

A Health Care Reform Agenda for Vermont

*What Federal and State governments should
do to create a consumer-friendly “patient
power” health care agenda based on
personal responsibility.*

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An Ethan Allen Institute Report

A Health Care Reform Agenda

What Federal and State governments should do to create a consumer-friendly “patient power” health care agenda based on personal responsibility

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About this report: This report was prepared by a working group convened by the State Policy Network in October 2002. SPN is an association that provides assistance to independent research organizations devoted to discovering and developing market-oriented solutions to state and local public policy issues. (www.spn.org).

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The foregoing contributors agree with the philosophy and generally support the policy proposals in this report, but do not necessarily support every specific recommendation.

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I. Introduction

Health care has become the major item on the nation's domestic agenda. Since 1965 dramatic changes in the health care industry, including numerous federal and state government interventions that were designed to improve access to affordable, quality health care. These interventions have instead produced a system that more and more Americans believe is not meeting their expectations for affordable, quality health care. The purpose of this report is to present concisely the important components of a new health care reform agenda, with a focus on policy steps that can be taken at the state level.

The federal government, through its own health care programs, the workings of the tax code, and its regulatory activities, plays a major role in shaping the health care market. No state-oriented health care policy can operate independently of those programs, laws and policies. This paper does not attempt to specify detailed reforms at the Federal level - such as Medicare reform, FDA regulation of medicine and medical devices, prescription drug benefits, patients' bill of rights, and Veterans Administration programs. It does suggest certain needed changes at the federal level that will strengthen the capacity of states to implement a reform agenda.

Health services are offered by a vast network of hospitals, nursing homes, clinics, doctors, dentists, and other professionals. There is strong reason to believe that this network is burdened by inefficiencies, sometimes gives rise to medical problems, and sometimes fails to take full advantage of new procedures, treatments, and technologies. While important, these problems are beyond the scope of this paper.

II. Basic Philosophy

There are two competing paradigms for health care policy.

The Service Delivery Paradigm

This paradigm is based on the concept that health care services are "delivered". Patients are viewed as largely passive vessels into which competent professionals pour the elixir of "health care". It holds that health care should be delivered through public or publicly controlled managed care organizations, where treatment decisions are made by gatekeepers with incentives (or instructions) to restrain costs.

Individual choices about health care and health insurance should be discouraged, because individuals are not competent to make such important choices, and when they do make choices they do so with only their own interest in mind, rather than the good of society as a whole.

The measure of social progress is the number of people whose health care expenses are paid for by some form of "insurance", whether it is actuarially-based insurance offered by an insurance company, or a promise to provide needed care offered by an HMO, Medicare, Medicaid or the Veterans Administration.

The service delivery paradigm sees the goal of health policy as "universal coverage", a medical-financial system comprehensively managed by a government authority through regulations, price controls, budget caps, reimbursements, and rationing, principally or entirely fi-

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nanced by taxation. Only such a system can provide “universal access” and assure cost containment (that is, can ration care to match available revenues.)

The Patient Power Paradigm

This contrasting paradigm views patients not as passive receptacles of care, but as empowered consumers. It contends that the primary responsibility for maintaining wellness and paying for health care rests with the informed individual and family, not with the government. Patients are not mere passive receptacles for the delivery of health care. They are conscious human beings whose understanding, involvement and cooperation are essential to maintaining or restoring wellness. People who regularly make important decisions about family, career, and investments must be considered competent to recognize the essentials of healthy lifestyle choices and effective self-treatment for non-acute conditions.

Over a lifetime the great majority of health problems are the predictable result of unwise individual choices. Wellness can be significantly increased and demand for expensive health care can be significantly reduced if individuals are educated as to the personal health and economic consequences of their choices, especially those relating to smoking, drinking, drug use, exercise, nutrition, and sexual activity. Every public and private health-related program should offer a strong health consumer education component, and public policy should reward individuals and families who make healthy choices.

Health insurance exists to reimburse individuals for the expenses incurred in coping with serious and unexpected health occurrences. It was never intended to pay for expected and predictable wear and tear. First dollar or low deductible coverage amounts to prepayment of medical bills. It leads directly to costly overutilization of health resources. When consumers become cost-sensitive by purchasing a substantial amount of services directly from providers, consumers themselves control overutilization. To return to this rational and effective system of insurance, patients should pay for their own health care until a relatively high deductible is reached. Only at that level should third party (insurer) payment for health expenses begin.

The patient power paradigm sees competition among providers in nonemergency situations as essential to create a functioning health care marketplace. Informed and empowered consumers will reward providers for quality, efficiency, convenience, cost effectiveness, and patient satisfaction.

The model program recommended here is built squarely upon the Patient Power Paradigm.

III. Desirable Federal Changes

1. Congress should enact a Federal income tax credit for health care expenses. Consumers, especially those who do not enjoy employer-provided coverage, often lack the means to obtain affordable health insurance. That can be remedied by a federal income tax credit for the purchase of insurance. The credit should be refundable (paid in cash if the credit amount exceeds the consumer’s tax liability); advanceable (made accessible to taxpayers in advance of income tax filing); and inversely proportional to income.

President Bush’s proposal (2002) for a sliding scale credit up to \$3000 for a family of four would dramatically reduce the number of families now without insurance by making it possible for them to afford coverage in a competitive marketplace. It would also dramatically re-

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duce any need for states to expand Medicaid into ever-higher income groups, and reduce state expenditures for that purpose.

2. Congress should encourage individuals and families to create tax-favored Medical Savings Accounts. Tax-deductible MSAs are available under Federal tax law for the self-employed and employees in firms with no more than 50 employees. MSAs are usually coupled with a relatively inexpensive high deductible major medical insurance policy. Individuals and families can use funds deposited in an MSA to pay for such routine expenses as physical examinations, immunizations, vision care, prescription drugs, dental work, and other medical costs incurred before the insurance policy's annual deductible is reached.

MSAs give families a financial incentive to use preventive care to maintain wellness. As balances in their MSAs increase, they can switch to higher deductible coverage and pay lower premiums without giving up major medical protection. In addition, many doctors will give up to a 50 percent discount for patients who pay for treatment at the time of service, a practice that an MSA makes easy.

Unfortunately the restrictions enacted by Congress in 1996 have discouraged MSA use. The federal law should be changed to allow any individual or family to create an MSA regardless of income or employment status; allow employee and third party contributions; allow carryover of unspent balances to a new year; allow more flexibility in the policy deductible; and make the authorizing legislation permanent.

Similar to MSAs are health care benefits provided by a tax-favored employer-funded Flexible Spending Account ("cafeteria plan"). Through their FSA employees can purchase a number of benefits including health coverage. However unspent FSA balances cannot be rolled over into a succeeding year; they revert to the employer. Setting up an FSA plan to meet the detailed IRS requirements involves considerable expertise and cost.

Internal Revenue Service Revenue Ruling 2002-41 in June 2002 authorized a new product similar to an MSA but without some of the MSA restrictions. The ruling allows employers to deduct contributions to employer-owned "Health Reimbursement Arrangements" (HRAs), from which employees are reimbursed for their qualified health expenses. The year-end balance in an HRA can carry over to the ensuing year.

The Federal government should rationalize these three similar plans into one unambiguous, simple, flexible plan, readily available to all persons regardless of income or employment status, and allowing carryover of unspent balances for future use for the approved purposes. The operative principle is that all persons in the workforce ought to enjoy tax equity, whether self employed, retired, employed by a company that provides health benefits, or employed by a company that does not.

3. Congress should enact legislation to create a national legal framework for Individuals and Families to enroll in Association Health Plans and Individual Membership Association plans. AHPs are health insurance plans created for associations of small businesses in a number of states. They would be regulated for financial solvency and truthful representation under one Federal law instead of the diverse benefit-laden insurance laws of the several states. Each plan would offer various coverage choices to members. AHPs could purchase insurance for their members or be self-funded (liable for payment of claims from their own reserves, bolstered by stop loss insurance to protect against catastrophic claims.)

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IMAs would be similar interstate associations created to insure individuals who are members of professional societies, churches, fraternal societies, etc. Both of these multi-state plans would expand affordable choices for consumers and avoid costly state mandates.

4. Congress should enact legislation to override state laws to allow employers to purchase a variety of insurance policies for employees, rather than requiring one group policy covering all employees. Sec. 106 of the Internal Revenue Code allows employees to choose their health insurance from different carriers, a practice known as “list billing”, and still retain the tax exclusion for the money their employers spend on the insurance. However, most states have passed legislation prohibiting employers from doing so. By ending this practice, employers could allocate a defined contribution for each employee, who then selects a suitable policy from a menu of choices. If the policy costs more than the employer’s defined contribution, the employee pays the difference. The employer serves as the intermediary to manage employee enrollment, bill employees for their share, and remit payments to insurers. The key to making this policy work is to allow insurers to underwrite each applicant. Those who are medically uninsurable at the time of application should be allowed to enter the state’s high risk pool, with the employer’s contribution directed to the pool.

5. The Federal government should make block grants to the states in place of complex Medicaid, SCHIP (state children health insurance program) and DSH (disproportionate share hospital) payments. This would allow states maximum flexibility to design their own programs to assist lower income families, just as the landmark TANF welfare reform act of 1996 did for income support.

6. Congress should pay health care providers the full cost of services provided to Medicare patients. Cost accounting for health care services is admittedly complicated and involves numerous arbitrary cost allocations. However it is widely acknowledged that both Medicare and Medicaid reimbursements to providers are well below the market cost of services rendered. This underpayment requires providers to shift costs to other patients who have private sector insurance. This in turn results in a premium cost increases - in effect an unlegislated tax on private health insurance to subsidize government health care programs.

In addition, chronic and severe underpayment by government programs, coupled with complicated, demanding and often arbitrary reporting requirements, has become an increasing incentive for health care professionals to simply refuse to treat patients in those programs. Higher levels of government reimbursement to providers should be coupled with substantial simplification of reporting requirements, a reduction in aggressive prosecution for relatively minor and unintentional technical violations, and an end to completely unreasonable “health crime” penalties.

7. Congress should expand Medicare+Choice options within the Medicare program. Allowing more seniors to apply an average Medicare payment to the purchase of private insurance would give them a range of choices and expand insurance markets.

8. Congress should enact a Medicare prescription drug benefit. Such a benefit should be designed as an income-based subsidy deposited in the beneficiary’s prescription drug security account, coupled with private insurance for extraordinary costs. The availability of such a benefit would directly reduce state Medicaid costs with respect to dual-eligible patients (principally poor and disabled seniors who benefit from both programs) and beneficiaries of state-financed drug purchase assistance programs. Federal block grants to the States would of course be adjusted to reflect such reduced spending.

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9. Congress should enact medical malpractice reform. Soaring malpractice judgment awards have seriously raised the costs of medical care (especially for obstetrics-gynecology) and insurance premium costs in many states, and have even driven professionals out of medicine. Corrective federal legislation would include imposing a limit on non-economic and punitive damages and attorney's fees; ending joint and several liability (where every contributory party is at risk for the entire judgment, regardless of its contribution to the injury); adopting a high tort standard of "gross and willful negligence" in medical malpractice cases, in place of a standard that allows plaintiff victories where the doctor makes a well-informed, rational judgment call that leads to harmful results (especially important for charitable and humanitarian care); and (as in Nebraska) assigning punitive damage awards to state high risk pools, health information system support, or other public programs instead of to the plaintiff's attorney. (These steps could also be taken in individual states, but usually fail due to concentrated opposition from the trial bar.)

10. Congress should cap and eventually phase out sec. 105 income tax deductions for employer-sponsored health insurance plans. This would leave employers to organize a menu of plans, provide information, aggregate employee portfolio groups, and perform administrative duties, but not pay for premiums. Employees would earn higher wages and salaries, make their choice of plans, and pay for the premiums out of their MSAs or other similar tax-favored accounts. Depending on their income levels, employees would have a choice of tax deductibility or a tax credit. This would allow the tax deductibility and credit to vest with the individual employee, and remove the regressive deductibility of employer health care contributions for high-income employees. Employees would own their plans. The plans would be fully portable when the employee changed employers or retired. Balances in the MSA could be assigned to others via gift or bequest.

This proposal is obviously a very fundamental change that will not come easily, as employer-provided health insurance has for 60 years been a major feature of American life. It should, however, be discussed in connection with any comprehensive program of federal tax reform.

IV. Desirable State Level Initiatives

1. States should make sure that consumers have ready access to health education and consumer information. A patient power approach works only when consumers have access to sufficient information to make intelligent choices. State health education programs (including high school curricula) should emphasize personal responsibility for important lifestyle choices. They should also help consumers learn about various treatment and insurance options, and the qualifications, performance and cost records of medical care providers. In recent years much useful information has become available through both public and private web sites and through internet-based patient groups (an outstanding example is Coloradohealth.com).

2. States should roll back costly health insurance mandates. Currently the 50 states enforce over 1500 mandates on insurance policies, covering such matters as pregnancy, mental healthy parity, substance abuse, and acupuncture. Consumers ought to be allowed to buy low cost basic policies, and add riders for additional coverage, just as they do with auto insurance.

States should enact the Mandated Benefits Review Act proposed by the American Legislative Exchange Council (1998). It would create an independent committee charged with reviewing the cost-effectiveness, medical efficacy, and social impact of each benefit mandate. All existing mandates would expire on a date certain unless reauthorized by the legislature. All proposed future mandates would require a financial impact study before legislative enactment.

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3. States should allow the sale of low-cost basic coverage insurance policies that do not include cost-inflating mandates. Whatever the result of mandated benefit rollback, such policies should at least be available to lower income workers and families who lack employer-sponsored insurance, to maximize the likelihood that they will be covered for catastrophic medical events.

4. States that have adopted community rating and guaranteed issue should repeal those laws. Strict community rating requires insurers to charge the same premium rate to all insureds regardless of their age, gender, medical history, and other factors. (Modified community rating typically allows a rating band of +/- 10-20 percent.)

Community rating is particularly perverse for shifting the costs of insurance from older more affluent but less healthy families to younger, healthier families trying to get started in life, while bearing the burdens of college loan repayment, home mortgage payments, and entry level incomes. Every other form of insurance (auto, property, life) sets premiums that relate to the insured's risk of incurring a loss. By prohibiting insurers from varying premiums based on age, gender, medical history and other factors, community rating makes true insurance impossible. The result is invariably the destruction of the insurance market and a reduction in coverage as young, healthy people abandon policies they can no longer afford.

Guaranteed issue requires insurers to accept every applicant at any time regardless of his or her health history. This policy encourages adverse selection, as people who expect to remain healthy (usually young people) choose to stay out of the insurance pool altogether, sign up for insurance coverage when they foresee the imminent need for coverage, and drop the coverage when they believe they no longer need it.

While both of these mandates lead to demonstrably undesirable results, guaranteed renewability is a mandate that ought to be continued. It requires insurers to continue coverage for any insured so long as premiums are paid; coverage cannot be terminated as a result of high medical costs. Typically the premium for a policy is related to the claims experience of the group of which the insured is a member.

5. States should allow insurers to offer healthy lifestyle discounts. When states have implemented strict community rating, premium discounts for non-smoking, responsible drinking or other healthy lifestyle choices are not allowed (because it would shift costs from people with healthy lifestyles to people with unhealthy lifestyles). Encouraging personal responsibility is a key to sound health care policy. All states ought to allow insurers to offer such discounts for responsible behavior, as they do for auto insurance (driver training, good driving records, air bag use etc.).

6. States with income taxes should allow taxpayers and third parties to deduct contributions to MSAs. Alternatively, states could match a sliding scale federal tax credit for the purchase of health insurance.

7. States should create Medicaid Health Accounts and insurance vouchers for their acute care Medicaid case load (not including permanent chronic care patients). This would put Medicaid patients into a normal insurance market and give them the means to buy suitable policies (at least basic coverage.) Medicaid eligible families would be allowed to devote their MHA balances in excess of expected needs to a personal health-related benefit not otherwise covered by traditional Medicaid. Since the MHA is funded by appropriated funds and not by contributions from taxable entities, the federal MSA rules would not apply.

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States would also need to supply considerable health information and education to enable MHA families to make wise choices, along the lines of the Florida Cash and Counseling program. A MHA debit card, similar to those increasingly used for TANF (welfare) payments, would be a practical way to manage the accounts.

8. States should create high risk pools for persons with chronic high cost medical conditions, who have been rejected by insurers as uninsurable or quoted premiums that are far beyond their capacity to pay. Such pools, now in operation in some 28 states, typically charge insureds 150 percent of the normal premium for their classification. The pool's expenses above premiums collected should preferably be financed by state appropriations, but some states finance them in part by a tax on insurance premiums.

9. States should enact medical malpractice reform as an important component of broad-based tort reform. States should reform medical malpractice law in the same way as recommended for federal action (supra, III-9). Such action would include imposing a limit on non-economic and punitive damages and attorney's fees; ending joint and several liability (where every contributory party is at risk for the entire judgment, regardless of his contribution to the injury); adopting a high tort standard of "gross and willful negligence" in medical malpractice cases, in place of a lower standard that allows plaintiff victories where the doctor makes a well informed, rational judgment call that unexpectedly leads to harmful results (especially important for charitable and humanitarian care); and assigning punitive damage awards to state high risk pools, health information program support, or other public program instead of to the plaintiff's attorney.

10. States should make full-cost payment to Medicaid providers. Many states have succumbed to the temptation to finance expanded government health care by forcing providers (hospitals, doctors, nursing homes, dentists, etc.) to serve Medicaid populations at significant discounts from the actual cost of services. Faced with this mandatory exaction, providers are forced to increase prices to private patients). This cost shift leads to higher private insurance premiums, more workers dropping coverage due to the higher cost, and more demand for the expanded but underpaying Medicaid programs. In addition, doctors and dentists may decide to stop treating Medicaid patients.

Medicaid underpayment of true costs is an unlegislated tax on health care providers and through them, on their private patients. If governments are going to qualify citizens to receive health care benefits at nominal cost, governments must honestly face the fiscal consequences.

11. States should not attempt to enact price controls on prescription drugs, or require pharmaceutical companies to give a supplemental rebate on their products in return for the state allowing doctors to prescribe those companies' products for Medicaid patients. Such schemes, which essentially amount to blackmail, are ethically unacceptable. On a practical level, they are likely to result in serious damage to the capacity of the pharmaceutical industry to develop and market valuable new drugs at a time when the use of drugs to preclude far more costly hospitalization has improved the quality of life for millions of consumers, and saved them (and state governments) untold billions of dollars.

States may of course specify that only older, less expensive or generic drugs be prescribed for Medicaid patients, but in every such case the state should demonstrate that the savings not be outweighed by the higher costs of recurring treatment and hospitalization that newer and more expensive drugs may be able to avoid.

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12. States and local governments should support community health centers. Such clinics, with local community support and partially staffed by volunteer medical professionals, can play an important role in preventive care and treatment of non-acute medical problems for people not enrolled in Medicaid or in transition between jobs. Helping them meet overhead expenses is a valid use for taxpayer dollars, especially where the availability of low cost clinic treatment reduces patient visits to high cost hospital emergency rooms.

13. States should repeal Certificate of Need programs that regulate the expansion of medical facilities. The CON process, enacted to prevent costly duplication of facilities, has rarely if ever had that result. Maintaining a competitive market requires easy access by competitors who believe they can offer health care more efficiently and satisfactorily than existing providers. The CON process has more often been used as a weapon by politically powerful providers to deny entry to those competitors and thus preserve a service monopoly.

14. States should allow greater flexibility in practice boundaries among health care professionals. As is relatively common in medically underserved rural areas, trained and experienced nurses, physician assistants, and nurse practitioners should be allowed to administer treatments where patient risks and opportunity costs are low and the time and money costs of engaging a physician are high. Such flexibility does involve higher patient risk, but it may well not be so high as the risk incurred by delaying treatment until examination by a physician is possible. The use of telemedicine makes such flexibility much more feasible.

15. States should encourage individuals to purchase long term care insurance. Consumers who purchase LTI policies receive a predetermined level of benefits for long term care services through a private insurer. If the benefits under the private plan are exhausted and the individual still requires services, states should make Medicaid assistance available, but allow the patient to exclude the value of the benefits purchased under the policy from Medicaid's required spend-down of the patient's assets.

This relatively new type of insurance is most cost-effective when contracted for early in adult life. As such, its beneficial effects are far in the future. Nonetheless as a way of easing Medicaid problems in the future states should offer favorable tax treatment for LTI premiums, while avoiding rigid requirements on policy design.

States should also inform people about viatical life insurance policies, which advance payments to living insureds for their imminent end-of-life medical expenses.

16. States should consider pooling state and local government employees into a large health care plan offering numerous coverage choices, like the Federal Employees Health Benefits Program (FEHBP). The employing governments would make defined contributions on behalf of their employees, and the employees would choose the policies that best met their needs, adding their own funds as required. Such a program ought to be designed to promote an MSA-high deductible option, and operate through debit card technology.

17. States should seek to recover through their income tax systems the costs of uncompensated care provided to persons who choose not to buy health insurance. Providers would report the costs of uncompensated care to the state tax department on a 1099-type form in the patient's name. For example, the patient could be required to add the lesser of one-tenth of the total uncompensated cost or \$10,000, to his or her reported gross income each year. The balance would be carried forward for up to ten years.

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Whatever is collected from taxpayers would be remitted to the account of the provider. For persons with low or zero income tax liability, little or no funds would be recovered. For persons in higher tax brackets who ought to be able to pay insurance premiums but choose not to, the recovery requirement would discourage going without health insurance in the expectation that providers would write off the cost of their services as charity care. While the receipts from this program would fall far short of recovering the total uncompensated costs, the program would encourage personal responsibility and the purchase of insurance coverage.

V. Additional Useful Actions

There are a number of additional useful and desirable actions that the non-governmental entities ought to take to improve outcomes and efficiencies in the health care market. Among them are: more accurate and efficient medical record keeping; “focused factories” for treatment of specific conditions; disease management; virtual diagnosis; personalized medicine based on the patient’s genetic profile; gene therapy through modified foods; curbing unnecessary medical procedures; using computerized science-based treatment protocols; complementary medicine and nutrition; electronic monitoring of outpatient medication and care; and increased use of durable power of attorney for patients in terminal stages of life.

In addition, all health care providers should protect the privacy of medical records unless granted explicit consent by the patient, and medical professionals should resist the temptation to redefine various habits, behaviors, and discontents into problems requiring “medically necessary” treatment.

VI. Summary

America faces an important choice between two diametrically opposite health care visions.

The Service Delivery Paradigm relies on providers and bureaucrats to determine how much and what kind of health care shall be delivered to individual patients under a government-controlled plan, and when and by whom.

The Patient Power Paradigm relies on empowered consumers looking after their own wellness, making informed choices among different treatments and providers, and purchasing insurance to protect against catastrophic medical events.

Put another way, it is a choice between government being primarily responsible for the health of its citizens, or the citizens themselves, aided by information and when necessary financial assistance, accepting primary responsibility for their own wellness.

When this choice is articulately put to citizens, Patient Power is likely to be the winner.

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Ethan Allen Institute

The Ethan Allen Institute, founded in 1993, is Vermont's independent, nonpartisan, free-market public policy research and education organization – a “think tank” for issues facing Vermonters.

The Mission of the Institute is to influence public policy in Vermont by helping its people to better understand and put into practice the fundamentals of a free society: individual liberty, private property, competitive free enterprise, limited and frugal government, strong local communities, personal responsibility, and expanded opportunity for human endeavor.

The Institute's areas of interest include –

- Vermont's economic future, particularly the vitality and diversity of its competitive free enterprise sector.
- The fiscal practices and condition of state government – taxation, spending, and borrowing.
- State and local regulatory practices, and their effect on the economy and the rights of the people.
- The improvement of education for all Vermont children, and particularly the expansion of competition and choice for all.
- The preservation of free, accountable, democratic government, where public decisions are made at the level as close as possible to the people themselves.
- The strengthening of Vermont community and family life, and the protection of local government from burdensome and costly mandates.

The Institute advances these ideas through print and radio commentaries, publications, newsletters, conferences, debates, and public dinners and meetings.

The Institute is supported by the annual contributions of over 600 Vermonters. It is governed by an 11-member Board of Directors and has a 19-member Advisory Council.

The Institute is a 501(c)(3) educational organization, contributions to which are tax deductible for individuals and corporations. The basic annual membership is \$25.

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