



Issue Analysis

Political Malpractice

Health Insurance Misdiagnosis and the Destruction of Medical Wealth

By Gregory Conko and Philip Klein

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Executive Summary

President Barack Obama and congressional Democrats have proposed a major restructuring of the American health care system. They argue that Americans spend too much for health care of often dubious quality and that tens of millions of Americans lack meaningful access to health insurance. In turn, they have proposed structural reforms to the existing private and public health care financing systems that are intended to increase coverage, lower costs, and improve health care quality.

Most Americans agree that our health care system is broken and must be fixed. But it is increasingly clear that what ails health care is not too little, but too much government intervention. Federal and state tax preferences for employer-sponsored health insurance distort the market in a way that limits choices for individuals, reduces competition among insurers, and artificially inflates costs for health care services. For most working Americans, switching jobs often entails switching health plans and doctors or losing coverage altogether, while many others find non-employer-sponsored insurance unaffordable or difficult to obtain.

Efforts by federal and state governments over the past few decades to solve these problems have generated additional burdens and distortions, leading to increasingly bigger problems. To ensure affordable coverage for those in poor health or with potentially expensive medical conditions, governments have implemented guaranteed renewability, guaranteed issue, and community rating laws that force healthy individuals to subsidize those with higher health care costs. Many states require insurance policies to pay for niche specialists, including acupuncturists, pastoral counselors, and massage therapists, or to cover alcoholism and substance abuse treatment, smoking cessation, and in vitro fertilization. But these regulations further raise the price of insurance coverage, leading many healthy individuals to forgo insurance altogether.

Similarly, numerous state and federal restrictions on who may provide medical services and how they must be delivered have hindered the development of innovative ways for medical professionals to offer more convenient and lower-cost health services to consumers. A combination of government and medical professional lobbying has restricted the supply of new doctors, creating an artificial scarcity and contributing to rising prices. And medical products regulation substantially raises the cost of producing new drugs and medical devices, often without increasing their safety.

Instead of reducing these burdens, Democratic health reform proposals would impose more regulations on insurers, place mandates on individuals and employers to purchase health insurance, provide subsidies for individuals to pay for health care coverage, expand Medicaid, and create a new government-run “exchange” through which individuals and businesses could purchase strictly defined coverage from private insurers. But more government intervention will only add cost and complexity to the health care system; without solving the underlying problems.

As an alternative, policy makers should eliminate the many layers of market-distorting government regulation that have produced our current crisis. To truly reform America's health care system, policy makers should:

1. Modify tax policy to eliminate the disincentives for individual purchase of health insurance and health care.
2. Eliminate regulatory barriers that prevent small businesses from cooperatively pooling and self-insuring their health risks by liberalizing the rules that govern voluntary health care purchasing cooperatives.
3. Eliminate laws that prevent interstate purchase of health insurance by individuals and businesses.
4. Eliminate rules that prevent individuals and group purchasers from tailoring health insurance plans to their needs, including federal and state benefit mandates and community rating requirements.
5. Eliminate artificial restrictions on the supply of health care services and products, such as the overregulation of drugs and medical devices, as well as state and federal restrictions on who may provide medical services and how they must be delivered.
6. Improve the availability of provider and procedure-specific cost and quality data for use by individual health consumers.
7. Reform the jackpot malpractice liability system that delivers windfall punitive damage awards to small numbers of injured patients while it raises malpractice insurance costs for doctors and incentivizes the practice of defensive medicine.

Each of these changes would help to fix our broken health care system by reducing costs and enabling better informed, cost-conscious decision making. By themselves, they will not guarantee access to health insurance among those with chronic preexisting conditions. But if we reform the existing maze of federal and state regulation, we will then be able to address the problem of the truly chronically uninsured. Because they are a fraction of the 46 million individuals who now lack insurance or government health coverage, it would then be possible to create targeted programs to help subsidize their health insurance costs without breaking the bank and without distorting the rest of the health care and health insurance markets.

Introduction

President Barack Obama and congressional Democrats have proposed a major restructuring of the American health care system. They argue that Americans spend too much for health care of often dubious quality and that tens of millions of Americans lack meaningful access to health insurance. In turn, they have proposed structural reforms to the existing private and public health care financing systems that are intended to increase coverage, lower costs, and improve health care quality.

Nearly everyone agrees that the country's health care system is in trouble. Americans spent more than \$2.2 trillion—roughly 16 percent of GDP—on health care in 2007.¹ Nevertheless, critics complain that, at any given time, an estimated 46 million people living in the United States have no health insurance and are not enrolled in a federal or state government health care plan such as Medicare or Medicaid.² Those who do have health coverage have limited choices, but see annual costs growing much faster than the pace of inflation, and have no good way to measure the quality of the care they are receiving.

Lurking behind these raw statistics, however, is a complex and nuanced web of tax and regulatory policies that have given rise to the current situation. For decades, politicians have enacted a number of policies—both broad and narrowly-targeted—intended to expand health care coverage, improve quality, and contain costs. But, the laws they have enacted have been lumped, one on top of another, over the years, with little or no effort to ensure that they would incentivize appropriate decision-making, act in congruence with other rules, or even achieve their intended goals. As a result, America's health care system today is a strange hybrid, delivering care through a combination of government-operated programs and highly regulated private insurance plans.

Government-run programs, such as Medicare, Medicaid, and the State Children's Health Insurance Program, account for roughly 46 percent of every dollar spent on health care in the United States.³ Private sector health spending is heavily regulated at the federal and state level, and its availability is influenced significantly by the tax benefits attached to employer-sponsored health insurance plans. Furthermore, while close to 15 percent of the U.S. population is not covered by a public or private sector health care plan, these people nevertheless received an estimated \$84 billion of health care services in 2008, roughly 65 percent of which was provided free of charge and paid for by a combination of government subsidies and higher fees charged to insured patients.⁴ The distortions

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introduced into the system by this vast amount of government intervention exacerbate the problems of cost, quality, and accessibility. They raise administrative complexity, insulate individuals from the need to make rational economizing decisions, and fail to reward health service providers who deliver superior quality care.

Nevertheless, while the president and members of Congress are once again engaged in an effort to “reform” the health care system, they have failed to acknowledge that decades of government policy have contributed substantially to the problems we now confront. Instead, they have taken sport in scapegoating America’s medical profession and insurance and medical products industries, the very institutions that make medical services available in the first place. At a July 2009 Capitol Hill press conference, House Speaker Nancy Pelosi denounced insurance companies as “immoral,” and as “villains,” who “are doing everything in their power to stop a public option from happening and the public has to know... They have had a good thing going for a long time at the expense of the American people and the health of our country.”⁵ What began as a good-faith effort to help rein in costs and expand coverage to the uninsured has degenerated into bitter name calling as skeptics point out the high costs of the reform proposals and the threat of government intrusion on the doctor-patient relationship.

Those who seek further politicization of health care at the federal level, and who argue that there is a “right” to health care, have demonized insurance and pharmaceutical companies, but have steadfastly refused to recognize the source of medical wealth, which must be created before it can be distributed. It makes little sense to argue that there is a “right” to health care, however. After all, we do not think of other necessities, like food and housing, as things to which all Americans have a right, in part because establishing a right to something implies that others have an obligation to supply it. What if no one chose to be a physician or nurse? How would such a right be sustained? Much of the scientific knowledge that makes today’s medicine possible did not exist as little as a few decades ago. As the British physician Anthony Daniels posits: “Where does the right to health care come from? Did it exist in, say, 250 B.C., or in A.D. 1750? If it did, how was it that our ancestors, who were no less intelligent than we, failed completely to notice it?”⁶ And what does it mean to have a right to something that simply did not exist a decade, a year, or even a month before?

Instead of acknowledging these basic fundamentals, reform advocates have proposed adding new layers of bureaucratic intervention without regard to how these changes would fit together with the already haphazardly constructed regulatory framework, or whether their proposals would ultimately frustrate the very ends they seek. The health care reform plans now being debated in Congress will raise costs, limit choice, and reduce the quality of health care for most Americans. Benefit and coverage mandates, reimbursement caps, and premium restrictions forced on the health care sector will reduce the supply of the innovative private market solutions and greater choice that we desperately need.

A rational approach would instead remove the many distortions and barriers that currently prevent private health care markets from working efficiently and effectively. Real reform should:

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insurance among those with chronic preexisting conditions. But, if we reform the existing maze of federal and state regulation, we will then be able to address the problem of the truly chronically uninsured. Because they are a fraction of the 46 million individuals who now lack insurance or government health coverage, we would be able to create targeted programs to help subsidize their health insurance costs without breaking the bank and without distorting the rest of the health care and health insurance markets.

What is Wrong with Our Health Care System?

Americans spend over \$2 trillion every year on health care products and services, an average of \$7,400 per person.⁷ In addition, health care costs have grown by an annual average of 2.4 percentage points faster than the GDP since 1970, an increase that threatens to become much larger in coming years. The Centers for Medicare and Medicaid Services projects that, if no significant structural changes are made in the health care market, spending will top 20 percent of GDP within the next decade.⁸

During most of the 20th century, these rising expenditures have been accompanied by vastly better quality of care, but today many believe that the value of health care services received do not justify the costs. And, as health insurance premiums rise year after year, millions of Americans find it harder to afford health insurance, while millions of others remain in employer-provided or government-run plans that are not well matched to their individual needs. In most cases, individuals have very little choice among health care plans, and competition among providers is limited. For most working Americans, switching jobs often entails switching health plans and doctors or losing coverage altogether.

Who are the Uninsured?

Not all of those who lack insurance represent a public health problem. Official statistics suggest that approximately 45.7 million people—or roughly 15.3 percent of the United States' population—were not covered by private health insurance or a government health program at some point during 2007.⁹ However, this number obscures important differences among the uninsured. For example, many of those who lose health insurance when switching employers, or when they lose a job, lack insurance for only a few months. Only an estimated 36 million go a year or longer without coverage.¹⁰ The former are therefore not “chronically” uninsured, and including them in the total is somewhat misleading.

In addition, some 9.7 million of the uninsured—21 percent of the 46 million total—are legal or illegal immigrants, with the newest immigrants being the least likely to have insurance coverage.¹¹ While the most recent immigrants also tend to be disproportionately represented among the poor, foreign-born, naturalized U.S. citizens are nearly as likely as native-born citizens to be insured. The data suggest that new immigrants will transition toward insurance coverage over time.

While a majority of those who are uninsured have household incomes lower than 200 percent of the federal poverty level, the National Institute for Health Care Management estimates that, in 2006, some 12 million of the uninsured were eligible for Medicaid or the State Children's Health Insurance Programs, but were not enrolled.¹² Reasons for passing up enrollment in such programs vary, but some eligible individuals may be unaware of the programs, not know how to enroll in them, or face administrative hurdles when attempting to enroll. Others may wish to avoid the social stigma associated with taking public assistance. Still others may simply wish to forgo enrollment until they need care.

Delaying enrollment until it is needed may be especially attractive for two reasons. Medicaid grants retroactive coverage for some health expenses incurred up to three months prior to the date of application, provided that the enrollee would have been eligible during the retroactive period.¹³ In addition, the Emergency Medical Treatment and Active Labor Act (EMTALA), passed by Congress in 1986, requires hospitals and ambulance services to provide care to anyone needing emergency treatment regardless of their ability to pay, even if it means that some bills are never paid.¹⁴ As a result, the uninsured receive tens of billions of dollars worth of health care services every year, which are effectively paid through cross-subsidies in the form of higher prices charged to insured patients.¹⁵

Not all of the uninsured are poor, however. In 2007, over 38 percent of the uninsured lived in households with an income above \$50,000. Just over 9 million, or 20 percent of the uninsured, have household incomes greater than \$75,000 per year.¹⁶ Some of these individuals include people who live in households with two or more unrelated workers who cannot pool their incomes for the purposes of buying "family" health insurance coverage. But, many others have merely experienced a temporary period without insurance coverage as they switch jobs, while still others have consciously chosen to forgo insurance.

Of course, not everyone who can afford to pay for health insurance can get it. An estimated 11 percent of applications for health insurance

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in the individual market are denied for medical or non-medical reasons,¹⁷ so some portion of these non-poor uninsured individuals likely represent problematic cases. Still, there clearly is a substantial number of Americans who can afford health coverage, but choose to go without it for varying lengths of time. One important reason for doing so is the rising costs of health care and the belief that the value of coverage does not justify the cost.

Why Have Health Care Costs Risen So Rapidly?

Health care costs have risen rapidly for a number of reasons related to our nation's rising wealth and aging population. As our wealth rises, we must spend less and less to meet our basic food, clothing, and housing needs, so more wealth becomes available to spend on higher valued goods and services. Because we value health so much as a nation, we invest more in medical research, and that investment yields better and better methods and technologies. Health conditions that a generation or two ago were viewed as death sentences, such as cancer and heart disease, have become treatable. In addition, life expectancy is much greater today than it was just a few decades ago, and the proportion of our population over age 50 continues to rise. As the population ages, the prevalence of serious but treatable chronic health conditions rises alongside it. Thus, our investment in and adoption of new medical technologies can account for a portion of long-term health care cost inflation.¹⁸ In that regard, rising health care expenditures are a net good.

However, as Nobel Prize-winning economist Milton Friedman wrote in 2001, rapid technological advances in agriculture, transportation, and communication have lowered prices in each of those other industries: “[S]pending initially increased after nonmedical technical advances, but the fraction of national income spent did not increase dramatically after the initial phase of widespread acceptance.”¹⁹ Indeed, in the small number of health care markets in which most expenses are paid for directly by patients—such as laser eye surgery and cosmetic surgery—prices have tended to fall substantially over time as competition and cost-conscious purchasing make these areas much like other consumer markets, despite the adoption of increasingly sophisticated technologies.²⁰

It is clear, then, that the cause of spiraling health care costs is not medical innovation per se, but the structure of the health care market. That structure has been shaped—and distorted—by a series of misguided government policies. As a result, the vast majority of health care bills are paid by someone other than the patients who receive the care.

In 2007, individual consumers paid only 12 percent of all health care costs directly out-of-pocket, whereas government programs like Medicare and Medicaid paid over 46 percent of national health expenditures, and private health insurance plans paid just under 35 percent.²¹ Even the uninsured did not pay most of their own health care costs. According to the Urban Institute, the uninsured received approximately \$84 billion in health care services in 2008, of which some \$54 billion was provided free of charge and “paid for” by a combination of government subsidies and higher prices charged to insured patients.²²

The unfortunate result of this third-party payment phenomenon is that individuals rarely know how much their insurers or the government are being charged for health care services. They act as though they are spending someone else’s money, and therefore do not make rational cost-conscious choices about which services to receive.

How did this situation come about?

Ordinarily, any benefits received by workers from their employers are considered income and the value of those benefits is taxable just like cash compensation. However, beginning in 1943, the Internal Revenue Service ruled that it would exclude employer-purchased health and pension benefits from income, so workers did not have to pay taxes on them.²³ With wage and price controls in place during World War II and labor scarce, many employers took advantage of the favorable tax status to attract workers with highly valued fringe benefits. In 1954, the ruling became a permanent part of the federal tax code, and these benefits are similarly excluded from state taxes.²⁴

The tax preference for employer-sponsored health insurance is substantial. While some individual health care expenses are deductible from income taxes, workers who obtain health insurance through an employer-sponsored plan pay neither income taxes nor payroll taxes on any amount of the employer’s share of premiums.²⁵ And, in most cases, workers also pay no taxes on their own contributions to health insurance premiums. Thus, even employees at the lowest income tax bracket who wish to purchase health insurance in the individual market must do so with income that has been reduced by Social Security and Medicare taxes at the combined rate of 15.3 percent of income, reduced again by federal income taxes of 10 percent of taxable income, and, in some cases, reduced a third time by state and local income taxes. Thus, other things being equal, workers in the 10-percent tax bracket pay about a third more, and those in

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the 25-percent bracket pay about two-thirds more, to buy the same level of insurance coverage individually as do those who receive health benefits from an employer.

Businesses have defended the tax preference for employer-sponsored health insurance because it lets them provide substantial benefits at a small fraction of the cost their workers would have to pay in the individual market. Because of the favorable tax treatment, employers have faced an incentive to purchase increasingly more generous benefit packages in lieu of higher cash wages. As a result, by 2006, employer-sponsored plans accounted for 62 percent of health insurance coverage among the non-elderly in the United States, according to the Employee Benefits Research Institute. Government programs covered an additional 18 percent of non-elderly Americans, and only 7 percent of Americans actually purchased their own health insurance.²⁶

The tax preference for employer-sponsored health insurance creates several problems, however. The most significant of these is that workers generally do not see a direct link between the cost of their health care and the premiums they pay. Except for some modest cost-sharing arrangements such as co-payments, patients almost never see how much their health care actually costs, and they receive no benefit for passing up what their doctors recommend. As a result, employees and their families enrolled in firm-sponsored plans have no incentive to make economizing choices about which health services to obtain and which to forgo. Furthermore, because there is little market demand for cost and quality data, health consumers have very little information available to make wiser choices even if they wanted to do so. The end result is that, by one estimate, “[T]ens of billions of dollars are spent annually on services whose value is questionable or non-existent.”²⁷

Doctors, too, have an incentive to recommend expensive treatments and procedures that may have little medical value because a third party—the insurer or employer—is paying the bill. After all, the extra care may provide some value to the patients, only in very rare cases would it cause them any harm, and it permits doctors to submit higher bills. Additionally, many doctors report that they must practice “defensive medicine,” ordering arguably unnecessary tests and prescribing additional treatments, in order to protect themselves against potential malpractice lawsuits in the event that a seemingly routine condition turns out to be more serious than suspected.²⁸ Although the net cost of defensive medicine is difficult to measure, even skeptics acknowledge that a small percentage of medical

interventions, may be attributed to a conscious concern about malpractice liability.²⁹ Some studies suggest that the effect may be substantial, raising health care costs perhaps by as much as 3 to 9 percent in certain states.³⁰

Consequently, both doctors and their patients believe that more is necessarily better, as long as someone else appears to be paying for it. Ultimately, though, workers do pay for this excessive care in the form of higher insurance premiums paid by employers, which results in lower cash compensation. In addition, with so few Americans actually wishing to purchase insurance in the individual market, the range of choices is far lower than it likely would be otherwise.

Escalating Costs and Managed Care

This situation was sustainable for the first few decades following World War II, when medical science was rather crude by today's standards, and there was little that physicians could do for most patients with serious conditions. Total national health expenditures were just \$27.5 billion in 1960, \$74.9 billion in 1970, and \$253.4 billion in 1980, compared to more than \$2.2 trillion today.³¹ Physicians and hospitals found that insurers would pay for virtually any services that were "usual, customary, and reasonable," and insurers rarely questioned doctors' judgment about what fell into that category.³²

As this seemingly unlimited pot of money was funneled into the health care sector, it helped to fuel vast improvements in medical science. With innovative (and expensive) new diagnostic and treatment technologies, doctors and hospitals could do far more for patients. With new treatments to spend on, annual double-digit health care cost inflation became common. In 1983, Congress, seeking to rein in costs, began changing the way Medicare paid for various health care services. Instead of paying whatever bills doctors and hospitals submitted, Medicare began paying hospitals a predetermined amount based on each patient's diagnosis, regardless of the actual cost incurred in treating the patient.³³ Congress implemented similar set fee schedules for direct physician payments and outpatient services in 1992 and 2000, respectively.³⁴ The goal was to limit excessive payments and give health care providers an incentive to eliminate unnecessary treatments.

Private businesses found a need to cut costs as well. As increased global competition made American businesses more cost conscious during the 1980s, fewer employers were willing to provide an endless stream of

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money for health care benefits, and those who continued to offer health plans began to look for ways to trim their costs.

Initially, there was so much fat in the health care system that cost trimming was easy, and insurers were able to experiment with various ways to “manage” care and restrict the use of health services deemed unnecessary. By the 1990s, these utilization restrictions included provider networks and negotiated lower fees for specific services, “capitation” payments in which doctors were compensated per patient instead of per treatment, gatekeeper systems that limited access to medical specialists, financial rewards to doctors who kept per patient billing to a minimum, and limits on hospital stays for various conditions, among others.³⁵

Managed care firms also implemented evidence-based practice guidelines intended to direct physicians toward treatment regimens judged as providing the best value per dollar of costs. And the most fully integrated plans, typified by staff-model HMOs, engaged in rigorous “case-management,” which was helpful in limiting costs and in coordinating and streamlining the care of patients with multiple conditions. By some measures, the most intensively managed plans were actually increasing health care quality.³⁶ However, liberal critics derided these mechanisms as “cookbook” medicine, and the practices were denounced by politicians and consumer advocates as an effort by insurers and employers to justify skimping on needed health care. Insurers offered plans with various combinations of these and other managed care techniques, but the sometimes severe restrictions generated horror stories in the news media that tainted the entire notion of managed care, and patients rebelled.³⁷

Patients had come to view getting all the health care they wanted as an entitlement, and efforts to restrict their use of health care services became viewed as a violation of the public's right to health care. The public and media backlash against managed care helped to scuttle President Bill Clinton's health reform efforts, which relied substantially on the very same use restrictions and care management techniques to help cut costs.³⁸ It also subsequently forced employers and insurers to roll back many of the most severe managed care practices.³⁹ This evolving climate yielded a situation in which government and businesses had the will to reduce costs, while the public refused to contemplate the most effective cost-containment strategies.

Mandated Benefits and the Managed Care Backlash

The managed care backlash eventually also would spawn a series of federal and state-level restrictions on various utilization management techniques. Among the most well known of these is a provision in the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) that requires health insurance coverage for a hospital stay following childbirth generally to be no less than 48 hours for the mother and newborn child.⁴⁰

States implemented hundreds of individual benefit mandates for health insurance policies issued within their jurisdictions. Some states require coverage of niche specialists, including acupuncturists, pastoral counselors, marriage therapists, and massage therapists. Others mandate coverage for alcoholism and substance abuse treatment, smoking cessation, in vitro fertilization, mental health services, and hair prostheses. According to the Council for Affordable Health Insurance, a research and advocacy association established by insurance firms and small businesses, the total number of benefit mandates across all 50 states has exploded from a handful in the late 1960s to a staggering 2,133 today.⁴¹ The additional cost of any one given benefit mandate is often quite small, raising premiums by an average of between 0.4 and 0.9 percent, according to a study by economists at the University of Minnesota,⁴² but the cumulative impact of these mandates can raise premiums by 20 to 50 percent, depending on the state and the specific benefits included.⁴³

Some, mostly large, employers can escape the requirements of many state regulations by self-funding (or “self-insuring”) their health care policies, rather than purchasing insurance from a commercial firm. The federal Employee Retirement Income Security Act of 1974 (ERISA) specifically exempts such self-insured health benefit plans from most state insurance regulations, including mandated benefits and premium taxes.⁴⁴ More than 70 million Americans, including both workers and their dependents, are covered under such “ERISA plans,” representing approximately 55 percent of all non-governmental group coverage in the United States.⁴⁵

However, the administrative costs and financial risk of self-insuring put this option out of reach for most small and many medium-sized firms. Only 12 percent of workers in firms with fewer than 200 employees are covered under such self-insured ERISA plans.⁴⁶ Consequently, the cash-strapped small businesses that are least able to afford the substantial added

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In addition, while consumers of most products and services are free to shop among providers in every U.S. state for the best deals, neither individuals nor businesses of any size are free to purchase health insurance from less harshly regulated insurers in other states.

costs of state benefit mandates—and their employees—are the ones most likely to face them. An analysis by the consulting firm Mercer found that administrative costs make up nearly 20 percent of the premiums charged to insure groups of 200 or fewer employees, compared with less than 10 percent for groups of 2,000 or more,⁴⁷ and the burden of complying with a complex maze of regulatory schemes in various states contributes substantially to this administrative cost inflation.

In addition, while consumers of most products and services are free to shop among providers in every U.S. state for the best deals, neither individuals nor businesses of any size are free to purchase health insurance from less harshly regulated insurers in other states. Unlike self-insured ERISA plans, fully-insured policies purchased from an insurance firm must comply with the state insurance regulations in the jurisdiction where every individual enrollee lives. The majority of U.S. states require insurance firms to be licensed by the state and comply with all of the state's regulations in order to sell insurance policies to in-state residents. And federal law forbids individuals and firms from purchasing out-of-state insurance policies of all kinds.⁴⁸ Thus, insurance purchasers may not shop around to find a better deal on a policy subject to the lower regulatory burdens in another state. Of course, HIPAA began adding federal benefit mandates, such as mental health benefits and the minimum hospital stays following childbirth mentioned above, which apply to self-insured ERISA plans as well health coverage purchased from an insurance company. But, currently, these federal benefit mandates are fewer and somewhat less onerous than those in most states.

Attempts to Expand Coverage

Other federal and state regulations arose for the purpose of ensuring coverage for those with preexisting medical conditions and for limiting the premiums charged to those with higher-than average medical expenses. For example, another of Congress's goals in passing HIPAA was to address the phenomenon known as "job lock," in which workers or families who have insurance provided by an employer become reluctant to leave a job for fear of losing health benefits. This is especially relevant for workers or family members who develop chronic medical conditions while covered under a job-based health plan. An estimated 80 percent of health insurance policies guaranteed renewability from year to year prior to passage of the HIPAA legislation,⁴⁹ so the loss of coverage by a given employer merely for experiencing higher claims was rare. Still, there was substantial fear among

the chronically ill that switching jobs might result in loss of health coverage if the new employer refused to enroll the worker or refused to cover the preexisting condition.

A 1995 study by the U.S. General Accounting Office (GAO, since renamed the Government Accountability Office) found that a majority of employers had waiting periods preventing new hires from enrolling in employer-sponsored insurance plans for several months after beginning work—most for three months or less, but some for a period of one year or longer. The GAO estimated that between 1 million and 3.6 million American workers in a given year faced job-lock concerns,⁵⁰ though some respected economists believe the true number was significantly lower.⁵¹ HIPAA, passed by Congress the following year, limited the use of preexisting condition exclusions to no more than one year and required the new employer's plan to cover any ongoing treatment for the preexisting condition.⁵²

Because the majority of employer-sponsored plans had coverage restrictions that were already below the HIPAA limits, the biggest burden of this statutory requirement is the expense to former employers of certifying for any workers who changed jobs that they were covered under the prior firm's health plan and for how long.⁵³ This and other bureaucratic hassles simply added to the expense of providing health insurance and made it more likely that, on the margin, employers would opt not to provide it. Thus, while it does little to reduce the job-lock concerns that some workers have, HIPAA may contribute modestly to the number of uninsured Americans.

HIPAA and many state laws also prohibit most group health plans from denying workers or their family members coverage or from charging higher premiums based on preexisting medical conditions. HIPAA, for example, guarantees certain small employers and individuals who lose job-related coverage the right to purchase health insurance from any firm that offers coverage in those markets. And many state laws also guarantee that employers or individuals who purchase health insurance can renew the coverage regardless of any health conditions of the individuals covered.⁵⁴

Many states have also enacted “guaranteed issue” laws, which require insurance companies to offer coverage to anyone who applies, even if the applicant has a preexisting condition. This makes it feasible for healthy individuals to forgo insurance altogether until a medical condition arises. It would be like forcing auto insurers to write a policy after the driver has been involved in an accident. Such rules tend to drive up premiums for those who do have insurance because there are fewer healthy people to subsidize those who require extensive treatment. Nevertheless, New York,

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When community rating is combined with guaranteed issue laws, there is very little downside risk to forgoing insurance until a serious medical condition arises.

New Jersey, Massachusetts, Ohio, and 27 other states have guaranteed issue laws that forbid insurers from denying coverage on the basis of a preexisting condition.⁵⁵

Guaranteed issue laws may have limited impact by themselves, since they do not inherently prevent insurers from setting premiums at a level high enough to account for expected health care costs. More expensive are state “community rating” laws, which forbid insurers from setting premiums at a level commensurate with the risk posed by individual enrollees. Such laws are intended to force healthy enrollees to subsidize those with high medical care expenses and require insurers to charge the same or a very similar amount to all members. Under the strictest community rating rules, every plan member must pay the same premiums regardless of age, health status, or claims history. There are a variety of less strict forms, in which, for example, insurers may differentiate premiums to account for certain risk factors such as age and sex, but not for health status. And in the least strict forms, health status may be considered, but the difference between the highest and lowest premiums charged may not exceed a state-set limit.⁵⁶

In theory, the purpose of community rating is to prevent the premiums charged to very sick individuals from becoming so high as to be unaffordable. The problem is that it forces healthy people, especially the young, to pay much higher premiums than they otherwise would. But, when young and healthy people are forced to pay actuarially inflated premiums, many choose to forgo insurance altogether.⁵⁷ Under community rating, the only incentive to pay the inflated insurance premiums is the knowledge that, eventually, healthy people too will suffer an illness requiring expensive medical treatment. But, when community rating is combined with guaranteed issue laws, there is very little downside risk to forgoing insurance until a serious medical condition arises. As a result, average insurance premiums must rise to compensate for the disproportionate number of unhealthy enrollees, and the number of uninsured grows. One study that examined New Jersey’s very strict community rating and guaranteed issue laws estimated that they caused health insurance premiums in that state to more than double.⁵⁸

Initial attempts by states to enact strict forms of community rating were obvious failures, so the trend has been toward the adoption of less strict, “modified community rating” schemes.⁵⁹ Still, studies suggest that, on average, these modified community rating regulations raise premiums by 10.2 to 17.1 percent for individual policies, and by 20.9 to 33.1 percent for family policies.⁶⁰ Eventually, as healthy low-risk individuals perceive these

higher costs as not justified, they tend to drop their coverage, so community rating rules also modestly contribute to the number of the uninsured.⁶¹ Especially in the individual market, non-risk-based pricing leads to a phenomenon known as adverse selection, in which the healthiest individuals drop their coverage and insurance risk pools are left with fewer and fewer healthy enrollees to subsidize the increasingly larger proportion high-risk beneficiaries. The inevitable result is further escalating costs that make higher premiums necessary.

Restrictions on the Supply of Health Care

Similarly, numerous state and federal restrictions on who may provide medical services and how they must be delivered have hindered the development of innovative ways for medical professionals to offer more convenient and lower-cost health services to consumers. For example, states and the federal government have tried to prevent the development of physician-run specialty hospitals that provide care for only a small class of medical conditions, such as cardiac or cancer treatment, despite evidence that these facilities often tend to achieve better outcomes.⁶² States and the federal government have also used antitrust laws to prevent physicians from bargaining collectively to lower their malpractice insurance costs.⁶³ Joint ownership of some health facilities, such as labs for testing blood, is also generally prohibited by federal and state antitrust laws.

Physicians themselves often take advantage of state rules to prevent competition. State medical licensing laws often forbid non-physician clinicians—such as nurse practitioners, who are registered nurses that have completed advanced training in the diagnosis and management of common medical conditions and who may prescribe certain medicines—from delivering routine medical services without direct supervision by a licensed doctor.⁶⁴ Furthermore, the American Medical Association has, until only recently, successfully lobbied Congress to keep the number of available medical school and residency slots artificially low so as to restrict the supply of doctors.⁶⁵ And physicians have used licensing laws to forbid the so-called “corporate practice of medicine,” in which health maintenance organizations create fully integrated health clinics and hospitals, and hire physicians on a salaried basis, rather than paying them for each service provided.⁶⁶

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choice for health consumers in the market. Most firms can afford to offer only a single health plan to workers. And, while quality of care matters to employers, most have been focused on reducing the annual increase in costs to the extent feasible given the extensive regulation in the health care market. The limited amount of cost and quality information available in the marketplace today is geared toward the dominant purchaser: employers. And nearly all the regulation added over the past few decades, including HIPAA, were geared, not toward supplying greater choice, but to try “to lock an outdated, employer-based insurance market structure into place.”⁶⁷

Consumer-Driven Health Insurance

One modest attempt at shifting some choice and power over health care purchasing decisions from third parties to the consumers themselves has been the move by employers to adopt so-called “defined contribution” health insurance plans. Unlike the traditional “defined benefit” approach in which employers choose a single health insurance plan for all employees, in a defined contribution plan, employers determine how much they are willing to contribute toward health care expenses, and then provide several health insurance options from which employees may choose.⁶⁸ These may include a choice among conventional fee-for-service plans, managed care plans that restrict utilization but cover extra preventive services, and high-deductible insurance plans combined with personal health accounts. An example is the Federal Employees Health Benefits Program, which makes a large number of fee-for-service and managed care options available for federal government workers and their families. Some private sector employers now offer a similar range of choices.⁶⁹

The advantage of defined contribution plans is obvious: They permit individual workers to choose among various plans that best fit their needs. However, only the largest employers are capable of developing and maintaining such programs. A more realistic attempt to shift greater health care purchasing power into the hands of consumers has been a limited experimentation with a variety of options called Medical Savings Accounts (MSAs), Health Savings Accounts (HSAs), Health Reimbursement Arrangements (HRA), and Flexible Spending Arrangements (FSAs).

MSAs and HSAs are tax-exempt savings accounts that must be paired with a high-deductible health insurance policy, and into which individuals or their employers may deposit a limited amount of money every year for the purpose of paying “out-of-pocket” for most low-cost,

routine expenses, such as doctor visits and prescription drug purchases. HRAs and FSAs are employer-sponsored programs, typically combined with either a conventional or high-deductible insurance plan, in which workers are expected to pay out-of-pocket for some routine health expenses such as vision, dental, or preventive services, but are reimbursed for specified expenses with tax-exempt contributions from the employer in the case of a HRA, or tax-exempt salary reduction in the case of a FSA.⁷⁰

Each of these arrangements puts a certain amount of control over health care spending in the hands of the patients themselves, and three of the four can be—though need not necessarily be—structured to reward patients directly for cost-conscious spending. HRAs for example, may be designed to pay unused sums remaining at the end of each year in cash to the covered individual, subject to taxation.⁷¹ In MSAs and HSAs, sums remaining in the account at the end of each year can accumulate tax-free, providing an extra financial cushion. And, when the MSAs and HSAs are set up by individuals, rather than employers, unspent accumulated sums can be converted upon retirement into an IRA-like retirement account.⁷² Amounts annually allocated to a FSA, on the other hand, work on a use-it-or-lose-it basis; they must be spent during the year, and may neither be rolled over into the next year nor paid out to the covered employee.⁷³

HIPAA created a small pilot program for MSAs, but these were limited to self-employed individuals and businesses with 50 or fewer employees, and they had to comply with numerous state-level restrictions, so enrollment remained fairly low.⁷⁴ In 2003, as part of the Medicare Prescription Drug, Improvement, and Modernization Act, Congress broadened the availability of these accounts, which were renamed HSAs, and enrollment has increased. But they are still governed by many of the same state regulations covering traditional insurance policies, which in some states effectively prohibit health insurance policies with a high deductible. Thus, even with these positive changes, enrollment remains limited.⁷⁵ Today, an estimated 8 million Americans are covered under HSA plans, approximately three-fourths of whom receive this coverage as an employer-sponsored benefit. Only 1.8 million HSA enrollees are in the individual market, though that is up from just over half a million as recently as 2005.⁷⁶

The primary purpose of creating these accounts is to provide an alternative to traditional employer-sponsored health plans that puts patients themselves in charge of most medical purchasing decisions. Individual enrollees, whether in a personally maintained or employer-sponsored

HSA, control most discretionary expenses, such as preventive care, prescription drug purchases, and routine doctor visits. The high-deductible insurance component serves mainly to insulate enrollees from the cost of catastrophic health events. Enrollees reap the benefit of cost-conscious decision making, as unused sums may continue to accrue tax free from year to year. And the tax exemption helps to place such plans on a more equal footing with traditional employer-sponsored insurance.

Furthermore, the premiums for high-deductible health insurance policies tend to be considerably lower than those for comprehensive policies, making the plans more affordable, and arguably drawing in younger and healthier individuals who might otherwise forgo more expensive coverage. In January 2005, premiums for high-deductible health plans paired with an employer-sponsored HSA or HRA averaged \$2,700 per year for single coverage and \$7,900 for family coverage, compared with an average premium level for all employer-sponsored health insurance plans of \$4,000 for single coverage and nearly \$11,000 for family coverage.⁷⁷ In 2009, the high-deductible health plan premiums in the individual HSA market averaged just \$1,473 for singles in the 20- to 29-year-old age range.⁷⁸ A study by the American Academy of Actuaries found that those covered under HSA plans have average multi-year annual cost savings of 3 to 5 percent compared to an equivalent group of traditional health insurance plan enrollees.⁷⁹

Despite their many benefits, HSAs still have some noteworthy drawbacks. For example, while HSA enrollees have an incentive to economize when evaluating discretionary health care purchases, the tax exemption may still lead to over-consumption of health services at the margin. Nevertheless, because sums deposited by individuals into their personally maintained HSAs are exempt only from income taxation, not payroll taxes, they still purchase less health care than do traditional employer-sponsored health insurance. And, while premiums for high-deductible insurance policies are considerably lower than for comprehensive policies, low-income earners, who would benefit very little from the income tax deduction, may still find it difficult to afford coverage under a HSA.

In addition, federal rules rigidly define how HSA accounts may be used and the kinds of high-deductible insurance plans that may be purchased through them. Individuals who open HSAs on their own, rather than through an employer program, can make tax deductible contributions into the account, but they are required to purchase a particular form of health insurance with a

rigidly defined range of deductibles and “stop-loss” coverage to limit out-of-pocket spending. Federal rules set a maximum annual contribution limit of \$3,000 for individuals and \$5,950 for families for 2009, or the amount of the insurance deductible, *whichever is lower*,⁸⁰ and they cannot be paired with a conventional first-dollar coverage or low-deductible insurance plan. Importantly, individual HSA enrollees must pay insurance premiums with fully taxed income, not tax-exempt funds in the HSA.⁸¹

Another effort to provide small businesses and individuals outside the workplace increased health insurance access is the development of Association Health Plans. These are group insurance purchasing arrangements offered to members of established organizations or associations—such as professional societies or groups of similar small businesses—that exist for a purpose other than to buy insurance. Association Health Plans can help to lower the administrative costs associated with individual and small-group purchasing and underwriting. However, they are still bound by most state regulations, including benefit mandates and community rating rules, which raise premiums and make healthy young individuals less willing to participate.⁸² As a consequence, as Tom Miller of the American Enterprise Institute (AEI) has pointed out, they generally have “failed to attract a critical mass of customers needed for bargaining leverage and scale economies.”⁸³

In addition, unlike self-insured ERISA plans, the policies covering each individual must comply with the state insurance regulations in the jurisdiction where each enrollee lives. Consequently, when the association plan includes enrollees from more than one state, the plan administrator and the insurer must ensure compliance with a complex maze of premium and coverage requirements that vary from state to state. As a result, any administrative cost savings that might have come along with the group purchasing arrangement is usually erased by the complexity of dealing with myriad state regulations, a fact that has led many insurance companies to cease offering policies to multi-state associations.⁸⁴

In the end, even with more even-handed tax treatment, those who buy insurance coverage outside the workplace would continue to face higher costs. Employer-sponsored group plans, particularly in mid-sized and large firms that are capable of self-insuring, have substantial economies of scale that make them less costly to administer. Furthermore, younger and relatively healthy individuals are less likely to resent (or even be aware of) the implicit cross-subsidies they provide for their older coworkers—and they will tend to benefit from those cross-subsidies as

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they themselves age. Thus, there is considerably less adverse selection in employer-sponsored plans. Risk pools formed outside large firms and solely for the purpose of providing health insurance, on the other hand, tend to be less stable, more heterogeneous, and less likely to be replenished with good risks.⁸⁵

Another substantial drawback to HSAs and Association Health Plans is that no good or consistent market for price and quality information currently exists to help individual health consumers make effective purchasing choices. As AEI's Tom Miller has argued: "We just don't know enough about what works and who performs better, if not best. We lack sufficient data, effective measures, and standards. Even when they exist, they are not widely available or usable at the consumer level."⁸⁶ If more individuals were making their own health care consumption decisions, we would normally expect the market to supply this information—at a price. But, in the meantime, we lack the kind of information on provider outcomes and prices that would help health consumers increase the value of care they receive per dollar spent.

Medical Products Regulation

For the past century, American consumers have benefited from thousands of new pharmaceuticals and medical devices that combat disease, alleviate the symptoms of illness, and infirmity, and improve patient well being. There is considerable evidence that these new products generally improve the span and quality of life in a remarkably cost-effective way.⁸⁷ According to a recent National Bureau of Economic Research study, patients suffering from serious illnesses, such as heart disease, diabetes, and cancer, who were prescribed relatively newer drugs were more likely to live longer than comparable patients taking older drugs.⁸⁸ Still, while pharmaceutical expenses account for just over 10 percent of total medical costs, they are a growing component of overall health care expenditures,⁸⁹ and drug companies have been roundly demonized by critics.

Yet, creating, testing, receiving regulatory approval for, and manufacturing pharmaceuticals is a hugely expensive endeavor. Economists Joseph DeMasi of Tufts University, Ronald Hansen of the University of Rochester, and Henry Grabowski of Duke University found that the average cost of developing a new drug totals roughly \$802 million.⁹⁰ Economists at the U.S. Federal Trade Commission (FTC) were skeptical of that claim, so they conducted their own study of drug costs and concluded three years later that the average new drug costs between

\$839 and \$868 million to bring to market.⁹¹ Importantly, the FTC study also indicates that drug development costs are substantially influenced by the level of FDA regulation. The FTC economists found, for example, that the average cost of developing a treatment for HIV/AIDS is around \$479 million—much lower than the average for all drugs—in part because AIDS drugs have been regulated less strictly than other drugs. That, in turn, results in substantially lower costs and quicker times to market, both of which have obvious benefits for patients.

Recent years have seen some concern over allegations of hurried approvals with insufficient attention paid to drug safety. Contrary to those perceptions, however, FDA has actually become progressively more cautious and slower to approve new medicines during the past decade. Although legislative changes—such as the Prescription Drug User Fee Act of 1992 and the FDA Modernization Act of 1997—and various internal changes within the agency have helped at the margins to modernize and streamline the drug development process, the rate at which new drugs appear in the marketplace has slowed considerably.

FDA's Center for Drug Evaluation and Research (CDER) approved a mere 24 new medicines with truly novel chemical compounds in 2008, and only 18 in 2007.⁹² That is down from recent highs of 53 in 1996 and 39 in 1997. Yet, from 1993 to 2004, the number of CDER personnel rose by 50 percent, and total funding allocated for drug reviews more than tripled.⁹³ Over that same period, pharmaceutical industry research and development expenses steadily increased by 147 percent, and the number of approval applications for innovative new drugs rose by 7 percent.⁹⁴

Although the length of time it takes FDA to review and approve New Drug Applications (NDAs) has fallen since the early 1990s, essentially all of that decline occurred between 1993 and 1998.⁹⁵ Nevertheless, at an average length of nearly one year, those reviews still substantially exceed the 180-day action period mandated by the Food, Drug and Cosmetics Act.⁹⁶ Furthermore, that time period measures only the agency review of a submitted application, which comes after as long as 10 years—and sometimes longer—of actual testing.

The regulatory burdens on the clinical testing phase of development have also increased substantially since the 1980s. Since then, the average number of clinical trials conducted to support each NDA has more than doubled, and the average number of patients in those trials has nearly tripled.⁹⁷ This additional scrutiny does little to make new medicines

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safer, but it does delay or block the availability of new treatments, and it makes those new drugs that do appear on the market vastly more expensive.

Counterintuitively, longer reviews do not improve drug safety. Research conducted by FDA itself shows that the rate of drug approval withdrawals has remained essentially unchanged over the last 25 years, despite rising and falling approval times during that period.⁹⁸ On the other hand, the health benefits of faster approval decisions far outweigh the risks associated with the small number of unsafe drugs that occasionally do make it to market. A study by economists from the University of Chicago, Massachusetts Institute of Technology, Biogen Idec Inc., and Westfield Capital looked at all 662 drugs approved by FDA from 1979 to 2002 and concluded that, even if every withdrawn drug provided no benefits at all, the faster pace of approvals beginning in the 1990s benefited patients with an extra 180,000 to 310,000 years of life—three to five times greater than the worst case estimate of harms.⁹⁹

Ultimately, the high retail prices of pharmaceuticals reflect the vast expense of developing those products. But, as the FTC study of drug development costs suggests, rationalizing and streamlining the medical products review process could help to lower development costs substantially, which in turn would help to put slight downward pressure on medical cost inflation.¹⁰⁰

The problem of securing affordable access to health care gets the lion's share of airtime and ink in the health reform debate, but the focus on affordability partly misses the point of what it means to increase medical wealth. Today's health reformers ought to study ways of removing obstacles that restrict the *supply* of health care as a way of holding down costs and expanding access. Increasing everyone's "right" to health care without a corresponding increase in the availability of care services and products will place tremendous upward pressure on costs.

What Is Wrong With the Democratic Proposals?

During the 2008 presidential campaign, candidate Barack Obama made clear that he viewed substantial reform of the American health care system as a priority for his administration. Five years earlier, in a speech to the AFL-CIO, then-Illinois State Senator Obama said: "I happen to be a proponent of a single-payer universal health care plan... We may not get there immediately, because first we've got to take back the White House, and we've got to take back the Senate, and we've got to take back the House."¹⁰¹ And, as recently as May of this year, he said, "If I were starting

a system from scratch, then I think that the idea of moving towards a single-payer system could very well make sense.”¹⁰²

Still, he did not actually propose a single-payer universal health care plan. Instead, he outlined a proposal with a series of features that would theoretically preserve the major elements of the current bifurcated system, but which would substantially increase the role of government in health care financing and regulation. President Obama now says that too much is vested in the current system to scrap private insurance entirely. Instead, he has laid out broad principles for reform that would retain a significant role for private health insurance, and he left the drafting of specific health care legislation up to Democrats in Congress.

As Congress left Washington for its August recess, there were three different bills under consideration. In the House of Representatives, the Ways and Means, Energy and Commerce, and Education and Labor committees worked together to produce one piece of legislation, H.R. 3200, the America’s Affordable Health Choices Act of 2009. The Energy and Commerce Committee approved it on July 17, but as of early September, the bill had not been voted on by the full chamber. In the Senate, another proposal, also called the Affordable Health Choices Act, had cleared the Health, Education, Labor and Pensions (HELP) Committee, although it had not been formally introduced or assigned a bill number. Members of the Senate Finance Committee were still discussing options to include in a third bill, which was not available, even in draft form, at the time of this writing.

Broadly speaking, the current proposals all seek to impose more regulations on insurers, place mandates on individuals and employers to purchase health insurance, provide subsidies for individuals to purchase insurance, expand Medicaid, and create a new government-run “exchange” through which individuals and businesses could purchase strictly defined coverage from private insurers. The House bill also provides for the creation of a new government-run insurance program that would compete with private insurers.

Many lawmakers think that greater government control is necessary for solving health care problems in the U.S., but the very need for reform stems largely from government meddling with the health care system through the tax code and burdensome state and federal regulations. Over time, each new intervention has added to a maze of complexity, further distorting the market for health care and requiring some new fix.

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Federal Regulation of Private Insurance

There are few better ways to demonstrate how government begets more government than to review the evolution of efforts to overhaul the nation's health care system. When lawmakers set out from the premise that they need to manipulate the market into behaving in a way they consider more socially responsible, it inevitably leads down the path to a government takeover. For example, one of the leading criticisms of the status quo is that, despite numerous state and federal efforts to increase health insurance coverage, gaps remain in federal and state regulation that allow some insurers to deny coverage to applicants if they suffer from preexisting medical conditions. Critics see this as a clear market failure, arguing that for-profit insurers do not have an incentive to take on new customers whose health care costs are likely to exceed premiums.

The idea of requiring insurers to offer coverage to anybody who applies, regardless of medical status, sounds simple enough. Guaranteed issue rules enjoy the support of 79 percent of the public, according to a July poll by the Pew Research Center for the People and the Press.¹⁰³ But, if insurers are required to offer coverage to people with preexisting conditions, they could respond by charging higher premiums to cover those applicants' much higher health care costs. To prevent this, policy makers propose wedding the requirement with community rating rules that bar insurers from charging sicker customers more than healthy customers.

These two measures are included in the health care bills working their way through Congress this year.¹⁰⁴ But, as states that have already enacted them have discovered, the provisions have disastrous unintended consequences. While such regulations make health insurance more affordable for high-risk patients, they drive up the cost of insurance for healthier individuals, giving them less reason to enter—or remain in—the market. Making matters worse, because insurance companies cannot deny coverage to anybody, those who are healthy are given every incentive to defer purchasing insurance until they get sick.

Kentucky is a textbook example of such a regulatory regime gone awry. In 1994, the state legislature passed a health-care reform package that imposed both requirements, causing a mass exodus of insurers from the state. Within two years of enactment, about 60 insurers had exited the market, according to the Kentucky Office of Insurance. This left the state with only one private insurer in the individual market, plus a now-defunct state-run plan. As a result, Kentucky was forced to rescind the regulations

in an effort to woo back insurers.¹⁰⁵ Maine faced similar problems after it adopted such regulations.¹⁰⁶

But guaranteed issue and community rating are just a few of the regulations that will be enshrined into federal law if the bills now working their way through Congress, or similar legislation, were to impose the same kind of benefit mandates on the whole nation. Insurers in states that now have relatively few mandates would have to comply with the new federal rules. And employers that now escape onerous state-level requirements by establishing self-insured ERISA plans would be burdened with new federal mandates.

The House and Senate bills would create new government bureaucracies that would be responsible for specifying what insurers must cover, essentially designing the policies in Washington. Under the Senate Health Education Labor and Pensions bill, for instance, all health insurance plans would have to cover substance abuse treatment, mental health services, preventive care, and several other services. And a new Medical Advisory Council would be tasked with defining which additional benefits must be covered in order to “qualify” as insurance.¹⁰⁷ The House bill would similarly establish a federal panel to recommend new benefit mandates, and it would also forbid certain cost-sharing mechanisms, such as co-payments, for certain services, including preventive care.¹⁰⁸

We have already seen the effect of such requirements at the state level. Benefit mandates make it impossible for many younger and healthier individuals to purchase policies with cheaper monthly premiums that suit their limited health care needs. Instead, they must pay top dollar for benefit-rich plans that cost far more than their annual medical spending, or go without insurance at all. Artificially high prices cause many such individuals to drop insurance coverage altogether, leaving fewer “good risks” in the insurance pool to subsidize those who require chronic and expensive care. The net effect of imposing these requirements at the federal level would be to further raise the price of health insurance, and make the cost of obtaining it much greater than its expected benefits for an even greater number of people.

Mandatory Purchase

Instead of scrapping failed ideas after seeing their results, lawmakers have proposed fixing the problem created by an intrusion into the market with yet another intrusion. All of the bills now in Congress would mandate

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that businesses provide health insurance coverage to their employees or pay a tax that would be used to help fund subsidies for the uninsured.¹⁰⁹ Individuals who are not covered under an employer-sponsored or government plan would also be required to purchase insurance coverage or face a tax penalty.¹¹⁰

The House bill specifies that employers must pay for at least 72.5 percent of the premiums for an individual plan and 65 percent of a family plan for full time employees. Businesses must also cover part time employees with a premium contribution reduced to reflect the lower number of hours worked. If they do not, businesses with payrolls exceeding \$400,000 would be required to pay a tax of 8 percent of their payroll, which would be used to help finance the exchange.¹¹¹ Businesses with payrolls between \$250,000 and \$400,000 would pay a sliding-scale tax of 2 to 6 percent.

Bringing everyone into the system would enable insurers to recoup losses from providing health care to those with preexisting conditions with profits generated by collecting premiums from people who have few medical expenses. Thus, America's Health Insurance Plans, the industry trade group representing insurers, has said that insurers would be willing to support guaranteed issue rules as long as government forces all Americans to purchase their products.¹¹²

An individual health insurance mandate has been compared to state laws requiring that drivers buy car insurance,¹¹³ but the analogy does not hold up for several reasons. While a car insurance mandate only requires that someone purchase car insurance if he or she owns a car, a health insurance mandate would apply to *everyone*. And, while the purpose of car insurance is to make sure that drivers can pay for damages they may cause others, the health insurance mandate is imposed on individuals to cover the cost of medical care they would receive themselves. Furthermore, car insurance mandates are not even especially effective, with an estimated 13.8 percent of drivers going without coverage in 2007, according to the Insurance Research Council.¹¹⁴

Another problem with insurance mandates is that if the government requires individuals to purchase insurance, then it must define what constitutes sufficient or "qualifying" coverage. For instance, in the House bill, all Americans are required to purchase coverage that is deemed "acceptable" by a Health Choices Commissioner.¹¹⁵ Thus, under such legislation, Congress would delegate the decision over what constitutes "acceptable" coverage to an appointed official who, facing an incentive

to accumulate greater authority, would likely ratchet up coverage requirements. And, as various state legislatures have done, Congress itself would likely add new benefit mandates over time.

Federal Subsidies and Medicaid Expansion

Once government reaches the point at which it mandates and defines coverage, it cannot stop there. It is problematic to require people to obtain coverage if they cannot afford it—so government has to help pay for it. The biggest cost in the \$1-trillion-plus health care bills floating through Congress is the cost of paying for more Americans to get coverage, which Democrats hope to accomplish by expanding Medicaid eligibility and offering sliding scale subsidies for individuals to purchase insurance.¹¹⁶ The Congressional Budget Office (CBO) estimates that the proposals being debated could add as many as 20 million people to the Medicaid rolls, an expansion which alone would cost the federal government around \$500 billion over 10 years.¹¹⁷

However, financing and proper accounting for a Medicaid expansion get a bit tricky. Currently, the federal government pays 57 percent of the cost of Medicaid and the states pick up the remaining 43 percent.¹¹⁸ While the House bill would have the federal government pick up the tab for this Medicaid expansion, the latest draft of the Senate Health, Education, Labor and Pensions Committee bill has the federal government covering the cost for only the first five years, after which the burden would gradually shift to the states.¹¹⁹ Medicaid spending is already hammering state budgets, and the program has played a prominent role in California's budgetary problems. Nevertheless, the HELP legislation could eventually impose hundreds of billions of dollars in new spending requirements in already cash-strapped states.¹²⁰

Here again, recent experience suggests that such an expansion may be more difficult than envisioned. In 1994, Tennessee experimented with expanding Medicaid coverage, but, by 2003 its health care system was deemed "not financially viable" by consulting firm McKinsey and Co. and Democratic Governor Phil Bredesen was forced to rein in the program.¹²¹

Democrats have also proposed subsidies for the purchase of private health insurance for individuals who earn too much to qualify for Medicaid; the subsidies would decrease as individuals' incomes rise. Although the exact figures vary from bill to bill, House Democrats have proposed making individuals with household incomes as high as 400 percent of the federal poverty level—\$43,320 for individuals or \$88,080

Once government reaches the point at which it mandates and defines coverage, it cannot stop there.

for a family of four—eligible for some amount in subsidies.¹²² The CBO has estimated the 10-year cost of these subsidies alone at \$773 billion, although in reality that is more like a six-year estimate because the subsidies would not kick in until the plan’s fourth year.¹²³

The ideal solution would be to remove the tax preferences and governmental obstacles that actively disadvantage multi-employer pooling and insurance outside the workplace and let individuals sort themselves into the purchasing arrangements that best suit their needs.

Health Insurance Exchanges

Mandating coverage and subsidizing purchase are merely two steps in the current proposals. Another question remains: Where will these individuals purchase insurance? As noted above, government meddling with the tax code, as well as the imposition of thousands of benefit mandates at the state level, have stifled the development of a functioning market for individual insurance. To lawmakers, the problem is not that government overregulation has hindered the market. Instead, they argue that there cannot be a true market for individual coverage because getting a good deal on insurance requires purchasing it as part of a larger risk pool (such as a big employer). Indeed, even in the absence of burdensome regulation, there would remain administrative hurdles in the individual and small group markets that make large group purchasing far more attractive to many purchasers.

The ideal solution would be to remove the tax preferences and governmental obstacles that actively disadvantage multi-employer pooling and insurance outside the workplace and let individuals sort themselves into the purchasing arrangements that best suit their needs. Instead, the Democratic proposals have tried to solidify the status quo by further incentivizing traditional employer-provided health insurance.

The proposals do, however, provide for the creation of an insurance purchasing exchange that would enable individuals to use their government subsidies to purchase insurance in a larger, government-organized risk pool. The idea is to allow individuals to band together to take advantage of some of the administrative simplicity offered by large employer purchasing, such as lower marketing and underwriting costs. The House bill envisions one national exchange,¹²⁴ while the HELP bill would establish health insurance exchanges called “Gateways” in every state. While the latter legislation claims to offer flexibility in how states set up the exchanges, any state that refuses to establish an exchange within four years will have one imposed on it from Washington.¹²⁵

The insurers offering plans through these exchanges would (for the most part) be private sector firms, but government would strictly

regulate the minimum benefits offered in each plan, and would institute guaranteed issue and community rating rules. Importantly, under the House bill, once the exchange becomes fully operational, private insurers would no longer be able to offer coverage in the individual market except through the exchange. Thus, not only would individuals not covered under an employer-sponsored plan be forced to purchase insurance, their only option would be to purchase it through the exchange.¹²⁶

Beyond the threat to liberty inherent in forcing individuals to purchase government-designed insurance policies from a government-run exchange, there is ample evidence that such a system would have devastating financial consequences. In 2006, Republican Massachusetts Governor Mitt Romney signed a health care bill that contained all of these elements—the mandate, the subsidies, and the exchange. While the plan has been successful at expanding coverage to the uninsured, this increased coverage has come at a colossal cost.

A survey conducted by the Massachusetts Medical Society found that many primary care physicians have ceased taking new patients, and the average waiting time to see a physician has risen as the influx of new patients has spiked even as the number of new doctors entering general practice keeps falling.¹²⁷ *The New York Times* reports that, “[G]overnment and industry officials agree the [Massachusetts] plan will not be sustainable over the next 5 to 10 years if they do not take significant steps to arrest the growth of health spending.”¹²⁸ State Treasurer Timothy P. Cahill, a Democrat, told the *Boston Globe* that the plan is too expensive. “We’re all still waiting for the savings,” Cahill said. “Universal healthcare was supposed to eventually save us money.” He cautioned that, “It’s a warning for the federal government as it looks to do something similar.”¹²⁹

The Massachusetts debacle should serve as a cautionary tale against expanding government influence over health care, yet liberal health reform advocates argue just the opposite—that it is all the more reason why we need an even greater role for the federal government. For instance, in March, White House Domestic Policy Council Director Melody Barnes was asked about the rising costs in states that have tried to expand coverage. “One of the things that many of the governors and others in the states who have been focused on the state plans have said is in order to get costs really under control, we’re going to have to look at this issue on a national level,” Barnes replied.¹³⁰

Beyond the threat to liberty inherent in forcing individuals to purchase government-designed insurance policies from a government-run exchange, there is ample evidence that such a system would have devastating financial consequences.

It would be hard to achieve a genuinely level playing field when the federal government would be running the national health care exchange, setting the rules of the game, and subjecting insurers to heavy regulation.

Government-Run Plans

One major point of contention among the congressional Democratic plans is whether reform should include a “public option”—that is, a government-run, not merely government-supervised, health insurance program like Medicare or Medicaid for the non-elderly middle class. Diane Archer, in a report for the liberal Institute for America’s Future, has argued that, far from representing too massive of an expansion of government, the reason why the Massachusetts health care legislation has failed to control costs is that it relied too heavily on private insurers. “It offers no countervailing power through a public health insurance plan to drive competition, offset insurer market power and rein in costs; rather it maintains the status quo that has led to spiraling health care costs.”¹³¹

Liberal health reform advocates have argued that any true health care reform must include the creation of a new government-run plan, which they call the “public option” (because “public” polls better than “government”¹³² and “option” implies choice). As Jacob Hacker, a professor at University of California at Berkeley and one of the early proponents of the idea, has said, “I really don’t think we can mandate our way, or regulate our way, into getting private insurance to operate in a public-spirited way.”¹³³ Supporters argue that a government-run plan could compete against private insurers on the government-run exchange, which would help keep all premiums lower and make sure insurers offer quality coverage. President Obama has said that, “The thinking on the public option has been that it gives consumers more choices and helps keep the private sector honest.”¹³⁴

Proponents of the government-run plan further argue that if private enterprise is so superior, insurers should not have a problem competing against the government. But it would be hard to achieve a genuinely level playing field when the federal government would be running the national health care exchange, setting the rules of the game, and subjecting insurers to heavy regulation. Furthermore, there is good reason to suspect that the federal government might subsidize the public plan from general tax revenue or use its hefty bargaining clout to demand below-cost deals with physicians and medical products manufacturers as it has done with Medicare.

Even small price differences could have huge consequences. Consulting firm The Lewin Group has estimated that, depending on how widely available the government plan is and whether it is able to pay doctors and hospitals Medicare reimbursement rates, it could ultimately result in the shift of 119 million people from private insurance to the

government plan, representing roughly two-thirds of the private market.¹³⁵ This would give the public health plan a substantial advantage over private competitors and would permit the public option to lower premiums, attracting individuals away from private insurance firms by drastically undercutting them.

Furthermore, in truly competitive markets, private enterprises that lose money are forced to go out of business. As Robert Moffit of The Heritage Foundation has noted, it is unlikely that the government-run plan would be allowed to fail.¹³⁶ A perfect example is the history of Freddie Mac and Fannie Mae. For decades, both companies were described as private enterprises, but were in fact designed by Congress as government-sponsored enterprises (GSEs). As such, they benefitted from the federal government's implicit backing, which enabled them to borrow money at cheaper rates than their competitors to finance home loans, and eventually to dominate the mortgage market.

For years, critics argued that the implicit federal guarantee distorted the home mortgage market because investors and borrowers believed that the government would bail out Freddie Mac and Fannie Mae if their investments turned sour. But supporters of the GSEs, including Rep. Barney Frank (D-Mass.), insisted those concerns were unfounded.¹³⁷ The critics were eventually proved right. In 2008, when both companies were collapsing under the weight of bad loans, Congress and President Bush orchestrated a \$200-billion bailout, giving the federal government an ownership stake in these allegedly "private" companies.¹³⁸ In light of this experience, if a public option health plan is created and signs up tens of millions of beneficiaries, it is simply unrealistic to believe that the federal government would not use taxpayer dollars to rescue the program if necessary.

Perhaps a closer parallel is the student loan system. For 43 years, the government has subsidized student loans made by private companies through the Federal Family Education Loan Program. In 1993, a new program was introduced under which government made loans directly to students, alongside private firms. But this July, with the backing of President Obama, Rep. George Miller (D-Calif.) introduced legislation that would have all lending done directly by the government, doing away with private firm participation altogether.¹³⁹

Such examples have led many skeptics to believe that the public option may well have been designed for the purpose of getting Americans, over time, to adopt a single-payer system in which government is the sole

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purchaser of health care. Recall Barack Obama's 2003 statement that he was "a proponent of a single payer universal health-care program," and his admonitions that incremental reforms would have to be made first in order to set the stage for eventual adoption of a fully government run program. "[A]s all of you know, we may not get there immediately," Obama said in 2003.¹⁴⁰

Even some Democrats have acknowledged publicly that the introduction of a government-run plan would lead to a single-payer system over time. "I know many of you here today are single-payer advocates, and so am I," Rep. Jan Schakowsky (D-Ill.) told a progressive audience in April 2009.¹⁴¹ "And those of us who are pushing for a public health insurance option don't disagree with the goal. This is not a principled fight. This is a fight about strategy for getting there, and I believe we will." In July, the group Single Payer Action confronted Rep. Barney Frank (D-Mass.) on why a single-payer health care plan was off the table. He responded, "I think if we get a good public option, it could lead to single-payer, and that's the best way to reach single-payer."¹⁴²

Perhaps because the financial risks of a public insurance option are so clear—and because the underlying motive for it seems so transparent—many Senate Democrats have opposed including it in their bills. Instead, support in the Senate seems to have evolved toward the creation by government of seemingly independent, but government regulated non-profit cooperative insurance programs, or co-ops.¹⁴³ Like existing health insurance co-ops, these would in appearance be "owned" collectively by the insured members, rather than by government. But, as non-profit organizations, they would be free from the need to make a profit on their insurance business, and therefore could keep premiums lower than those of for-profit competitors. However, as critics have pointed out, these government-sponsored co-ops would be very tightly controlled by federal or state governments and therefore would be little more than a disguised public option.¹⁴⁴

Paying for Reform

Democrats have encountered the most trouble in their health care push in their attempts to come up with a way to finance it. President Obama has proposed Medicare and Medicaid cuts of \$622 billion that include reducing hospital subsidies, slashing payments to private insurers as part of the Medicare Advantage program, and eliminating waste, fraud, and abuse.¹⁴⁵ But even if Obama were to achieve the promised savings, that still would not get Democrats all the way to the expected cost of the proposals, resulting in a number of other tax measures.

The President's favored idea was to cap the charitable deductions that higher income individuals could claim, but that met immediate resistance from members of Congress who were concerned that it would hurt donations to non-profit organizations.¹⁴⁶ The Senate Finance Committee considered capping the tax advantages enjoyed by purchasing employer-based insurance, but it faced stiff resistance from labor unions and the measure polled poorly among the general public.¹⁴⁷ Lawmakers have also considered "nanny state" measures, like taxing soda and other sugary drinks, arguing that it would not only raise revenue, but also reduce obesity in the process.¹⁴⁸ The House bill includes a tax "surcharge" on those with incomes above \$350,000.¹⁴⁹ Combined with the expiration of the Bush tax cuts, it would bring the top marginal tax rate to over 50 percent in 39 states, according to an analysis by the Tax Foundation.¹⁵⁰

There are other measures within the legislation that should also be considered taxes. The employer "pay or play" provisions described above, which would mandate that businesses with payrolls exceeding \$250,000 provide insurance to their employees or pay a tax on their payrolls is one such provision. The National Federation of Independent Business has estimated that such an employer mandate could cost 1.6 million jobs.¹⁵¹

While Democrats argue that their plan does not tax the middle class, the individual mandate is in itself a middle-class tax hike. Most directly, it would impose a 2.5-percent tax on those who do not buy insurance.¹⁵² It is true that current proposals offer subsidies to help people buy insurance, but even the more generous subsidies in the House Democratic health care bill cap off at 400 percent of the federal poverty level—\$43,320 for individuals or \$80,080 for a family of four.¹⁵³ Yet, according to Census data, more than 9 million of the uninsured have household incomes over \$75,000.¹⁵⁴ It seems apparent that there will be millions of Americans with annual incomes below \$250,000 who will not qualify for subsidies, yet will be forced to either spend thousands of dollars a year on insurance or pay a penalty.

Cutting Costs or Cutting Quality?

The plans also propose several cost-cutting measures that, advocates argue, would help reduce the amount of ineffective and unnecessary services that private health insurers and government programs currently pay for. Many of these, however, are of dubious value and may tend to increase, rather than decrease health care costs. For example, each of the congressional proposals mandates insurance coverage for preventive care services,

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Comprehensive studies suggest that, on balance, preventive care services add to health care costs, not reduce them.

which, it is argued, would simultaneously reduce costs by improving health and permitting early diagnosis and treatment of potentially costly conditions.¹⁵⁵

But, while there are opportunities for preventive care to reduce costs—by, for example, encouraging better diet, fitness, and smoking cessation, and by better managing certain health conditions such as diabetes—most comprehensive studies suggest that, on balance, preventive care services add to health care costs, not reduce them.¹⁵⁶ The costs of added screening, for example, are themselves substantial, and, ironically, often tend to cause more money to be spent on costly treatment than would otherwise be the case. As Dartmouth University Professor of Medicine Gilbert Welch wrote in *The New York Times*, “Screening for heart disease, problems in major blood vessels and a variety of cancers has led to millions of diagnoses of these diseases in people who would never have become sick.”¹⁵⁷ According to a comprehensive review of the cost and benefits of preventive care published in the *New England Journal of Medicine*, “[S]creening costs will exceed the savings from avoided treatment in cases in which only a very small fraction of the population would have become ill in the absence of preventive measures.”¹⁵⁸

Another significant cost-cutting proposal is the creation of a federal program to engage in so-called comparative effectiveness research, which would examine the effectiveness and expense of various medical treatments and decide which ones should be paid for by government health care plans. For many years, such research, on what is also known as evidence-based medicine, has been conducted by the U.S. National Institutes of Health, the Agency for Health Care Research and Quality, and by numerous other public and private sector researchers.¹⁵⁹ But, in the February 2009 stimulus bill, Congress and President Obama allocated \$1.1 billion to fund a Federal Coordinating Council for Comparative Clinical Effectiveness Research in order to centralize and analyze results of this research for use by federal health programs.¹⁶⁰ The congressional Democratic health reform proposals rely substantially on the outcomes of such research for projected cost savings.

In theory, research on clinical effectiveness can help doctors better understand the likely benefits of the medicines they prescribe and improve the quality of care they deliver. But congressional advocates support the program specifically because it would, in the words of former Democratic Sen. Tom Daschle, “have teeth” because “all federal health programs would have to abide by [its recommendations], and those programs

account for 32 percent of all health spending and insure roughly 100 million Americans.”¹⁶¹ The point of centralizing comparative effectiveness research is to adopt the results into federal reimbursement practices in order to keep patients from getting more expensive medications and procedures. Experience with evidence-based medicine in the U.S. and abroad should lead observers to wonder whether such a program would effectively cut costs, and whether it would reduce health care quality as well.

The comparative effectiveness council is modeled on a British government program called the National Institute for Health and Clinical Excellence, known by the ironic acronym NICE. That program denies British citizens access to many expensive breakthrough drugs for debilitating and life-threatening conditions like cancer, multiple sclerosis, Alzheimer’s disease, and macular degeneration because those medicines are not sufficiently effective for every patient who takes them. As Karol Sikora, a leading UK cancer specialist, observes, “The real cost of this penny-pinching is premature death for thousands of patients.”¹⁶²

Programs such as the UK’s NICE, and even many of the evidence-based medicine studies already conducted in the U.S. are limited by the fact that individual patients differ substantially in physiology. According to former FDA official Henry I. Miller, “[F]or many classes of drugs—among them statins, anti-hypertensives, pain-relievers and antipsychotic medicines—the selection of the appropriate drug among many possibilities requires a delicate balancing of effectiveness and acceptable side effects in each patient.”¹⁶³ However, the clinical research conducted to compare different treatments must, in order to produce statistically significant results, evaluate groups of patients that are highly similar, and are therefore not representative of the population at large. That’s why, for decades, comparative effectiveness research has produced incrementally useful information, but has failed to systematically change the practice of medicine.¹⁶⁴

In the end, comparative effectiveness review is too crude to produce results that are broadly generalizable across all patients suffering the same illness. Thus, adopting comparative effectiveness research results into health programs as mandatory treatment guidelines would most likely result in inappropriately denying many patients access to useful treatments. It could also stifle the development of innovative new treatments that tend to be hugely expensive when first discovered, but which eventually become far less costly after they are introduced and doctors begin using them more broadly.¹⁶⁵ On the other hand, if research results serve merely

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as treatment *recommendations*, there is little reason to believe they would have much effect on physician behavior, or be effective in cutting costs.

Worse still, because it would be a government program, subject to the same political machinations as other government bodies, the comparative effectiveness council could recommend denying coverage for expensive treatments that are effective for only a small number of patients while rubber stamping approval for treatments that are politically popular, but ineffective. For example, in May 2009, the NICE program recommended that the UK's National Health Service (NHS) pay for acupuncture for the treatment of lower back pain,¹⁶⁶ despite copious amounts of evidence showing that acupuncture works no better than random pin pricks.¹⁶⁷ While expensive medicines to treat rare cancers would benefit only a small number of patients, many millions of people suffer from lower back pain and support the use of acupuncture. Therefore, it is no wonder that the former are not covered by the NHS, but the latter are.

Similarly, Democrats have proposed creating an Independent Medicare Advisory Council (IMAC) to make recommendations about Medicare payment rates and other reforms.¹⁶⁸ Like the comparative effectiveness council, the IMAC would theoretically be empowered to make tough choices about reimbursement practices, but it would be designed in such a way as to be subject to immense political pressures. Members would be "appointed by the President, confirmed by the Senate, and [would serve] for five-year terms. The IMAC would issue recommendations as long as their implementation would not result in any increase in the aggregate level of net expenditures under the Medicare program."¹⁶⁹ Still, it would be up to the "President to approve or disapprove each set of the IMAC's recommendations," and "Congress would then have 30 days to intervene with a joint resolution before the Secretary of Health and Human Services is authorized to implement them."¹⁷⁰

Ironically, the IMAC has been proposed in order to replace the existing Medicare Payment Advisory Commission (MedPac), a congressional advisory body that is widely perceived as being ineffective because its recommendations are too easily ignored by Congress.¹⁷¹ The new proposal would nevertheless require Congress to affirmatively vote to reject the IMAC recommendations, but it would give both Congress and the President an opportunity to prevent unpopular cost-cutting recommendations from being implemented.

Polls show that a majority of Americans support several aspects of government intervention,¹⁷² but they are overwhelmingly opposed to a total

government takeover of the health care system.¹⁷³ However, as we have seen, government cannot stop at a modest intervention. Once Washington gets involved, lawmakers end up with proposals under which government forces individuals and businesses to offer insurance or pay a tax.

Government raises taxes to finance subsidies to individuals to purchase insurance at a government store; such insurance is either “private” coverage that is designed by government bureaucrats or a new government plan that, over time, would allow government to take over the entire health care system. Instead of going down the path toward government-run health care, Americans should look to eliminate government barriers that hinder the development of a functioning free market.

Curing What Ails Health Care

Most Americans agree that our health care system is broken and must be fixed, but it is increasingly clear that what ails health care is not too little, but too much government intervention. We have seen how, over the past few decades, each new effort by federal and state governments to solve some perceived flaw in the health care market has generated onerous burdens and distortions that have led to increasingly bigger problems. Instead of still more government intervention that will add cost and complexity to the health care system, we need to eliminate the many layers of market-distorting government regulation that have produced our current crisis.

We need to move toward a system that gives individuals more choice and control over how their health care dollars are spent. This does not necessarily mean eliminating employer-sponsored group purchasing or other group health insurance arrangements, because individuals might choose those options for valid reasons. But making people more conscious of the cost of their health care, and providing greater opportunities for them to benefit from cost-conscious decision making will help rein in costs and deliver health care services in a form that better suits the varying needs of different individuals. In order to truly reform America’s health care system, we should:

- 1. Reform tax policy to eliminate the disincentives for individual purchase of health care services and health insurance.***

Neither tax nor regulatory policy should discriminate between employer-sponsored arrangements on the one hand and individual or non-work group purchasing on the other. This would put more control over health expenditures in the hands of individuals,

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Ideally, Congress and state legislatures should repeal the tax exclusion for employer-provided health insurance, which at the margin incentivizes overconsumption of health care services.

provide some incentive for patients and doctors to make cost-conscious decisions, and help to insulate those who lose a job from the prospect of also losing their health insurance.

Favoring employer-sponsored health insurance at the expense of privately purchased insurance and out-of-pocket expenditures artificially suppresses the individual market for care, and puts undue power over health care decision making in the hands of third parties. The considerably lower administrative and underwriting costs of large-group purchasing do make employer-sponsored health insurance a reasonable choice for many Americans, but it also has considerable drawbacks. Today, losing a job very often means losing health insurance coverage—at least for a time—as fewer options are available in the artificially stunted individual market. And, because only the largest employers can afford to offer workers a choice among various health insurance plans, most Americans have little choice over the structure of their health care purchasing.

Ideally, Congress and state legislatures should repeal the tax exclusion for employer-provided health insurance, which at the margin incentivizes overconsumption of health care services, and reduce tax rates in order to make the change tax neutral. But, as long as government continues to favor health spending with favorable tax treatment, governments should equalize the taxation of health spending so that individual and non-workplace health care and health insurance purchases are treated no differently from employer-provided health insurance.

Some reform advocates have proposed a loosening of the restrictions on Health Savings Accounts and high-deductible health insurance plans in order to give individuals greater control over their health expenditures and a greater stake in cost-conscious purchasing. But, while HSAs can be a useful tool, a better solution is to deregulate and equalize the tax treatment of all health purchasing plans and let individuals sort themselves into the arrangements that best suit their needs.

- 2. Eliminate the barriers that prevent businesses from cooperatively pooling and self-insuring their health risks by liberalizing the rules that govern voluntary health care purchasing cooperatives.*** Currently, large firms can escape much of the complex and

expensive maze of state regulation that drives up insurance costs by establishing self-insured health plans subject only to federal regulation. But small and medium-sized businesses typically cannot establish such plans on their own, and the available alternatives force cooperative plans to comply with an array of varying rules and tax regimes in every state in which a covered employee resides. Freeing up the rules that inhibit small-group pooling would vastly expand the affordability of health insurance benefits for small and mid-sized firms.

3. *Eliminate the barriers that prevent interstate purchase of health insurance by individuals and businesses.*

A patchwork of state-level coverage and price regulations substantially raises the price of health insurance in high-regulation states and puts coverage out of reach for many employers and individuals. Yet a combination of federal and state rules prevents the residents of one state from purchasing coverage from an insurer in another state, in order to take advantage of the lower premiums offered in a low-regulation jurisdictions. Enabling all Americans to purchase health insurance from a firm in the state of their choosing would give individuals and businesses access to lower premiums, produce nationwide competition among insurers, and expose the costly burden of state-level regulation.

4. *Eliminate rules that prevent individuals and group purchasers from tailoring health insurance plans to their needs, including federal and state level benefit mandates and community rating requirements.*

Mandated benefits and community rating substantially drive up the cost of insurance for everyone, and they force some individuals to subsidize others by purchasing insurance coverage they neither want nor need. By one estimate, the guaranteed issue and community rating rules in New Jersey raise premiums by as much as 100 percent. Every state mandates that insurance plans cover certain benefits, such as acupuncturists, pastoral counselors, marriage therapists, and massage therapists. And, though most of the individual mandates cost little, the aggregate burden of the nation's more than 2,100 benefit mandates can raise premiums by as much as 20 to 50 percent. Although well intentioned,

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these rules contribute to the problem of escalating health care costs and put health insurance coverage out of reach for many Americans. Eliminating these rules at both the state and federal levels would lower costs, contribute to expanded coverage, and allow individuals and group plans to choose the health purchasing options that best suit their needs and their budgets.

5. *Eliminate artificial restrictions on the supply of health care services and products.*

Numerous state and federal restrictions on who may provide medical services and how they must be delivered have hindered the development of innovative ways for medical professionals to offer more convenient and lower-cost health services to consumers, whether in the form of specialty hospitals or small clinics. A combination of government and medical professional lobbying has restricted the supply of new doctors, creating an artificial scarcity and contributing to rising prices. Similarly, medical products regulation substantially raises the cost of producing new drugs and medical devices, often without increasing their safety. Reforming the rules that artificially restrict the supply of innovative health care products and services can help to reduce cost and increase quality in a way that improves our overall medical wealth.

6. *Improve the availability of provider and procedure-specific cost and quality data for use by individual health consumers.*

With the vast majority of Americans in health insurance programs that provide first-dollar coverage, there is little market demand for information about the cost and quality of individual treatments or physician services. If there is a role for government to fill in improving health care quality and availability, it is in the delivery of reliable, consumer-oriented data on the cost and quality of health care goods and services—until a fully functioning private market is capable of providing the information.

7. *Reform the jackpot malpractice liability system that delivers windfall punitive damage awards to small numbers of injured patients while raising malpractice insurance costs for doctors and incentivizing the practice of defensive medicine.*

Although tort reform advocates often exaggerate the effect of

runaway liability on health care costs, the effect is real and significant. Few would suggest that injured patients be denied the opportunity to recover damages awards equal to the cost of their physical, mental, and economic injuries. But a surprisingly large amount of some malpractice awards is comprised of punitive damages, intended not to compensate the patient for injuries, but to punish medical providers for their negligence and deter future negligent acts by those providers and others. Although the existence of punitive damage awards arguably does play an important role in improving the quality of health care services, excessive punitive damage awards needlessly raise costs and incentivize health care providers to deliver unnecessary treatment. At the margin, capping punitive damages may help in the broader effort to rein in health care costs.

Each of these changes would help to fix our broken health care system by reducing costs and enabling better informed, cost-conscious decision making. Although by themselves they will not guarantee access to health insurance or health care among those with chronic preexisting conditions, if we reform the existing maze of federal and state regulation, we will then be able to address the problem of the truly chronically uninsured. Because they are a fraction of the 46 million individuals who now lack insurance or government health program coverage, we would be able to create targeted programs to help subsidize their health insurance costs without breaking the bank and without distorting the rest of the market for health care and health insurance.

Conclusion

Government tax policies, third-party purchase of insurance, a deep-rooted entitlement mentality, and the forced injection of technology into the government-dominated medical system help drive spiraling costs and uninsurability, and threaten further damage. Obviously, cases of fraud and abuse (as politicians often emphasize) exist as in any human endeavor. But, as a rule insurance companies, doctors, and employers are not to blame for the fact that some individuals are uninsurable, and punitively scapegoating those groups would only decrease the supply of insurance for everyone and expand the pool of uninsurable individuals. It is unfortunate that America's employers, doctors, insurers, and medical products manufacturers, by creating an abundance of medical wealth, have

If we reform the existing maze of federal and state regulation, we will then be able to address the problem of the truly chronically uninsured.

Empowering consumers to make choices in the market will not be accomplished overnight, but a series of reforms can help get us there.

something for politicians to exploit and therefore have become political targets. When political opportunists are openly hostile to the nation's greatest benefactors, we have a serious problem that makes reform far more difficult.

Permitting flexibility for evolving insurance contracts is vital. In a world of rising health prices, differing tastes, changing medical technology, and optional and cosmetic procedures, nothing is more critical than fluidity of contractual offerings to the flourishing of tomorrow's health care industry. This is particularly true in an environment in which doctors and insurers are helpless against rent-seeking interest groups and government medical planners who lobby for more public funding and for greater authority. Proper market responses to individual, family, business, and non-business group choices can expand the array of policies between basic and catastrophic, between deductible and co-pay options at various price levels.

Empowering consumers to make choices in the market will not be accomplished overnight, but a series of reforms can help get us there. Policy makers should reform tax policy to eliminate the disincentives for individual purchase of health insurance and health care. They should do away with barriers that prevent small businesses from cooperatively pooling and self-insuring their health risks; barriers that prevent interstate purchase of health insurance by individuals and businesses; and benefit mandates, community rating requirements, and other rules that prevent individuals and group purchasers from tailoring health insurance plans to their needs; and restrictions on the supply of health care services and products. Policy makers should improve the availability of insurance data to individual health consumers. Finally, they must reform the jackpot malpractice liability system that raises malpractice insurance costs for doctors and incentivizes the practice of defensive medicine.

Government intervention helped create the distortions that negatively affect America's health care market today. Unfortunately, the Obama administration and the Democratic majorities in the Senate and in the House of Representatives seem to be focusing their reform efforts on expanding the role of government. Instead, they should re-examine the prior interventions that brought us to this point, and begin to unwind the tangled web of government involvement in health care.

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