Health Care Policy Center Journal
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Preventive care tips from the American Academy of Pediatrics:

> Parents need to be advised that rigid, motorized pool covers are not a substitute for 4-sided fencing, because pool covers are not likely to be used appropriately and consistently.
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> Pediatricians should alert parents to the dangers that standing water presents to children. Parents need to be advised that they should learn CPR; and they should keep a telephone and equipment approved by the US Coast Guard (eg, life preservers, life jackets, shepherd's crook) at poolside.

When people talk about more money for preventive care and health education, this is what they have in mind. These tips are two of the 190+ verbal advice directives that the American Academy of Pediatrics (AAP) thinks that physicians should verbally deliver to their patients in the name of preventive care. The Academy also recommends various

health screening questions, most of which make nosy neighbors look as inquisitive as big box store clerks. They begin with do you ride in airplanes, continue with things like "Do you have a swimming pool or spa at your home," and progress to the utterly outrageous "Do you have firearms at home," and "Does your child have 'toy' firearms at home."

Note the scare quotes around toy. To the AAP, there is no such thing as a toy firearm.

Paying cash and facing a big hospital bill?

Since the 1930s, hospitals have priced their services as if third party payers were their only customers. As more people are using their own money to pay for health care, demanding patients are beginning to change how hospitals look at things. The HospitalVictims.com web site aims to compare local hospital prices with those received by Medicare. The idea is to prevent the unconscionable overcharging of cash payers that was routine until recently, and to help people negotiate prices that are fair to both sides. The organization maintaining the website tends to take an adversarial stance against hospitals (with, in some cases, good reason). Given the murky nature of hospital and academic financial accountability, whether Johns Hopkins is the relevant comparison is anybody's guess.

Other data on hospital pricing are beginning to be made available by hospital associations in various states including Minnesota and Wisconsin. States are getting into the act as well. Florida has a website that provides health care statistics, including average prices, for all hospitals in the state. Some individual hospitals also post prices. See San Francisco General for an example.

Catholic Health Initiatives in Denver and Centura Health are partnering to test new software developed by Financial Healthcare Systems. The radical idea behind this test is that people should have an estimate of their out-of-pocket costs before they register at a hospital. This is progress. So is the front end system being used by Parkland in Dallas.

That U.S. hospitals still have a long, long, way to go from the point of view of cash paying patients is evident from a comparion with the web page of the all cash BUPA hospitals in the United Kingdom. BUPA quotes all inclusive prices for common procedures on its web page and provides quality indicators like MRSA infection rates, surgical site infection rates, and unplanned readmissions. It helps arrange financing.

Hospitals that depend on cash payment are responsive to patients because their customers are real people spending their own cash, not employers, big insurance companies, or even bigger governments. The potential that cash payment from real customers has to change things for the better is something that people proposing health reform plans institutionalizing third party payment for everything would do well to remember.

The problem of hospital costs

Hospitals receive almost a third of total health care spending. Their published rates, like the room rates on the back of hotel doors, have very little to do with what people actually pay. Hospitals are the black hole of health care reform.

Like all businesses, hospitals have considerable latitude in how they calculate earnings and allocate costs. There is evidence that both for profit and not for profit hospitals manage their reported earnings. Among other things, discretionary spending can be adjusted up or down at year end to get to desired profit levels. Changes can also be made in the reserve for retrospective third-party payment adjustments.

A major problem in the United States is that the major hospital customers are Medicare, the biggest of big government, and other third party payers. As a result, hospitals have historically sucked up to government and have treated people who pay their own bills extraordinarily poorly, routinely charging them the highest possible rates.

Because people receiving hospital services have traditionally had little say in hospital matters, governments in the U.S. have been able to systematically reduce hospital payment rates with little concern for how hospitals seeking to recoup their lost revenues actually treat patients. The usual government defense has been the dunderheaded claim that hospitals need to be more efficient and that arbitrarily lowering prices will make them so.

Like the hospitals, U.S. governments have exhibited relatively little concern for the possibility that changes in reimbursement rates could degrade the quality of care for everyone while raising costs for those who pay for their own care via cash payment or private insurance.

Hospital acquiescence to the rapacious greed of government has done significant damage to private health care in the U.S. In order to make up for inadequate payments from public pay patients, hospitals have tried to extract higher payments from private pay patients. To the extent that they have been able to do this, they have made government officials better off. Extracting more money from private pay patients means more money for government programs without overt tax increases. It is a win-win situation for elected officials. They get to promise voters ever increasing piles of goodies that they don't pay for, and the hospitals are their enablers.

A problem with this approach is that because it raises the cost of private care relative to public care, it encourages more people to become dependent on failing public systems. The Lewin group has told the Colorado Health Care Reform Commission that private payers in Colorado now pay 1.88 of hospital cost, Medicare pays 0.81 of cost, and Medicaid pays 0.71 of cost. When Milliman Consultants examined payment rates for Premera Blue Cross in Washington state, their results suggested similar levels of underpayment. In 2004, 80 percent of Washington hospitals lost money on Medicare patients and 82 percent lost money on Medicaid patients. Under a set of reasonable assumptions about the ratio of hospital costs to medical costs, Milliman calculated that

government irresponsibility likely raised the cost of each family's private health insurance by $490 a year.[1]

Recent research suggests that at roughly 60 percent of the children enrolled in the last SCHIP expansion had private insurance but switched to SCHIP when the lower cost option became available. If SCHIP reimburses at Medicaid rates, its expansion, as is the case with any Medicaid or Medicare expansions, means that more costs are loaded onto private payers, more people drop out, and provider financial stress increases. Commercial physician payments were 24 to 45 percent above Medicare prices and 13 to 137 percent above Medicaid prices.

The low payments probably explain a great deal about the shortages in areas in which large segments of the population have their health care paid for by Medicaid or Medicare. With such low government payments, neither hospitals nor physicians can afford to provide good service in areas without private payers. In some areas, neither hospitals nor physicians can afford to provide any service at all.

The other problem, one that is endemic in both U.S. government controlled health systems and those in other countries, is that low reimbursements lead to inaccurate prices which creates lousy, more expensive, service. The Swedes have centralized records available for the whole population. Stromberg, Ohlen, and Svensson studied the total costs generated by prospective payments for hip fractures in the Swedish system. After the implementation of prospective payments in Stockholm in which the government pays a flat fee for treatment of any hip fracture, orthopedic stays fell from 20 to 12 days.

On the surface, this looks like an improvement in efficiency. In fact, it was achieved by earlier discharge to other facilities like geriatric wards. Because bed days doubled in the geriatric wards, total costs actually increased by 12 percent under prospective payments. As the abstract of the paper puts it, "prospective reimbursement aimed at reducing the costs of acute care does not necessarily result in overall savings."[2]

Limited evidence available suggests that reimbursement rates in the U.S. create similar inefficiencies as well as increasing mortality, reducing the amount of rehabilitation offered, encouraging hospitals to shift surgeries to an outpatient basis, and creating an incentive for quicker but sicker discharges.

After Medicare instituted prospective payment, Kosecoff *et al.* found that the percent of patients discharged to their home in an unstable condition went up by 5 percent.[3]

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[1] Will Fox and John Pickering. May 2006. *Payment Level Comparison Between Public Programs and Commercial Health Plans for Washington State Hospitals and Physicians.* Milliman Consultants and Actuaries for Premera Blue Cross. Online version accessed August 1, 2007. http://www.wsha.org/files/65/PaymentLevelPaper.pdf

[2] L. Stromberg, G. Ohlen, and O. Svensson. February 1997. "Prospective payment systems and hip fracture treatment costs," *Acta Orthop. Scand,* 68, 1, p. 1-2.

[3] J. Kosecoff *et al.* October 17, 1990. "Prospective payment system and impairment at discharge. The 'quicker-and-sicker' story revisited." *JAMA,* 264, 15, 1995-6.

Unstable discharge is associated with a higher mortality rate. Fitzgerald, More, and Dittus found that between 1981 and 1986 the mean length of hospitalization for elderly patients with hip fracture decreased from 21.9 to 12.6 days and the maximal distance walked before discharge fell from 93 to 38 feet. The proportion of patients discharged to nursing homes rose from 38 to 60 percent, and the proportion of patients who were still in a nursing home one year after their hip fracture also rose, from 9 to 33 percent.[4]

Non-profit hospitals appear to react to reimbursement cuts by attempting to charge other patients more for other services. For profit hospitals are more likely to cut unprofitable types of service. This is not an efficient way to run a health care system, as improper pricing can lead people to make wasteful use of health care services. When most of the people in a particular area are dependent on government programs for third party payment, hospitals are unable to make up lost revenues by overcharging private pay patients and leave entire areas without service. This is a particular problem in rural Colorado and does not bode well for so-called health care reforms that expand Medicaid at the expense of private insurance.

Different problems arise when well meaning regulators stifle innovation by seeking to protect hospitals by shielding them from competitors. It is no accident that ambulatory surgery was started by physicians who thought that they could provide better service. Only after ambulatory surgery boomed in independent centers did hospitals open competitive facilities. It is also no accident that U.S. patients are much more likely to get care on an outpatient basis than patients in countries that have adopted government monopoly health care. When government runs health care, hospitals form a significant interest group. Officials can unwittingly end up running the health care system to benefit them and their (often unionized) employees. As certificate of need laws and legal bans on physician stakes in specialty hospitals show, hospital legislative clout can stifle innovations that pose a threat to hospital primacy in their legislative cribs regardless of their potential benefits to patients.

Like other business, hospitals can do a better job of controlling their costs. Unfortunately, cost control is a nasty, difficult, business. Getting people to really focus on it usually requires a full scale economic recession or a market that is so competitive that profits can be increased only by cutting costs or offering better service for the same price. It is far easier to lobby government for legal protection than to compete. A central problem for anyone interested in health care reform is how to give hospitals an incentive to innovate and cut costs without eliminating services that the people actually receiving the services value. The large, integrated, health care systems that so many health care reform activists admire often fail miserably at this task. They are organized to please planners and providers with the result that their costs tend to be sky high.

In Wisconsin, 2 large areas of the state are each served by a single monopoly health care system facing little competition. These systems control primary care practices that do

[4] J.F. Fitzgerald, P.S. Moore, and R.S. Dittus. November 24, 1988. "The Care of Elderly Patients with Hip Fracture. Changes Since implementation of the Prospective Payment System. *New England Journal of Medicine,* 320, 13, pp. 871-2.

specialist and hospital referrals. The primary care practices, which may lose money, are run as feeders to the exceptionally profitable hospital systems that own them. Competition is eliminated by denying physicians not employed by the systems access to system hospitals and by not allowing primary care physicians to refer to outside specialists. The areas with hospital monopolies have hospital prices that are among the highest in the nation.

Any serious health reform discussion dedicated to the goal of providing more health care to more people must consider how to ensure that hospitals face competitive threats. The only known way to do this is to guarantee that people who need health care have a spectrum of choice in how they get their care. The only way to do that is to eliminate laws that discourage competition or dictate the format in which health care must be delivered. Policy should also take care to make sure that people who are buying care can pick up their cash and go elsewhere if conditions warrant.

Government health insurance not worth paper it is printed on

Some prominent Colorado health reformers think that everyone will be better off if more people rely on government for their health care. Unfortunately, stories about government inability to meet its current health care promises are increasingly commonplace. They show that health care, like food, housing, communications, and transportation, is far too important to be left in the hands of government.

New estimates suggest that New Jersey's liability for current and future public employees' health care costs are $69 billion over the next 30 years. The state would have to set aside $6.3 billion this year to keep pace with long-term liabilities. New Jersey employee health care costs will be roughly $2.2 billion this year. The state's 2007 budget is $33.6 billion.

In 1994, after passing legislation that made individual health insurance virtually unavailable, New Jersey simply stopped setting aside funds for future employee health care. The savings that it did set aside have now been spent. Edwards and Gokhale estimate that New Jersey has an estimated $190,658 in unfunded state retiree health costs for each active state worker.[5] New Jersey officials are naturally ignoring the problem and whining that there is no money in the current budget.[6] Demands for a tax increase cannot be far off. California and Maryland are in even worse shape.

Though Colorado does have unfunded liabilities for its retirees, and by extension for their health care costs, it is in better shape than New Jersey. In December 31, 2005, the

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[5] Chris Edwards and Jagadeesh Gokhale. October 2006. *Unfunded State and Local Health Costs: $1.4 Trillion,* State Tax & Budget Bulletin No. 40, Cato Institute. Online version accessed August 16, 2007, http://www.cato.org/pubs/tbb/tbb_0925-40.pdf.

[6] Medical News Today. July 31, 2007. "New Jersey's Health Care Liabilities For State, Local Government Retirees Total $69B, Study Shows." Online edition accessed August 3, 2007, http://www.medicalnewstoday.com/articles/78160.php

funding ratio for the Health Care Trust at the Colorado Public Employee's Retirement Association was 17.1 percent. This means that for every dollar of the actuarially determined benefits payable by the health fund, the state has put aside assets with an actuarially determined value of 17 cents.[7]

In 2005, Wilshire Research estimated that 54 of the 64 state retirement plans that provided actuarial data in 2004 were underfunded.[8] In 2006, Wilshire looked at 125 state retirement systems. Of the 58 systems that reported actuarial data for 2005, 49 were underfunded with a ratio of assets-to-liabilities of 77 percent. States that have been flirting with taking over the private health care system, California, Wisconsin, and Illinois come immediately to mind, have also been issuing bonds to cover state and local underfunded retirement liabilities.[9] As Alan Lavine notes in *Financial Advisor* magazine, at some point bond buyers will refuse to fund the deficits and problems with underfunded pensions and health care liabilities could lead to cutbacks in services. In short, health care is too important to be left to the public sector. Government may promise to pay, but the historical record suggests that it makes no plans to do so.

The federal government is no more responsible than New Jersey. Medicare is a financial disaster that elected officials have known about for decades and have chosen to ignore. The 2007 Trustee's report shows that annual assets will fall below annual expenditures in 2013, that the hospital insurance trust fund will be exhausted in 2019 and that Medicare tax income will pay only 79 percent of costs. It would take an immediate 122 percent in the payroll tax, or an immediate 51 percent of program outlays, or some combination of the two, to bring the program into balance.

Since government promises to pay for health care are worthless, the only health care reforms worth considering are those that work to limit the number of people dependent on government, and to limit third party payment. Rather than expanding government payments and promises, the goal should be to develop a system that makes it possible for people to use the power of compound interest to save when they are young in order to defray the higher health care costs that they can expect to incur in old age.

How much does private health insurance really cost?

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[7] Colorado PERA, Comprehensive Annual Financial Report for the Fiscal Year Ended December 31, 2005. Online version, http://www.copera.org/pdf/5/5-20-05.pdf.

[8] Julia K. Bonafede, Steven J. Foresti, and Benjamin J. Yang. March 10, 2005. 2005 Report on State Retirement Systems: Funding Levels and Asset Allocation. Wilshire Research, online version, http://www.wilshire.com/Company/2005_State_Retirement_Funding_Report.pdf . Julia K. Bonafede, Steven J. Foresti, and John Dashtara. March 14, 2006. 2006 Report on State Retirement Systems: Funding Levels and Asset Allocation. Wilshire Research, online version, http://www.wilshire.com/Company/2006_State_Funding_Report.pdf. Both reports accessed August 16, 2007.

[9] Alan Lavine. June 2006. "Storm Clouds for Municipal Bonds," *Financial Advisor*. Online edition accessed August 16, 2007. http://www.fa-mag.com/past_issues.php?id_content=3&idArticle=1244&idPastIssue=110.

All kinds of claims are being made about the affordability of individual health insurance in Colorado. Many of them are ridiculously ill-informed. As there are a number of websites that give basic information on this, one can only conclude that those who cite grossly high numbers on the cost of insurance are attempting to scare the public away from private insurance. Of special interest is the fact that the Massachusetts Connector Authority, an idea that is all the rage in certain Colorado health policy circles, is now quoting individual insurance prices that are far higher than those currently prevailing in Colorado.

At present, the major difference between Massachusetts and Colorado is that Massachusetts imposes a much higher regulatory cost on its individual health insurance market. Colorado's individual insurance market, in comparison, has been relatively lightly regulated. In the early 1990s, Massachusetts passed guaranteed issue for the individual market. It severely impaired the market for individual health insurance in the Commonwealth. Like so many other health care reforms, the Massachusetts Connector Authority is an attempt to paper over the problems caused by previous reforms touted as a solution to earlier ills. The political calculation is that people have short memories and that with a little lipstick they won't recognize that particular pig. The Connector is basically a way to distract people from the pig of disastrous bureaucratic meddling with the lipstick in the form of a bribe paid out of a pile of new tax money.

The prices quoted for individual health insurance on company websites are generally for individual policies for people in good health. The rates quoted vary with age, tobacco use, and geographic location. People who are overweight, use tobacco, have had past health problems, or engage in certain dangerous activities can expect to payer higher premiums to compensate for the higher medical costs experience suggests that they will generate. Older people pay more because older people are more likely to have large health care expenses. The good news is that older people usually also have higher incomes. Most reputable firms offer individual policies that cannot be cancelled by the companies unless a covered individual stops paying premiums or commits fraud. For a sampling of websites offering automatic quotes see Assurant Health, eHealthInsurance, Humana, Kaiser-Permanente, Rocky Mountain Health Plans, and CoverColorado.

People with severe chronic disease generally will be refused insurance. The whole point of health insurance is that people who are healthy purchase it in order to protect themselves from financial ruin should they become ill. For people who are uninsurable, the states offer heavily subsidized products that act like health insurance. In Colorado, the program is called CoverColorado.

While browsing the web for prices is a good first step, people looking for health insurance should also consider contacting an insurance broker. Brokers can be extremely helpful. Good ones provide valuable information on how companies and policies differ, careful explanations of the differences between competing policies, and good advice on tailoring policies to an individual's specific financial situation. Good brokers will not represent bad companies. In some cases, reputable brokers can also help consumers by interceding with insurance companies.

To get a general idea of health insurance costs, a 40 year old non-smoker who lives in Denver and is commercially insurable can purchase a Kaiser-Permanente health savings account (HAS) qualified policy with a $2,000 deductible, and no costs after the deductible, for $168.24 a month. A Humana $2,500 deductible HSA qualified policy with no payments after the deductible is $122.31 a month. The least expensive policy listed on eHealthInsurance is a policy with a $3,000 deductible, a drug discount card, and an annual preventive exam. After the first $3,000, the individual is responsible for 20% of all charges up to $5,000. It retails for $82.00 a month. Reducing the deductible to $1,250, and the out-of-pocket limit to $3,750, increases premiums to $99.00 a month.

Plans that offer financial alternatives to HSAs are also available. Kaiser-Permanente offers an HMO plan with $30 office visits, no deductibles and no coinsurance for $196.72 a month. Rocky Mountain Health Plans offer a $2,500 deductible plan, with a $5,500 limit on charges except for $30 copays on office visits, and $10 prescriptions for generic drugs for $112.44 a month. Humana offers a $7,500 deductible plan with no coinsurance, tiered prescription drug coverage limiting the cost of any prescription to no more than $65, and $300 worth of annual preventive care for $50.33 a month. Celtic offers an indemnity plan with a $2,500 deductible, drug coverage, and a $7 million plan maximum with no further costs after the deductible is met for $267.41 a month.

If the same 40 year old man is uninsurable, health insurance with a $1,000 deductible is available through Cover Colorado for $295.93 a month, $192.74 if he qualifies for a low income discount. A CoverColorado policy with a $2,000 deductible that qualifies for a health savings account is $200.73 in Denver, $127.01 with the low income discount. This is roughly $70 a month more than fairly similar HMO policies and $80 more than roughly comparable commercial insurance policies.

Insurance for a child is much less expensive. Humana offers a policy for $26.89 a month with a $7,500 deductible and prescription drug coverage. Once the deductible is met, all additional costs are covered. UnitedHealthcare offers a $2,500 deductible plan, with prescription drug coverage, a total out-of-pocket limit of $4,500, and $25 office visits for $106.71 a month. Aetna offers a PPO plan with prescription drug coverage, $500 deductible, a $2,000 out of pocket limit and $20 office visits for $119.00 a month. After meeting the $500 deductible, individuals pay 20% of all additional charges up to a maximum of $1,500.

The 40 year old man and his ten year old child have a choice of 83 family plans on ehealthinsurance alone. They range from a Humana plan with a $7,500 deductible with drug coverage for $69.85 a month to a Rocky Mountain Health Plan policy with a $2,500 deductible and $30 office visit for $159.56 a month to a UnitedHealthcare plan with a $2,500 deductible for $177.03 a month, and a Kaiser-Permanente HMO plan with no deductibles, no coinsurance. and $30 office visits for $383.59 a month. Aetna offers a PPO policy with a $500 deductible and a $4,000 out-of-pocket limit, a tiered drug plan with a $40 maximum per prescription and $20 office visits for $470.00 a month.

Plans offered by the Massachusetts Connector Authority for a 10 year old child in a Boston zip code do not give one much confidence in the ability of extensive regulation to reduce costs. Massachusetts Connector plans currently start at $162.37 a month for a $2,000 deductible, $25 physician office visits, and no prescription drug coverage. Plans comparable to Colorado HMO plans with drug coverage, a $2,000 deductible, and a $35 office visit cost $238.93 a month. In Colorado, the comparable Aetna PPO plan described above retails for just $119 a month.

People will argue that the Massachusetts Connector plans are guaranteed issue, meaning that they are available regardless of health status. This is correct. But CoverColorado plans are guaranteed issue as well, and include coverage for prescription drugs. For an uninsurable child 10 years old, the maximum premium is $162.70 for a $1,000 deductible, $125.30 for a $2,000 deductible. This means that for a $2,000 deductible, CoverColorado at $125.30 is less expensive than a Massachusetts Connector plan by almost $100.00 a month. $100.00 a month in savings pays for a lot of office visits. For household incomes under $50,000, CoverColorado premiums may be as low as $85.00.

The Massachusetts plan penalizes the parents of the healthy children, the vast majority, in order to offer guaranteed issue coverage to all. This is inefficient and unfair. It raises the rates paid by the vast majority of parents, most of whom have healthy children. In doing so it discourages the purchase of private insurance coverage. This is an important consideration. As discussed above, at estimated 60 percent of children enrolled in SCHIP expansions already had private coverage. Their parents dropped private coverage for them in order to enroll them in SCHIP to take advantage of the lower rates for public coverage.

The problem is that coverage is not medical care. Since SCHIP programs generally reimburse at Medicaid rates, SCHIP expansions likely fuel the vicious circle of inadequate government payments leading to higher private costs and a sharp decline in the quality of care. For this reason, it is likely that reforms that promote SCHIP expansion do more to expand dependence than they do to provide more medical care for more people.

Colorado achieves guaranteed issue by subsidizing insurance for the uninsurable directly. It does this via general tax revenues and assessments on health insurers, assessments that are ultimately paid by everyone who purchases health insurance. Rather than supporting a bureaucracy to control all health insurers, those taxes support a far more limited bureaucracy, one that focuses on providing coverage to roughly 5,000 Colorado residents who cannot purchase health insurance due to pre-existing conditions.

Expanding Medicaid increases preventable hospitalizations

In a 2007 study of the effect of expanding Medicaid to cover all adults with incomes at or below the federal policy level, Saha *et al.* found that rates of preventable hospitalization increased from an average of 46.1 per 10,000 people to 54.9 per 10,000 people. Over the

same time period, the non-Medicaid insured population had a slight decline in preventable hospitalization rates. So much for the claim that expanding Medicaid coverage reduces costs by getting people care earlier and preventing more expensive hospital visits.

Government monopoly health care in action: recent tales form the NHS

Unlike the American press, which is intent on blaming private health insurance for the ills of the American system, British newspapers have no qualms about publicizing the truly grotesque actions of the government monopoly National Health Service. Recent stories include the plight of Olive Beal, a 108 year old woman who has been told to wait 18 months for a hearing aid by Britain's National Health Service. Meanwhile, more people are leaving British hospitals suffering from malnutrition. Of those who were well nourished when they entered the hospital in 2001, 157 people became malnourished while in the hospital. By 2006 the number had increased to 321 despite a drop in hospital admissions.[10]

Finally, the *Daily Mail* reports that staff at the NHS Good Hope Hospital in Sutton Coldfield England have been asked to cut laundry bills by turning over sheets and pillowcases between patients rather than sending them to the laundry. The object is to reduce the hospital's £500,000 laundry bill. As one might expect, the hospital has lately been having a problem with hospital acquired infections.

Still think it is a good thing that Britain spends less on health care than the United States?

What's going on at the Colorado Health Care Reform Commission

New Tax Proposals

Even as a Commission subcommittee debates the details of its proposal, it has had the Lewin Group model the effects of several new taxes. The results were contained in a July 14th memo available on the Commission website. The taxes modeled were:

1. A $2.00 a pack increase on the price of cigarettes—revenues are forecast to increase by $210,641,011. The Lewin model assumes that everyone will follow the law. Pessimists will note that Hamas, Hezbollah, and al Qaeda have been running lucrative cigarette smuggling organizations on the east coast for years and that creating huge price differentials with neighboring states is asking for a massive increase in criminal activity.

[10] Daniel Martin. August 6, 2007. "More patients go hungry as 13m meals are thrown away." *Daily Mail*, online version accessed August 6, 2007.
http://www.dailymail.co.uk/pages/live/articles/news/news.html?in_article_id=473388&in_page_id=1770

2. Raise the tax on spirits from $0.6026 per liter to $5.63 per liter, the tax on wine from $0.073 per liter to $0.66 per liter and the tax on beer from $0.08 a gallon to $0.26 per gallon. The outrageous tax increase on spirits is projected to raise $78,836,798. Why scotch drinkers should be penalized so much more heavily than wine drinkers is unknown.

3. Put a 2 or 5 percent tax on carbonated soft drinks.

4. Put a 2 or 5 percent tax on nuts, pretzels, cheese puffs, microwave, popcorn, and potato chips.

Lewin estimates that Colorado households spend $630 a year on carbonated soft drinks and buy 31.8 pounds of taxable salty foods at $2.93 a pound. This equals about $93 a year. Another way to look at this is that the please tax me more people figure that the average Colorado household can afford to spend at least another $700 a year on health care but doesn't need to.

Other taxes that have been proposed by various groups, but that have apparently not yet been modeled, include a take-out coffee tax, new payroll taxes, corporate income taxes, an increase in the Colorado income tax, taxes on employers, a tax on each hour worked, a tax on health care providers, and taxes on luxury goods. How one determines a luxury good is unspecified. To some, it could be anything not purchased at Wal-Mart. Taxing health care providers is perverse because it makes health care more expensive for people who purchase their own care. One can speculate that reformers who support provider taxes while simultaneously claiming that health care is too expensive do so for at least two reasons. The first is that it allows them to capture more federal money. The second is that making private care more expensive increases dependency on the public sector.

The Commission also requested that Lewin model the benefits of increasing the share of managed care in Colorado Medicaid by increasing reimbursement for suppliers of Medicaid managed care. Back in the 1990s, Colorado Medicaid beneficiaries were herded into managed care. Managed care providers said they were so efficient that they would accept 95 percent of the comparable fee-for-service payment. All of Colorado's Medicaid managed care providers have now folded. Managed care did not work as advertised. In some health care reform wonderlands this is apparently reason enough to throw more money at it.

Developing the Commission reform proposal

On Friday, June 15, 2007, Colorado Health Care Reform Commission staff circulated an e-mail asking Commissioners to suggest questions that would form the basic framework of its health care reform proposal. Responses were due on Monday, June 18 by 5 pm so that they could be assembled and passed at the full Commission meeting on June 19, 2007. The timing, the process to create and pass these questions, the fact that the outside experts responding generally support increased government control of individual health

care, and the questions that resulted, shed considerable light on how the Colorado Health Care Reform Commission makes decisions.

After staff reported on what it considered the common threads in the questions received from Commissioners and the outside experts, representative questions were drawn up. Commissioners commented. The questions were written on large sheets of paper hung in the front of the room. Each Commissioner was given the same number of stars, like the kind used on grade school performance charts, to stick by his favorite questions. The questions that got the largest number of stars were the winners.

The official list, as communicated in an email to Commission members was:

> What will be the role of the individual for obtaining or paying for care?
> Will there be an individual mandate?
> What will be the role of employers?
> What will be the role of government?
> Will there be an expansion and/or reform of the Medicaid and CHP+ programs?
> Will portability or continuity of coverage be assured?
> Will there be subsidies to assure affordable coverage?
> What will the minimum benefits be?

A Commission subcommittee is now hard at work coming up with a health reform plan to determine all of this.

What is notable about these questions is that many of them rest on assumptions that are debatable at best. To begin with, neither government nor employers pay for health care. All health care payments are by individuals. The Lewin Group has informed the Commission that it assumes that individuals who purchase employer provided coverage pay for it through lower wages. The existing economic literature generally agrees. Health care that is provided by government is paid for by individual tax payers.

What these questions are really concerned with is the extent to which people should be expected to subsidize health care for people that they have never met. Some of those people truly need help. Others need to get to work.

These questions also make it crystal clear that the Commission has, by default, narrowed the definition of coverage to an insurance model in which a third party is responsible for paying for people's health care. The insurance model, as Massachusetts, Maine, and Wisconsin have discovered, will never cover everyone. For example, the Commission has heard public testimony that it will not work for homeless Coloradans. Some fraction of the uninsured will always prefer to simply show up at a clinic or hospital and demand care. They will not purchase insurance or sign up for subsidized plans. In a free society, there is no known way to make them do so.

The questions substantially ignore regulatory cost. This is an important omission in view of the fact that Professor Christopher Conover of Duke University estimates that

unnecessary regulation constitutes about 10 percent of U.S. health care spending every year. They do not consider whether government programs displace private efforts, who needs health care but is not getting it, why the Commission feels that it has any expertise in determining minimum benefits for people it has not met, the extent to which hospitals manage to make the privately insured pay for low government reimbursements rates, and the fact that private insurance markets have already solved the problem of continuity and portability.

The questions say nothing about measures to reduce the cost of health care or measures that might increase the competitiveness of Colorado's health care market.

A set of questions for those who wish to evaluate health care reform proposals with an open mind is attached below. They begin with the assumption that people want different things and that those wants vary over their lifetime. They assume that there is no one best way to deliver health care, particularly in the face of technological change. It therefore follows that government should remain neutral with respect to how health care is delivered and with respect to how people choose to protect their assets from the threat of large health care losses. Subsidies to people judged to deserve them should be explicit, and those who have to pay those subsidies should be treated fairly. Finally, because a wealth of real world experience suggests that competitive pressures reduce the cost of health care in the long run, reform initiatives should also focus on exposing various segments of the U.S. health system to competitive pressure.

Criteria for Evaluating Health Care Reform Proposals

1. **Does the reform proposal include the necessary conditions to make it possible for people who pay for health care to get good value for their money—**

   Many people who advocate for particular health care reforms have difficulty understanding that health care is just one of many ways that people have to spend money. Instead, they believe that they, or some set of experts, can precisely determine exactly what each person requires in order to maintain good health. They call this the required minimum benefits plan.

   In reality, spending on health care is just one of many possible things that a person can buy. Deciding how much to buy requires a tradeoff with other goods. Some people get their teeth cleaned every four months because they hate flossing and brushing. Others floss and brush regularly, need cleaning only once a year, and skip the recommended every 6 month treatments. Some people are content to get their cancer care locally. Others want top flight care and pay more for treatment from internationally known specialists for the latest in treatment. Some people are content to have the attending physician in the emergency room stitch up the cut on their face. Others are willing to wait longer and pay more to have a plastic surgeon do it. Some people make do with glasses even though they have high incomes and could afford vision correction surgery. Other people on much lower incomes hate glasses and painstakingly save thousands of dollars to fund their vision correction surgery.

   A good health care system recognizes that different people want different things. It does not prescribe the same kind of care for everyone in a given category. It does not push care on people who do not want it. It does make it clear that different modes of care require different resources by pricing them accordingly. If you want to see a dentist every 4 months because you don't want to floss, fine, but you will have to pay the cost of that by forgoing a few hundred dollars worth of spending on other things.

1.1. Pricing

Does the proposal further market pricing for medical services? Market pricing means getting out of the way. It is more a matter of not doing certain things than an activist formula requiring that certain rules be followed. Think dentists, think corrective vision surgery. Forget Medicare price controls.

Does the reform ensure that any physician or health provider, and any facility, is free to treat any patient in exchange for direct payment of a

mutually agreeable fee? This is an essential protection for people who might be trapped in government programs in which the government pays too little to attract competent providers. If people are allowed to negotiate their own fees they can at least buy care by adding their own money to government payments.

1.2. Outcomes—should be measured by people buying care, not isolated experts, politicians, bureaucrats, social workers, or special interest groups.

1.2.1. Does the proposal ensure that patients can determine the treatments they will receive, and physicians the treatments they will provide, subject to their own consciences?

1.2.2. Does the proposal include organizational provisions that ensure that firms, industries, professions, and subsidy recipients will not be able to use the reform plan to their financial advantage?

1.2.3. Do all outcome measures look at things from the individual's perspective?

1.3. Consumer protection—mainly provisions to ensure that people have a variety of ways to pay for their health care, that government is neutral with respect to any delivery and financing system that may evolve, that participation is voluntary, and that health insurance can be tailored to individual needs.

1.3.1. Does the proposal ensure that participation in government programs is voluntary?

1.3.2. Does the proposal encourage people to accumulate assets that may be used for future health care expenses in lieu of third party insurance?

1.3.3. Does the proposal allow people to modify the amount of financial risk they are willing to bear by choosing among different third party insurance policies as their circumstances change?

1.3.4. Does the proposal remain neutral with respect to the form that third party insurance should take as long as insurers can meet their contractual obligations?

1.3.5. Does the proposal remain neutral with respect to paying for health care with cash or with third party insurance?

1.3.6. Does the proposal subject businesses operating in health care to the same rules as businesses operating in other sectors of the economy with respect to anti-trust, ownership, pricing, contracting, and reporting requirements?

1.3.7. Does the proposal protect people from involuntary participation in any non-governmental insurance program?

1.3.8. Does the proposal allow the purchase of health insurance that is not associated with an employer?

1.3.9. Does the proposal ensure that people can buy health insurance from any insurance company approved by a state government?

1.3.10. Does the proposal allow for the fact that people purchase health care from a variety of sources, some of which are both outside of Colorado and outside of the United States?

1.3.11. Does the proposal protect consumers from arbitrary restrictions on their ability to access medical therapies?

1.4. Government obligations—primarily to remain neutral, reduce regulatory burden, be a good steward of tax dollars used to provide subsidized care, and treat everyone equally.

1.4.1. Does the proposal include mechanisms to ensure that government programs do not use government power to compel unpaid services from providers?

1.4.2. Does the proposal have mechanisms to ensure that government treats all providers fairly and does not discriminate between providers via different payments for the same service or regulatory structures that favor some providers over others?

2. Does the proposal contain adequate structures for reducing costs?—primarily by ensuring that health care is provided in a contestable market and that the freedom to contract and set prices is free from government compulsion.

2.1. Does the proposal ensure that all providers and third party payers in the health care systems are subject to credible competitive threats?
2.2. Does the proposal expose existing providers, including government and quasi-government entities, to competitive pressures?
2.3. Does the proposal ensure that all entities using or providing health care are free to contract with others as they see fit?
2.4. Does the proposal ensure that participation in any health care program under the control of Colorado state government, or any entity created by statute, is voluntary?
2.5. Does the proposal ensure that any physician or health provider, and any facility, is free to treat any patient in exchange for direct payment of a mutually agreeable fee?
2.6. Does the proposal ensure that for profit and non-profit providers are treated equally?

3. **Regulatory reform**

3.1. How does the proposal plan to determine which health care regulations produce a net benefit and which produce a net cost?
3.2. Does the proposal embrace legal reforms that protect participants in the Colorado health care system from unreasonable torts and contradictory regulations?
3.3. Does the proposal require that businesses operating in health care are subject to the same rules as businesses operating in other sectors of the economy with respect to things like anti-trust, ownership structure, pricing, contracting, payment, purchasing, taxation, and reporting requirements?
3.4. Does the proposal protect consumers from unreasonable charges?

3.5. Does the proposal contemplate legal reforms that would encourage all participants to exercise good judgment?
3.6. How does the proposal plan to determine whether current licensing, inspection, and reporting requirements produce net benefits?
3.7. Does the proposal contemplate legal structures that will protect providers from arbitrary and capricious peer reviews?
3.8. Does the proposal reduce legal barriers to entry affecting hospitals, specialty hospitals, long-term care providers, in-store medical practices, insurers of all kinds, providers of professional services, drug and device manufacturers, and suppliers of drugs and medical equipment?
3.9. Does the proposal contemplate the legal reforms that would be necessary to encourage people who wish to create charity care clinics can do so without risking their personal assets?

4. Does the proposal promote the use of economically efficient subsidies designed to maximize the general welfare?

4.1. Does the proposal reform Medicaid?

4.1.1. Do Medicaid subsidies accrue to individual patients rather than to providers?
4.1.2. Can individual Medicaid patients spend the money that they receive at the provider of their choice? Can they purchase necessary supplies and services from the supplier of their choice?
4.1.3. Does the proposal contemplate regulatory reform that allows the program to develop regulations and programs that treat different Medicaid populations according to their needs?
4.1.4. Does the proposal contemplate Medicaid reforms that encourage Medicaid clients to use their Medicaid benefits wisely?
4.1.5. Does the proposal include public access to Medicaid financial data so that amounts paid to providers, vendors, consultants, administrators, contractors, overseers, investigators, tax collectors, auditors and so on, as well as the purpose of the expenditures, can be clearly discerned?
4.1.6. Does the proposal provide ways to discriminate between—and effectively manage—financial arrangements for people in legitimate need and those who take unfair advantage of subsidized and safety net programs?
4.1.7. Does the proposal ensure that taxpayer-funded services will be provided only to eligible persons for eligible services?
4.1.7.1. How will the proposal ensure that taxpayer-funded services are not provided to deceased persons, persons with fraudulent identification, nonresidents, persons not meeting financial requirements, illegal aliens, and so on?
4.1.7.2. What penalties will be assessed for those who try to defraud the system by faking evidence of eligibility?
4.1.7.3. What mechanisms in the proposal are designed to ensure that payment for taxpayer-funded services is actually rendered?

4.2. How does the proposal contemplate providing medical care for people who, by reason of incapacity or simple cussedness, do not comply with administrative requirements?
4.3. Will the subsidies contemplated by the proposal encourage or crowd-out private mechanisms for financing medical services?
4.4. Does the way subsidies are distributed in the proposal deepen Colorado's "low-wage trap" by imposing effective marginal tax rates on low-income people trying to work their way out of dependency?
4.5. How does the proposal plan to distinguish between essential and non-essential health care services?
4.6. How does the proposal contemplate ensuring that taxpayer-funded programs provide good value for the money spent?
4.7. Given that funds for taxpayer-funded programs are limited, how will the proposal manage the tradeoffs that are necessary in a resource constrained subsidy program?
4.8. How does the proposal propose to measure the effectiveness of taxpayer-funded subsidy programs?
4.9. How does the proposal plan to determine the type and level of subsidies?

5. **Programmatic considerations**

5.1. Does the proposal have a sunset provision?
5.2. How does the proposal plan to measure whether it is a success?
5.3. What trigger mechanisms automatically sunset the proposal in the event of budget excesses or poor performance?