huge bureaucracy within the industry which costs a small fortune to sustain, and creates perverse incentives throughout. For the most part, the insured and the patient are far removed from any purchase/value equation - thus the title *Disconnect*, which describes what has happened to the consumer in our healthcare marketplace.

Discontent might also be an appropriate title for this book. We have created a system that is consuming tons of our resources and no one is satisfied with the results - not the insureds, the patients, the employers, the doctors, the hospitals and other providers of care. Certainly not the guy between jobs or with a small employer who can't afford the cost of individual coverage, or any of us needing to access the non-existent trauma center as closures for these facilities continue. The relationship now between insurance companies or government

payers and the healthcare providers is contentious at best. Successful alliances forged early on have now turned adversarial. We got to this place with the best of intentions, but we have reached the point where the industry requires a major overhaul to bring us out of this mess.

Until now, the intricacies of the healthcare system have not been top of mind for most of us. Even I, who have been in the industry for nearly 20 years, did not take a step back until now to really assess the big picture and begin to understand how the financial incentives got so convoluted. Most of us have just taken it for granted that Medicare is a good and necessary government program to ensure that our aging population has access to healthcare. A good job is one that comes with great healthcare benefits, so this becomes a key factor in our employer assessment, never really questioning how that relationship came about. And of course, we as a society feel an obligation to take care of anyone who is in a circumstance where they can't take care of themselves, so government programs expand to take care of the poor and uninsured. But have you ever stopped to consider just who exactly is paying for all this stuff? We're beginning to see that more and more is now coming directly out of our pockets in terms of higher premiums or share of premium and co-insurance. But that is only the tip of the iceberg. What about the billions and billions of dollars swirling around in the background that many of us don't even consider. And who's really in charge of deciding what we're spending all this money on?

DISCONNECT - Why Healthcare Costs Keep Rising In America and What YOU Can Do To Protect Yourself and Your Future exposes the root causes behind the dysfunction within the healthcare industry. It asks that we all rethink the government policies that have led us to this current state of affairs. It proposes solutions to replace the current system with an intelligent balancing of market forces and government intervention. Although we all have a clearly vested interest in staying healthy, an interface with the system is inevitable for each of us at some point, and probably at multiple points in our lifetimes. Whether sick or healthy, insured or not, we are all affected in some way by the spiraling costs and tremendous amount of cost shifting that takes place today. We need to restructure the financing and delivery of healthcare so that the basic economic forces governing supply and demand can once again prevail. It is time for a change. It is time to act.

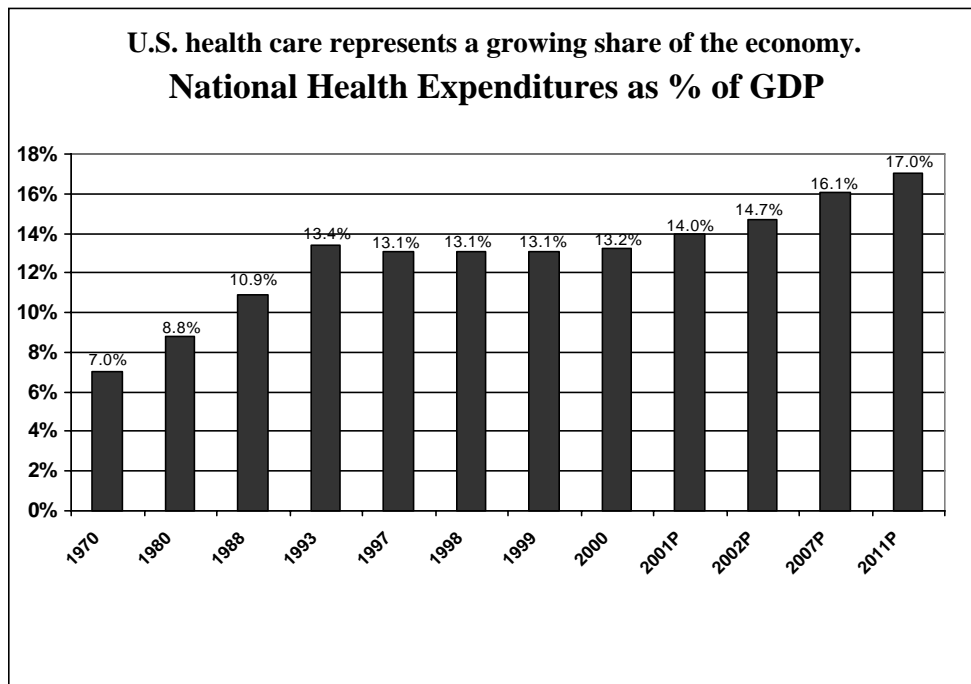
“Experience should teach us to be most on our guard to protect liberty when the government’s purposes are beneficial. Men born to freedom are naturally alert to repel invasion of their liberty by evil minded rulers. The greater dangers to liberty lurk in insidious encroachment by men of zeal, well-meaning but without understanding.”

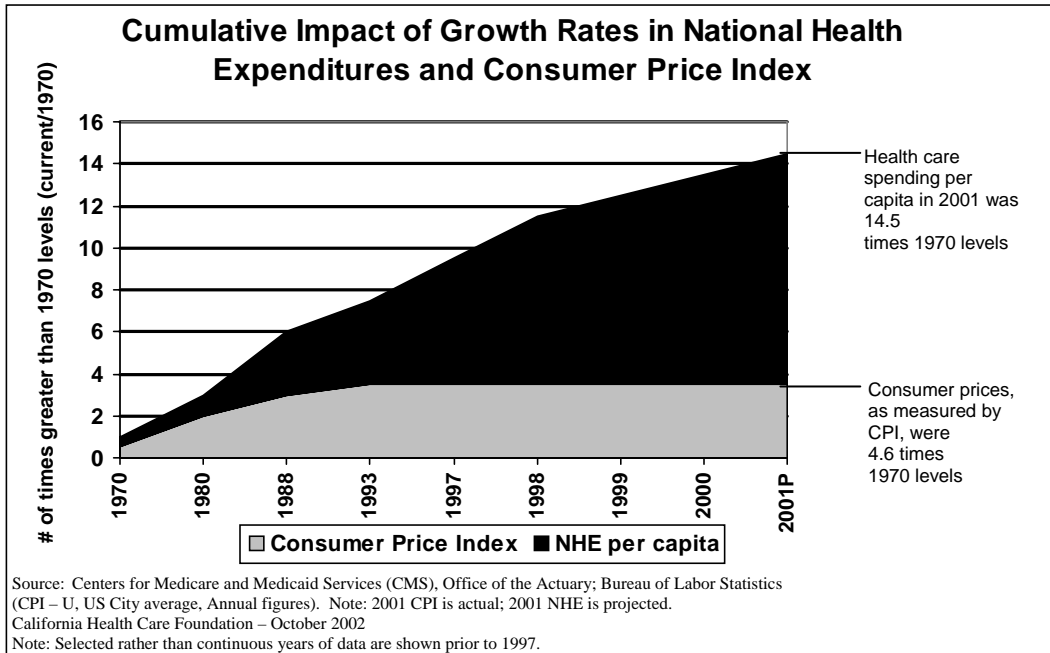
**Justice Louis Brandeis
Olmstead v. United States, 1928**

Chapter 1

JUST HOW MUCH ARE WE SPENDING ANYWAY?

In 1996, healthcare spending in the United States passed the trillion-dollar mark for the first time. If that sounds like a lot of money, it's because it is. At that time it was 13.6% of the GNP (gross national product), consuming over one seventh of our nations resources. It was more than twice the percentage of consumption in Japan. Since then, healthcare spending has continued to grow at a rate much higher than overall inflation. The recent era of managed care curbed those increases somewhat, but now we are again experiencing an unprecedented rise. According to the Center for Health System Change, health spending in the United States increased 10% during 2001, the largest jump in more than 10 years.¹ Though the trend has slowed, by the end of 2002, we had spent \$1.5 trillion and by the end of 2003 we had spent nearly \$1.7 trillion.² In the not too distant future we will have doubled the 1996 trillion dollar mark! We are experiencing healthcare inflation rates over three times the rest of the economy. Unless we alter our course dramatically, this is just the beginning of an escalating cost trend, the likes of which we have never seen.





Other than the fact that the United States spends more on healthcare than any other nation in the world (and still wrestles with the problem of having over 43 million people, or 15% of the population uninsured), the issues we have faced are not unique. According to Milton Friedman, “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 advance 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.”³

If that is the situation in most developed countries, than it shouldn’t surprise us that the wealthiest country in the world is also spending the most on healthcare. But before we might aspire to get our costs in line with those of other industrialized nations (of 29 countries for which we have data, 16 spend between 7% and 9% of GDP on medical care), we should probably take a moment to consider why the gap may be so large. We also shouldn’t lose sight of the fact that the major features cited by Milton Friedman generally continue to prevail across the globe.

Our costs might be easier to rationalize if healthcare outcomes in the U.S. ranked favorably above the rest of the world, but unfortunately, they do not. Perhaps it is just our American lifestyle that then drives the need for significant additional healthcare expenditures. According to the Centers for Disease Control, more than 50% of our potential for lifelong health is determined by our personal behaviors.⁴

In Larry Elder's best seller, *The Ten Things You Can't Say In America*, he cites the following: "We have 6 million regular drug abusers, 30,000 homicides yearly, 200,000 diagnosed cases of AIDS, crack babies, and alcohol abuse costing more lost work time and money than any other drug. Twenty percent of adults still smoke, and among young women, cigarette smoking is *increasing*. With hundreds of thousands of Jane Fonda Workout tapes sold and Jenny Craig outlets popping up all over the place, Americans still overeat. Our consumption of fat, cholesterol, and sugar remains high. Most Americans get no or inadequate exercise."⁵ The Health Insurance Association of America estimated in 1994 that healthcare attributable just to unhealthy lifestyles required \$188 billion of our expenditures.⁶

So how else do we rationalize these extensive cost differences? Often proponents of national healthcare as a solution to cost and access issues cite Canada and the UK as systems that eliminate huge administrative costs through their single-payer, universal coverage. One study determined that in 1999, Canada's per capita costs were 43% less than those in the United States,⁷ but reported costs are not always comparing apples to apples. In Canada, much of the reported costs do not reflect the costs of administering government healthcare spending, nor do they reflect the opportunity cost of capital to the extent U.S. figures do. U.S. figures include vastly greater expenditures on research and development (which benefit Canada as well as the rest of the world), and reflect care for a slightly older population than that in Canada. In addition, the benefits extended to senior citizens in the U.S. (in which the last year of life often consumes 30% of an individual's lifetime expense) far exceed those offered to the elderly in Canada. With respect to the UK, and in Canada as well, access to care for those in need of it most is difficult at best. For example, while the U.S. has 6,000 cancer specialists, the UK has only 300 to serve one fourth as many people. Only 40% of the UK's cancer patients ever get to see specialists.⁸ Healthcare may cost more in the U.S., but when you're

in a life and death situation, you have a much greater chance for survival being here rather than there.

It is often suggested that the world's phenomenal technological advances are what is driving the continual rise in the cost of healthcare in the U.S. Pharmacy costs, in particular, have been increasing at double digit rates for the past few years. Other countries may postpone the proliferation of expensive applications, but in the U.S. there is hardly ever a shortage of the latest technology. Probably the worst value for the money expended, our hospitals are packed with all the latest advances (along with too many beds and too many administrators). As a result of our delivery systems immediately acquiring the new technology, we must then absorb the costs of maintaining huge amounts of excess capacity. For example, more than 60% of the 150 heart transplant centers in the U.S. performed fewer than twelve of them a year, dropping below the minimum number recommended by the federal government for quality care.⁹ This proliferation of technology is mainly for marketing purposes and the survival of those institutions providing the services. Unlike other industries that are price competitive, in healthcare, new technology actually enables providers to *raise* their prices.

Why Concern?

Why are we even remotely concerned about how much the U.S. spends on health care? We aren't concerned about how much the U.S. spends on shoes, or peanut butter, or legal services, or entertainment, or transportation, or housing. I doubt if there is a single person who could even tell you what we spent on those things in 2002 without looking it up. We aren't concerned about the total cost of those other sectors of the economy because people spend whatever they want to spend on them. It is their money and spending on those things competes with all the other things they might spend money on. Third party payment means that health care does NOT have to compete with other uses of the money, so we have no way of telling whether we are spending too much, too little or just the right amount.

Greg Scandlen
Center For Consumer Driven Healthcare
September 2003

What has made the technological revolution for healthcare so different from other industries? In all other cases, technological development has *lowered* cost so that less overall is expended. Consider how advances in communication, transportation and food have changed our lives for the better while releasing resources to spend on other new products and services. Consider our relatively recent experience with personal computers and the Internet. Did we really expect costs to escalate? Clearly progress has led to a reduction, not an increase, in cost per unit of output. According to Milton Friedman, "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 regulatory role. In medical care, government has come to play a leading role in financing, producing and delivering medical services.¹⁰ The U.S. has less government involvement than most developed countries, but as we shall see, through our government programs, and by indirectly subsidizing medical care through favorable tax treatment, policies have been established which prevent normal laws of supply and demand to maximize market conditions. This is precisely why we don't experience cost reduction with technological advances, and why distorted incentives prevail at most every turn as we navigate through our healthcare system.

Maybe a trillion or two dollars isn't too much, or possibly even not enough. After all, our health is important and in a wealthy nation such as ours, we deserve the best. The really key question, however, is are we spending this money efficiently and intelligently? We are all footing this bill either directly or indirectly through wages and taxes, but for the most part, if we are lucky enough to have coverage, someone else is generally making our purchasing decisions - determining what insurance plan we'll have, determining what benefits are covered, determining at what prices the providers will be paid. Because of this disconnect between the consumers of healthcare services and the providers of healthcare, the natural forces of supply and demand in the marketplace have been thrown completely out of whack, and are certainly not reflected in the pricing structure. But as the costs continue to escalate, and they will if the current conditions prevail, we are all going to be forced to absorb those increases by paying a greater share of the costs directly out of pocket for increased premium costs and copayments at the time of service - or perhaps many of us will be forced to forego health insurance altogether. We have now reached the point where this disconnect between patient and provider can no longer be accepted or tolerated.

The remainder of this message points out some fairly significant dysfunction within our system, some train wrecks waiting to happen, and some possible solutions to get us back on track. The solutions will allow us to individually and collectively manage our healthcare dollars efficiently and intelligently. We can effectively address the needs of the uninsured.

And we can eliminate a great deal of the rampant dissatisfaction within our healthcare system across the board.

Chapter 2

HISTORICAL CATALYSTS - HOW DID WE MANAGE TO ELIMINATE ALL NORMAL ECONOMIC FORCES IN HEALTHCARE?

In the last century, there were several major policy blunders that have had tremendous influence in shifting the healthcare industry completely outside the realm of rational economic forces. The first was probably the least offensive, but troublesome nevertheless. The others had the profound effect of disconnecting the majority of consumers from the market, and the final blow swept up most of the rest, and continues to fuel irrational consumption in the healthcare marketplace.

In the early 1900s, the American Medical Association lobbied heavily, and government complied in passing stringent licensing procedures, which resulted in the closing of numerous medical schools and a reduction in the supply of medical personnel. Although today we see a proliferation of what is termed alternative medicine, early on, these types of practitioners were forced out of the game and have struggled ever since. Doctors have fairly effectively disadvantaged a huge segment of providers over the years, and through regulation, have controlled many activities capable of being performed equally as well, and at far less cost, by other less expensively trained personnel. Economist Milton Friedman calls the AMA “perhaps the strongest trade union in the United States.”¹ He says, “For decades it kept down the number of physicians, kept up the costs of medical care, and prevented competition with ‘duly apprenticed and sworn’ physicians by people outside the profession.”² The AMA continues to control the number of medical school graduates by limiting enrollment opportunity, and though partially the result of other influences, has also been successful in maintaining high income levels for their constituency. Adjusted for inflation, income per physician nearly tripled in the last half of the last century.³

Though labor unions always hinder the natural forces of supply and demand somewhat, things really didn’t begin to get completely out of hand until World War II. The government financed the war by printing money and imposing wage and price controls. This resulted in a shortage of labor, so in order to attract scarce labor at the frozen wage levels, employers

began to offer medical care as a fringe benefit. Interestingly enough, the IRS did not catch on for quite some time to the fact that employers were not including the value of the fringe benefit when reporting workers' earnings. By the time they did, workers so accustomed to the practice made such a fuss that Congress responded by legislating that medical care provided by employers would be tax exempt.

BIG MISTAKE! When employers can purchase health insurance and deduct its full cost as a business expense as well as avoid the added expense of payroll taxes, and employees who receive the insurance do not pay any payroll or income taxes on its value, that arrangement is much more compelling financially for both parties rather than simply paying the employee higher wages. This policy encourages compensation to be paid out in benefits rather than wages, fueling the proliferation of comprehensive employer sponsored group health insurance while contaminating the viability of non-group insurance. The value of this generous tax subsidy exceeds \$140 billion annually, and individuals have access to it only if they are working and only if their employer can afford to provide health insurance. Many small employers cannot. Individuals purchasing insurance on their own have no tax advantage and must pay with after tax dollars.

Not only does this seemingly innocuous provision of income tax code create an unfair advantage over the "have nots", it has had the profound effect of distorting the normal purchasing process in healthcare by disconnecting the actual consumers of healthcare from purchase decisions and by skewing their perceptions of the real cost. Numerous studies have demonstrated that individuals will consume more, and more expensive services if someone other than the consumer is bearing the cost.⁴

Finally, with the enactment of Medicare and Medicaid in 1965, we opened the floodgates for havoc in the medical marketplace, and have been dealing with it ever since. Now we move the next largest segment of the population into this disconnect from purchasing decisions, and turn on the tap to seemingly unlimited funding. When Medicare was set up in 1965, the politicians projected its cost in 1990 to be \$3 billion - which is equivalent to \$12 billion

when adjusted for inflation to 1990 dollars. The actual cost in 1990 was \$98 billion - eight times as much.⁵ In the two decades following the passage of the Act, the cost of a typical hospital bed day increased eightfold - far higher than inflation over the same period.⁶ Periodically the government tries to rein in the costs through fixed reimbursement schedules, but this tactic has resulted in increased utilization to make up for the shortfalls, as well as providers simply shifting more and more costs to the private sector.

So basically today we are in a situation where most payments to doctors and hospitals and other providers of care are made not by the patient, but by third party payers - either an insurance company, an employer or the government. Similarly to the socialistic healthcare systems out there, nobody spends other people's money as frugally as they spend their own and when people don't pay for things, demand soars.

Larry Elder has described this phenomenon fairly succinctly. "It's like this. I once had an apartment with

utilities included. In my old apartment, during hot summer months, or cold winter months, I turned the thermostat off when I left the apartment and put on the heat or air when I returned. Once I moved into a 'utilities included' apartment, I left my heat and air on all day, thus insuring a perfect climate when I entered the room. Now I knew that somehow I would pay, but that the cost would be distributed over all the tenants in the building. So the conscientious tenant who cuts off his or her air would, in effect, subsidize my carefree use of utilities. Eventually we all pay, but the effects become gradual and diffused over a number of people. Similarly, with employer-provided insurance, and 'hidden premiums', employees have less incentive to refrain from seeing doctors for minor reasons, and less incentive to watch and manage one's own health."⁷ We have created a situation where the insured has little or no incentive to weigh the value proposition for any and all services being rendered in relation to their cost.

Cause and Effect

I agree. But it wasn't just the wage/price freeze and exclusion from income of employer-sponsored benefits. I would go back further to the creation of Blue Cross and the exemption from anti-trust laws the Blues enjoyed, the cozy arrangement BC had with hospitals, and the resulting market domination that made third-party payment the standard everyone else had to emulate. Add to that Hill Burton and the federal subsidy of high tech facilities resulting in higher cost care for everyone, and McCarran-Ferguson and the advantage insurers were given over other financial institutions, and Taft-Hartley that encouraged benefits to be collectively bargained and you have one hell of a mess.

Greg Scandlen
September 2003

Is it really appropriate for an outside party to be making the ultimate choice in healthcare decisions? Should the quality you receive be dictated by who is paying the bill? Third party payment creates the bureaucratization of medical care and radically changes the relationship between providers and patients. It also plays havoc with our ability to operate efficiently and intelligently.

ONE HUNDRED YEARS OF MARKET DISTORTION	
<ul style="list-style-type: none"> • Medical Profession Forms Cartel to Reduce Competition and Raise Prices Through State Licensing Laws 1900-1929 Organization on Blue Cross 1930-1949 • Through State Enabling Laws, Hospitals Dodge Anti-Trust Restrictions And Form Vertically Integrated Payment Systems 1930-1949 • The Federal Government Exempts Fringe Benefits From the Wage and Price Freeze, Encouraging More Compensation to be Paid Out in the Form of Benefits, Not Wages That Would Encourage Non-Group Health Insurance • The Federal Government Gives Tax Break Only to Employer-Sponsored Health Insurance - Not to Individual Insurance, and Not to Direct Payment • The Federal Government Puts Seed Money Only Into Hospital Construction, Tilting Health Care Delivery to Expensive High-Tech Institutionalized Care • The Federal Government Provides an Anti-Trust Exemption and an Exception to the Interstate Commerce Clause of the Constitution Exclusively to the Insurance Industry 1930-1949 Growth Era 1950-1965 • The Enactment of Medicare and Medicaid Results in a Surge of Health Care Spending and Substitutes Government Spending for Out-of-Pocket Spending • All of these provisions are designed to reduce costs by limiting their supply and controlling the costs of services - precisely the wrong remedy at a time of artificially inflated demand. 	<p>Greg Scandlen Galen Institute</p>

Milton Friedman describes Max Gammon, a British physician who, after an extensive study of the British system of socialized medicine, formulated what he called “the theory of bureaucratic displacement.” In Health and Security, 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 partially socialized U.S. medical system.⁸

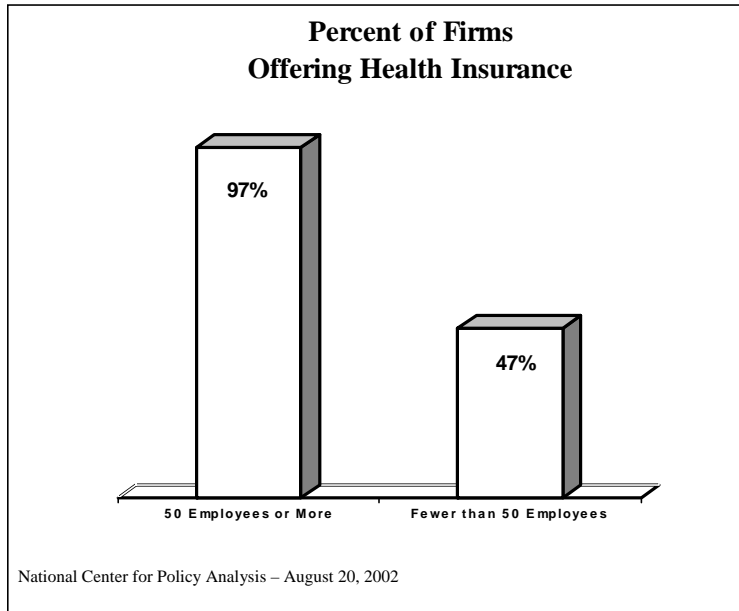
In the U.S. we have had phenomenal success with capitalism and private enterprise. In most markets, suppliers initiate the search for efficient production techniques out of a desire to satisfy customers. In healthcare, however, we depend upon the demand side to force producers to produce efficiently. It’s just not working. What we are seeing is Gammon’s

Law at work. The normal laws of supply and demand *don’t* work in healthcare precisely because the government has intruded, regulated, mandated, and dictated, distorting incentives all along the way.⁹

HOW FEDERAL POLICY CONTINUES TO CREATE HUGE DISTORTIONS IN THE HEALTHCARE MARKETPLACE

By and large, the market for healthcare in the U.S. is now under the control of politicians who initially tried to solve complex economic problems with simple regulation. Unfortunately, when some part begins to take a turn for the worse, their immediate response now is to pile on more complex and intrusive regulation and have the government continue to micro manage the situation even further. Let's review how some of these well intentioned policies tend to royally muck up the works.

The unfairness of the generous federal subsidy for insurance provided through employers has been addressed in the previous chapter. Actually, those in the highest income tax brackets are receiving much greater benefit than those in lower tax brackets, and certainly much more than those not receiving any benefit at all because they have no access to employer provided coverage. The "unfairly neglected", if they are middle income, must earn twice as much to pay for health coverage with after tax dollars, and then often find they must pay almost twice as much as that again for similar coverage with an individual policy. What's really amazing is that the \$140 billion plus price for this existing arbitrary blessing is never taken into consideration when politicians are nickel and diming the cost of legislation to provide equal tax treatment across the board. And even then, attempted efforts have targeted selected groups of individuals, rather than just biting the bullet and acknowledging that we should just make this fair for everyone. Period. Until now.... the first major step to rectifying this situation became law in November 2003, but most folks aren't aware of this, and the market is just now beginning to react. The ramifications of this change are discussed fully in Chapter Eleven.



To expand on the previous discussion regarding this tax provision and the resulting third party payment, we suffer a number of other negative consequences as well. First, the whole notion of “health insurance” has transformed itself into one of “prepaid healthcare”. Rather than protecting one’s assets from some catastrophic event, healthcare coverage today is generally fairly comprehensive, covering most regular, recurrent and less costly health needs as well as catastrophic illness. Because of the tax provision associated with the purchase, it encourages greater and greater amounts of spending with pre-tax dollars by the employer rather than post-tax dollars by the employee. Not only does this bias towards more comprehensive plans lead to much higher administrative costs, as a consequence, the majority of us are way overinsured and the coffers of the insurance companies have grown substantially.

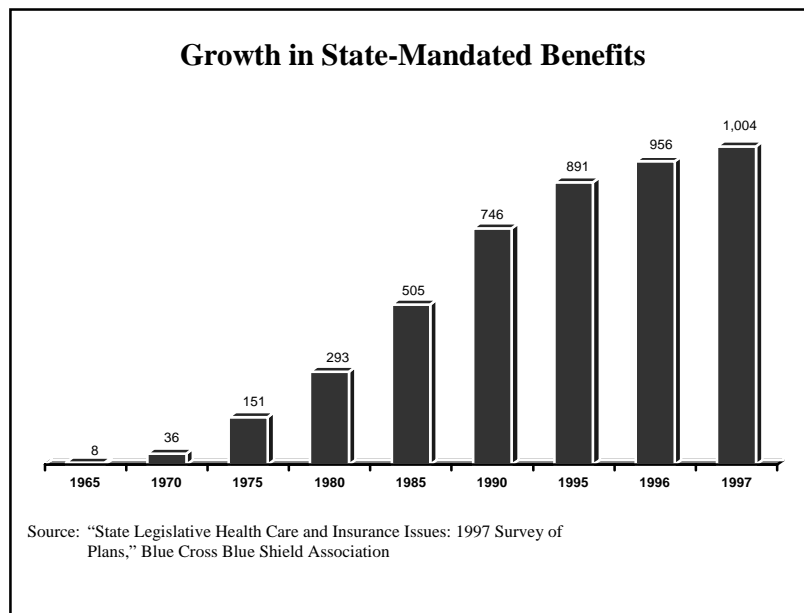
Not only are we way overinsured, but we have limited influence over what is being covered. For 83% of the employers, there is only one healthplan made available to their employees - take it or leave it. The rest generally offer a choice of only two or three options. Your preferred providers may not be in the network. A drug you need may not be on the plan’s formulary, or prescription drugs may not be covered at all. It may be that you rely on alternative medicine to stay healthy, so you have a limited need for the coverage, and wind up spending out of pocket *with after tax dollars* for numerous services and products that aren’t covered under the plan. How often really does any one size fits all approach best meet our individual needs?

Another negative consequence of having health insurance tied to employment is that whenever there is a job change, it requires a change in health plan. Even without a job change, employers are generally re-evaluating their healthcare coverage choices annually, so essentially employees are subject to a change in coverage and provider networks every 12 months. This is ridiculous. Why on earth should we all be subject to such disruption, particularly when there are very definite advantages to maintaining continuity of care with providers familiar with our medical history?

For those fortunate enough to have benefited from the government's generous subsidy for an extended period, the absurdity of this situation really hits home when they leave an employer who has been providing their healthcare coverage and they either don't have a job for a while or get a new job where coverage isn't provided. Now in all its paternalistic wisdom, the government has mandated that your previous employer allow you to continue your coverage through them for another 18 months to ease the transition, but with the beefed up benefit packages and the fact that you now have to pick up the entire tab yourself, you are subject to unbelievable sticker shock at a time when you can probably least afford it. Your other option is to shop the individual insurance market, subjecting your family to extensive medical underwriting and a re-evaluation of your risk. At this point you might be thinking, health insurance premiums have been funded for me and my family for years, which should be building up into a pool of money that can take care of us when we're sick. Maybe we're sick, and maybe we're not, but why at this point should we be forced to go back to square one, getting no credit for what has already been paid in over the years? The longer you've been around, the riskier you become, particularly when every medical encounter over the course of your and your family's lifetime must be scrutinized to determine to what extent you might actually need to access the new healthplan's benefits. Often if there is even the slightest hint that you might need to access a service, coverage is declined for standard policies and you are steered into government "guaranteed issue" pools along with everyone else who might have a "pre-existing" condition, as the starting gate constantly gets readjusted throughout our lifetimes. You ain't seen nothing in terms of sticker shock until you have arrived here!

In their defense, the industry is not entirely to blame for the sorry state of the individual health insurance market. One thing that particularly drives up costs and influences behavior in this

market is the fact that the government has taken a special interest in determining what consumers need. For the last 35 years, state legislatures have passed laws compelling private insurance to expand its range of coverage. Known as mandated insurance benefit laws, they force insurers, employers and managed care companies to cover specific providers or procedures not usually included in basic healthcare plans.¹ In 1965 there were only eight state-mandated benefits. Today there are more than 1000. They cover services ranging from alcohol and drug abuse to in vitro fertilization. They cover providers ranging from acupuncturists to naturopaths. They cover heart transplants in Georgia, liver transplants in Illinois, hair pieces in Minnesota, marriage counseling in California and pastoral counseling in Vermont.² Although this legislation is nearly always styled as consumer protection, it is almost never the result of consumers lobbying for it, but rather the result of extensive lobbying by special interest providers looking for ways to increase their own volume of business. The cost is ultimately borne by the consumer, with no choice in paying for a collection of services they may not even want.



While some of this stuff can affect health insurance across the board, the majority of it actually winds up affecting a small minority of the private insurance population. Generally states exempt their own Medicaid population and even their own employees. Most large and

medium sized companies avoid state mandates by self-insuring under the Employee Retirement Income Security Act (ERISA), which preempts state law and shields self-insured companies from state regulation.³ So the segment of the population actually subject to the mandates and bearing the brunt of these actions is that which is most vulnerable: individuals and families who purchase their own insurance and employers and employees of small businesses.

National Center for Policy Analysis Estimated Additional Cost for Certain Benefits, Calendar year 1997		
Benefit	Estimated Additional Annual Cost	
1. Minimum Stay Maternity	less than 1%	<\$35*
2. Speech Therapy	less than 1%	“
3. Drug Abuse Treatment	less than 1%	“
4. Mammography Screening	less than 1%	“
5. Well Child Care	less than 1%	“
6. Podiatry	less than 1%	“
7. Papanicolaou (Pap) Smears	less than 1%	“
8. Vision Exams	1% to 3%	\$35 - \$105
9. Chiropractic Treatment	1% to 3%	\$35 - \$105
10. Alcoholism Treatment	1% to 3%	\$35 - \$105
11. Infertility Treatment	3% to 5%	\$105 - \$175
12. Mental Health Care	5% to 10%	\$175 - \$360
Total	15% to 30%	\$525 - \$1,050
*Based on a standard family policy without mandates costing \$3,500 per year.		
Source: Milliman & Robertson.		

Mandates also come in the form of restricting administrative processes. The current focus on federal regulation has been targeted on dismantling many of the cost management restrictions that have been imposed by HMOs. This will have a tremendous impact on increasing the cost of healthcare.

The regulators have also subjected the individual insurance market to community rating requirements. This means that health insurers are required to charge everyone who lives in a certain area the same rate regardless of their health status. This is intended to prevent discrimination against the sick, but in actuality it tends to have just the opposite effect. It causes insurers to recruit healthy people, often reflected subtly in benefit design and network offerings, and to do their best to avoid anyone suspected of actually needing the services as explained in the underwriting commentary above. The rates for these plans will escalate over time, driven by what is termed adverse selection. Those who require lots of services will persevere in getting on the plan or remaining on the plan over the long term. Those who don't, will eventually bail or never join at all because the premium cost, based on their expected needs, is prohibitive. Essentially this pricing mechanism is based on half the people subsidizing the other half, which results in a ton of high utilizers as the only folks willing to stick around and pick up the tab.

Which now brings us full circle to fully understand the problem with the uninsured. Currently we have over 43 million people uninsured in this country and the number is growing. We would have more, but for the fact that we have in place fairly extensive safety net programs for the poor in the form of Medicaid. Because of government mandates and other factors contributing to extremely high costs for insurance in the small group market, nearly one half of all businesses with less than 50 employees cannot afford to offer health insurance. So these 43 million people are that portion of the "unfairly neglected" segment of the population that does not have insurance provided by an employer, makes more than the poor so does not qualify for Medicaid,

*Why Insurance Premiums in
New Jersey
are the Highest In the Nation*

- 1) Community rating-- charging the same price whether one is 18 or 64, male or female. The young and healthy don't value insurance enough, so bail out-- only the older and sicker remain. Prices rise.
- 2) Guaranteed issue-- people can avoid insurance until they have good reason to buy it--like they sense they may be getting sick. One can find he has hepatitis C, buy insurance, then wait the one-year pre-existing condition period, and be fully covered for very expensive interferon.
- 3) Mandated \$300. per year yearly allowance per person for "preventive care." This add \$500 per person in insurance premium when you factor in the paperwork.
- 4) Government mandates for specific treatments.
- 5) Making high deductible insurance illegal. No one is allowed to purchase insurance with a deductible higher than the MSA deductible of \$4500 for a family. Again, the healthy have better things to do with their money.
- 6) Government regulations different for small businesses, big businesses, HMO's, individual policies, etc. A great patchwork of regulations that leaves us all confused.

That's it in a nutshell. How to ruin insurance in one lesson. How to fix it? Everyone I speak to looks at their part of the elephant and refuses to see the big picture. Maybe after the next election.....

Alieta Eck

November 2003

and either can't afford the excessive rates for insurance offered in the individual market, or has deemed that the value proposition for their personal situation is simply not there and have opted to go without health insurance. Actually a large portion of the increase as this segment

The Number of Uninsured

The 40 million uninsured estimate suffers from a number of well documented problems. Estimate for chronic uninsured from more tightly structured surveys is more like 9-10 million. These are relatively small numbers in a population of 300 million. They should not drive policy. If they did, government concern for the homeless would be determining how Americans buy their shelter and finance their home purchases. Developers and homebuilders would have to fill out paperwork for every faucet installed, and we'd all be living in cramped, ill-designed, public housing at astronomical rents.

If sensible regulation and an end to government cost shifting led medical care costs to decline to, say, the price of a car for most serious illnesses, why would people need health insurance? After all, 200 million Americans appear to have no trouble affording personal transportation...

Linda Gorman
August 2003

of the population occurs in households earning \$75,000 a year or more.⁴ The most recent increase added another 2.4 million, cutting across income levels, employer size and citizenship status, bringing the total for people without coverage to 15.2% of the population.⁵ So, there is a pretty logical explanation for why this phenomenon occurs. Up until very recently (December 2003) there has been no tax relief for these individuals and regulation artificially raises the price for them. But more importantly, again in the government's infinite wisdom and spirit of consumer protection, and precisely because of more government mandates, it is increasingly easy to obtain health insurance after you get sick. And if a catastrophic emergency arises, it is against the law for an emergency room to turn anyone in need away. So why should it surprise anyone that the "unfairly

neglected", opt to skip the insurance? It often makes more financial sense to simply wait for their luck to change when a future employer or the government will take over responsibility for figuring out what they need and providing it for them.

While increases in the numbers of uninsured continually set off warnings of a public crisis, there really is no crisis. Lacking health insurance is not the same as lacking access to medical care and people without health insurance are treated everyday. Most are neither destitute nor derelict, and they pay their bills. Generally most of the uninsured are short term, usually between jobs, and most pay out-of-pocket for their health needs. Uncompensated care is 3.5% of total healthcare spending. This is a trivial amount of money that will be reduced even more as we extend tax subsidies to people who buy their own coverage.⁶

One final point before we move on is the need to recognize the havoc that is wrought through the price controls established for government programs. Government expenditures including Medicare and Medicaid programs are nearly 50% of total healthcare spending. Most of us are funding these programs as well as emergency care extended to the uninsured through payment of our taxes. But we are also indirectly funding them further through the rampant cost shifting that exists in the industry. To control costs for these government programs, fee schedules and price controls are imposed. Often the reimbursements do not cover the cost, particularly those established for the Medicaid programs. To make up for the shortfalls, providers have shifted costs to the private sector for years by charging significantly higher fees for the same services. “Billed charges”, particularly for hospitals, are set at levels far above the actual cost to provide the services. Very seldom do third party payers pay billed charges. They are in continuous negotiations to secure discounted rates and resolve payment issues. But the unreasonable and irrational moving targets for paying providers creates an unparalleled level of contention and confusion. Basically the provider’s response to dealing with price controls for over one half of their business, is to go after whatever the market will bear for the rest of it. Unfortunately the uninsured have been their most vulnerable target, since third party payers, rather than the patient, are generally paying the bills, this bizarre pricing model has continued to prevail.

THE HUGE MEDICARE PROGRAM IMPACT - WHY IMMEDIATE STEPS FOR REFORM ARE CRITICAL

Whether or not you are even close to retirement age, it is fairly important to have at least a basic understanding of how this program operates and how its policies effect just about everything else that goes on in the healthcare industry. Most of us will reach retirement age at some point, so how care is accessed and delivered at the time in our lives when we generally need it most should concern each of us. Baby Boomers may be starting to get just as exposed as the current Medicare recipients by being involved in caring for elderly parents. No matter how young and far removed you feel you are, everyone paying taxes is footing the bill - and it's a pretty large bill that is growing at a phenomenal rate.

As mentioned earlier, nearly 50% of all healthcare spending is paid by the government largely through the Medicaid and Medicare programs, with Medicare's accelerated growth imminent, in part propelled by our demographic shifts. It is a system of central planning and price regulation in which bureaucrats control nearly all aspects of the financing and delivery of medical services. With a growing proportion of all care being rendered subject to government price controls, the obvious result is still even greater cost shifting to the private sector, a sector which will be proportionally shrinking over time. What we have is a recipe for disaster, which is only exacerbated as the government attempts to add a prescription drug benefit for seniors on top of it. It is time for the politicians to wake up.

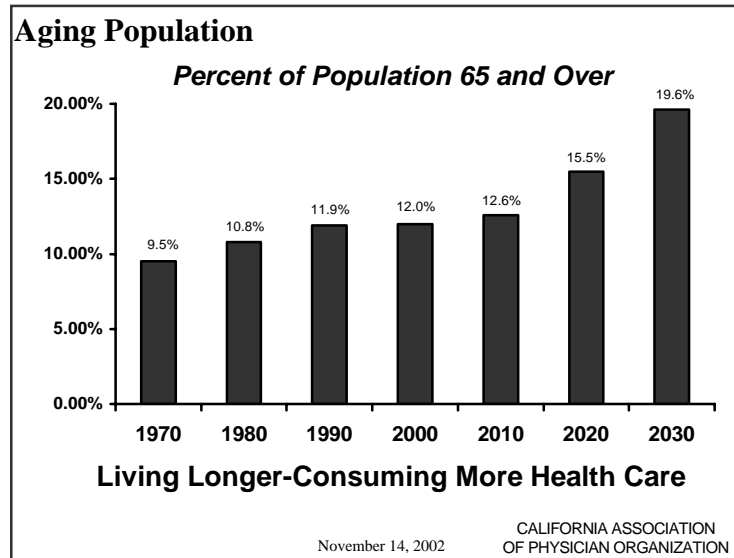
Government Healthcare

Medicare is not an insurance program. Medicaid is not an insurance program. SCHIP is not an insurance program. Do not call them insurance programs. Call them government health care. They are paid for by general tax revenues, more or less. The fees charged the people in them have no relationship to costs. People pay taxes and fees to these programs, not premiums.

Linda Gorman
July 2003

In 1965, the average senior struggling against an impoverished old age received \$1 per year in healthcare-related government support. Thanks to Medicare, that number has vaulted to

\$7,000 today.¹ Intentions were certainly honorable back in 1965 when the government determined the need to guarantee access to good medical care for every senior citizen in the nation. Back then there were less than 20 million seniors, they weren't living long into retirement, and a large percentage of them were relatively low on the socioeconomic scale. Maybe it's precisely because they weren't living all that long that coverage for long term care was not even considered.



Today we have a totally different scenario. In the last century there has been an eightfold increase in our 65+ population. We went from 3 million to 33 million, and by conservative estimates we are projected to reach 70 million by 2035. Due to modern science, these folks are living considerably longer than back at the programs inception, and have now emerged as the most affluent segment of our society. They have moved from underdog status to bulldog status. Today's 50+ men and women now control 80% of all the money in U.S. savings and loan institutions and represent \$66 of every \$100 invested in the stock market. In addition, a remarkable 70 to 75 percent of all older men and women own the homes in which they live, about three-quarters of which are completely paid off.² Robust government entitlements; home ownership; a lifetime of savings and investment; and recent discounts on airfares, hotel stays, rental cars, movies, financial services, and dining have all contributed to drive the official poverty rate for those age 65 and over from about 35 percent early in the 1960s to an all time low of 10.5 percent today.³ Yet we continue to maintain this program of "social insurance" whereby the younger segment of our society continues to pay taxes, an ever

increasing proportion of which goes to improving the welfare of another, senior citizens who are often in a much better position to provide for themselves.

But the day of reckoning is approaching. The pyramid scheme that funds our greatest entitlement programs is about to derail. The record taxes of today's baby boomers have been able to fund Social Security and Medicare, but future generations will simply not be large enough to support our impending demographic shift. Between 2010 and 2030, the size of the 65+ population will grow by more than 75 percent, while the population paying payroll taxes will rise less than 5 percent.⁴ Those that have done the math predict that without major alterations in both these programs, 40 percent or more of every worker's paycheck will be needed to cover old-age entitlements.

Untapped Assets

Many elders claim need for government help when they knowingly or unwittingly have adequate funds secured in their fully owned, unencumbered houses. Reverse mortgages and viatical settlements of various sorts could liberate cash for these people while nevertheless they would retain possession of their own homes until they die. They would have money available for MSAs, for long-term-care policies or LTC itself, and maintain dignity and choice for medical care. At the elders' deaths, their beneficiaries would get less money on the sale of those now "mortgaged" homes.

Each elder homeowner would have benefits of the property's value, independence that comes from choice, and retain a life estate. What are the stats for the majority of people over 65 living on fixed incomes who do not realize they are living in a bank?

Dr. Madeleine Pelner Cosman, Esq.
August 2003

But does it make sense for younger workers to be heavily taxed to provide entitlements for those elders who really don't need them? "Do we deserve such special treatment?" asks former President Jimmy Carter in *The Virtues of Aging*. "The fact is that I and more than a million other Social Security beneficiaries would be considered quite wealthy, while many of the Americans supporting us may be struggling to make ends meet."⁵

With Medicare, what we seem to have is a multi-billion dollar program that shifts funds

from one generation to the next, where it is probably needed least, and in the process has contributed significantly to the spiraling inflation we experience in the healthcare industry. In addition, the program violates all principles of sound insurance and most definitely is not meeting the needs of today's seniors.

Libertarian Harry Browne writes in *Why Government Doesn't Work*, "The elderly now pay from their own pockets over twice as much for health care (after adjusting for inflation) than they did before Medicare began. And most older people now find it harder to get adequate

medical service.”⁶ Medicare is not a comprehensive health plan. Most coverage in the private sector includes prescription drugs since their use is generally a tradeoff for other types of treatment. Nor does Medicare provide catastrophic coverage, which most consider the primary tenet for insurance. The program covers the whole gamut of routine medical services, those that could easily be paid by most seniors, but not the cost of long term care, which is the greater financial threat for those with ever increasing life spans.

Medicare is an acute care model. We spend huge sums to treat patients and almost nothing

Why Medicare?

Medicare was never meant to help people in need. It was meant to expand big government. Back in 1961, Dr. Ed Annis, President of the AMA, made a valiant attempt to stop JFK from starting Medicare, explaining, at a speech in Madison Square Garden in NYC, that there were already good programs for senior citizens in need, and that private insurance was growing rapidly in the senior population. We didn't need a big new program.

He said, that Medicare would make government responsible for "everyone over 65 ...That means everyone--the rich, the well-to-do, the comfortable.. The American taxpayer, whose payroll tax would be hiked by as much as 17 percent to start with in order to pay for this program certainly has a right to question the free ride those who do not need these benefits would be taking at the expense of his children."

Further, "this bill would put the government smack into your hospitals, defining services, setting standards, establishing committees, calling for reports, deciding who gets in and who gets out, what they get and what they don't, even getting into the teaching of medicine and all the time imposing a federally administered financial budget on our houses of mercy and healing."

Anyway, Dr. Annis was prophetic, and certainly understood that helping the poor was low on the list of priorities for the party that wanted the big program. For the poor single mom who has to foot the bill for the rich millionaire was not considered at all.

Alieta Eck, MD
August 2003

on prevention. Approximately 28 percent of the entire Medicare budget is spent on a patient's last year of life. Many healthcare businesses reap their greatest profits when the dying process is protracted. In fact, if we allowed elderly patients the dignity of dying a natural death at home, we could save approximately \$50 billion per year, which could be used for others who urgently need assistance, such as the more than 20 million uninsured children and adolescents in this country.⁷

Ken Dychtwald, Ph.D., the best selling author of *Age Power* addresses the prevailing mismatch of our priorities. "Many aspects of our current healthcare system are out of sync with our emerging problems: Our scientific research priorities are misaligned with the diseases of the aging; healthcare professionals are not skilled in geriatric medicine; our financing mechanisms do not emphasize prevention or cost effective treatment of age-related illnesses; and our long term care services are underdeveloped and fragmented. Even Medicare is based on an acute

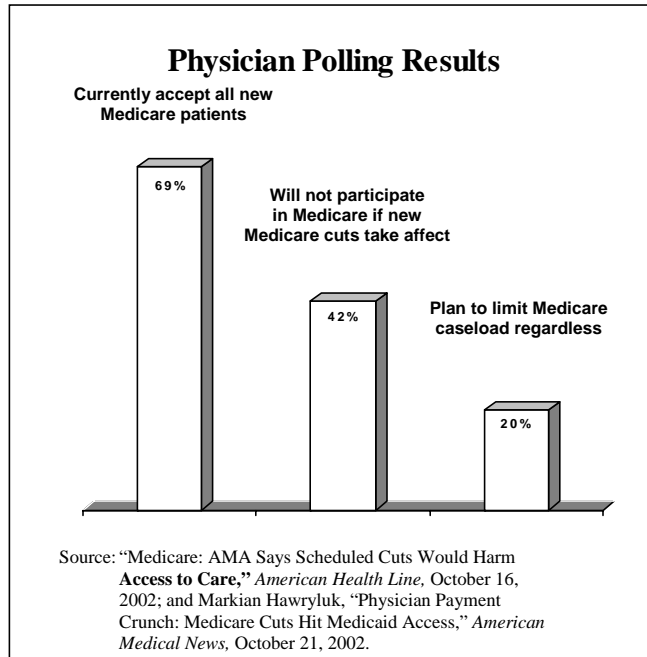
care model most appropriate for the young. We are spending enormous sums of money on the wrong things and, not surprisingly, the results are mediocre at best.”⁸

He goes on to suggest that additional funding is not needed to solve the problems, but rather “by redirecting the priorities and resources of this system, we could be producing much healthier elders and greater longevity for a far smaller amount than we are now spending. If we are to solve these problems before reaching an era of crushing chronic disease epidemics, we must:

1. Commit greater attention and resources to the scientific research required to delay, or if possible, eliminate the diseases of aging.
2. Provide the academic training and continuing education to ensure that healthcare professionals are fully competent at meeting the needs of the new old.
3. Make disease prevention and self-care a national priority.
4. Orient the economic incentives of our healthcare system towards healthy aging.
5. Establish a more humane, respectful, and cost-effective approach to death and dying.⁹

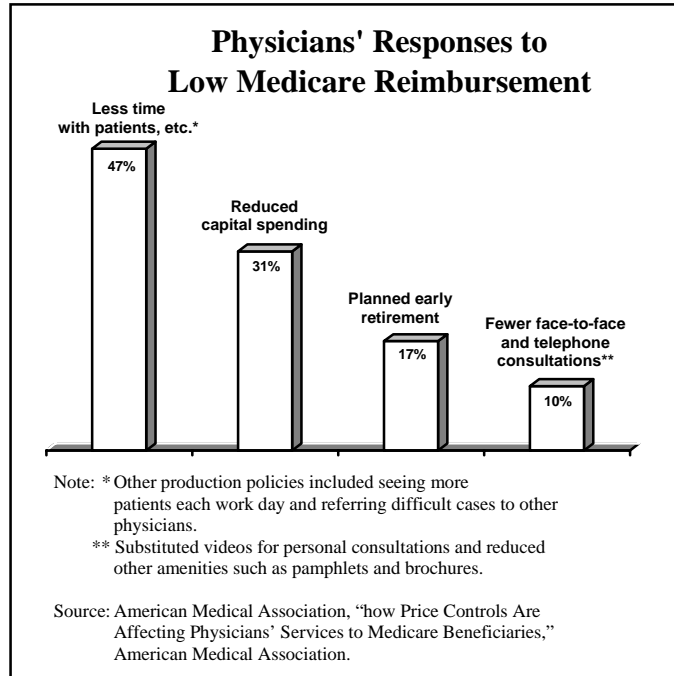
Medicare has definitely been misguided. Of almost 100,000 medical residency and fellowship programs that Medicare has helped to support, less than 1% were in geriatric medicine. While Medicare paid nearly \$7 billion in graduate medical education costs in fiscal year 1998, only a tiny fraction of those dollars were directed toward the clinical education of physicians who focus on the healthcare needs of older adults.¹⁰ Men and women over 65 already consume a third of all healthcare spending, approximately \$342 billion, yet the National Institutes of Health (NIH) spends only 8 percent of its \$15.6 billion research budget for aging-related research.¹¹

The focus for Medicare seems to be on curbing cost increases for office visits and procedures. With the current Medicare reimbursement structures, there are limited incentives for providers to develop state of the art, comprehensive treatment programs targeted at treating the major chronic conditions that consume the majority of our healthcare resources. Direct and indirect costs for heart disease, cancer in all forms (with breast and prostate cancer being particularly predatory among older adults), strokes, arthritis, osteoporosis and Alzheimer’s are estimated to be more than \$500 billion annually.¹²



In fact, the cost control efforts for the Medicare program are so severe that increasing numbers of physicians are ceasing to participate. According to the AMA, almost 30 percent of physicians limit the number of new Medicare patients they will accept - or do not accept Medicare patients at all.¹³ Severe shortages of physicians willing to take on Medicare patients are now being reported in retirement Mecca's like Florida and Colorado. Many seniors now have to make as many as a dozen calls just to find a physician who is still accepting new Medicare patients. Others are dropped by their longtime doctors when they turn 65.¹⁴ Physician responses to government price controls include less than satisfactory encounters with elderly patients.

The lesson in this complex of problems is not that the government should pay higher physician fees to Medicare providers. Rather patients should be able to pay market rates for physician services. Some physicians may charge higher fees for greater skills or extra services provided. Some patients may choose to pay higher fees for desired amenities. Government price fixing is no solution to the healthcare needs of the elderly.¹⁵ We are



finding that the shortages prevalent in most nationalized healthcare systems worldwide are now beginning to permeate our social “insurance” Medicare program.

Any discussion on Medicare would be remiss without including the current focus on how to best include a prescription drug benefit. Since the failure to cover pharmaceuticals can often result in more costly therapies, any sound health insurance program will cover drugs, as we see is generally the case with private insurance. Vaccines and pharmaceuticals have played a major role in reducing healthcare costs. In recent years, pharmaceuticals have abated the damage caused by hardening of the arteries, high blood pressure, emphysema, and ulcers. A new class of ulcer medications, introduced in 1977, reduced the number of operations from 97,000 to a mere 19,000 ten years later and even fewer now. The drugs clocked in at a cost of \$900 per patient, while the ulcer surgery costs about \$30,000.¹⁶ Columbia University professor Frank Lichtenberg analyzed three years of data (1996-98) and found that the additional dollars spent on newer brand-name drugs reduced other health-care spending by more than seven times as much. Furthermore, nearly 18 cents of each dollar spent is plowed back into research and development.¹⁷

Of concern is not the fact that our politicians are now attempting to address the need, but rather how they are going about it. To even consider simply tacking on a multi-billion dollar supplemental benefit to our already dysfunctional Medicare program is extremely remiss. I shudder to think what will happen to pharmaceutical costs for the private sector once large scale price fixing begins for the elderly. Think back to what has happened with the cost of a hospital stay since 1965.

Additionally we must consider what impact government intervention will have on research and development in the pharmaceutical industry. We complain about the rising costs of prescription medication and the obscene profits that are reaped by the industry, but clearly the

The Cost of Drugs

A lot of Americans like to demonize drug companies. Some of my patients join in the chorus.

For example, Levaquin, a broad spectrum antibiotic, costs the patient about \$10 a day. It is very effective for pneumonia, sinusitis, pyelonephritis and many other infections. I don't use it much - but when I do I tell the patient about the cost and the need for them to fill and take the prescription - otherwise they might end up in a hospital.

Pneumonia used to kill people - now it is usually treated successfully as an outpatient with medicines like Levaquin. Seems to be that drug companies are providing a real service to mankind - unlike reporters who can't get their facts straight.

Most folks without insurance generally can appreciate that a \$100 prescription can keep them out of the ER and from an admission to the hospital - which could bankrupt them. Other patients aren't so quick. When they start getting on their high horse about drug costs, I go to the PDR, copy the formula for the drug in question and tell them they can either go home get out their chemistry set and manufacture the drug themselves (after all, the formula has already been provided for them) or they can reward PhD chemists what they're worth. They get the idea.

Robert S. Berry MD
June 2003

advances that are being made are phenomenal. Brand- name drug companies already face shorter effective patent periods than other industries. Although all patents last 20 years, drug makers spend 8.5 years, on average, putting their drugs through an extensive FDA approval process. That means only 11.5 years remain for the manufacture to sell the drug and recoup its costs before generic competition ensues. These costs have grown dramatically, from \$231 million per drug in 1987 to \$802 million in 2000. Only about three out of 10 drugs brought to market will earn enough revenue to recoup their costs. Currently lower priced generic drugs constitute over half the market for prescriptions. Brand-name manufacturers, meanwhile, must remain highly profitable if they are to continue the research and development that yields

breakthrough drugs. Developing new drugs is a high- risk proposition - only one out of 5000 compounds that are tested will make it to market. And as any investment counselor will tell you, greater risk demands a higher return on investment in order to attract capital.¹⁸

The U.S. has taken the lead worldwide in the pharmaceutical industry primarily due to strong patent protection and relative freedom from price controls. An environment of primarily third party payment has perhaps also contributed to the industry's ability to maintain attractive profits and higher prices at home while tapping other markets globally. With greater regulation we run the risk of stifling the innovation we desperately need to head off the chronic epidemics that appear immanent with our changing demographics. A better tactic with respect to rising costs would be to simply inject free market dynamics back into the purchase decisions.

So how do we provide drug coverage to the elderly without destroying the pharmaceutical industry and also address the current train wreck waiting to happen with the Medicare program? All of the issues with limited access, spiraling costs, reduced innovation for quality and limited consumer choice can all be addressed by following the example congress has already taken when creating and reforming programs for federal employees and retirees.

Per Christopher Middleton at the Pacific Research Institute, Medicare should be reformed by creating a new defined contribution program, using as a general model the Federal Employees Health Benefits Program (FEHBP). The FEHBP covers virtually all employees and retirees of the federal government.

The RX Debate

The debate on prescription drugs and Medicare is beyond sad. They will undoubtedly pass a program, and in no more than 10 years people will look back and be outraged at how stupid we all were. ..

Overseas the social systems are failing one by one and many countries are trying to move toward a system that includes significant elements of private enterprise...

A disastrous drug program will get us to a crises sooner, and perhaps that is what we need; we need another crash for the public to realize just how big the bubble is.

Mark Litow, F.S.A.

This new defined contribution Medicare system should have the following features:

- The federal government should make a simple defined contribution on behalf of each enrollee. This means that the government contribution will be the same regardless of the amount of premium for the enrollee's chosen plan. A simple defined contribution is superior to the "premium support" schedule used by the FEHBP. It gives enrollees the proper incentives for weighing benefits versus costs when shopping for a plan, will do the best job of containing costs (both premiums and government contributions) over the long term, and will allow for the greatest diversity of plans in the new system.
- Like the FEHBP, enrollees in the new defined contribution Medicare system would choose their plan during an annual "open season" period lasting about one month. Education materials and web sites, however, would be available to recipients prior to open season.
- Current beneficiaries should be subject to a grandfather clause, allowing them to remain in the old defined benefit Medicare program if they wish. During the annual open season period, these beneficiaries would be given a non-reversible option to switch over to the defined contribution Medicare program. All new Medicare beneficiaries should be required to enroll in the defined contribution Medicare system.
- Participating plans in the defined contribution Medicare system should be allowed to risk adjust their premiums by age group. The federal government should follow suit by adjusting its contribution by age group. Risk adjusting for age serves as a preventive measure against the effects of adverse selection that the FEHBP has had to deal with from time to time.
- The defined benefit and defined contribution Medicare systems should exist clearly separate from each other, with separate federal oversight agencies. The Office of Personnel Management (OPM) is an excellent candidate to oversee the new defined contribution Medicare system, given its long history with the FEHBP. The Centers for Medicare and Medicaid Services (CMS) should continue as the federal agency in charge of the defined benefit Medicare system.

With these changes in place, the new defined contribution Medicare system will give seniors real consumer choice, provide access to different types of health plans that must compete to offer quality health care coverage, and involve seniors in controlling the costs of health care. Prescription drug coverage will be available to all, without the government price controls that would reduce research and development for new drugs.¹⁹

Moving away from traditional Medicare, with all its deficiencies, to a competitive model with choices is certainly not a negative as many politicians would like you to believe. Medicare recipients are currently locked into a dysfunctional program where they are having to absorb out-of-pocket nearly 50% of their total costs as it is. They need the opportunity to have access to the variety of coverage available in the private sector. Most people turning 65 today have a lifetime of experience in the private healthcare sector. Particularly as that sector also experiences reforms in benefit offerings over the next several years, it is highly unlikely that they will be satisfied with the Medicare program of today.

A precedent for this type of transitional approach to government reform occurred in 1983 when, in order to limit the federal government's future liabilities, the federal employees extremely generous defined benefit Civil Service Retirement System (CSRS) was closed off to new employees and replaced with the Federal Employees Retirement System (FERS). FERS retains a less generous defined benefit and is dominated by a defined contribution that operates similarly to many 401(k) plans. The CSRS program has been shrinking over time, only covering employees that were hired before January 1, 1984, and will at some point cease to exist. It makes a lot of sense for a similar fate to occur with our current outdated and dysfunctional defined benefit Medicare system.

Future Expectations

People approaching Medicare eligibility today are different than the stereotype of yesterday. They are better educated, healthier, and increasingly equipped with the experience and resources needed to make their own decisions in health care.

At the same time, they will be less likely to have third-party support for their medical needs as employers continue to cut back on retiree benefits or take a "defined contribution" approach to funding those benefits.

Greg Scandlen
Consumer Choice In Medicine

With all the money currently being expended on healthcare for the elderly - through tax revenue, Medicare premiums, supplemental insurance and out of pocket expense, there is enough money that can be reallocated to purchase a single acceptable health policy that adequately covers prescription drugs and catastrophic risk. The ideal scenario would be for

Public vs. Private Sector

Wrong-headedly, certain Democrats and former Medicare bosses like Nancy-Ann DeParle and Bruce Vladeck love the fact that Medicare is a giant single payer, soon to have a finger on nearly half of all medical spending as the baby boom retires. Their idea of cost control is for Medicare to be so big that it can dictate the prices that doctors, hospitals and drugmakers receive for their services. This, we're here to tell you, is the seed corn of the "Medicare fraud" people keep yelling about.

Ms. DeParle, Mr. Vladeck and other Medicare advocates can be heard piping up that those seniors like the system the way it is. Any idea that older voters should be asked to restrain their appetites or put up with inconvenience for the sake of other important national purposes is treated as anathema. "What's best for Medicare beneficiaries" should be our lodestar, says Ms. DeParle.

Huh? Medicare, let's remember, is a handout, and the people who pay for much of it -- working taxpayers -- have interests that need to be considered too.

At the same time, let us not exaggerate the benefits of Medicare reform. Medicare will never be an efficient program. It will never be a driver of efficiency in the larger health-care economy. Only the private sector can do that -- with spillover effects that would make Medicare more efficient and affordable too.

But private-sector health care itself is in serious need of reform, thanks to the mortal flaw of tax-free treatment of company-provided health insurance, which drove a frugal consumer out of the equation. Only then will the ax strike the root of our current dissatisfactions.

Holman W. Jenkins Jr.

Wall Street Journal, July 9, 2003

retirees to be able to simply take their existing health policy into retirement. Certainly seniors should have access to the same types of coverage as non-seniors. Another good reason to abolish the traditional Medicare defined benefit structure is that it would liberate doctors and hospitals from the existing regulatory excesses and red tape, and liberate us all from the havoc played in the market by government price controls. The rampant opportunities for fraud and abuse that Medicare experiences today would be significantly reduced. Seniors would have the opportunity to choose from a variety of options and there would be no need to continually change the law to change a benefit plan. Once Medicare beneficiaries have the same access to coverage as the private insurance market, they could then also

benefit from additional reform proposals discussed more fully in Chapter 9.

THE RISE AND FALL OF HMOs AND MANAGED CARE

Government intervention into the world of healthcare with the advent of the Medicare program resulted in the medical profession becoming less efficient, less innovative, and less cost effective, with the private market soon to experience the effects of higher costs as health care providers charged them more to offset the lower reimbursement rates provided by the government. This became the catalyst for the emergence of the “dreaded” HMOs beginning in the early ‘70s, and certainly holding their own throughout the ‘90s. Because government rules and regulations had so distorted the fee-for-service system, these institutions were set up to standardize care and provide lower costs, with an emphasis on the promotion of preventive care. Unfortunately, managed care has not been able to change the underlying incentive structure created by third party payment.

By 1996, HMO enrollment had penetrated 31 percent of the employment-based insurance market. Gradually, over time, we transitioned from health insurance to prepaid health care. Considering the tax advantages associated with employer provided coverage, this shift comes as no surprise.

The basic premise behind a Health Maintenance Organization’s (HMO’s) ability to control cost and quality is that, unlike in the fee-for-service world where the more a physician provides, the more he will earn, with prepaid healthcare the incentive is only to provide that which is necessary. Since providers are responsible for the ultimate health of all their prepaid members, there is no incentive to skimp on necessary services that may prevent further complications down the road. Ideally, to keep costs down and to remain competitive, there is an incentive to develop effective systems and protocols for the delivery of care. By promoting preventive measures and coordinating all the care that is provided to a member, quality should be a natural outcome.

So how do HMOs go about managing their member's health care on a prepaid basis? The most effective model in terms of coordination is when care is managed and delivered by a large multi-specialty medical group that employs the majority of the providers needed for the population they serve. Kaiser Permanente has been the industry leader, but not always the most cost effective, and as they have found, their model cannot necessarily be replicated in all markets. Other "bricks and mortar" players have come and gone, or are still hanging on with moderate success, but quite frankly the volatility of the patient base makes it difficult to survive, with open enrollment decisions more heavily influenced by the employer rather than the employee.

The truth of the matter is that health care is still very much a cottage industry. Most of the HMO growth has come through the development of Independent Provider Associations (IPAs) to serve as the network for the product in a given geographic area. To gain access to HMO patients, an individual physician must contract with an IPA who in turn contracts with one or more HMOs (who in turn are contracting with numerous employer groups, who are negotiating arrangements on behalf of their employees). Talk about a consumer disconnect! More often than not, the IPAs contract on a prepaid basis for each member assigned to them, so they then operate under the same incentives to coordinate and provide only necessary care.

For a number of years, HMOs have in fact been successful in curbing the rising cost of health care, particularly in the late '80s and early '90s. Much of this success can be attributed to the diligence of health plans and their provider sub-contractors to actively pursue sharply discounted payment rates in exchange for directing large volumes of business to selected hospitals and physicians. Thus emerged the concept of consumers being tied to a defined network of providers to obtain the most attractive benefits or oftentimes any benefit at all. When providers are compensated on a pre-paid basis and assume risk for the services provided, it necessitates this "lock-in" requirement. Health economist Michael Morrissey defines managed care as nothing more than "selective contracting".¹

The expectation was for efficiencies to emerge as providers assumed risk, and in some instances that did occur, particularly in the large medical group model. But for the most part, an initial wave of medical management swept through the industry, reducing hospital stays

and actively moving patients to lower levels of care, when warranted, to reduce costs. Intensive case management for high risk diagnoses and chronic diseases has also played a role in reducing costs, but the industry has reached a point where what was considered “low hanging fruit” in terms of tactics for cost containment have now been exhausted. And many patients subjected to rigorous medical guidelines and limitations on choice, have not been satisfied with the results.

How does an HMO go about eliminating unnecessary care? In an effort to bring some rational standardization to the delivery of health care, they may have been erring more often on the side of rationing than rational. Martin Feldstein, the economist who once chaired the President’s Council of Economic Advisors, notes in a review of nearly thirty years of his research that “I now recognize the fundamental importance of the uncertainty of health care technology...although doctors know a great deal, uncertainty is ubiquitous in health care...Even after diagnosis and treatment, uncertainty remains...even the...relation between behavior and outcomes is often very uncertain.”²

In the early days of the managed care revolution, it was thought that a single set of national guidelines could be established for physicians practicing in all parts of the country. John Goodman, in *The American Experience with Managed Care*, points out that in the early 1990’s, the American Medical Association and the RAND Corporation agreed to jointly develop national practice guidelines, and Congress mandated that the Department of Health and Human Services do the same. A single set of national guidelines is consistent with the theory that managed care protocols are based on science. But the evolution of managed care has produced just the opposite—a blossoming of thousands of guidelines. By 1989, there were 700 sets of guidelines developed by 30 national organizations. Today, about 1,800 sets of guidelines exist. Managed care organizations, hospitals, private researchers, and pharmaceutical organizations have developed thousands of others. All these guidelines suggest that managed care protocols are primarily designed to give each plan a competitive edge in reducing costs, irrespective of science.³

In managed care, certain procedures and care for all high cost cases are subject to “prior authorization” by the plan according to some set of guidelines being followed and the judgment of the plan’s medical director. As a general rule, most requests from physicians are authorized since medical ethics seem to prevent most physicians from doing things that are clearly unnecessary or failing to do the clearly necessary. Often a major function of the process is to simply steer the patient to the most cost effective contracted provider. When a request is denied for a reason other than the service not being a covered benefit, it generally falls into a vast gray area where medical consensus has not yet been reached.

In 1989 Robert Brook of the RAND Corporation asserted that “perhaps one-fourth of hospital days, one-fourth of procedures and two-fifths of medications could be done without.”⁴ In support of this contention, RAND researchers pointed to wide variations in 123 medical procedures for Medicare patients in various parts of the country.⁵

	Panel’s Assessment ¹		
	Appropriate	Equivocal	Inappropriate
Coronary angiography²	74%	9%	17%
Carotid endarterectomy³	35%	32%	32%
Upper gastrointestinal Endoscopy⁴	72%	11%	17%
Overall	60%	18%	22%

Source: RAND Corporation study, reported in the *Wall Street journal*, March 22, 1990.

¹Based on medical records of 5,000 Medicare patients.
²Use of x-rays and dye and a catheter to explore obstruction of the coronary artery in the heart
³Surgical removal of obstruction in major arteries to the brain.
⁴Fiber optic examination of the esophagus and upper intestine.

But John Goodman points out that variation in treatment does not necessarily reveal that patients are being over treated or shortchanged. A follow-up RAND study collected medical records for 5,000 Medicare patients treated around 1980 and convened a panel of experts to judge the appropriateness of the three high volume procedures (coronary angiography, carotid endarterectomy, and upper gastro endoscopy). The widely published results indicated that more than one-fifth of all the procedures performed were deemed unnecessary, and thus

became Exhibit A in building a case for the managed care revolution. A closer look at the study reveals, however, much less consensus. Experts had to be brought in because appropriateness could not be determined by simply consulting the medical literature. Discussion and peer pressure brought the group closer to consensus, but the most remarkable fact about the RAND study was that even with all the efforts to arrive at a definitive judgment, 7 of 9 experts could agree less than half the time that the procedures were either definitely appropriate or definitely inappropriate.⁶ There are wide ranges between a do-no-harm standard and a conservative standard, and Goodman suggests “ These findings imply an enormous range over which discretion can be exercised and still fall within the bounds of good science and medical ethics. Put crudely, these studies point to the prospect of a health plan being able to make a great deal of money by substantially reducing the number of procedures performed without violating any professional code of conduct.”⁷

Another View of the RAND		
Study on Unnecessary Medicine		
	Percent of Time 7 of 9 Experts Agree that Procedure Is:	
	Appropriate	Inappropriate
Coronary angiography	50%	12%
Carotid endarterectomy	13%	17%
Upper gastrointestinal endoscopy	46%	7%
Overall	36%	12%

Source: RAND Corporation study, reported in Robert H. Brook, “Practice Guidelines and Practicing Medicine: Are They Compatible?” *Journal of the American Medical Association*, Vol. 262, No. 21, December 1, 1989, p.3021.

Milliman & Robertson is one of several organizations that have published guidelines on appropriate lengths of stay for surgical procedures that HMOs and other managed care organizations use. An assumption in formulating guidelines is often that if a length of stay objective is met somewhere in the United States, it can be met anywhere. Generally standard practice fails to meet standards based on state of the art processes that have yet to be implemented, and during the transition period, patients are subjected to less than ideal care situations.

Goodman has provided an excellent case study on mastectomies.

Case Study

M&R guidelines state that an ordinary mastectomy can be performed outpatient with a stay as short as six hours. There is a facility that meets this standard, but it is the only place in the world that does so—the John Hopkins Breast Center in Baltimore, Maryland. Under the leadership of Dr. William Dooley and Lillie Shockney, the center has revolutionized breast surgery by investing time, effort and energy in learning how to do the procedure differently from standard practice.

For example, whereas a mastectomy would ordinarily average about two hours, Dr. Dooley does it in 47 minutes. Because the center uses a different anesthesia and anesthetizes the patient for much less time, recovery is quicker and there are fewer side effects. Patients have the option of spending the night in the hospital, but almost all choose to go home. They can do so because several days prior to surgery they go through a three-hour training session with their care partner (usually someone who lives at home with the patient). Such training is important because patients need to be able to monitor their own progress and recognize signs of potential trouble. In addition, after surgery a nurse visits the patients in their homes twice.

The result is lower cost, higher quality and satisfied patients. Yet if an HMO insisted on outpatient surgery without the changes in hospital techniques and patient training, the risk of unhappy patients reappearing in the emergency room with further complications might greatly increase.

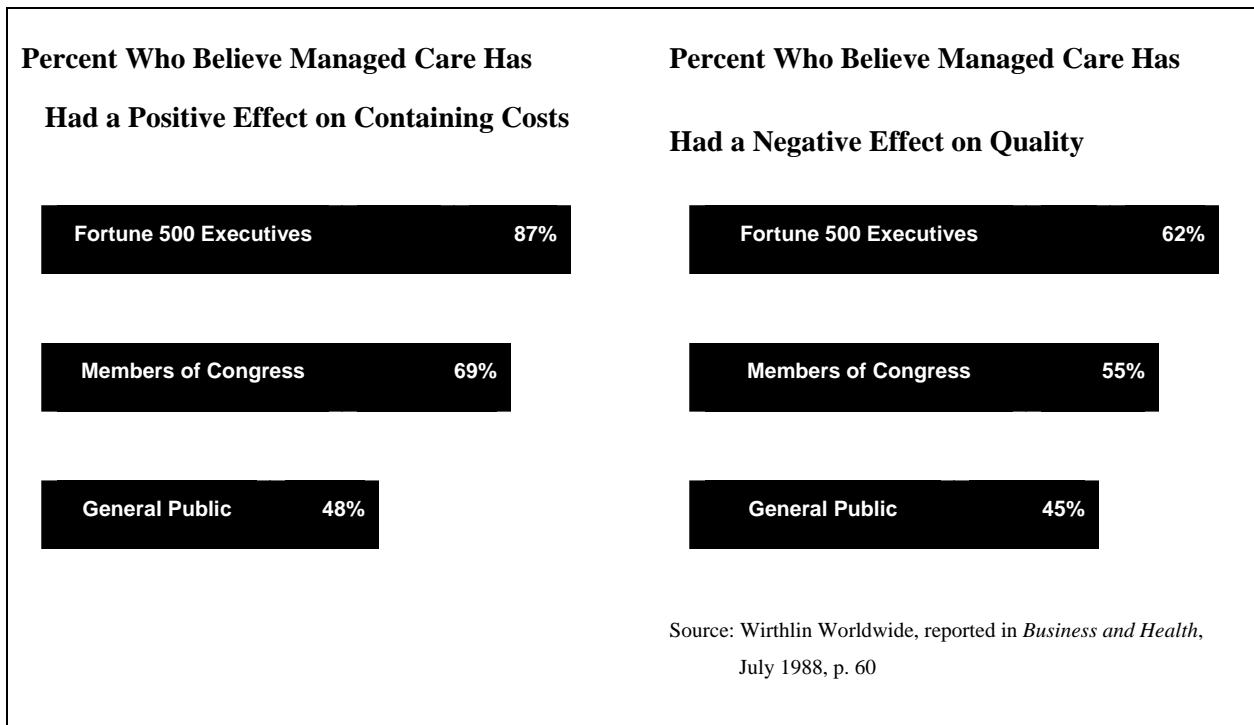
Economic Implications of the M&R Study

What the John Hopkins Breast Center has designed is a *more efficient* way to perform breast surgery. Women are not simply sent home earlier; they are *enabled* to go home early. And the fact that more hospitals around the country have not copied the techniques indicates just how inefficiently our health system functions, compared with other markets.

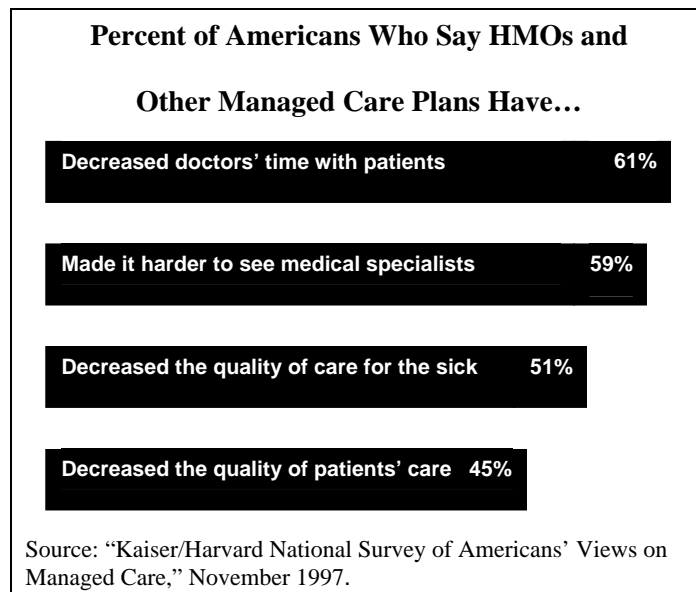
The RAND study focused on the decision to perform surgery; and many critics concluded that unnecessary care was being delivered for economic reasons. However, the opposite incentive is present with respect to length of stay. Most physicians have a direct or indirect economic incentive to reduce length of stay. The fact that it takes so long for efficient surgical techniques to be widely adopted implies that doctors are not responding quickly enough to economic incentives!

Why not? It is tempting to conclude that physicians find it easier to continue inefficient surgical procedures and the risks of early release than to invest in learning more efficient techniques. Unfortunately, this conclusion is consistent with the idea that managed care rewards cost reduction at the expense of quality more than it rewards cost reduction produced by greater efficiency and subsequent quality improvement.⁸

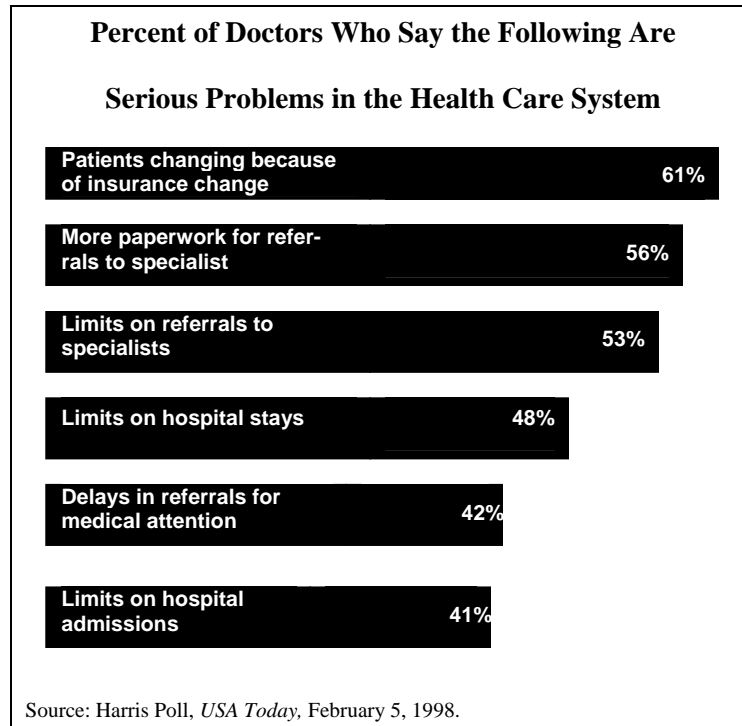
What about all the hype regarding coverage for preventive services? The HMO notion that preventive care will also reduce costs in the long run should also be examined. Contrary to popular belief, preventive care is generally not an investment good that promises a positive rate of return. The specific exceptions to this rule, however, are prenatal care for at-risk mothers, immunizations for childhood diseases and smoking cessation advice. Unfortunately, most people belong to the same HMO for only a few years, so even those investments do not generally pan out for an individual health plan. Most preventive care is actually a consumer good that creates a personal benefit in return for its cost. Despite the popular mythology, routine checkups for children and adults, pap smears, mammograms and most other diagnostic tests do not save the healthcare system money.⁹ Unless patients are specifically at risk, the benefit derived is peace of mind, and not an expenditure that will collectively reduce overall costs in the long run.



Nearly half the general public and certainly the majority of members of congress and large employers believe that managed care has had a positive effect on containing costs. The system that managed care replaced was dysfunctional. When doctors and patients could make unfettered decisions and send the bill for those decisions to insurance companies and employers, the inevitable consequence was rising costs. During the 1970s and 1980s, healthcare spending was increasing at roughly twice the growth rate of the economy as a whole—a trend implying that health care would consume the entire gross domestic product by the middle of the next century.¹⁰



But the perception now is also that managed care has had a very negative effect on quality. In all fairness, however, managed care is not entirely to blame. In the American health care system, we have turned insurers into buyers of health and rely on those buyers to force suppliers to become efficient. Yet the buyer's (insurer's) interest in holding down costs is not the same as the consumer's (patient's) interest in obtaining high quality. So in response to cost-reducing pressures from third-party payers, providers may find it easier and cheaper to cut costs by lowering quality rather than by investing time, effort and resources to become more efficient.¹¹



Dr. Robert Brook, the RAND researcher who more than any other single individual has promoted the ideal of achieving better, more efficient care through managed care guidelines, admitted in mid-1997 that the system isn't working. According to Brook, competition among provider groups to become selected is focusing exclusively on price. "Nobody is measuring anybody based on quality," he says.¹² Those sentiments are echoed by Paul Ellwood, the former Nixon Administration health advisor who coined the term "health maintenance organization" and who is sometimes described as the "father of managed care." "The idea was to have health care organizations compete on price and quality" says Ellwood. "The form it took, driven by employers, is competition on price alone."¹³

In the past couple of years there has been an attempt to develop and communicate meaningful quality measures, particularly as managed care organizations have now resorted to tiering provider networks in order to match cost with member choice. But healthcare administrators continue to struggle with the identification of meaningful measures, which is not surprising since an individual consumer's assessment of quality is normally very subjective based on a combination of factors, not the least of which is cost. Key to the ultimate determination of quality by a patient is the ability to access accurate and relevant outcomes information concerning the procedures and providers in question.

Quality will not evolve by mandating that physicians adhere to practice guidelines. Managed care guidelines have failed us in a number of ways.

- Guidelines tend to be based on average patients in average circumstances, ignoring the individuality of the non-average.
- Guidelines tend to encourage decisions that ignore patient attitudes.
- Guidelines tend to encourage decisions that ignore patient's willingness to pay for risk reduction.
- Guidelines often entail hidden value judgments that patients may not share.
- Guidelines tend to give scientific respectability to health care rationing.
- Guidelines based on outcomes research can never reflect state-of-the-art knowledge at the time medical decisions are made.
- Guidelines based on outcomes research can never capture all the relevant information physicians need to make decisions.
- Although guidelines are theoretically based on science, all too often they are rule-of-thumb protocols.¹⁴

Quality will ultimately emerge through the delivery of "patient centered" care in which the individual's values will be incorporated, not through strict adherence to managed care protocols.

In recent years, HMO enrollment has declined from the high in 1996 of 31 percent to 23 percent of the employment based insurance market in 2001. During this time, PPO enrollment grew from 28 percent to 48 percent.¹⁵ While PPO plans provide more options to members in terms of accessing providers, they are still managed care plans nevertheless. The insurance benefit is tied to a contract made between the provider and the insurer, irrespective of the wants and desires of the patient. Much of the care, at least for those most in need of care, is subject to prior authorization. Costs are no longer under control, and demand for services is rampant. Are we still saving costs by eliminating unnecessary services? Are we saving any costs through providing more preventive care? Are we saving any costs by providing "coordinated care", particularly in light of the tendency to offer IPA networks where efficiencies found in a group model simply cannot be achieved? Have we achieved the goal of uniform, scientifically based medical practice?

Managed care did hold down costs for a time, but more likely that not, cost pressures have induced physicians to deny care and skimp on quality far more than they have induced them to practice medicine efficiently. In perpetuating this model in its current form, we will get more of the same. It is time to try a different approach.

A QUICK REVIEW OF WHY A NATIONAL SINGLE PAYER SYSTEM IS NOT A VIABLE ALTERNATIVE

A national debate regarding appropriate ways to fix our troubled healthcare system has once again resurfaced. There is an underlying feeling from those on the left that the private sector has had its chance and cannot produce affordable and accessible healthcare. Never mind that government intervention and policies have been responsible for mucking up the works in the first place.

According to Linda Gorman, Director of Health Care Policy Center at the Independence Institute , a non-profit, non partisan Colorado think tank, “The proponents of big government health care have little to offer beyond the expansion of 40 years of oppressive regulation designed to force-feed patients a one-size-fits-all medical care only a bureaucrat could love. In the name of universal coverage, they push for Medicare and Medicaid expansions that would bring everyone under the dysfunctional government umbrella in the name of universal coverage. No matter that both programs are predicted to be bankrupt early in the 2020s.”¹

Many politicians along with vast numbers of ordinary citizens often have an idealized view of socialized medicine. The goal is to grant every person equal access to healthcare while controlling cost, but the inevitable outcome in almost every socialized healthcare system has not been the

Collectivism vs. Individualism

The historian Paul Johnson has observed that collectivism vs. individualism has been the overarching political struggle of the 20th century, and that is certainly turning out to be the case in medicine. Probably more than any other factor, the tilt toward collectivism has been the major factor responsible for the rising costs of health care in the past three decades. It helps to understand that these rising costs are simply a form of inflation. What is inflation but the devaluing of money relative to other things? What money are we most likely to devalue? Not mine, not yours, but theirs, everyone else's money - the government's, the insurance company's, the employer's. Because many peoples' health expenditures are often kept to partial insurance premiums, low deductibles, and low fixed copayments, individuals have been effectively removed from the role they play in all other financial transactions. They are no longer the judges of value and quality, the questioners of the need for the expenditure, the watchdogs of abuse. Instead bureaucracies must be paid to perform those functions, and more and more complex systems are created to contain the costs. But because artificial price controls have never been effective in controlling inflation, the costs continue to rise. In the bargain people are increasingly finding that they are paying other costs as well in terms of their freedom of choice over intimate matters and the privacy of their medical records.

Richard B. Warner, M.D.
The Real Culprit
December 1997

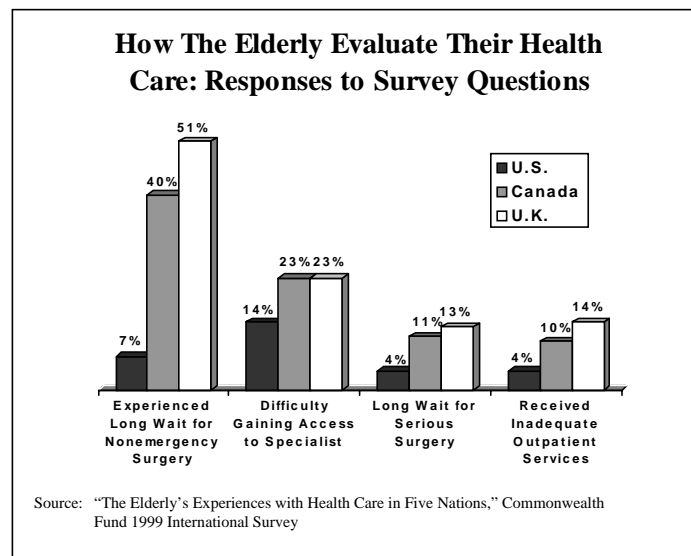
establishment of greater efficiencies, but rather has been the rationing of care - often through placement on a waiting list for medical treatment. Ironically over the course of the past decade, almost every European country with a national health care system has introduced market-oriented reforms and turned to the private sector to reduce the costs of care and increase the value, availability and effectiveness of treatments.² Countries like Sweden, Britain, Australia, Germany, and the Netherlands have actually been looking to the U.S. for guidance.

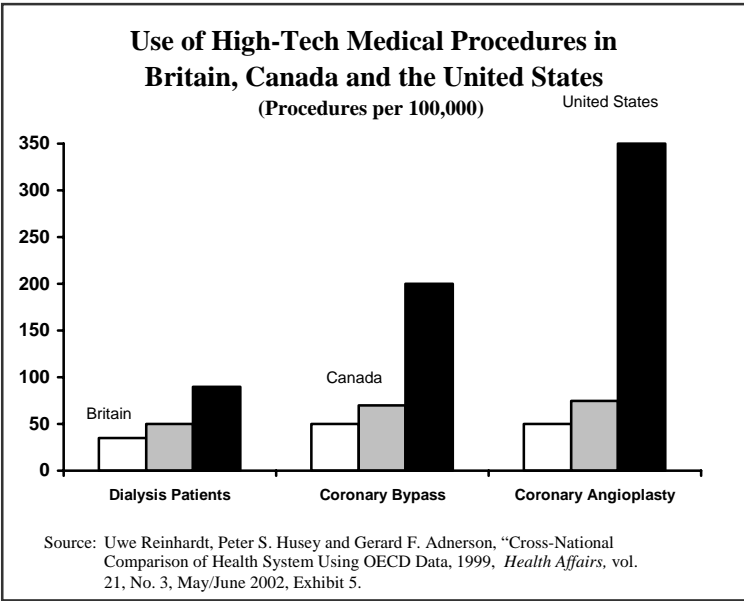
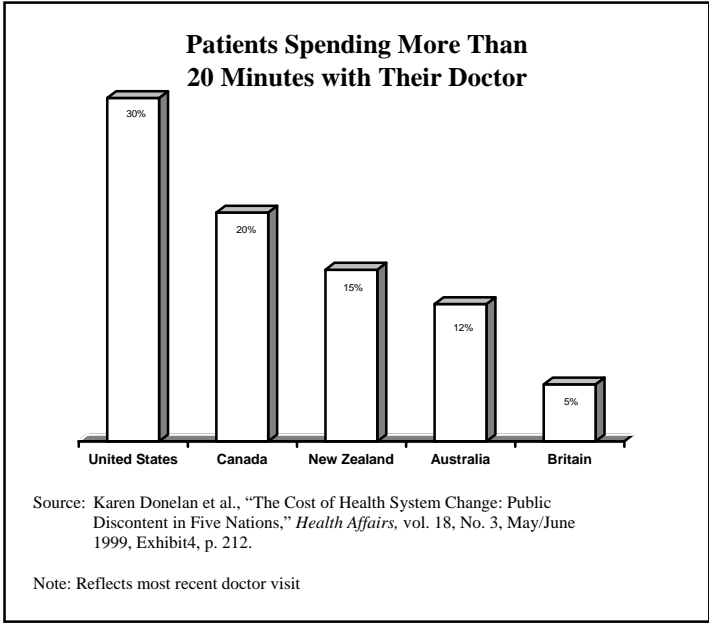
Centralized Health Systems

The old-fashioned centralized health systems are beginning to crack around the globe. Just last week Germany passed legislation requiring its citizens to pay more out of their own pockets for health care. It is becoming clearer that what worked badly in the 20th century will only work worse in the 21st.

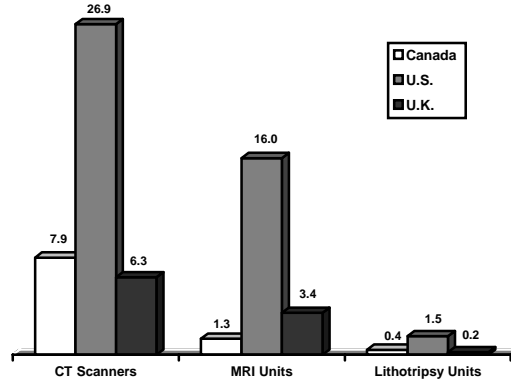
Ronald Baily
Reasonline October 2003
Health Insurance Crisis Again

Although our own health care system is currently failing us in a number of ways, we should be very clear about the enormous deficiencies of national health insurance before we flock to that model as a solution to our problems. The following tables provide comparisons between the U.S. and other countries' national health care systems on some services, outcomes, and satisfaction.



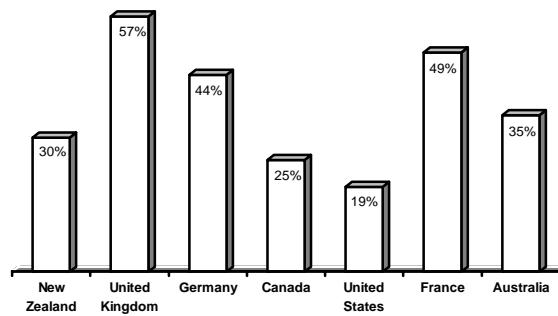


Access to Modern Medical Technology in the U.S., Britain and Canada (1996)

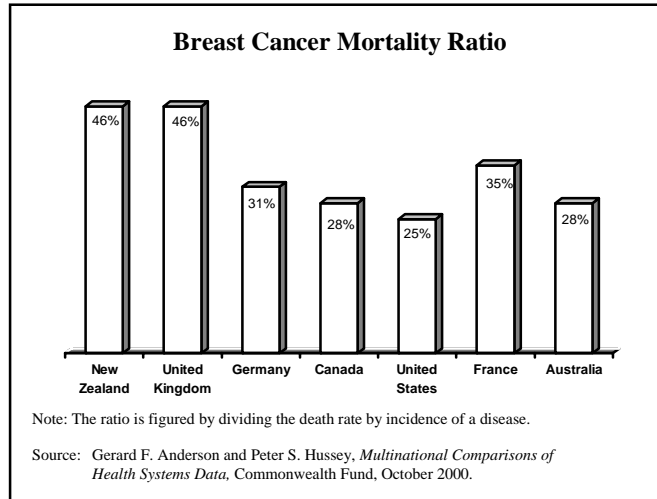


Source: Gerard F. Anderson and Jean Piere Poullier, "Health Spending, Access and Outcomes: Trends in Industrialized Countries," *Health Affairs*, Vol. 18, No.3, May/June 1999, p.178-192; and Stephen Pollard, "European Health Care Consensus Group Paper," "Centre for the New Europe, January 4, 2001

Prostate Cancer Mortality Ratio



Source: Gerard F. Anderson and Peter S. Hussey, *Multinational Comparisons of Health Systems Data*, Commonwealth Fund, October 2000.



In reality, national health insurance programs are not achieving the goal of equal access and reduced cost. In rationing by waiting, the poor are pushed to the back of the lines. With no profit motive, there is no incentive for providers to compete or offer greater efficiencies in the delivery of care. The concept of “free care” unleashes unprecedented demand with more patients receiving a lesser share of the limited resources available - coupled with an enormous public tax burden.

The flaws become apparent when extensive medical intervention is needed. The ones who suffer most in a socialized system are the few who require expensive procedures with life saving potential and those most in need of care - actually those suffering from a catastrophic illness or event that one would most likely want to insure themselves against the potential cost.

But when government and politicians are running the healthcare system, public choice, or the desires of the masses take precedent because they produce the votes for reelection.

Inexpensive services with marginal health benefits become available to large numbers of people while high end services with life saving potential for the few are minimally provided. For example, the British taxpayers are supporting over 15 million non-emergency ambulance rides each year and extensive social work and health visitor services for the elderly, but they have limited access to CT scanners and kidney dialysis.

**Non-Medical Spending by
The British National Health Service**

	Per Year
Non-emergency ambulance rides*	15,000,000
Missed Physician appointments**	10,000,000
Patients receiving non-medical services***	1,500,000

* Only 4 million rides were classified as emergency or urgent.

** The estimated cost of missed GP appointments is \$350 million dollars.

***Community services includes such items as meals on wheels, homecare, daycare, home adaptations and professional support.

Source: Community Care Statistics 2000/2001, Referrals, Assessments and Package of Care for Adults, UK Department of Health, 2001, Table P2f.1.

**Non-Medical Services by the
British National Health Services**
(Number of Community Services Performed)

Home Alterations	375,000
Occupational therapy	456,000
Daycare services	260,000
Homecare/home help services	578,000

Source: Community Care Statistics 2000/2001, Referrals, Assessments and Package of Care for Adults, UK Department of Health, 2001, Table P2f.1.

Beware of the left and its healthcare nationalization project. Per Linda Gorman, they are indecently well funded, until recently they owned the moral high ground, and they have been reinforcing their institutional positions since at least the late 1980s.

Expanding the government's role in healthcare will lead to more and more accommodation of special interests like those vested in maintaining and growing the bureaucracy, not your personal interests as a health care consumer. The prosperity of our great country has been

propelled by capitalism, not socialism. Why on earth would we consider entrusting something as important as our personal healthcare and that of our families to a government entity? Considering the enormous cost associated with this segment of our economy, do we really want to turn the decision making completely over to the politicians?

There has got to be a better way.

Letter To Uwe Reinhardt

Dear Dr. Reinhardt,

I just finished reading your article entitled, "Is There Hope For the Uninsured?" I was struck by your impression that only government can solve the problem, and your pessimism that this will not happen very soon. I would challenge you to consider the private sector as a better alternative. Back in the 50's and 60's, before Medicare and Medicaid, most cities had free clinics, run by volunteer doctors, that cared for the poor. True charity did exist, and did not require big, expensive, bureaucratic government programs.

I would like to invite you to the grand opening of the Zarephath Health Center, a small health center that will be run completely by volunteers and designed to help the working or disabled poor. There are many New Jerseyans who have recently lost their jobs, work in jobs that do not have health benefits, or are self-employed and cannot come up with the \$1000. per month needed to purchase health insurance. We will provide health care at a very low cost or for free to these people.....

Sincerely,

Alieta Eck, MD, Administrator
Zarephath Health Center

Alieta goes on to share more of her reaction to Uwe Reinhardt's long ten page article.

On page three he made an incredible observation:

"Even as well-situated a person as the late former mayor of New York City, John V. Lindsay, eventually could not afford his out-of-pocket outlays for the treatment of a variety of chronic illnesses late in his life, prompting a compassionate Mayor Rudy Giuliani to appoint him to no-show city jobs that came with municipal health insurance."

So Rudy Giuliani broke the law to fleece the public, and Uwe calls this compassion. Maybe Rudy could just give no-show jobs to all the uninsured in NYC, and voila, the problem will be solved. The liberal mind staggers the imagination

Alieta Eck, MD
August 2003

*Speech from the Chairman of Council, Dr. Ian Bogle, CBE
Monday, 30 June 2003, British Medical Association (BMA) www.bma.org.uk*

Chairman, members of the Representative Body,

This is my last speech as Chairman of Council.

I prefer to say my goodbyes in private, but I must begin by offering my thanks to BMA staff and Council colleagues for their support over the past five years.

This can be a lonely job at times, but their commitment, their encouragement and their companionship have helped keep my spirits, and my sanity, intact.

I have been at the helm of the BMA during one of the most interesting and challenging periods in its history – moves towards greater openness and accountability in assessment of performance and fitness to practise, three major contract negotiations and a government modernisation programme that will have far-reaching consequences for the future of the health service and the future of the medical profession.

When I leave this stage for the last time on Thursday, I will be bowing out of medicine and medical politics for good.

The one memory that will linger long after the sweet taste of negotiating successes and the sour taste of acid encounters with self-serving secretaries of state have left my palate is the creeping, morale-sapping erosion of doctors' clinical autonomy brought about by micro-management from Whitehall which has turned the National Health Service (NHS) I hold so dear into the most centralised public service in the free world.

The stifling of innovation by excessive, intrusive audit and the imposition of Department of Health diktats.

The shackling of doctors by prescribing guidelines, referral guidelines and protocols.

The suffocation of professional responsibility by target-setting and production-line values that leave little room for the professional judgement of individual doctors or the needs of individual patients

No doctor has any trouble signing up to genuine, evidence-based efforts to drive up standards and improve the quality of services to patients.

But the paranoid centralism which has characterised this and previous governments' handling of the NHS will not lead to improvements in patient care. It will turn professionals into bean counters answerable not to their patients but to politicians, auditors, commissioners and managers under pressure to deliver on edicts, priorities and targets emanating from Richmond House.

I'm nearing the end of a 40-year career in medicine – a career that I have loved and from which I have drawn enormous personal and professional satisfaction.

Nothing comes close to the unspoken but absolute trust that exists between patient and doctor, to the privilege of being let into people's lives and people's thoughts, to the patient who says 'Thank you doctor, that helped'.

But when I look back over my career and how the practice of medicine has changed in that time, there is one thought I cannot shake from my mind. The challenge, the responsibility, the risk that I relished, and that I regarded as being fundamental to my professional status, have all but disappeared.

MARKET DRIVEN HEALTH CARE POSSIBILITIES

There are numerous opportunities for transforming the delivery of healthcare into a much more efficient operation. Unfortunately our current financing mechanisms are not conducive to this transformation. Examples of efficiency seem to surface randomly every once in awhile, like the treatment of mastectomies at John Hopkins, but we find that these instances are generally the result of one or two entrepreneurs catering to fee for service clientele, not from the pressures of third party payers.

Increasing health care costs and “inefficiencies that plague the market won’t change until competition forces old models to be redesigned,” states Stanford University business professor emeritus Alain Enthoven. He compares the current employer-sponsored healthcare market to the U.S. automobile market during the “decline of the American car when (they) were best known for being expensive and unreliable,” before “cost-effective” imports, like Hondas, entered the market.¹ But how can the “Hondas” of health care emerge when the actual consumer or patient is far removed from the purchase decision, and the inherent incentive for the third party payer is to avoid attracting those in need of costly services?

According to Harvard Business School Professor Regina Herzlinger, “the key to the successful transformation of the retailing, automobile, and information industries has been consumer supremacy. The American economic system automatically sorts out winners and losers by permitting the customers to pick their favorites. Consumers vote with their dollars, choosing the retailers, cars, and information services that best meet their needs for convenience and mastery. The system encourages entrepreneurs as well, handsomely rewarding those who succeed. Those rewards are well earned - after all, the innovators take tremendous risks to ferret out the best ways to satisfy demanding assertive customers. Responding to the needs of the consumer revolutionary requires a daring, visionary businessperson, not a bureaucrat or a social engineer. But entrepreneurs do not pick their

customers pockets to earn these handsome rewards. These ventures are crafted without wild increase in cost and, more usually, with decreased costs.”²

Industry Drivers

The reality is that for 100 years government has inserted itself into the health care system in every way imaginable. Almost every time it gets it wrong (look at tax policy, look at ERISA, look at Nixon's wage and price freeze, look at the health planning act of the 1970s). Being wrong is not a crime, but government has a unique inability to correct its mistakes. Which is why markets are a better approach. Markets are able to brutally punish mistakes and generously reward successes.

Greg Scandlen
August 2003

While we continually experience numerous technological advances, on a more limited scale, we have seen some great innovation in health care delivery. A good example is a privately owned, for-profit facility, Shouldice Hospital in Toronto, Canada. They offer only one procedure: repair of abdominal hernias. The charge for the procedure at Shouldice is only \$2,000 compared to anywhere from \$2,400 to \$15,000 in American hospitals. The readmission rate at Shouldice is less than 1 percent indicating first rate quality at a very competitive price. Shouldice is so good because what it does it does often and well. The average

surgeon there performs 600 procedures per year, while the average general surgeon typically performs less than 30 hernia operations per year. Since operating teams at Shouldice work together continuously, they learn how to function as a team, working efficiently and making fewer mistakes. Surgical team members at a typical full service hospital lack the familiarity and experience working with each other that is needed to duplicate the quality and efficiency evidenced at Shouldice.³

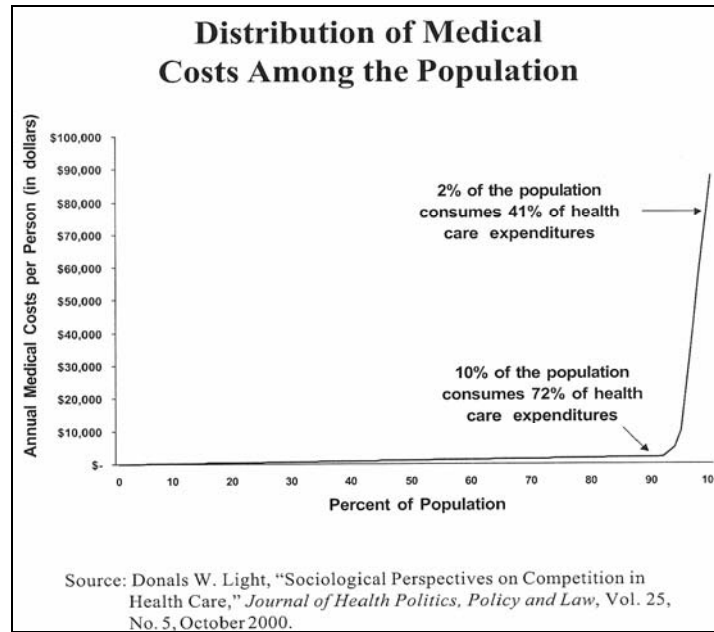
There are other examples as well where small entrepreneurial operations are springing up to transform the delivery of care through application of a very specific focus and investment in the technology and operating systems that bring about increased productivity. Dr. Denton Cooley, the Texas heart surgeon who installed the first artificial heart, has used a combination of innovative techniques and high volume to cut the cost of bypass surgery from \$23,000 to \$11,000. At Salick Health Centers, a nationwide chain of cancer treatment centers, patients receive all medical services - screening, chemotherapy, counseling, reconstructive surgery - in one setting: waiting times and delays are reduced, survival rates are higher, and costs are lower.⁴

Unfortunately a third-party payer is less likely to support the development of innovation in health care delivery. After all, here the purchaser's goal is to avoid those who can benefit most by this innovation so any association with these types of endeavors is extremely counter productive.

Transformation of the healthcare system will rely on a shift to consumer supremacy. If that can be accomplished, these types of applications will be ripe to flourish. Herzlinger predicts a move from “a confusing jumble of multipurpose providers to a range of lean enterprises that are clearly focused on single health care objectives, smartened up with technology, and smoothed out with integrated operating systems. Say good-bye to the general purpose health care provider. Say hello to the focused health care factory.”⁵

Most of us accessing the health care system today know that inconvenience is rampant and the process is complicated. Health care is organized around the myriad of distinct provider specialties, not by the requirements of the individual patient. Since most health care costs are generated by a small percentage of patients and the diseases of those patients are highly concentrated, tremendous benefit could be derived initially by simply targeting efforts at a handful of high cost diseases. John Goodman has paraphrased Herzlinger's observations thus:

- Thirty-three percent of the 13 million asthma patients account for 73 percent of the \$6.2 billion annual cost of treating the disease; yet most asthma patients are treated haphazardly - by doctors, pharmacists and hospital emergency rooms.
- Diabetes afflicts 6 million Americans and accounts for 16 percent of national health care spending; yet studies show that their treatment is far from optimal.
- Since just five diagnostic categories (cardiovascular, injuries, cancer, genitourinary and birth-related) account for 50 percent of the nation's healthcare bill, focus factories concentrating on only these five categories could control cost and quality for half the nation's health care bill.⁶



The opportunities are there, but only by placing consumers back in control of the purchasing decisions can we accelerate the innovation we so desperately need to curb health care inflation and more effectively deliver care. It's the consumer of services, not the insurance company or the government, that can accurately assess the relationship among health care costs, health status, and productivity, and it is the patient who will take a longer-run view of the impact of innovations in managing his chronic disease.

Herzlinger describes the consumer in the context of health care. "Real consumers are people who weigh the price of a product against its quality. If the quality isn't good enough for the money, they don't buy it. Producers quickly get the message. Then they madly innovate to provide consumers with the quality they want at the price they are willing to pay for it. The winners do well, the losers go out of business. In a real market, cost control does not come about because producers limit goods or services; it comes about because producers innovate—they develop new ways to give consumers what they want. Although advocates of government-controlled health care systems rail against competition, it is key to the success of virtually every sector of our economy."⁷ She describes how this dynamic has worked so well in the eyewear sector.

COMPETITION AND CONTACTS

Consumers wanted contact lenses that were easy to wear, easy to use, disposable, and inexpensive. Manufacturers continually innovated so that consumers got what they wanted. At the moment when Johnson and Johnson introduced disposable contact lenses that cost \$2.50 a pair, most others cost ten times as much. As a reward, J&J won a multihundred-million-dollar market. Consumers also wanted eyeglasses that were fashionable, easy to obtain, available in a wide variety, and inexpensive. They got them. Mind you, the market cannot work miracles—you cannot buy genuine Armani frames for \$49.99. But you can get a reasonable facsimile of them for that price. Why do consumers control the eyewear sector? Because they pay for most of it directly, not through an insurer.

***Regina Herzlinger
Market Driven Health Care***

Patients today have much greater access to information about their doctor's options and their own. In this age of the Internet, with an abundance of accessible information for health care consumers, there is no better time to restore the marketplace we have systematically contaminated over the past half century. For the "Hondas" of health care to emerge in an employer based system, Enthoven concludes a need for most employers to offer multiple choice and expose employees to full responsibility for premium differences. In every instance of health care consumption, we must somehow re-connect the health care consumer to the value proposition of the purchase.

Next we will explore a rational way to restructure government incentives and benefit offerings so that an environment of ever increasing productivity can prevail, and each of us can have fair and equitable access to the health services we need.

Points To Consider

"Health care may be the most entrenched, change-averse industry in the United States. The innovations that will eventually turn it around are ready, in some cases - but they can't find the backers."

"The resistance to low-cost alternatives is understandable, but it's not in the best interests of the industry or of the patients it serves."

"Rather, we're talking about being open to disruptive technologies and business models that may threaten the status quo but will ultimately raise the quality of health care for everyone."

"If the natural process of disruption is allowed to proceed, we'll be able to build a new system that's characterized by lower costs, higher quality, and greater convenience than could ever be achieved under the old system."

"In any industry, a disruptive innovation sneaks in from below. While the dominant players are focused on improving their products or services to the point where the average consumer doesn't even know what she's using, they miss simpler, more convenient, and less costly offerings initially designed to appeal to the low end of the market. Over time, the simpler offerings get better - so much better that they meet the needs of the vast majority of users."

"That creates the potential for upstart companies to introduce 'disruptive innovations' - cheaper, simpler, more convenient products or services that start by meeting the needs of the less demanding customers. Disruptive technologies have caused many of history's best companies to plunge into crisis and ultimately fail."

"Many of the most powerful innovations that disrupted other industries did so by enabling a larger population of less-skilled people to do in a more convenient, less expensive setting things that historically could be performed only by expensive specialists in centralized, inconvenient locations."

"We need many more such disruptions - and today we have them within our reach. Unfortunately, the people and institutions whose livelihoods they threaten often resist them."

"It's in physicians' best interest to embrace this change. Rather than fight the nurse practitioners who are invading their turf, primary care physicians should move upmarket themselves, using advances in diagnostic and therapeutic technologies to perform many of the services they now refer to costly hospitals and specialists. They should, in other words, disrupt those above them rather than fight a reactionary and ultimately futile battle with the disrupters from below."

"If consumers and providers are given choices, the use of disruptive technologies will migrate to those applications where they create real value."

"History tells us that major new growth markets coalesce when products, processes, and information technologies let less highly paid groups of people do things in more convenient settings. To truly disrupt the health care system, venture capital, entrepreneurial energy, and technology development need to flow toward these enabling initiatives. Rather than focus on complex solutions for complex problems, research and development need to focus on simplification."

"In other words capital should be focused on initiatives that can provide better care with "less complexity driven overhead."

"The health care industry today is trying to preserve outmoded institutions. Yet the history of disruptive innovations tells us that those institutions will be replaced, soon enough, with new institutions whose business models are appropriate to the new technologies and markets."

"The lessons for today's medical institutions: don't be scared to invent the institution that could put you out of business, and stop investing in dying business models."

"Government and health care industry leaders need to step forward - to help insurers, regulators, managed care organizations, hospitals, and health professionals work together to facilitate disruption instead of uniting to prevent it. If they do, some of the established institutions will fail. But many more health care providers will realize the opportunities for growth that come with disruption - because disruption is the fundamental mechanism through which we will build a higher quality, more convenient, and lower cost health care system. If leaders with such vision do indeed step forward, we will all have access to more health care, not less."

Health Commons Institute Partnerships Spring 2003
Will Disruptive Innovations Cure Health Care?"
by Clayton Christensen, Richard Bohmer, and John Kenagy.

FINDING A MODEL FOR A MORE EFFECTIVE HEALTH CARE SYSTEM -
THE SINGAPORE EXPERIENCE

Since most healthcare systems worldwide are more nationalistic and socialistic than ours in the United States, and are fraught with the pitfalls described by Milton Friedman, it's tough to find the prototype of an improvement on what we have. There are actually very few places on earth that seem to have a good handle on effectively providing health care for their populations. Fortunately, a few alternative financing schemes have emerged over the past couple of decades in Chile, South Africa and Singapore that provide opportunities to learn from the experience of others and proceed ahead in the United States with the valuable benefit of happenstance hindsight. Each of these countries has implemented to some degree a form of the medical savings account concept in ensuring access to health care. The results have been quite promising.

Let's take a look at what has transpired in Singapore. Singapore is a small island city-state at the tip of the Malaysian peninsula. After 140 years of British rule, Singapore achieved complete independence in 1965. With no natural resources other than a hardworking and tolerant population, this tiny nation (population currently 4 million) has built one of the most robust economies in the world. Since independence, the paternalistic and authoritarian government in Singapore has promoted an aggressive social program under which people are required to save to finance benefits that are often provided by government in most developed countries.

Singapore's health care system is considered world class and in 2001 was ranked first in terms of quality, access and cost when compared with the health care systems of seven other countries by Canadian health economist Cynthia Ramsey. These countries included Canada, the United States, the United Kingdom, Switzerland, Germany, Australia and South Africa.¹ Singapore struggles with the same challenges many other countries face- like the increasing cost of advances in medical knowledge and technology, rising expectations and demand for better and more sophisticated health services by an increasingly and more well-informed

public, rapid aging of the population and nurse shortages. They have been able to maintain their health care expenditures, however, at 3% of GDP for the past several years, with government subsidy of the public healthcare services less than one third the total.

Reimbursement to doctors and access to care and technology is very comparable to that in the United States, and while there are noted differences in the populations (their mix is admittedly younger), it is hard to rationalize the vast difference in cost versus the limited difference in outcome as our expenditure in the United States continues to move well beyond 14% of the total U.S. economy. How do they achieve such results? How can they provide comparable care while expending less than one quarter the resources that we do?

Somewhat unique to Singapore is a generally accepted notion regarding the role of personal responsibility in areas of social welfare. While most developed countries tax their citizens heavily to finance social programs, Singapore requires a certain percentage of one's wages be funneled into personal accounts earmarked for specific merit expenditures like housing, health care, education and retirement. Within guidelines, these funds are managed by the individual, so the citizens tend to have a notion of building personal savings rather than paying taxes, though the amounts required are certainly comparable to amounts collected in the United States for income taxes. The result, however, appears to be much more rational consumption on the part of their citizens.

Through this earmarked funding, every working person is required by law to set aside 6-8% of his income into his personal Medisave account which can be used to pay for the hospitalization expenses incurred by himself or his immediate family members. A portion of this amount funds premiums for Medishield, a catastrophic illness insurance scheme that is designed to help individuals meet the medical expenses from major or prolonged illness. In addition, the government maintains Medifund which acts as a safety net of last resort for those who are truly indigent. No Singaporeans are denied access into the healthcare system or turned away by the public hospitals because of the inability to pay. So what has been the result of this combined scheme of accountability and social responsibility?

OVERVIEW OF THE SINGAPORE HEALTHCARE SYSTEM

Healthcare Delivery System

In Singapore, there is a dual system of healthcare delivery. The public system is managed by the government while the private system is provided by the private hospitals and general practitioners. 80% of the primary healthcare services are provided by private practitioners in private clinics (approximately 1,900) while 16 government polyclinics provide the remaining 20%. For the more costly hospital care, which includes secondary and tertiary specialist care, it is the reverse situation with 80% of the hospital care being provided by the public sector and the remaining 20% by the private sector.

Patients are free to choose the providers within the dual healthcare delivery system and can walk in for a consultation at any private clinic or any government polyclinic. For emergency services, patients can go at any time to the 24-hour Accident & Emergency Departments located in the government hospitals. The Singapore Civil Defense Force runs an Emergency Ambulance Service to transport accident and trauma cases and medical emergencies to the acute general hospitals.

There are a total of about 11,798 hospital beds in the 26 hospitals and specialty centers in Singapore providing a ratio of 3.7 beds per 1000 resident population. 84% of the beds are in the 8 public hospitals and 5 public specialty centers. Government's role as the dominant health care provider allows the Government to control the supply on number of beds, the introduction of high-tech/high-cost medicine, and the rate of cost increases in the public sector which sets the bench mark in terms of pricing for the private sector. The hospital beds are well utilized, with an average occupancy rate of about 81%.

The government has restructured all its facilities to be run as private companies wholly-owned by the government. This is to enable the restructured hospitals to have the management autonomy and flexibility to respond more promptly to the needs of the patients. In the process, commercial accounting systems have been introduced, providing a more accurate picture of the operating costs and instilling greater discipline and accountability. They are managed like not-for-profit organizations and do receive an annual government subsidy for the provision of subsidized medical services to the patients.

Healthcare Philosophy

The Singapore healthcare philosophy emphasizes the building of a healthy population through preventive healthcare programs and the promotion of healthy living. The population is encouraged through the public health education program to adopt a healthy lifestyle and be responsible for his own health. The population is made aware of the adverse consequences of harmful habits like smoking, alcohol consumption, bad dietary intakes and sedentary lifestyles. The child immunization program which is targeted against infectious diseases like tuberculosis, polio, diphtheria, whooping cough, tetanus, measles, mumps, rubella and Hepatitis B, is offered at the government polyclinics. Health screening programs have been introduced for the early detection of common ailments like cancers, heart diseases, hypertension and diabetes mellitus.

The government ensures that good and affordable basic medical services are made available to all Singaporeans through the provision of heavily subsidized medical services at the public hospitals and government clinics. The basic medical package reflects good, up-to-date medical practice, which is cost-effective and of proven value. But it will not provide the latest and best of everything. The treatment will be delivered without frills by trained personnel using appropriate facilities. It will exclude non-essential or cosmetic services, experimental drugs and procedures of unproven value. All private hospitals, medical clinics, clinical laboratories and nursing homes are required to maintain a good standard of medical services through licensing by the Ministry of Health.

The Singapore health care delivery system is based on individual responsibility, coupled with government subsidies to keep basic health care affordable. Patients are expected to pay part of the cost of medical services which they use, and pay more when they demand a higher level of services. The principle of co-payment applies even to the most heavily subsidized wards to avoid the pitfalls of providing "free" medical services. For those who choose to be accommodated in the lower classes or types of wards in the public hospitals, their hospitalization expenses are subsidized up to 80% by the government.

Although clearly a government run health care system, part of the efficiency is a direct result of the lighter bureaucratic and regulatory loads that Singapore places on the delivery system. At Singapore General Hospital, the ratio of caregivers to support personnel is 5:1, while in American hospitals we generally see a 2:1 ratio. The forced “self-insurance” through Medisave is directed at inpatient services and a few relatively expensive outpatient treatments like hepatitis B vaccinations, assisted conception procedures, renal dialysis, radiotherapy, chemotherapy and AZT therapy. The majority of all outpatient services are paid out of pocket with a defined government objective to rely on competition and market forces to improve service and increase efficiency. Doctors can generate relatively high personal incomes in spite of lower reimbursement rates because they practice with relative freedom from administrative encumbrances. Billing is simple, so a much larger portion of the professional fee goes home with the doctor rather than supports running the practice. The growth of American style third-party insurance is discouraged since that leads to the perception that medicine is free. Employers can contribute up to an additional 2% of salary to an individuals Medisave account, or many companies provide some coverage for outpatient treatments for their employees. Singapore has managed to create a largely self-funded healthcare system that requires people to first look to their own resources for health care, relying on the government only after their own resources are depleted.³

The Singapore health care system relies on aggressive government intervention for its success, and given the government intervention track record in the United States, that may be unacceptable to most Americans. The more applicable concept, however, is that of the prudent buyer who can obtain quality health care at low cost. Years of undefined national and state health policy, coupled with an employer-paid system that has isolated Americans from cost realities has made health insurance in the United States act like an entitlement program, thus creating an entitlement mentality for most consumers. There is much to be said for attempting to thwart the concept of “free” healthcare and minimizing the involvement of third-party payment in the healthcare system. At this point, cultural acceptance of personal responsibility for healthcare may be difficult for some Americans, but the existing situation calls for major changes in our mindset. If a medical savings account concept began to proliferate, it is very likely that prudent buying might begin to chip away at the high cost of healthcare in the United States.

FIXING THE FINANCING AND RETURNING TO A HEALTH INSURANCE CONCEPT
- CRITERIA FOR STRUCTURING AN IDEAL PLAN

For too long we have succumbed to the tyranny of the status quo. The healthcare marketplace has been distorted by tax policies that are mistargeted, miscalibrated, and open-ended. According to Milton Friedman, the high cost and inequitable character of our medical-care system is the direct result of our steady movement toward reliance on third-party payment. A cure requires reversing course, reprivitytizing medical care by eliminating most third-party payment, and restoring the role of insurance in 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 government, preferably state and local rather than federal, to financing care for the hard cases.¹

Even Milton Friedman admits, this is probably not a politically feasible approach. But as Dr. Mark Pauly, the vice dean of Wharton doctoral programs and Bendheim Professor at the Wharton School points out, extricating ourselves gracefully from the current situation will be much easier if we think of reform as a reformulation of the rules by which we govern ourselves - rules made to benefit everyone in the long run.² Because of history and error, government has tangled itself in the financing and control of what ought to be an individual's most personal choice: what to do to protect his and his family's health. As a result, the federal and state governments have borne substantial fiscal burdens that have affected how they perform their other legitimate functions.³

Numerous approaches to reforming the healthcare system are being debated. Universal coverage is a noble goal, which often conjures up the notion of a nationalized healthcare system. But perhaps we should begin to think of that goal in the context of a "Universal Healthcare Tax Credit". Already taxpayers are indirectly paying for the majority of healthcare that is delivered in this country either through government programs or through the additional \$140 Billion tax subsidy that is provided to those receiving coverage through

their employers. The goal, however, must be to more equitably redistribute these subsidies provided through the government so that each and every American has access to catastrophic health coverage and appropriate incentives and support to purchase needed health services. The responsibility for the government will

Health Benefits Exclusion vs. Tax Credits

The employer benefits in two ways -- he gets to take the cost of coverage as a regular business expense deduction. He also doesn't have to pay his share of FICA on the value of the coverage. This makes benefits slightly more attractive to the employer than wage compensation is.

The main value of the exclusion is to the employee. The value of the benefits is not considered compensation, so is free of any and all taxes -- state or federal, income or payroll.

If the employer does not provide coverage, the worker has to buy it on his own. But first he has to earn enough income to pay the taxes and have enough left over to pay the premium. If a policy costs \$4,000, the worker has to earn anywhere from \$6,000 to \$8,000 to have enough left over after taxes to pay the \$4,000 premium.

The tax credit idea would (or should) replace the exclusion for the employee. There are variations on the theme. Some would allow a choice of either the exclusion or a tax credit. Others have proposed a tax credit go to the employer, not the employee. Still others would offer a tax credit only to lower-income workers.

These are political variations. From an economist's point of view, all workers should be treated alike and tax policy should be neutral, not pick winners and losers. That's why I would prefer to make the same flat credit available across the board.

Greg Scandlen
August 2003

Currently the tax exclusion is worth \$120 billion a year -- if you are lucky enough to get coverage from your employer. Medicaid and SCHIP is worth what? (I don't even know what we spend on these programs) if you happen to meet the eligibility requirement. If you are self-employed, you get a deduction from income (but not from payroll taxes). If you work for a small employer, you can have a tax-free MSA. If your employer sets up an FSA or HRA, you get the advantage of that. If you have high expenses you can deduct them if they exceed 7.5% of your AGI, and on and on and on.

I say wipe out all this picking and choosing, and make available a \$1,000 tax credit for anyone who gets coverage. It is not a "mandate" because you are free not to use it. You won't be imprisoned or banished, your children won't be removed. You simply forfeit the \$1,000.

Will there be regulation of the available coverages? Of course. But there is already regulation of available coverages. There might actually be less regulation.

Will there be agitation to raise the \$1,000? Probably. But there are always people at the trough. That doesn't mean they get what they want. In fact, unlike the exclusion that automatically goes up without limit every time HC costs rise, this would be a fixed amount that would take an Act of Congress to increase.

Meanwhile, Medicaid and SCHIP would be gone, employer paternalism would be gone, individual choice and ownership would appear, portability would be complete, and we would have a dynamic market of coverage programs that need to please their customers if they want to stay in business.

This is a slam dunk good thing in my opinion.

Greg Scandlen
August 2003

continue to be massive, but the administration becomes incredibly simplified when the government's role remains strictly financial and the middleman for the majority of healthcare transactions is eliminated. The stumbling block to change is effectively circumventing all those with a vested interest in the current system who will be lobbying hard to maintain the status quo.

Fortunately for us, some of the greatest minds in healthcare economics have been giving this problem a great deal of thought over the past several years. The Health Policy Consensus Group is a task force of leading healthcare economists and health policy analysts, including researchers at the major market-oriented think tanks. The Consensus Group is working to increase public awareness that the tax treatment of employment based health insurance underlies many of the problems facing the private health sector in the United States. The incentive-based reforms the group proposes are intended to strengthen and rationalize the healthcare market. The Consensus Group believes that the competitive marketplace is the most appropriate way to restrain costs and to give Americans more responsibility and opportunity to choose their health insurance and healthcare arrangements.⁴

The Consensus Group has circulated a petition nationwide that has been signed by over 500 economists that agree that reforming the tax treatment of health insurance is essential to creating a more efficient market for medical care and health insurance in the United States. They have provided core principles to guide policymakers and the public in making key decisions about creating a true consumer-driven healthcare system.

Principles of Consumer-Driven Reform

- *Consumer Choice: Individuals should have choice in the medical care and healthcare coverage they obtain, whether they secure coverage as individuals or through their employers or other groups. Government policies should expand the opportunities for individual choice without dictating or distorting these choices.*
- *Competition: Consumers of medical services will receive the best value when providers are competing to offer the best price, quality and services. Therefore, the system should rely on market competition, not government regulation or price controls, to promote efficiency, quality and value.*
- *Responsible Budgeting: Government incentives to help targeted populations obtain private health coverage should be explicit, on budget, and reviewable.*
- *Fixed and Limited Incentive: Individuals and families with the same incomes should receive the same benefit when purchasing health insurance, regardless of their employment status or whether their employer offers health insurance. Individuals should not be able to increase their claim on taxpayer revenues by purchasing more health coverage.*
- *Expanded Access: In a market based upon consumer choice, a more attractive range of options for health coverage would be available to a wider range of people, including those currently without health insurance. Once the market is functioning more efficiently, it will be clearer whether further legislation is needed to enhance people's ability to secure health coverage.*

Principles of Consumer-Driven Reform (cont.)

- *Responsible Insurance: Health coverage should provide, at a minimum, protection against catastrophic loss- namely, high-cost, low-probability medical events. The tax system has encouraged movement away from the basic principles of insurance; instead health coverage has become a way to pre-pay routine medical bills. A first step towards reducing the number of Americans without health insurance is through insurance that provides access to medical care and protection against large expenses in the event of catastrophic medical events.*
- *Public-Sector Choice: Given the rapidly rising costs in federal healthcare programs, especially Medicare and Medicaid, the federal government should make full use of private-sector competition to control costs by giving beneficiaries more options to participate in the private market.*
- *Cost Awareness: Programs that enhance individual purchasing power will be more efficient because costs will be more visible to consumers. Programs and plans that make payments directly to providers insulate consumers from costs, artificially increase demand, and distort the healthcare marketplace.*
- *Full Information: Employers who provide health insurance should periodically inform their employees about how much of their compensation is being spent on health benefits and that this spending has reduced their cash wages by a commensurate amount.*
- *Community Versatility: The strength, diversity, and vitality of private-sector community organizations are an important resource in the health sector. Communities should experiment with public-private partnerships and other solutions for providing healthcare to low-income citizens, utilizing local resources to solve unique community problems.*
- *Group Purchasing: Tax and regulatory barriers to creating competitive private healthcare purchasing groups should be eliminated. Barriers to the creation of innovative provider groups should also be eliminated.*
- *Value: As a result of implementing these principles, consumers will obtain better value for their healthcare dollars. The price system will convey consumers' needs and demands. Competition will facilitate more efficient use of technology and continued innovation in products and service delivery, and will reduce waste and duplication.⁵*

The key recommendation from the Consensus Group is simple.

We recommend providing credits or other comparable fixed incentives, explicitly determined by legislation, to assist people in obtaining private health insurance.

The size of the incentive will depend upon how much taxpayer money lawmakers deem to be available. It could be structured in many ways. Some examples are:

- Credits or other fixed incentives could be used to purchase private group or individual health coverage, in combination with medical savings accounts for those who choose them.

- If tax credits are provided, they could be refundable, over and above the Earned Income Tax Credit.
- The size of the credit or alternative financial incentive could be adjusted to reflect risk or need, or it could be used to buy into a high risk pool for the uninsurable. These adjustments should be made while minimizing their effect on marginal tax rates.
- To expand access to coverage, state mandated benefit laws could be preempted for insurance purchased with this federal assistance, thus allowing a broader range of more affordable insurance products.

And what would be the key benefits to taking this kind of approach?

- Millions of Americans not eligible for the current tax subsidy would receive help in purchasing health insurance.
- Assistance can be targeted to those who do not have health insurance.
- It can be targeted to those in specific age, income, or other categories which legislators deem most worthy of the assistance.
- It gives individuals more choice in where they obtain health insurance.
- It allows individuals the opportunity to select the kind of health coverage that best suits their needs.
- It helps to minimize distortions in the marketplace.
- It is more equitable across income groups.
- The subsidy does not expand when an individual purchases more expensive insurance.
- It is available whether an individual's insurance is organized through employment based groups or elsewhere. The role of employers to obtain health insurance could be maintained by each employer, if they so desired.⁶

So what is being advocated here is to simply level the playing field between third party insurance provided by an employer or government and insurance that is purchased directly by individuals and/or opportunities to self insure through HSAs. Not only is this an extremely sound approach to reducing the ever growing number of uninsured in this country, it also has a rational application for greatly improving the support currently provided to beneficiaries

through our existing Medicare and Medicaid programs. Why would there even be a need to have separate programs? If all Americans were afforded an incentive healthcare subsidy appropriate for their circumstance, this simplified financing mechanism could be administered through income tax filings with the IRS.

PERHAPS THERE IS COMMON GROUND AFTERALL
Mandatory Universal Health Insurance

(excerpt)

Should the federal government require all Americans to buy private health insurance? This intriguing proposal is being pushed by the New America Foundation, a liberal policy shop in Washington, D.C. "Universal coverage in exchange for universal responsibility," is how the NAF characterizes it.

Make no mistake about it—private health care is imperiled in the United States, given that all of the Democratic presidential hopefuls want to expand existing government health care programs and/or create some sort of universal government-run system. The NAF proposal could derail this pernicious political dynamic.

The devil is in the details, of course. Still, the NAF plan offers some interesting possibilities. For example, mandatory health insurance coverage might be combined with desirable features such as Medical Savings Accounts which would encourage people to save and invest for future medical emergencies.

The NAF proposal preserves private insurance and allows consumers to choose among competing insurance plans and coverage options. Most intriguingly, NAF offers a way out of the dysfunctional employer-financed third-party-payer system that is so grievously distorting our current health insurance system. Employers would eventually devolve responsibility for health insurance to their employees by giving them the money the companies currently pay out to insurance agents. Employees would then have a strong incentive to shop around for the best health care deals, putting pressure on insurance companies to keep costs low.

Under the NAF plan, the federal government would provide subsidies to those people who could not afford an insurance policy—health insurance vouchers, if you will. This idea is comparable to the health care tax credit proposal by the free market health care think tank, the Galen Institute. Specifically, the Galen Institute suggests that the federal government offer tax credits of \$1,000 per individual and \$3,000 per family, to help currently uninsured Americans buy health insurance.

Maintaining our private health care system is vital, because American health care and medical science are the most advanced and innovative in the world. If a national single-payer health care system is adopted, most medical progress will be stopped in its tracks, and we'd all have the same equally bad health care forever. The NAF proposal offers a way to maintain our private health care system, expand consumer choice, lower costs, and allow medical progress to advance. It isn't perfect, but it's a lot better than the more politically likely alternatives.

Ronald Bailey, Reasonline
August 6, 2003

This approach effectively puts everyone in a “Defined Contribution” situation rather than “Defined Benefit” when it comes to healthcare coverage and benefits. Multiple qualified benefit options will allow people to purchase what makes the best sense for their situation. And the beauty is that the arrangements can be long term, not threatened by periodic changes in employment or changes in carriers by your employer. If most health insurance arrangements actually became long term, and the government subsidy/incentives were so attractive that very few people opted not to take advantage of them, the current issues regarding “pre-existing conditions” would for the most part disappear over time. Think of the possibilities.

What are some of the characteristics that an ideal healthplan might have? First, the initial premium should be related to applicant's expected healthcare costs at time of entry. This is determined based on such factors as age, sex and health status, which becomes less and less of an issue for individuals if they are appropriately incentivized at a young and healthy age to purchase coverage. The ideal plan then guarantees renewal, regardless of health status, with rate increases only proportionate to those experienced by the entire pool of insured. The coverage should protect against catastrophic accidents and illness, and also include treatment which reduces high risk costs, like immunizations and initial cancer treatment. To keep insurance affordable for everyone, individuals should self insure preference items, or those services that are not prompted by a risky event such as diagnostic tests and preventive medicine. Ideally there should be tax advantages to self insuring through the use of Medical Savings Accounts (MSAs). We might begin to see some options in health insurance move to a "casualty model" whereby the maximum payment exposure is established for a diagnosis and the insured is free to select and apply that reimbursement to providers of his choosing. This would be an environment particularly conducive to expansion and growth of the Focus Factory approach to treatment of chronic conditions presented in

Humana and Consumer Driven Healthcare

Humana was once the "poster child" for managed care in the US. As the story goes, a couple of years ago the VP of Human Resources was tasked by the CEO to "turn this thing around" and provide a state of the art health care program for Humana employees. The result was what at first blush appears to be an excellent Defined Contribution Consumer Driven Health Care and Insurance program that could be a real model for the country. Talk about a 180 degree turn!

Here is the deal. Humana has about 18,000 employees throughout the country. This is a very creditable pool on which to make underwriting and actuarial decisions. Of course, the underwriters in this case also happen to have the exact claims experience for all employees and their covered dependents. With this knowledge here is what they built:

Step 1: A benefit plan that offers 6 distinct coverage options including PPO, HMO and various deductible options - including High Deductible choices. Also included are standard health flexible spending accounts as well as HRAs(Health Reimbursement Accounts) tied to the High Deductible Health Plan.. In addition they include SmartSuite - a tremendous on line platform for assistance with education, information and enrollment. This is the basis for informed consumer choice.

Step 2: All employees and dependents MUST be covered under one of the plan choices unless they have coverage elsewhere. This is the mandate. And it comes with a defined employer contribution - but with no guarantee that the contribution will always be enough to cover the full premium of any particular plan option.

At Humana over 70% of the employees had claims of less than \$500 in the previous year. Humana is using that statistic to drive home the point that most employees should move to the high deductible plans - for their own financial good. They have determined some price points for premiums and employee contributions in order to make this work for Humana as well - at least so far.

The experiment is still in it's infancy - about 20 months or so for Humana and less than that for it's customers. No one knows for sure if this will work. But all initial reports indicate success. First premium increases were minimal. A sharp reduction in the purchase of "lifestyle drugs" when employees have both the carrot and the stick as incentive. No reduction in proper medical preventative treatment - annual exams, etc by employees.

Dick Matthews
August 2003

Chapter 7. In a casualty model the insurance company pays for conditions rather than care, and treatment decisions, such as level of care, etc. become a matter of choice by the insured.

It is understandable why we have migrated to a model of pre-paid healthcare instead of catastrophic coverage; we were incentivized by tax policy. Now as we attempt to reshape our financing model, it will be important to maintain an incentive/subsidy for individuals to purchase the routine services necessary to maintain their health as well as accumulate personal funds for future healthcare expenses. The initial pilot to test the viability of the Medical Savings Account concept has failed due to major flaws in it's structure, but those flaws have been recognized and recent legislation (December 2003) makes MSAs, now referred to as HSAs (Health Savings Accounts), a key component in shifting to a consumer-driven market.

The basic idea behind the HSA is that the money saved on premiums, that are currently providing soup to nuts coverage, when converting to a catastrophic policy can be deposited in a savings account that is earmarked only for qualified healthcare expenditures. For example,

Who's Benefiting?

There are enormous benefits to MSAs. In their most recent report on MSAs, the Internal Revenue Service (IRS) found that 73 percent of people buying MSAs are previously uninsured. A report by the American Medical Association (AMA) entitled "Medical Savings Accounts the Health Care Coverage of Dependents and Children," found that the majority of MSA purchasers (70 percent) are families. Though restricted in who can buy them, and how many can be sold, still, MSAs are helping to provide individuals and small businesses with affordable access to quality health care.

This paragraph is from Karen Kerrigan's testimony on Mar 5, 2003 to the House Small Business committee. The cite is IRS Announcement 2002-90 (Oct 7, 2002)

in changing from a \$250 fee for service deductible plan to a \$2000 HSA deductible plan, there is likely to be about \$1300 in freed up premium dollars available to fund the HSA. Just like a retirement IRA, HSAs have preferred tax status and stipulations on how funds are accessed and spent without penalty. Ideally balances in the account as a result of prudent buying will build up over time as a form of self insurance for individuals to apply to more extensive health expenses in later years - quite frankly a fairly necessary mechanism to address the pending insolvency of Medicare.

Possible Build of Savings For Families With An HSA Under Different Time and Medical Expense Scenarios				
Account Balance After X Years	Age of Head of Household Starting at 30	Health Savings Account Balances (Assumes a \$4,000 Deductible)		
		After Family Medical Expenses of \$1,000 Each Yr	After Family Medical Expenses of \$500 Each Yr	Zero Family Medical Expenses
5 Years	35	\$17,406	\$20,307	\$23,208
10 Years	40	\$39,620	\$46,224	\$52,827
15 Years	45	\$67,972	\$79,301	\$90,630
20 Years	50	\$104,158	\$121,517	\$138,877
25 Years	55	\$150,340	\$175,397	\$200,454
30 Years	60	\$209,282	\$244,163	\$279,043
35 Years	65	\$284,509	\$331,927	\$379,345

Assumes 5% interest per year, and 100% of a \$4,000 deductible is deposited each year. One Medical Savings Account insurer has paid 5% interest on balances in their Medical Savings Account since January 1, 1997, and has not changed their interest rate since 1/1/97.

Possible Build-Up of Savings For Individuals With An HSA Under Different Time and Medical Expense Scenarios				
Account Balance After X Years	Age of Individual Starting at 25	Health Savings Account Balances (Assumes a \$4,000 Deductible)		
		After Individual Medical Expenses of \$1,000 Each Yr	After Individual Medical Expenses of \$500 Each Yr	Zero Individual Medical Expenses
5 Years	30	\$5,802	\$8,703	\$11,604
10 Years	35	\$13,207	\$19,810	\$26,414
15 Years	40	\$22,657	\$33,986	\$45,315
20 Years	45	\$34,719	\$52,079	\$69,439
25 Years	50	\$50,113	\$75,170	\$100,227
30 Years	55	\$69,761	\$104,641	\$139,522
35 Years	60	\$94,836	\$142,254	\$189,673
40 Years	65	\$126,840	\$190,260	\$253,680

Assumes 5% interest per year, and 100% of a \$4,000 deductible is deposited each year. One Medical Savings Account insurer has paid 5% interest on balances in their Medical Savings Account since January 1, 1997, and has not changed their interest rate since 1/1/97.

Archer MSA Coalition, Washington, D.C., October 2003

HSAs are targeted at controlling low cost, routine expenses. One study estimates that switching to a national system of HSAs could save \$33 billion annually in administrative expenses alone through immediate payment at the time of service, thus eliminating billing overhead and recognizing the value of non-deferred payment.⁷ A RAND experiment conducted over an 8 year period in the 1970s demonstrated conclusively that the use of medical services responds unequivocally to changes in the amount paid out of pocket. And, though fewer services were used, the lower use of services did not have a negative effect on health outcomes.⁸

Opponents to this concept might think that it works very well for the healthy to the detriment of the sick and those needing to access services. It will siphon the healthy out of the already strapped risk pools. But we currently have tens of thousands of risk pools, and none of them are subsidizing the others. Certainly with HSAs, people with low expenses gain, but people with lots of expenses gain as well because they will now have greater choice and are probably more sensitive to the restrictions of the current system. They are also the likely candidates to trigger their catastrophic coverage which then provides the next level of funding. Another Rand study, in fact, found that those who choose an MSA were on average the highest- risk people and considerably less wealthy than those who choose HMO coverage.⁹ It is also important to remember that this 10% of the population utilizing the majority of the services is actually always in flux, it could be any one of us at any time and that is why catastrophic insurance is important for each of us. Actually, the HSA concept is probably most beneficial to those with lower incomes, because they stand to gain a much higher percentage of savings relative to their income as we move to this model.

Having individuals and families manage their own health savings accounts can begin to address the current concerns of cost, access, quality and patient satisfaction that we continue to struggle with in the managed care environment. Greg Scandlen, the director of the Center for Consumer Driven Health Care at

Who's Benefiting, Part 2

I'd submit that MSAs work better for the sicker and lower income. This whole argument about it being for the wealthy and healthy is just plain bogus.

To the benefit of lower income folks, benefits from MSA are first dollar while most health plans have deductibles, coinsurance and copays. Deductibles, coinsurance and copays are barriers to care for low income folks. The MSA removes barriers.

MSA covers everything considered by the IRS to be "health care" expense. Health insurance, including government health insurance covers only those things included in the contract and refuses to cover anything else.

Personal experience: our MSA purchased \$1,000 worth of non-covered prescription drugs. If I had been poor and sick, I would have said, "Thank Heaven I had an MSA instead of traditional insurance."

Frankly, it would take chronic, expensive, long-term, insurance-covered illness for the MSA to be only as effective from a benefit standpoint than traditional insurance.

Its just a matter of doing the math.

I've had my MSA and used it since 1997. I have \$17,000 in the account after spending about \$4,000 over that time frame. A wealthy MSA owner would consider this \$17,000 fairly inconsequential. A poor MSA owner would consider \$17,000 a God-send.

Given my employer's continued contribution and the \$17,000 in the MSA, I can never be out-of-pocket for a covered medical expense for the rest of my life. Would this make more sense to a poor person or a wealthy person. MSAs are for the common folks.

Art Jetter CLU CFP RHU FLMI REBC LTCP
Art Jetter & Co - Insurance Marketing
October 2003

the Galen Institute, a free market think tank based in Alexandria, VA, has identified a variety of ways that HSAs can truly be a windfall for all. He has included the following:

- HSAs work to restore the patient to a position of influence in the healthcare system, while managed care leaves the patient as a passive recipient of other people's decision making.
- HSAs reduce the influence of third-party payers in the healthcare system, while managed care makes the third-party payer the predominant actor.
- HSAs help reduce costs by lessening the administrative burden on everybody, while managed care greatly increases the amount of healthcare dollars that are devoted to administration.
- HSAs help to restore the patient/physician relationship, while managed care weakens those relationships.
- HSAs encourage innovation and excellence in healthcare, while managed care encourages "cookbook" medicine.
- HSAs allow people to seek out alternative ways of maintaining and improving their health, while managed care either forbids, or discourages alternative medicine.
- HSAs encourage competition, while managed care encourages monopoly.
- HSAs facilitate portability for workers between jobs, while managed care locks workers into their current jobs.
- HSAs help assure continuity of care when patients change health insurers, while managed care disrupts continuity.

- HSAs enable people to seek the preventative care services best tailored to their own needs, while managed care covers only those services the bureaucracy prefers.
- HSAs increase quality by allowing patients to pay more to see a better doctor, while managed care tends to pay all participating doctors the same, regardless of their skill.
- HSAs allow people to build up a source of funds to pay for future healthcare needs, including long-term care and insurance premiums while unemployed, while managed care concentrates solely on the current year's expenses.¹⁰

The cost to provide a family's health coverage under our current model is fast approaching \$10,000 per year. This is absolutely not sustainable. The market-driven solutions sound

Paternalism

Any attempt to inject market discipline in health care is denounced as an assault on the poor. Somehow, self-interest cannot be trusted when what is at stake is a "basic need." As my earlier adversary put it, "Is there something more valuable than keeping people alive and healthy that society should be paying for?"

This form of mental illness might be called paternalistic paranoia. It is the belief that the market is out to get people, so the government must step in and make choices for them.

Instead, we might want to consider how the choices that people make reveal their own beliefs about what is valuable. W. Michael Cox and Richard Alm, in *Myths of Rich & Poor*, pointed out that in 1994 over 90 percent of poor households owned a color television. The majority of the poor owned microwave ovens, VCR's, and cable television hookups. Almost three-fourths of such households owned one or more cars. From this sort of data, one must infer either that there is something more valuable than health care coverage or that poor people have obtained enough coverage and are moving on to meeting other needs.

We could provide for the health care needs of the poor at far less cost by using vouchers in a market setting rather than using pervasive government intervention. However, as Sowell writes, "here, as elsewhere, the poor are being used as excuses to fasten a whole system of controls on all of us. The left uses the poor as political human shields."

Arnold King
America Is Crazy
TCS Tech, June 2003

almost too good to be true. It is hard to believe that all this could be achieved simply through the reallocation of existing funds. So many other reform proposals have hefty price tags attached. The folks that stand to lose some ground in this subsidy reorganization are those with higher incomes and lavish healthplans, but in the long run they may actually come to appreciate more a greater take-home pay in lieu of more benefits. The vast majority of Americans stand to gain as they assume control for their healthcare purchases. The reallocation can also include the vast amount of tax dollars currently funding the safety net for the uninsured. It could even include funds supporting the

Medicaid program. Everyone would have access to funds to purchase private insurance, selecting a program that best meets their individual needs. Aside from an interest in encouraging catastrophic coverage (which these proposals certainly do), there is no social reason why government at any level should dictate the content of health insurance plans, or establish policy that encourages others to do so as well. Individual consumer choice should be driving the healthcare marketplace. It is clearly time to step back and think outside the box that too many of us have become blindly accustomed to.

The Majority Are Missing the Point

The key issue I think in catastrophic plans is the premium differential between first dollar coverage and the catastrophic plan. We do business in 9 states and I would guess that the differential is something along the order of \$500 per month for a family - quick guess, no real research. That is \$6K per year. Here is my point: Give me 100 ordinary everyday employees right now with 2 plan choices - a typical first dollar managed care plan of some sort and a catastrophic plan with a \$25K deductible. A few will be risk takers and select the catastrophic plan and put the premium savings in their pocket - or their 401(k) plan. The vast majority will take the first dollar plan and the insurance company will have plenty of money to cover claims up to \$25K. The healthy ones will waste enough premium to cover the few that will actually incur the first \$25K of charges.

Dick Matthews

August 2003

IDENTIFYING WHERE YOU FIT IN THE CURRENT SCHEME OF THINGS

Often we as individuals don't stop and consider the entire financing scope when we think about healthcare costs. So many more of us are now feeling the effects of increased co-payments and coinsurance, and are now required to share more heavily in the up front premiums of employer sponsored health insurance. We gripe about more and more out-of-pocket costs, but to appreciate the entire picture, you must absolutely consider your employers contribution as well. That contribution is your money- money you have earned just as surely as your wages, but for many of us it is sort of "out of sight, out of mind". In this chapter, I urge you to take a very close look at your own situation.

If you are on Medicare, Medicaid, or some other government program, the sample worksheet provided requires some modification, but the conclusions to be drawn have similar application. Also recognizing that an unlimited taxpayer subsidy cannot continue indefinitely, a similar analysis is very helpful in transitioning to a defined contribution for government programs.

The sample worksheet that follows is applicable for those of us not on government programs. If you are receiving health benefits through your employer, it attempts to capture all premium dollars, as well as have you consider the value of the tax exempt status. Whether or not you receive insurance benefits through your employer or purchase health insurance directly, you can then compare your typical use of healthcare goods and services with the amount expended on premiums. If you are currently uninsured, the utilization analysis is still very helpful in determining what levels of coverage are best for your needs and what might be reasonable levels for government tax incentives and subsidies.

The variables for each of us are too numerous to clarify here, but this provides a good start to begin a personal cost/benefit analysis of your current coverage and utilization. The number of dependents, if any, is automatically reflected in the premium cost so obviously all expenses related to those dependents will need to be captured. Whether you have limited or

comprehensive benefits will be reflected in both the premium that is paid out as well as how the utilization costs are distributed between “Covered” and “Out of Pocket”. Your utilization history in and of itself clarifies areas where coverage is probably critical and other areas where self-insurance might be a better option. This exercise requires access to about 12 months of financial history related to your healthcare expenses, so if that seems to be a daunting task, plan now to begin to capture this information in a separate file going forward. Years ago, many people implemented a “shoe box” method in which they gathered their receipts until or in case they reached their high deductibles. It is probably a very good idea for you to now begin to track this information as well. Your healthplan can possibly provide some historical data, and it is very important to capture both your out of pocket expense as well as the dollars expended by your healthplan at their contracted rates. This can often be determined from the Explanation of Benefits (EOBs) sent by the healthplan, or by asking the healthplan or your healthcare providers directly.

Some of you may be surprised by the costs you uncover. Either they seem extremely high for the patient’s benefit derived from the service, or they may seem fairly reasonable compared with what you feel you might experience if you had to deal directly with your provider. Many people feel that only the government or large insurers are capable of negotiating reasonable rates. If this is the case, please rest assured that more and more providers these days are recognizing the advantages of cash transactions with patients for routine services, and are often willing to extend even better rates to patients when the onerous claims processing and billing cycle can be eliminated. As stated earlier, we’re currently spending billions and billions on administrative red tape that could be reduced considerably with the swipe of a credit or debit card or cash.

Now some of you may pencil this all out and say thank goodness I’ve got insurance. You’re experiencing the throes of a catastrophic episode or are treating a chronic illness. You’re reaping lots more in benefits than you’re expending. According to statistics, that might be about ten percent of you. The majority of you, however, will probably say “good grief” since you will most likely discover a huge gap between the premium dollars expended and the actual costs paid out by insurance. Humana found that over 70% of their employees

accumulated less than \$500 in claims annually. This is the perfect scenario to move to a health savings account model.

So, if a good portion of you see the light, channel a good portion of those premium dollars into a “healthcare IRA” so to speak, and purchase a high deductible catastrophic policy, where’s the money left in the system to pay for the healthcare for the those of you who came to the conclusion of “Thank goodness I’ve got insurance”. This is perhaps the biggest fear of those opposed to the MSA financing concept. A simplistic conclusion might be that a ton of money will be taken out of the system and stashed into personal savings accounts, while ninety percent of the costs will still remain to take care of the very sick.

But au contraire. A decision to support and migrate to a new healthcare financing mechanism is not an assault on the sick and frail. The ideal is for a system of nearly universal catastrophic coverage to prevail, and no one is suggesting otherwise, but once everyone becomes the stewards of their routine healthcare purchases, we begin to transform the entitlement mentality into that of prudent buyer. Once this happens, the fat in the system will begin to melt. This move is critical to bringing about reasonable and rational consumption, significantly reducing fraud and abuse, eliminating much of the bureaucracy and administrative cost that is now so prevalent, and creating an environment where the market driven focus factories of the future can cost effectively meet the needs of those currently consuming the lion’s share of the dollars.

Consider all that you’re expending, including that expended on your behalf by your employer because that money is in fact your forgone wages. This we will call your *Personal Healthcare Expense* (never mind all the additional tax dollars you spend on taxes to support other people’s healthcare). Then take a look at what you’re actually getting in return. This is an attempt to quantify your return on investment, so to speak (knowing that investment also includes a promise of coverage should a catastrophe hit). Finally, get a handle on what you’re personally contributing above and beyond you’re immediate needs (the *Risk Pool Contribution*), dollars you’ll probably never have access to since next year you may be forced to seek insurance from somebody else.

Hopefully this eye opener will turn you into an activist. Now is the time to demand that your healthcare dollars cease to be squandered and that you become very connected to your purchases in the healthcare marketplace. And the money doesn't disappear from the healthcare system. What accumulates just becomes earmarked for your own specific healthcare needs down the road - something truly of value when Medicare goes bust. It's your money! Take a good look at what's happening to it now.

“If people need protection, it is from the stupidity of low deductibles.”

Francis Kendrick, August 2003

**HEALTHCARE EXPENDITURES
PERSONAL EVALUATION**

Analyze prior 12 months of history for self and all covered dependents.
Incorporate any estimates for an anticipated change in health status.

\$ EXPENDED FOR HEALTH INSURANCE COVERAGE - annual costs

Premium cost paid by employer (If you don't know, ask)	_____
Premium cost paid by employee	_____
Total Premium for Employer Sponsored Coverage	_____
Premium cost for Individual Coverage (including COBRA)	_____
Uninsured - Proceed to next section	0

\$ EXPENDED FOR NON-COVERED ITEMS, CO-PAYS, COINSURANCE, AND DEDUCTIBLES

Office Visits	_____
Lab Tests	_____
RX	_____
Hospitalization	_____
Outpatient Surgery	_____
Vision	_____
Dental	_____
Mental Health	_____
Chiropractic	_____
Alternative Medicine	_____
OTC (over the counter medications)	_____
Other	_____
Out of Pocket Total	_____

ACTUAL COSTS COVERED BY INSURANCE - review EOBs or ask healthplan*

Office Visits	_____
Lab Tests	_____
RX	_____
Hospitalization	_____
Outpatient Surgery	_____
Vision	_____
Dental	_____
Mental Health	_____
Chiropractic	_____
Alternative Medicine	_____
Other	_____
Insurance Claims Total	_____

TOTAL PREMIUM COST + OUT OF POCKET TOTAL = **PERSONAL HEALTHCARE EXPENSE**

_____ + _____ = _____

OUT OF POCKET TOTAL + INSURANCE CLAIMS TOTAL = **PERSONAL HEALTHCARE UTILIZATION**

_____ + _____ = _____

TOTAL PREMIUM COST - INSURANCE CLAIMS TOTAL = **RISK POOL CONTRIBUTION**

_____ - _____ = _____

Other Considerations:

- +The value of the tax advantage for Employer Sponsored Coverage = The Total Premium X Your Effective Total Income Tax Rate.
- +Consider the value of foregone benefits in the case of dual coverage for spouses.
- +Also consider the value you might place on unrestricted choice and elimination of the hassle factor for most transactions.

*In the case of HMO capitated coverage, estimate the cost of services utilizing the healthplan's fee for service rates

Time For Insurers To Go

The proper function of insurance in a free market should be as a financial service, not as a privatized public health agency. Insurers should do what they do best – provide protection against large non-budgeted personal expenses such as the loss of a home, serious accidents, or major medical expenses.

Instead, the nation's largest insurers have forced a corporate version of Hillary Care on middle-class Americans by duping employers into buying overpriced product, adding 38% administrative costs to health care, and jacking up rates and insurer profits in the middle of a recession.

We have indeed “exhausted all the other options.” Economic facts will no longer support the current system. National average family premiums of \$9000 a year don't wash with a \$42,000 median family income. The comprehensive health insurance economic model is simply no longer viable.

What's it like for real American families under the current system? They earn \$3500 a month. After taxes they have \$2800. Subtract housing, utilities, and transportation, and they're left with \$1000 a month. That's less than \$250 a week for three to four people to pay for food, clothing, emergencies, and savings. Families can't do it, and are often financially wrecked by common out-of-budget expenses, as evidenced by our inexcusable bankruptcy rates.

Then add the \$233 monthly average for comprehensive insurance co-payments and deductibles, and balance becomes impossible. No wonder most hospitals are only collecting around 55% of the relatively small co-payments due from fully-insured families.

Neither can employers continue. On top of the \$42,000, they pay another \$6750 to the health insurance industry, driving median family wage costs up to \$50,000. Meanwhile, they compete against foreign labor costs of \$1000 a year or less under NAFTA, GATT, China MFN, and WTO.

There is a way out. \$5000 deductible policies can generally be purchased for around \$250 a month for most families, as opposed to the typical \$750 comprehensive policy. If employers freeze their benefit cost outlays at current levels, a median income family gains an extra \$500 a month to pay cash for everyday health care. Whatever is not spent on health goes to savings or the general economy.

If employers and employees are smart, they'll use Medical Savings Accounts to keep the \$500 tax-free and reserved for health care expenses. If Congress is smart, they'll approve the expansion of the MSA program as called for in the House version of the Medicare Prescription Drug Plan.

But tax-deferred or not, it's time for an all-out revolt against the traditional health insurance industry, both for the sake of our health and overall economy.

President Bush's tax cuts for median income families amount to about \$30 a month. In contrast, families moving from comprehensive coverage to a \$5000 deductible policy will receive an additional \$275 a month in their paychecks. 82% of those families won't need to spend it on health care, creating an economic stimulus nearly ten times that of the tax cuts. The best part – it comes from the hide of the comprehensive health insurance industry, instead of the federal budget.

Now is the time for every worker in the country to demand a high-deductible policy from their employer, and the savings either in cash or a tax-sheltered account. If employers refuse, workers should quietly seek a new employer who will comply.

Now is the time for every employer to revamp their benefit plans by eliminating comprehensive coverage and giving their workers the savings as a raise. If workers object, help them find a new employer who's more willing to be driven off-shore.

To do nothing is to exhaust our last free market option.

John E. Stone, September 2003
Director of U.S. Freedom Foundation, a nonprofit organization in Washington, DC with a chartered goal of restoring middle-class economic freedoms.

INFLUENCING THE OUTCOME - VOICE YOUR CONCERNS AND VOTE WITH YOUR FEET

The very good news for all of us is the recent passage of the Medicare Prescription Drug, Improvement and Modernization Act of 2003. No, not the part about expanding the entitlement with a \$400 billion underestimated price tag . That should probably just hasten the financial demise of traditional Medicare, forcing real reform for Medicare within the next decade.

The part about the bill that we should all be celebrating is the part that creates new Health Savings Accounts (HSAs) to help individuals under age 65 save for qualified medical and retiree health expenses *on a tax free basis!* HSAs are essentially Medical Savings Accounts (MSAs) but without the restrictions governing the federal Archer MSA demonstration project. HSAs have become a *permanent* feature of the tax code. They will be accessible to just about everyone, even the unemployed, and will profoundly change the individual health insurance market. They can be made available through cafeteria plans, so therefore should also be very big in the fully-insured mid-market - employers with 100 to 1000 employees. Overnight, the playing field just got a bit more even for those of us wanting to take back our freedom to choose. Keep an eye open for the plethora of emerging health care options, and make your desires known in the workplace and the marketplace.

We are at the beginning of a savings and investment transition similar to that of the individual retirement accounts (IRAs). This approach also has the very real possibility of streamlining the majority of everyday financial transactions in healthcare, eliminating tons of bureaucracy, and restoring the basic market forces of supply and demand back into the industry.

Here are the particulars:

Effective January 1, 2004

Eligibility

- Individuals under the age of 65 are eligible to contribute to an Health Savings Account if they have a qualified health plan.
 - For self-only policies, a qualified health plan must have a minimum deductible of \$1000 with a \$5000 cap on out-of-pocket expenses (indexed annually).
 - For family policies, a qualified health plan must have a minimum deductible of \$2000 with a \$10,000 cap on out-of-pocket expenses (indexed annually).
- Preventive care services are not subject to the deductible. In addition, coverage for accidents, disability, dental care, vision care, and long-term care is not subject to the deductible.

Contributions

- Contributions are allowed up to 100% of the health plan deductible. The maximum annual contribution is \$2,600 for self-only policies and \$5,150 for family policies (indexed annually).
- Individuals age 55-65 may make additional “catch-up” contributions of up to \$500 in 2004, increasing to \$1,000 annually in 2009 and thereafter. A married couple can make two catch-up contributions as long as both spouses are at least 55. Catch-up contributions will help individuals accumulate assets for retiree health expenses.
- Contributions may be made by individuals, family members and employers.
 - Contributions made by individuals and family members are tax deductible (for the account beneficiary) even if the account beneficiary does not itemize. Employer contributions are made on a pre-tax basis and are not taxable to the employee. Employers will be allowed to offer HSAs through a cafeteria plan.
- Investment earnings accrue tax-free.

Distributions

- HSA distributions are tax-free if they are used to pay for qualified medical expenses, such as:
 - Amounts paid for the diagnosis, cure, mitigation, treatment or prevention of disease,
 - Prescription drugs,
 - Qualified long-term care services and long-term care insurance,
 - Continuation coverage required by Federal law (i.e. COBRA),
 - Health Insurance for the unemployed,
 - Medicare expenses (but not Medigap), and
 - Retiree health expenses for individuals age 65 and older (Note: retiree health plans would not have to meet the \$1,000/\$2,000 minimum deductible requirements.)
- Distributions made for any other purpose are subject to income tax and a 10% penalty. The 10% penalty is waived in the case of death or disability. Upon death, Health Savings Account ownership may transfer to the spouse on a tax-free basis. The 10% penalty is also waived for distributions made by individuals age 65 and older. ¹

Within weeks of passage of the legislation and at subsequent intervals, the U.S. Treasury Department has issued Implementation Guidelines, a significant step forward in speeding the market adoption of HSAs. This clearly reflects the high priority of the Bush administration to provide affordable health coverage to all Americans. A 30% to 40% savings is regularly reported for companies and individuals who switch to Health Savings Accounts. The guidelines remove any questions for both insurers and the insureds who are or are about to be in the Health Saving Account market.

The money deposited into the Health Savings Account is not “new money”. Rather it is money saved by purchasing a higher deductible health policy, which has substantially lower premiums. Obviously, the older you are, the greater your premiums are above average, but in many cases, the health savings account approach produces net savings in addition to retention of control over a significant portion of the dollars.

Comparing Current Health Insurance Costs to Current Health Savings Accounts

\$755.67	Average monthly premium for average 2003 Family Health Insurance
\$9,068	Annual 2003 Cost of Family Health Insurance in the U.S. according to the Kaiser Foundation

***Family Medical Savings Account Offered
By an MSA Insurer***

\$264	Average Monthly Premium for a \$3,350 Deductible Family Health Insurance Policy
\$3,168	Annual Premium for a \$3,350 Deductible Family Health Insurance Policy
<u>\$3,350</u>	Cost of Fully Funding the Health Savings Account
\$6,518	Total Cost of Premium and 100% Funded MSA

Compare Costs:

\$9,068	Annual 2003 Cost of Family Health Insurance in the U.S. according to the Kaiser Foundation
<u>\$6,518</u>	Total cost of Premium and 100% Funded MSA
\$2,550	Savings Per Year with a Fully Funded MSA ²

The Bush Administration has been supportive of policy and tax reform to bring about a more market driven healthcare industry. The president's original budget proposal included \$89 billion in new health credits to make private health insurance more affordable for Americans who do not have employer- subsidized insurance. His budget plan for the Department of Labor would have created Association Health Plans (AHPs) that would provide millions of small business owners and their employees access to quality, affordable health care by creating greater bargaining power, economies of scale, and administrative efficiencies for

small businesses. In the January 2004 State of the Union Address, Bush spoke of making the catastrophic insurance premium as well as the Health Savings Account fully tax deductible for all individuals, not just the self employed. Big changes evolve over time, and involve lots and lots of compromise along the way. It appears there is no straight shot to the finish, but major blocking and tackling along the way.

Making HSAs available to 250 million non-elderly Americans is a huge step forward. According to Greg Scandlen at the Galen Institute's Center for Consumer Driven Health Care, "Allowing them to control their own resources will build a constituency for change. When these folks become eligible for Medicare, they will not want to surrender their freedom to a government bureaucracy." ³

Within hours of passage, Senate Minority Leader Thomas Daschle (D-S.D.) and others in the socialistic, single payer set, were seeking a follow-up Medicare "Correction Bill". They hope to repeal the new health savings accounts as well as the demonstration projects in which Medicare would compete with private health plans in selected markets. They are correct in citing huge flaws in the legislation that will require repeal and modification. I beg to differ that the health savings account piece is one of them, nor do I believe that their approach to solutions mirrors mine.

Interestingly enough, the politicians and the Washington bureaucracy can get things done fairly quickly when they know that a high percentage of the public is behind the change. Consider President Bush's signing of the legislation to activate the do-not-call list in fall of 2003, despite a U.S. judge's ruling that the program was unconstitutional.

It is imperative now to do two things. First, by all means, take advantage of the tremendous personal benefit now available by switching to catastrophic health coverage and opening a health savings account. It will give you greater control over spending decisions and enable you to seek the best value for your dollars. You will also become a front runner in beginning

the essential change of putting doctors and patients back in control of medical decisions. Let your desires be known, and vote with your feet.

Secondly, we still have a long way to go - a lot of regulation to rescind, a lot of bureaucracy to dismantle. We cannot continue to sit along the sidelines as disinterested parties. Pay attention, and make your concerns known on a regular basis to your government representatives. With today's Internet communication, this really isn't as tough as you might think. Now that you understand what is at stake - what you have to lose and what you have to gain - become an active voice. If active voices can keep telephone solicitors at bay, we should be able to take on the much more crucial crusade of eliminating third parties in our medical decisions.

The time to act is now!

CONCLUSION

Healthcare and health insurance is complex and complicated, but certainly not beyond an average person's comprehension. Average people understand all kinds of markets and healthcare should not be an exception. We have allowed it to become much more onerous and complicated than it needs to be, simply by failing to pay much attention to where it's been heading these past forty years. It is an escalating cost that we have been conditioned to blindly accept, but there is absolutely no good excuse for continuing in that mode.

On a number of fronts, reclaiming the concept of an ownership society in America will bring us prosperity in the twenty-first century. The opportunity that Health Savings Accounts brings to consumers is a major step towards reforming our dysfunctional healthcare system. HSAs offer the account holder the ability to fund their short-term healthcare needs and to offset financial risk related to illness or injury. In those two ways, HSAs serve the basic purposes of those seeking health insurance. However, HSAs are unique and offer other advantages to the purchaser such as the development of financial assets, tax-free savings for health purchases, flexibility during retirement, portability, leverage in price negotiation, the ability to comparison shop, the capture of savings for future healthcare purchases, and finally, protection against the insolvency of Medicare.¹ Finally – there is a level playing field for the individual to reclaim control.

To be honest, in the first nine months since the inception of HSAs, only a smattering of compelling High Deductible Health Plans that qualify for HSA compatibility have emerged. They are particularly sparse or non-existent in some geographic areas. It is critical that we as consumers pull the demand rather than wait for our health insurers to push it. Why? Those same insurers have been making fairly sizeable investment income off of your high premium dollars that flow into their reserves. When we take control, a good portion of this money will be sitting in the accounts of millions and millions of HSA holders, earning each of them investment income instead. With few exceptions, it has been pretty apparent that most health insurers just don't seem too anxious to migrate a good portion of their existing business to this new option.

The greatest challenge now is educating the public – making everyone aware that Health Savings Accounts are available and how they play a key role in bringing affordability back to healthcare. We are embarking on a huge transition in healthcare financing that will affect millions of stakeholders. The transition will be far from smooth, and we should expect numerous bumps along the way, but I’m confident that the healthcare marketplace will be finally headed towards a more maximized state. Things can’t turn on a dime, so expect that there will be many physicians and hospitals and other providers of healthcare traveling right alongside consumers on the learning curve as well.

Be aware of what is possible, seek the solutions that make the most sense for you, and don’t settle for anything less. The era of Consumer Directed Healthcare has been launched. The alternative to accelerating its adoption is fast approaching a major meltdown of the delivery system. I will close with a physician’s letter of concern that had been shared with Larry Elder. The future is in our hands. The choice is yours.

Dear Larry,

I have said repeatedly that until the patient becomes involved with their care in a fiduciary manner, the demand for care will continue to overwhelm the supply, creating a backlog in patient care. Costs have been distorted by the insurance companies and the government. Medicare has truly distorted the picture. And still, the government continues to add to the confusion and redistribution of funds by suggesting that medications should be paid for.

Just a few interesting things to address in the future: 1) The administrative costs of healthcare run between 70% and 80% of the healthcare dollar. 2) The patient’s responsibility for the healthcare dollar has decreased from 55% of the healthcare dollar in 1975 to 19% of the dollar in 1997. 3) The fact that government and large insurance agencies make healthcare decisions completely distorts the concept of capitalism. Deciding a personal healthcare issue based on the “greater good” is socialist and is dangerous. The only way the patient will recapture their decision making power is to assume financial responsibility...

I have often said, “we are just too good.” We continue to treat the poor like the rich; those who can’t pay are treated no differently than those with great insurance. Economically speaking, we have driven the value of our services to ZERO when we do it for free over and over again. We are tired of the public’s perception that we are rich. I can assure you. IT AIN’T SO.

When I present my colleagues with these depressing issues they shrug their shoulders and tell me that they are just too damn tired to try to change things. They feel defeated and depressed. Ironically, not too many years ago, this country is where the best and the brightest could be found. Now, admissions are down in medical schools. The government is paying medical schools to decrease their admissions. The tide has turned. The brightest aren’t going to travel this road. When you and I are old enough to need special care, there will be a “C” student willing to work a 9-5 schedule deliberating life and death issues at our bedside. I shudder.

- Marcy L. Zwelling-Aamot, MD, FACE²

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ADDITIONAL RESOURCES

American Medical Association

515 North State Street
Chicago, IL 60610
Phone 312/464-5000

Association of American Physicians and Surgeons

The voice of private medicine since 1943. AAPS is a non-partisan professional association of physicians in all specialties.

1601 North Tucson Boulevard #9
Tucson, AZ 85716-3450
Phone 800/635-1196
Fax 520/326-3529
Email aaps@aapsonline.org

Center for Long-Term Care Financing

The center for Long-Term Care Financing is a 501(c)(3) nonprofit, nonpartisan, charitable organization dedicated to ensuring quality long-term care for all Americans.

2212 Queen Anne Avenue North #110
Seattle, WA 98109
Phone 206/283-7036
Fax 206/283-6536
Email info@centerltc.org

Citizens Council on Health Care

The Citizens Council on Health Care's mission is to enable individual control in health care decisions by supporting free market principles.

1954 University Avenue West #8
St. Paul, MN 55104
Phone 651/646-8935
Fax 651/646-0100
Email info@cchconline.org

Council for Affordable Health Insurance

The Council for Affordable Health Insurance (CAHI) is a research and advocacy association of insurance carriers active in the individual, small group, MSA and senior markets.

112 South West Street #400
Alexandria, VA 22314
Phone 703/836-6200
Fax 703/836-6550
Email mail@cahi.org

Drug Prices and Information

Helping consumers locate the best drug prices and information.

Employee Benefit Research Institute

2121 K Street NW #600
Washington, DC 20037
Phone 202/659-0670
Fax 202/775-6312
Email info@ebri.org

Galen Institute

The Galen Institute, Inc., is a not-for-profit, free-market research organization devoted exclusively to health policy.

PO Box 19080
Alexandria, VA 22320
Phone 703/299-8900
Fax 703/299-0721
Email galen@galen.org

Health Insurance Association of America

1201 F Street NW #500
Washington, DC 20004-1204
Phone 202/824-1600

HEARTLAND INSTITUTE www.heartland.org click “health care”

19 South LaSalle Street
Suite 903
Chicago, IL 60603
Phone 312.377.4000
Email think@heartland.org

The Heritage Foundation www.heritage.org click “Health Care”

214 Massachusetts Ave. NE
Washington DC 20002-4999
Phone: 202/546-4400
Fax: 202/546-8328

The HSA Insider / HSA Coalition www.hsainsider.com

308 B Constitution Avenue N.E.
Washington, D.C. 20002
Phone: 202/271-3959
Fax: 202/544/5552

Institute for Health Freedom

An honest source for information about policies that affect your freedom to choose your health care treatments and providers and to maintain your health privacy—including genetic privacy.

1825 Eye Street NW #400

Washington, DC 20006

Phone 202/429-6610

Fax 202/861-1973

Email Feedback@ForHealthFreedom.org

National Association of Health Underwriters

2000 North 14th Street #450

Arlington, VA 22201

Phone 703/276-0220

Fax 703/841-7797

Email info@nahu.org

National Center For Policy Analysis www.ncpa.org click “C D Health Care”

12770 Colt Rd. Suite 800

Dallas Texas 75251-6272

Phone: 972/386-6272

Fax: 972/386-0924

Pharmaceutical Research and Manufacturers of America

1100 Fifteenth Street NW

Washington, DC 20005

Phone 202/835-3400

Fax 202/835-3414

U.S. Department of the Treasury www.treas.gov click “Health Savings Accounts HSA”

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General Information: (202) 622-2000

Fax: (202) 622-6415