Vermont’s Health Care Policy

An analysis and response to the report of the Governor’s Bipartisan Commission on health care Availability and Affordability (The Hogan Commission)

January 2002
The Governor’s Bipartisan Commission on Health Care Availability and Affordability

Review and Critique

On December 4, 2001, after a year of work, the Hogan Commission issued its final report. After a decade of intense government health care activity, Governor Dean charged the Commission with, among other things, finding ways to guarantee “universal health care access” while “controlling costs”. This paper presents a summary of the Commission report, plus four critiques of that report. (Two additional reviewers, David Kendall of the Progressive Policy Institute and Prof. Regina Herzlinger of Harvard Business School, were unable to respond in the very short time frame.) It also includes the Ethan Allen Institute’s more detailed proposal for reforming health care policy in Vermont, and a Scandlen Report update on new directions in national health care policy.

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The Ethan Allen Institute, founded in 1993, is Vermont’s independent, nonpartisan free market public policy research and education organization. Please see the back cover of this report for a fuller description of its activities.

January 2002
Executive Summary

Governor’s Bipartisan Commission on Health Care Availability and Affordability

The Hogan Commission report did not contain an executive summary. This brief and selective summary was prepared by the Ethan Allen Institute. The full report can be obtained from the Legislative Council or on the web at www.state.vt.us/health/commission/docs/report-final.htm.

The Commission was created by Gov. Howard Dean’s executive order on January 24, 2001. Its members were former AHS Secretary Cornelius Hogan (chair), Elizabeth Costle (Commissioner of Banking, Insurance, Securities and Health Care Administration); M. Jane Kitchel (Secretary of Human Services); Rep. Frank Mazur (R-South Burlington); Rep. Thomas Koch (R-Barre); Sen. Nancy Chard (D-Windham), and Sen. Cheryl Rivers (D-Windsor). It met and received testimony throughout 2001 and released its report on December 4, 2001.

The Commission found that “Health care in Vermont is near a state of crisis ...and all health care sectors are on edge. Health care costs in Vermont, now exceeding $2 billion a year, are of a sufficient magnitude and are increasing at a sufficient rate to place state government itself in jeopardy, including every program for which it appropriates money...We are rapidly approaching the point at which these costs will directly conflict without our ability to do such things as to maintain roads and bridges or to provide cost effective services to our infants and children, to promote agriculture and tourism, or to provide any other services our citizens have come to expect.”

“We do not have a health care system in Vermont. That means:

1. No one is in control.
2. No one is responsible for ensuring that high-quality medical care is adequate for the needs of the public.
3. No one ensures that medical charges are appropriate or that they are paid in full.
4. There is a disconnect between the consumer receiving health care the entity paying the bill. Consumers are shielded from the cost of the service.
5. There is no global budgeting or targeted growth planning for health care in Vermont.
6. There is little in the way of public accountability for the performance of health care institutions, or for their long-term planning.
7. Although administrative costs, including those associated with government paperwork burdens, have reached an unacceptable level, no one has been able to do anything about it.”

Notwithstanding the foregoing findings, the Commission declined to recommend a government-run Single Payer system, because of the financial impact on small employers, wage effects on employees, doubts about government cost and utilization control, and the possibility of inadequate funding that would cause providers to leave the state. The Commission found that “the quality of health care in Vermont is considered to be good,” but quality measurements are limited.
Community rating (initiated in 1991) caused some insurers to withdraw from Vermont. “It has had the effect of lowering costs for older people and those with medical conditions while raising them for younger, healthier people. It does not provide incentives to avoid freely chosen risky behaviors. Higher prices for younger people and for businesses with a young, healthy workforce may result in their foregoing insurance entirely, or, in the case of small businesses, in their choosing to self-insure.”

Vermont ranks about average in the nation with respect to the number and scope of its insurance mandates. The individual insurance market is small, and thus vulnerable to adverse selection. “Insurance, which is intended to protect an insured from excessive cost, is not the same as a pre-paid health plan. They are different, especially in regard to their affordability. The fact that many people fail to distinguish between the two concepts complicates the discussion of health care affordability...The practice of third-party payment tends to shield both consumers and providers from understanding the cost consequences of their behavior and of the health and medical choices they make.”

“Many employed Vermonters find that the only health care coverage available to them is that chosen by their employer without regard to their particular needs or those of their families. As a consequence, some are insufficiently or inappropriately insured.” The Commission recommended sharply increased K-12 education in healthy behaviors.

To curb unnecessary utilization, the Commission recommended creation of a Common Care List of treatment protocols for the fifty most prevalent medical conditions. It also recommended a Risk List of treatments for which the health outcome benefits do not clearly outweigh the risks.

The Commission recommended a five-year pilot project, in which some 7000 VHAP enrollees would be given a “Preventive Incentive” account, making use of a smart card which they could use to purchase needed medical care. At year’s end, one half of any unspent balance could be applied by the enrollee to “college tuition, job training, child care etc.” The remaining half would revert to the state.

The Commission recommended numerous reforms to reduce the estimated 20 percent ($400 million) of health care expenditures consumed by unnecessary paper work and antiquated information exchange systems in both government and private sectors. Among the reforms are Electronic Benefits Transfer cards, Problem-Knowledge Couplers, Certificate of Need changes, a central electronic clearinghouse, and a medical records privacy law.

The Commission recommended that the state “increase Medicaid reimbursement rates incrementally until they reach Medicare levels.” It also insisted that the expected reduction in provider cost shifting be verified. It endorsed continued “aggressive participation in multi-state efforts to establish lower drug prices through collective purchasing power.”

The Commission was unable to achieve a consensus on three proposals: a) a VHAP buy-in, where small employers pay VHAP the costs of medical coverage for their employees, and VHAP pays providers at the same rate as Medicare; (b) relaxing Vermont’s strict community rating law to allow +/- 20 percent variation in premium rates based on such factors as age; (c) continued support of Vermont’s rural health centers using a cost-based reimbursement system.

The Commission report included a letter sent by the Commission to the Congressional delegation urging “increased flexibility for states and a streamlining of requirements for states and for providers.” The report also contains a large number of individual comments and separate views by various commissioners.
Review and Critique:

Grace-Marie Turner

Grace-Marie Turner is President of the Galen Institute, a free market think tank devoted to health care and tax policy issues. She is coordinator of the Consensus Group of health care experts from a number of leading national think tanks. She came to Vermont in May 2000 to testify before a field hearing of the U.S. Senate Committee on Health, Education, Labor and Pensions. She can be reached at galen@galen.org.

According to the Report, “Health care in Vermont is near a state of crisis – some of us would say it already is in crisis... Health care costs in Vermont ... are increasing at a sufficient rate to place state government itself in jeopardy.” (p. 3)

Most Vermont residents believe that the quality of the care they receive is high, but not everyone is covered by health insurance. The U.S. Census Bureau reported that in 2000, 89 percent of Vermont residents had access to some form of health coverage, leaving 11 percent uninsured. While this is far from its goal of universal coverage, Vermont is doing far better than the great majority of the other states in providing health coverage to its citizens.

Facilities that accept public funds also are required to provide medical treatment to anyone who needs care. This is far from ideal. It is expensive, inefficient, and promotes anxiety on behalf of uninsured citizens. But it is a safety net, and federal systems are in place to provide some payments for this uncompensated care. One way or another, people have access to essential medical care.

The crisis therefore seems to be in the demand on the state budget for health care services and in the cost of health care to businesses and individual citizens.

The Report observes that “Because Vermont has a high Medicaid participation rate, the pressures of Medicaid costs on the State budget are greater in Vermont than elsewhere” (p. 18)

Many states also are experiencing serious budget problems this year, largely because of the growth of entitlement spending in publicly-supported health care programs like Medicaid/VHAP. Once the entitlement is established, the only way to reduce spending is to either roll back the entitlement qualifications or services or to reduce payments to providers. The former are very difficult politically, and the latter is therefore too often the course that is chosen. But these low payment schedules cause problems of their own.

One proposal that was mentioned but not adopted by the Commission would allow small business to buy in to VHAP. By bringing more people into a program that already is breaking the budget, this would seem to move in precisely the wrong direction. It is an illusion that such a move would be cost neutral. It might be well to look at a different way of instituting cost savings in these publicly-supported programs. The Incentive Plan for Medicaid described in the report could provide such an opportunity, as I will discuss later.

The Report says that for many Vermonters “Health insurance is financially inaccessible.” (p. 11) Vermont citizens trying to purchase health coverage are faced with policies burdened by expensive state mandates and regulations, like community rating. The Report says “Community rating has the effect of lowering costs for older people and those with medical conditions while raising them for younger, healthier people. It does not provide incentives to avoid
freely chosen risky behaviors...Some insurers withdrew from the Vermont market because they did not wish to compete in a community-rated marketplace where they were required to insure all types of risks at similar rates.” (p. 9)

Further, the Report observes that a lack of consumer awareness of the costs of health care and a lack of responsibility for their own health are problems are also driving up the cost of health care. Another cost driver is administrative costs, estimated to be $400 million a year in Vermont.

“Government,” says the Report, “is causing some of these problems but limited scrutiny by government and by consumers has resulted in a lack of accountability by all parties. Simply put, there are enormous inefficiencies and unjustified paperwork burdens in the administration of health care.” (p. 23) The quality of care and access to care are being impacted by the cumulative effect of attempts at solutions.

“Medicaid’s reimbursement rates are causing both availability and affordability problems in Vermont, as care givers curtail the number of Medicaid patients they will see and as unreimbursed costs are shifted to commercially insured patients, raising the cost of claims and premiums.” (p. 27) It is clear that Vermont’s decisions over the years to expand access to publicly supported health care programs and the state’s expansion of mandates and regulations on the private insurance system have sown the seeds of the problems the state is now facing.

The solution is not to do more of the same but to look at a different way of controlling costs by engaging the consumer in the decision-making process. K-12 education in healthy behaviors and media literacy would be a start. But unless people have a financial stake in the process, there will be little incentive for them to change their behavior.

The Incentive Plan for the Vermont Health Access Program provides attractive options to move in this direction. This would give consumers an opportunity to have “more freedom and incentive to take charge of their health care...[with] greater consumer understanding of costs...” (p. 18). This pilot project could provide an incentive for recipients to be more responsible in their consumption of health care by making the costs visible. With a voucher or a smart card, they would realize they are spending real money, and if they save it, they could spend it for other necessities, including education (p. 21). Smart Card technology is another good way to empower consumers with information and to take advantage of the opportunity for new technologies not only to produce better medical care but also to provide cost savings.

The report recommends that the state apply for a federal waiver for this experiment. The Department of Health and Human Services has created a new waiver opportunity to give states much more flexibility in management of their Medicaid programs for optional populations. The new program is called Health Insurance Flexibility and Accountability (HIFA). As a former four-term governor of Wisconsin, HHS Secretary Tommy Thompson is very enthusiastic about this new initiative and the flexibility it will give to states, and he hopes many will take advantage of it.

Secretary Thompson said his department has cleared the backlog of Medicaid waiver requests dating back to 1986 from states wanting more flexibility so they can expand access to coverage, often with the same number of dollars. The result, he said, is that more than 1.5 million more people will be able to get health insurance this year than last. In this era of budget shortfalls, finding a ways to expand coverage without new expenditures is very good.
This new HIFA waiver may provide just such an opportunity. The key is that states are able to shed some of the mandates and regulatory red tape that provide excessively generous health benefits to some while leaving many others out in the cold.

The Report also describes ways to strengthen the insurance market and mentions (but does not endorse) “tax rebates for the purchase of all health insurance” including catastrophic policies (p. 31). In a very important footnote Commissioner Costle points out that the two measures may not be very effective without action by the federal government. This is exactly right, but there are hopeful signs that action will be forthcoming.

The idea of providing federal tax credits to uninsured workers is gaining a great deal of attention in Washington. Many of the problems with the large number of uninsured are rooted in flawed federal tax policy, and this federal tax credit initiative would begin to correct those flaws. If Vermont leaders were to stress the importance of this idea to the state to encourage federal action, enactment of tax credits could take some of the pressure off the state to fix the problems of the uninsured which are not of their making.

Providing tax credits to individuals and families would energize the market for private health insurance by giving people actual resources to assist them in purchasing the coverage of their choice. The credits would be refundable if taxpayers owed few or no taxes, and they could be advanceable – meaning people wouldn’t have to wait until they file their taxes to get coverage.

Wharton School economist Mark Pauly has produced several studies showing that credits would provide a powerful incentive for the uninsured to purchase health coverage. One study showed that 75 percent of the uninsured would buy a policy if they received a credit worth 66 percent of the premium cost. He also found that the market for individually-purchased health insurance is more vibrant and more affordable than conventional wisdom perceives.

The information economy also is providing new options for people to obtain coverage. For example, eHealthInsurance, an on-line health insurance brokerage, produced a study last summer showing that the average premium for individual and family policies purchased through the company ranged from $1,200 to $1,500 a year per person. And it wasn’t just bare-bones coverage; 88 percent of the individual policies surveyed could be considered comprehensive. If tax credits were enacted, the market would be transformed with new ways for individuals to buy coverage.

As referenced in the Report, linking health insurance to the workplace is a relic of World War II when employers needed a way to boost workers’ pay without running afoul of wage controls. The Internal Revenue Service then ruled that an employer’s contribution to health policies would not be counted as taxable income to employees.

This worked tolerably well for an Industrial Age economy when workers stayed with the same company for years or even decades. But workers now are highly mobile. The Bureau of Labor Statistics has reported that 13 million Americans typically change their job status every month, and millions lose their health insurance as they move from job to job, go back to school, and start new businesses. In these circumstances, it is difficult to sustain a political position that would either tether health insurance to the workplace or push more and more people into expensive, centralized government programs.
Tax credits and vouchers would help to equalize the current system, so that millions who are now shut out would have access to coverage. Giving individuals control over their health spending through private insurance is not just the right answer for the uninsured, but the only way to begin to impose sensible cost awareness on consumers. Tax credits could be the beginning of important consumer-driven changes in the health sector.

The Commission expressed alarm that the cumulative level of state spending on health care was nearly equal to the total state budget. But this is a false comparison. The state should not be concerned about how much people spend on health care if it is their money and citizens are spending it on something that they value - health care, education, housing, travel, or computers. The state’s concern should be over the amount of taxpayer money it is spending on health care and whether it is crowding out other legitimate services.

Finally, the Report seems to bemoan the fact that there is no health care system and “No one is in control.” That is exactly as it should be. No one is in control of the U.S. economy. Rather, it is run by the choices of consumers seeking the maximum value for their dollars, and sellers seeking to attract consumers by providing the service and value consumers demand for those dollars. One of the biggest problems in the health sector is that this natural process is interrupted. Consumers do not have control over the money. Providers are not forced to respond to consumers but to large private and public bureaucracies which make decisions for the ultimate consumers. When health care consumers are once again empowered to spend their own money and make their own decisions, the market will cater to their desires. The tax credit proposals would empower those without adequate means to participate. They would solve the insurance problem for millions of families, and help restore a workable market for everyone’s benefit.

**Review and Critique:**

**Greg Scandlen**

Mr. Scandlen is Senior Fellow in Health Policy at the National Center for Policy Analysis. He was formerly the executive director of the Council for Affordable Health Insurance and is one of the nation’s leading experts on defined contribution insurance plans. He can be reached at GMScan@aol.com.

The Governor’s Bipartisan Commission on Health Care Availability and Affordability should be commended for its recent report on Vermont’s health care problems. The Report is an important examination of the issues facing Vermont, and all of America, as we move ahead in the new century.

While the report examines the problems, it falls short in identifying the causes of those problems, and so fails to suggest credible remedies. Vermont’s current problems are the direct result of decades of well-meaning but misguided governmental activism in health care. Of all the stakeholders in the health care system – doctors, hospital administrators, insurers, employers, patients – only government can impose its will on others. All the rest are voluntary participants who must cooperate with each other to gain mutually beneficial results. In Vermont, the government has been especially intrusive in these relationships and must accept responsibility for its actions.
It seems clear that every time the Commission started down the path toward meaningful reforms, it found itself blocked by prior governmental policies that it was unwilling to challenge. Certificate of Need and Community Rating are two notable examples. Those who have long been active in shaping government health care policies are naturally reluctant to criticize their own handiwork.

If Vermont is going to confront its health care problems head-on, its leaders need to start over. They need to start looking for new and different approaches to health care delivery and financing, beginning with first principles. This is not easy to do, because we are all locked into traditional ways of thinking. We want to believe that old and familiar policies will continue to work with just a few tweaks here and there.

But consider this: there is an entire universe of services and products that can be considered “health care.” This universe grows every day as new research and technologies come along. In fact, we are currently on the cusp of a revolution in health care delivery with the decoding of the human genome and the miniaturization of electronic devices. There are new molecular level treatments and nano-technology. Even in more conventional terms, there are some 400 new drugs and treatments currently in the R&D pipeline. At the same time, people are rediscovering a host of ancient practices such as herbal medicines and acupuncture that were nearly lost in the scientific revolution in medicine.

It is impossible for any insurance mechanism to cover all of this. It is also undesirable, because third-party payment invariably leads to excessive use of the thing that is covered. There will always be some portion of legitimate health care services that are not part of any insurance mechanism, private or public. Vermonters will always have some portion of their health care choices uncovered by third-party payment.

We must decide, then, what portion of this universe of services should be covered by whatever insurance mechanism is created. Some things will be reimbursed by the insurance; others will be paid for directly. But different people will have different preferences. Some people are risk-averse. They want everything possible included in the insurance coverage regardless of how much the premiums might be. Others would prefer to pay lower monthly premiums and have more cash available to pay for needs as they arise. Some people would like to have nurse midwives included; others wouldn’t let a nurse midwife in the same room. Some people want abortion covered; others would never think about having an abortion. Some want herbal medicine included, or acupuncture, or dental care, or psychiatric social work; others do not. Even if they would use those services, they would rather pay cash for them instead of paying higher premiums and filing claims with an insurance company. Each person or family has their own preferences and values. Each should be able to acquire the insurance package tailored to those preferences and values.

Some may object that since families are not paying for the coverage, they should have no right to choose. But in fact, they are paying for it, even when their employer acts as the middleman. Employers consider the total cost of compensation when making hiring decisions. If the value of an employee’s labor is not at least equal to the total of wages plus benefits, that employee will not be hired.

The employer might prefer to pay out some portion of that total compensation in the form of health benefits because it reduces sick time expenses, encourages productivity, and lets the employer avoid the cost of payroll taxes on the health benefits portion. But every dollar paid out in benefits is a dollar that is not available to pay wages. Workers should not be disadvan-
taged if an employer decides to pay out the whole compensation in the form of wages rather than benefits.

What would the world look like if we each were able to control the resources available to us and choose the health insurance product we most preferred? It would look much more like all the rest of our economy. People would choose how much of their resources to put into insurance and how much to set aside for direct payment of services. They would shop around for the insurance provider that most closely gave them what they wanted at the price they wanted to pay. If the company did not satisfy their needs, they would drop it and look for a better one.

Would Vermont have a competitive insurance market? Of course it would. Vermont has a competitive market for automobiles, and new cars cost about the same as health insurance on a monthly basis. In such a market health insurers would have to use risk-based rating to price their products appropriately, just as auto and life insurers do. But that simply means that the people who are likely to consume more services and value their coverage more highly would be willing to pay more for it. Younger and healthier people would pay less because they don’t think it is as important.

Some people would be disadvantaged: those who are especially high risk or low income. The state could supplement their ability to pay with targeted financial assistance.

Meanwhile, Vermonters would come to value those insurance companies that gave them the best value. They might stick with an insurance company the way they currently stick with their banks. They might be interested in entering into a long-term contract with such a company, which would save the carrier considerable marketing, enrollment, and retention costs, and allow lower premiums. Other Vermonters might want to join purchasing clubs to achieve the same marketing efficiencies that employers currently enjoy. These clubs could be based in an affinity group, like a labor union, church, cooperative, credit union, or homeowner association.

In buying their own health insurance, Vermont consumers would become a lot more savvy about everything else relating to health care. They would be picking and choosing their own benefits program, so they would be more demanding about the way services are delivered. They might resent providers who were only available during business hours, forcing the consumer to take time off of work. They might insist on evening hours. They might not like driving great distances to go to a hospital for outpatient services. They might demand that hospitals decentralize their facilities, bringing services to the people instead of the other way around.

This is all speculation. No one can predict exactly how consumers will behave once they are empowered to make decisions. But that is precisely the point. Markets are effective because they are unpredictable. They solve problems in ways that no one can anticipate. And that is why a market-based system is essential.

We are entering a time of unprecedented change in health care. None of us can know what the system will look like ten or even five years from now. So none of us can prescribe the future. Attempting to do so closes off possibilities that are inconceivable today. The way to cope with such unpredictability is by trusting the people of Vermont to make their own decisions based on their own values and resources. The very last thing Vermont needs is more centralized planning and control. It’s time to move on.
**Review and Critique:**

**Dr. Robert Moffit**

*Dr. Moffit is Director of Domestic Policy Studies for the Heritage Foundation, Washington. He was formerly Deputy Assistant Secretary of HHS and is Washington reporter for the American Association of Physicians and Surgeons. His doctorate is from the University of Arizona. He can be reached at Robert.moffit@heritage.org.*

The Commission has done a creditable job in outlining the conditions of cost, access and quality in the Vermont health care system.

The Commission is quite correct when they say that Vermont does not indeed have a health care “system”. Indeed, the United States does not have a health care “system”. Over 46 percent of all direct health care spending in the United States is government spending, largely through the Medicare and Medicaid programs. The rest, of course, is private health care spending, which is done largely through the mechanism of third party payment in the form of employer-provided health insurance. Very little is provided through the individual health insurance market. As the Commission indicates, if only indirectly, the private sector portion of the health care system is highly regulated. Indeed, the private health insurance system is indeed one of the most heavily regulated sectors of the American economy.

In their survey the Commission notes that in certain areas Vermont is doing better than the rest of the nation. For example, Vermont has one of the highest rates of insurance coverage in the country (p.7); the quality of care is “good”(p. 6); and government coverage assures access to lower income persons, children, and expectant mothers (p. 7).

The Commission expresses concern that health care expenditures in Vermont are $2 billion a year and climbing. It is difficult to determine with any certainty what the citizens of Vermont should be spending on health care. Even if one were to assume that the $2 billion figure is much too high, it does not follow that there exists a magic formula for determining what Vermonters should be spending on their health care.

In prosperous societies it is more likely that citizens will spend more for health care than in less prosperous societies. The political decision to spend less, either through government budgeting or price regulation, imposes its own costs on patients and consumers. These costs can be very high. Examples are legion, even in prosperous and successful societies. When governments, unable to control consumer demand, control costs by rationing supply, the quality and availability of care suffers. Under Britain’s single payer National Health Service, for example, some 1.3 million persons are waiting in line for hospital services. The important consideration is not the sheer size of the cost of the health care services, but rather whether patients feel they are getting good value for their money. Government provision and allocation rarely result in patient satisfaction.

The Commission should note – explicitly – that there is one other important feature of health care financing and delivery which distinguishes it from virtually every other sector of the American economy: it is private, and yet it does not operate like a normal market. There is no “normal” intersection of supply and demand. Practically speaking, this means that one cannot achieve the normal control of costs that one finds in other sectors of the economy.
As the Commission does note, “consumer demand” does not mean the same thing in health care as in does in other sectors of the economy. The consumers of health care services pay little of their cost, at least directly. Third parties (government, insurance companies, managed care entities, etc.) are the actual paying customers. This is the only sector of the American economy where the consumer of a service and the customer of a service are two entirely different personalities.

The members of the Commission obviously have serious differences of philosophy. Some wish to transform the health care system into a public utility based on the notion that health care is a right of citizenship. Others wish to transform the current system into a free market system based on patient choice and competition among private providers and insurers. It is thus not surprising that the Commission is unable to reach agreement on policy.

Policy questions invariably come down to whether a relatively free market is desirable or possible. The Commission (p. 5) notes its desire to accomplish a number of objectives, including the promotion of personal responsibility, reduction of excessive administrative costs, improved supply and affordability of health care products, and restraint on unnecessary utilization. The market is far preferable to state regulation in achieving such objectives. If the Commission wants to get the benefits of a free market, then the obvious response is to allow the financing and delivery of health care to operate in a relatively free market like other goods and services in the American economy. The market mechanism controls costs efficiently. It also rewards for providers and insurers who satisfy patient demands. Government (Medicaid) would assist those without the means to participate in the market.

Even though Commissioners have fundamental differences over the direction of policy, they demonstrate some important areas of conceptual agreement. Among the most important is the comment (p. 3) that the problems are national or global in scope and beyond the capacities of the state authorities. They are absolutely right.

Health care reform at the state level represents a paradox of public policy. While states have the primary responsibility for the regulation of health insurance, they have little or no influence on the major economic variable that directs and shapes the fundamental structure of the American health insurance market: the federal tax treatment of health insurance. This fact is widely understood among economists, but very poorly understood and appreciated by the general public. No other single factor has a more profound influence on the American health insurance market than the Internal Revenue Code.

Under the current federal law, Americans can and do get unlimited tax relief for the purchase of health insurance on one condition: that they get health insurance coverage through their employer. As a result, 90 percent of the working Americans with health insurance coverage have employer-based health care coverage.

A broad range of economists, from the Progressive Policy Institute to the Heritage Foundation, have long argued that the federal tax treatment of health insurance has produced a series of intractable difficulties. These include an absence of portability in health insurance, a major distortion of the health insurance market, aggravated health care inflation, and a loss of patient control over health care decisions and the choice of insurance products. Tying health insurance to the workplace has created a direct and powerful relationship between job status, the kind of company that one works for, and access to affordable health care coverage. The economic literature shows that those who earn a high income from a large company invariably have rich health care benefits and also enjoy a big chunk of tax free income to boot. Those who earn less, from a small firm without a company plan, get no benefits and no tax break.
For all practical purposes, consumer demand does little to directly influence the supply of insurance products or services. Because millions of Americans erroneously think that their employers pay for health insurance out of company profits rather than through a corresponding reduction in their own compensation, there is little or no transparency in health care financing. Patients, as consumers, are largely insulated from the economic decisions that they make. They think that someone else – their employer – is paying for their health care. The Commission (p. 7) recognizes this. In this context, “consumer demand” does not have the meaning that it has in other areas of the economy, where individuals and families can make choices with their pocketbooks.

State insurance regulation policy largely reflects a desire on the part of state legislators to compensate for the deficiencies in the current health insurance market caused by the federal and often by state tax codes. It tries to do this because it is unable to eliminate the real cause of the distortions.

Some patients complain that their medical conditions are insufficiently covered or not covered at all in employer-based insurance. Some medical practitioners complain that their particular services are insufficiently available through the employer based third party payment system. They prevail upon state legislatures to force private insurance companies to cover these conditions, services or medical procedures. As a result today, states have imposed 1,403 specific benefit mandates on private health insurance, requiring insurers to cover a wide variety of conditions, services and medical procedures. In this area, Vermont has been, according to the Commission, an “average” state regulator. (p. 9)

Evidence on state experience in mandating benefits, treatments and medical procedures—as revealed in a recent report by a working group of the Institute of Medicine, is that political pressures routinely overcome the sound medical judgments as reflected in the professional literature.

Mounting empirical evidence shows that increasing regulation drives up health care costs, including administrative and compliance costs, and it increases the number of Americans who are unable to buy the more expensive insurance. According to the Congressional Budget Office, every 1 percent increase in health insurance costs nationwide causes between 200,000 Americans to lose coverage. Independent estimates put the figure even higher. As the CBO also reports, mandated benefits force employers to pass higher insurance costs on to employees in the form of lower wages or in reductions in other employment benefits covered. In 1999 Professor Gail Jensen of Wayne State University and Professor Michael Morrissey of the University of Alabama reported that as many as one in four of Americans are uninsured as the result of benefit mandates. They concluded: “Mandates are not free. They are paid for by workers and their dependents, who receive lower wages or lose coverage altogether”.

In 1996, the U.S. General Accounting Office (GAO) estimated that state mandated benefit laws accounted for 12 percent of the claims costs in Virginia, which had 29 benefit and managed care mandates, and 22 percent in Maryland, which then had 36 mandates. A similar study conducted by the actuarial firm of Milliman and Robertson for the National Center for Policy Analysis found that the 12 most common state-mandated benefits added as much as 30 percent to the cost of insurance. It would have been helpful to legislators if the Commission had studied the impact of Vermont’s mandated benefits on the cost of private insurance and access to coverage.
The Commission recommends (p. 19) the creation of a “Common Care List” and the establishment of recommended protocols for treatment of these common conditions. It calls for the collection and dissemination of information on quality care. In reality, there is often disagreement over the meaning of quality, particularly in health care. If the Commission intended an exclusive role for government to define and specify what is quality care, this should raise a red flag.

The danger is that, despite formal promises to retain a respect for scientific integrity, such a process would be vulnerable to politics. Recommendations can easily evolve into guidelines and guidelines can evolve into regulations. Consider the unpleasant experience of Medicare, where technology assessments and coverage decisions are often the subject of intense lobbying by provider groups, medical specialist and practitioner organizations, and even by members of Congress. It is best if practice and quality determinations are left to medical societies or independent organizations such as the Institute of Medicine.

The Commissioners estimate that the cost of administering health care in Vermont is on the order of $400 million per year, and expected to grow by about 8 percent per year (p. 22). A large fraction of those costs are certainly the result of compliance with detailed and sometimes contradictory federal and state government regulations.

One of the indisputable findings from recent Congressional inquiries into Medicare regulation is that doctors, hospitals and other providers bear very significant costs in complying with Medicare rules, regulations and guidelines. These costs are almost never counted as part of the true administrative costs of the Medicare program, which has been calculated at between 1 and 2 percent of expenditures. But these costs are very real. For example, a recent study by PriceWaterhouseCoopers for the American Hospital Association found that for every hour of care delivered to a Medicare patient, hospital officials spent about one-half hour complying with Medicare paperwork.

Reducing third party payment transactions would significantly reduce administrative costs in the private sector. The best way to do that, of course, would be through some form of Medical Savings Account option, where individuals and families would pay physicians directly for routine medical expenses up to the point where high-deductible insurance coverage begins. One of the glaring absurdities of the current arrangements is that the tax code exclusively favors payment of medical services through insurance, and thus disfavors direct payment for those services outside of insurance.

The expansion of patient choice and market competition requires getting people off of Medicaid and VHAP programs and into private sector health insurance. This can be accomplished by refundable tax credits or premium subsidies. This year HHS is pursuing ways to use public monies to subsidize private health insurance, rather than simply expand public programs.

The Commission’s “Incentive Plan for Medicaid” (p.20-21) is an excellent step in that direction, and the five year demonstration program holds promise for giving persons more independence and superior access to quality care. Such a program should be particularly attractive to physicians, who are increasingly unenthusiastic about participating in the Medicaid program.
Review and Critique:

John McClaughry

John McClaughry is President of the Ethan Allen Institute and a former member of the Vermont House and Senate. This critique first appeared as a Vermont media commentary on November 27, 2001.

Former California Governor Jerry Brown once observed that in matters political “you paddle on one side, then you paddle on the other side, and your canoe ends up going down the middle.” That’s an apt metaphor for the draft report of Governor Dean’s Commission on Health Care Availability and Affordability, chaired by former AHS Secretary Con Hogan. The finalized version is expected to go to the Governor and legislature in mid-December.

The introduction to the report reads like the introduction to a Bernie Sanders-Cheryl Rivers socialized medicine tract. “We do not have a health care system in Vermont. No one is in control. No one is responsible for ensuring that high quality medical care is adequate for the needs of the public. No one ensures that medical charges are appropriate or that they are paid in full... There is no global budgeting” or “public accountability” for health care institutions.

At this point the logical reader would naturally expect the conclusion: “Therefore, we (the government) must take control. Vermont needs a Health Care Czar who will make sure everybody gets all the high quality care the government thinks they need, all charges are appropriate, all budgeting is under government control, and everything not required is prohibited.”

Instead, the report makes a U-turn. It proceeds to deny that putting the government in charge of everybody’s health care is a good idea. The commission (not including Rivers, who will file a dissent on this point) rejects single-payer government-monopoly health care because it doesn’t believe government could manage it or pay for it, and that in any case there is no consensus for such an idea. The report also declines to support price controls on pharmaceuticals, about which Rivers will also doubtless have a lot to say, since she now has a very nice taxpayer-funded job peddling that nostrum around the Northeast.

Having completed this rhetorical about-face, the report makes a number of important and useful observations and recommendations. Among these are:

“The primary responsibility for maintaining wellness and paying for health care rests with the informed individual and family, not with the government.”

“Competition in health care and [insurance] coverage... tends to control costs, foster efficiency and maintain affordability”, and should be maximized.

“Community rating [of insurance premiums] has the effect of lowering costs for older people and those with medical conditions while raising them for younger healthier people. It does not provide incentives to avoid freely chosen risky behaviors.” Young people often drop coverage rather than pay the high costs of subsidizing the premiums of their richer parents’ generation.
“There is a disconnect between the consumer receiving health care and the entity paying the bill...Third party payment tends to shield consumers and provider from understanding the cost consequences of their behavior and of the health and medical choices they make.”

Individual health insurance premiums are only partially tax deductible, and are thus penalized compared to fully-deductible employer premiums.

There are “enormous inefficiencies in the administration of health care” within the health care industry. Solving this problem deserves a full-fledged study.

Vermont’s abysmally low Medicaid provider reimbursement levels should be increased to merely low Federal Medicare reimbursement levels. (From the hospital standpoint this is modest progress, but it’s still like being beaten up by the band instead of the football team.)

The report recommends an experimental “Incentive Plan for Medicaid”. Under it, 7000 enrollees in VHAP (expanded Medicaid) would get a state-funded smart card for health care expenses. The enrollee could use half of the balance at the end of the year to pay for job training, college credit, and similar programs. This is in effect a Medical Savings Account, but without the essential high-deductible private insurance policy. In deference to its collectivist members who dislike the idea of personal responsibility, the commission has to call it something else.

Although the draft report criticizes the malign effects of community rating – not the least of which has been the near destruction of the individual and small group health insurance market in the state – the commission can’t bring itself to recommend getting rid of it.

It’s a pity that the Hogan commission is unable to produce a principled and consistent reform program. Given the composition of the group, it should not come as any great surprise. The commission has gained ground by endorsing some important principles and rejecting some disastrous ones, but a sound and persuasive health care reform program still lies in the future.

**Important Resources for Health Care Policy**


Health Care Reform: The Market-Based Approach

Vermont’s Health Care Philosophy in 2001

For twelve years Vermont’s state government has aggressively moved ever further into the state’s health care market. A review of the events of these twelve years produces six major policy principles that underlie this progressive government intervention. They can be fairly summarized as follows:

1. Health care is “delivered”. Patients are passive vessels into which competent professionals pour the elixir of “health care”. Since “there is no such thing as an informed consumer of health care” (Howard Dean MD, 1992), health care should be delivered through 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 make choices with only their own interest in mind, rather than the good of society as a whole.

2. The measure of social progress is the number of people whose health care expenses are covered by some form of “insurance”, whether it is true 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.

3. The ultimate goal of health policy should be “universal coverage”, a medical-financial system comprehensively managed, through regulations, price controls, budget controls, reimbursements, taxes, and rationing, by a government “Authority”. Only such a system can assure cost containment (that is, can ration care to match available revenues.)

4. Until such time as a “universal coverage” system can be put in place, the state should enroll more and more people, of higher and higher incomes, in taxpayer-paid Medicaid. Since the federal government pays 60 percent of Medicaid costs, every effort must be made to qualify proposed expansions with HCFA. State-managed health care programs like Medicaid are a bargain for state taxpayers. Since the state drastically underpays for hospital services, the remaining unpaid costs can be shifted to private health insurance premium payers. Many persons who then become uninsured because they can no longer afford the higher premiums can then be covered by expanding access to the government program which produced the cost shift. This process steadily puts more and more Vermonters into taxpayer-financed health care. This constitutes desirable progress toward a single payer system.

5. Blue Cross, Vermont’s only domestic health care insurer, has a special social mission. The Commissioner of Insurance must take all necessary steps to protect the financial stability and soundness of Blue Cross. This necessarily requires that the commissioner become deeply involved in its management decisions. An important part of the Blue Cross mission is to offer health care coverage to all customers at the same “community rated” price, regardless of the costs incurred by different kinds of customers. Thus the healthy and the sick, the old and the young, the rural and the urban, the male and the female, must all pay the same premium for the same coverage. This policy disallows any consumer discount for healthy behavior, because such a policy would create a financial advantage to people who take better care of their health, and reduce the premiums paid by them to cover the costs of other people who do not take care of their health.

6. Since by community rating Blue Cross can’t compete with private carriers who charge customer groups on the basis of their expected claims — the practice long observed in life,
auto, workers compensation, and property and casualty insurance – the law must prohibit all carriers from using actuarial or experienced-based distinctions. This is the only way that Blue Cross can survive with its social mission intact. If competing insurers withdraw from the state rather than conform to this law, so much the better. Their political opposition to the expansion of government health care will thereby disappear, smoothing the path toward a single payer health care system.

What These Policies Have Produced

As a result of these policies, the political leadership of Vermont state government has brought about

- a massive exodus of commercial health insurers, and the collapse of a competitive health insurance market.

- an unfair burden on healthy young families, who are forced to subsidize the health care costs of sicker older people even though the older people are in their peak earning years and have long since paid off their education loans and home mortgages.

- an unfair burden on people who practice a healthy lifestyle, who are forced to subsidize others who smoke, drink to excess, use drugs, are obese, and underexercise with little regard to their health.

- the steady conversion of privately insured Vermonters into uninsured Vermonters, and then into government-insured Vermonters.

- the effective elimination of one of the most promising health insurance reforms of the 1990s, the Medical Savings Account, from the Vermont market.

- the recurring – and sometimes extralegal – regulatory rescue of Blue Cross, which has become a virtual ward of the state.

- the costly overutilization of health care by government-certified patients who have come to regard it as “free”.

- serious and chronic state underpayment of hospitals and nursing homes for ever-increasing Medicaid services, which forces them to shift costs onto privately insured patients, thus driving up premiums and causing more Vermonters to drop their increasingly unaffordable coverage.

- serious and chronic state underpayment of doctors and dentists for ever-increasing Medicaid services, which forces them to limit the number of Medicaid patients they will treat, or to refuse to treat Medicaid patients at all.

- binding state control of hospital budgets, making hospital management and capital investment subject to political approval.

- an increasing cost burden both on businesses competing in interstate commerce, and on small businesses serving a local market, leading to reduced job growth and reduced employee insurance coverage.

All of this has been accomplished under constant pressure from political leaders for the expansion of government health care, with the goal of creating a state single payer health system that is managed by political appointees, provides virtually free health care for all Ver-
monters who are below Medicare age and do not work for large employers, does away with private health insurance, puts the state in control of all health care providers, requires them to ration care to meet politically-determined budgets, and sends the bills for everyone’s health care to the taxpayers.

The past twelve years have seen some success in expanding health care programs to serve more Vermonters, instead of meeting their needs through traditional charity care. But the result of this “success” has been the progressive destruction of a competitive health insurance market, an increasingly serious shifting of costs to health care providers and their private pay customers, and the rapid escalation of health insurance costs for employers and employees alike.

True Health Care Reform

Two of the key features of true health care reform are equalizing the tax treatment of medical expenses and minimizing third-party payment for insurance claims. Both of these needed reforms, however, will require national action. There are nonetheless a number of steps that can be taken by the Vermont legislature to effect a market-based health care system.

A sound reform of health care in Vermont, including a badly-needed revival of a competitive health insurance market, should be based on these principles and policies.

1. The primary responsibility for maintaining wellness and paying for health care rests with the informed individual and family, not with the government. Over a lifetime – and especially up to Medicare eligibility age – individual choices are directly related to the great majority of health problems. The opinions of some doctors and program managers notwithstanding, 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.

2. Wellness can be significantly increased and demand for expensive health care can be significantly reduced if individuals are educated as to the personal health consequences of their choices, especially those relating to smoking, drinking, drug use, exercise, nutrition, and sexual activity. The explosion of health care information through periodicals and internet sources has led to a corresponding increase in patient awareness of health care considerations, self-medication, and lifestyle modification. Every public and private program, including especially high schools, should offer a strong health consumer education component, and reward individuals and families who make healthy choices.

3. Health insurance exists to protect individuals from unexpected occurrences. It was never intended to pay for expected and predictable wear and tear. First dollar or low deductible coverage leads directly to costly overutilization of health resources; the patient believes he or she is getting “free” care and thus consumes more of it, even though it yields little or no improvement of health outcomes. Such coverage should be strongly discouraged, even to the point of imposing a surtax on the premiums of first dollar policies.

4. Individuals and families should be encouraged to create tax-favored medical savings accounts. MSAs are coupled with a relatively inexpensive high deductible major medical insurance policy. Funds deposited in an MSA can be used to pay for such routine expenses as physical examinations, immunizations, vision care, prescription drugs, nutritional supplements, and all medical costs until the 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 25 percent discount for patients who pay for treatment at the time of service, a practice that an MSA makes easy. (Tax-deductible MSAs are available under Federal tax law for the self-employed and employees in firms with no more than 50 employees. The deduction carries through to state tax law because of Vermont’s piggyback income tax feature. Unfortunately the restrictions enacted by Congress in 1996 have discouraged their use. None of Vermont’s few remaining insurers actively markets MSA plans.)

5. The legislature should repeal community rating. Insurance carriers ought to be allowed to distribute the cost of insurance fairly among recognized actuarial categories such as age, gender, geography, and occupations. This traditional method of pricing coverage justly assigns costs in proportion to expenses incurred. Community rating has the regrettable effect of overcharging younger, healthier, but poorer families in order to subsidize older, sicker but wealthier (and thus more politically influential) families. Government mandates which have the effect of making the poor subsidize the rich are inherently unacceptable. Such mandates should be doubly unacceptable when their hidden purpose is to create a virtual monopoly for one struggling but politically influential health insurance company. The law should be changed to allow Blue Cross to use age and experience rating as well, while retaining its exemption from the premium tax through some transition period to subsidize its existing high cost books of insurance.

6. Insurance carriers should also be allowed to offer healthy lifestyle discounts. Auto insurance carriers offer discounts for safe driving records, the absence of traffic violations, security devices, and airbags. Property insurers offer discounts for fire protection. Most commercial health insurers offer discounts or “preferred” policies for non-smokers, etc. but such discounts are currently illegal in Vermont.

7. Government mandates that force insurance customers to buy coverage they do not want and will never use should be rolled back. These include pregnancy benefits, excessive drug and alcohol abuse coverage, and mental health parity. Lower income families ought to be able to buy a minimum-benefit policy that does not require them to subsidize the health care costs of others who choose to practice unhealthy lifestyles, or pay the costs of normal pregnancy and childbirth. By thus reducing the cost of basic coverage, thousands of Vermonters who have been incorporated into Medicaid will once again be able to pay their own way.

8. The state should resolve to pay the true cost of services provided to Medicaid patients by hospitals, nursing homes, and medical professionals. There is always some room for debate over what such “true cost” is, but the present practice of paying less than half of the going rate for Medicaid patients requires other patients to absorb a hidden tax on their own premiums to make up for what the government declined to tax openly. Unless the state resolves to pay its fair share for the care of “government patients”, providers will simply decline to provide treatment. In the case of hospitals, it is not possible to turn away patients; thus they – and probably many doctors as well – will eventually be forced to serve state-designated patients at state-specified prices. Bargaining over these price schedules will in time make Vermont’s medical profession into the equivalent of a trade union, with predictably consequences for professionalism.

9. Medicaid for acute care patients (other than the elderly or institutionalized) ought to be converted into an MSA-style program, with the state providing sliding scale subsidies for indi-
individual accounts. The MSA offers real incentives for involving customers in maintaining their own wellness, because they will not only live healthier lives but will benefit financially. It would almost certainly be less expensive for the state to fund MSAs and buy corresponding catastrophic coverage for such Medicaid-eligible Vermonters, rather than continually expand managed care or first dollar fee for service coverage. Since the taxpayers would fund these MSAs, there would presumably have to be some limitations on the use of the account balances. Allowed uses might include the purchase of long term care insurance, continuing education and job training, or other investments in family earning power, wellness, and independence.

10. The state should explore a program for the recapture of unpaid medical bills of persons who choose to spend their resources on things other than adequate health insurance. Such a program would be similar to an ordinary credit card account. The amount left unpaid by the patient would be debited to his account, and added back, over a period of years, to his reportable Vermont income. The amount added each year would be related to the patient’s expected income level as indicated by previous returns. The proceeds after administrative costs of the additional income tax would be shared with the providers. Such a program could not realistically be expected to recover a large fraction of unpaid bills, but it would forcefully emphasize the individual's responsibility for paying for care received. In so doing it would have a positive influence on patient behavior. The tax-based recovery could of course be avoided if the non-payer relocated outside of Vermont.

11. The legislature should create a high-risk pool to cover the health care costs of the medically uninsurable – persons with known, costly health care problems who have been denied coverage by an insurer. Over 100,000 people in 28 states now participate in such pools, commonly called Health Insurance Plans (HIPs), which date back to 1978. A typical HIP requires insureds to pay 150 percent of the average premium for a comparable coverage, with premium subsidies available for low-income insureds. It offers them a choice of competing insurance plans, including MSA plans and HMOs. Its costs are funded by assessing the premium receipts of all health insurers, a practice now supported by the companies themselves. Typically the fraction of the population covered by a HIP is around one percent. An added advantage of the HIP pool is that it makes it unnecessary to mandate guaranteed issue on insurers. However, the HIP must be viewed explicitly as a means of covering only the medically uninsurable, not as a vehicle for expansion of government-financed health care.

12. The legislature should examine and tighten tort liability standards governing medical malpractice to reduce the exposure of health professionals, hospitals, nursing homes, and HMOs to predatory tort suits. Provisions for arbitration of malpractice claims were included in Act 160 (1992) but were never put into practice because the universal access plan contemplated by that act was never adopted. The growing enthusiasm among trial lawyers for suing HMOs – and through them, the employer contracting with the HMO – makes this step one of top urgency.

13. The state should actively promote the purchase of long term care insurance. Act 160 of 1996 requires the state to “propose and implement methods that permit strategies to provide alternative financing of long term care services by shifting the balance of the financial responsibility for payment for long term care services from public to private sources by promoting public-private partnerships and personal responsibility for long term care.” In November 1997 the Department of Aging and Disabilities announced that it would implement a public education initiative to enhance the public’s understanding of the need, cost and options for financing long term care. Unfortunately no such initiative has been launched.
14. Vermont’s nine independent community-based free clinics merit continued state support. These clinics offer primary and preventive health care, wellness counseling, pharmaceutical assistance, and referrals to free or discounted specialist services for needy, uninsured Vermonters. They make use of the volunteer services of health care professionals, including complimentary treatment practitioners, students and community residents. Patients pay “what you can, when you can”. In 1999 the free clinics and the Burlington Health Center shared $500,000 from the state’s tobacco settlement fund, and received grants from foundations, federal programs, and community contributions. The grassroots free clinics serve a population that is often transient, between jobs, or otherwise hard to enroll in Medicaid, and do it as a genuine community service. A portion of the tobacco settlement fund should be set aside every year to assist the free clinics and encourage new clinics to organize in underserved parts of the state. AHS should refrain, however, from incorporating the free clinics into a bureaucratic system.

15. The legislature should, as essential housekeeping, revisit Act 160 of 1992 and systematically repeal all the provisions that failed, were ignored or abandoned, produced grievous consequences, or appear to commit the state to moving toward a government-controlled health care monopoly. Typical of the provisions meriting repeal is the statement of policy: “Comprehensive health planning through the application of a statewide health resource management plan linked to a unified health care budget for Vermont is essential.”

The only realistic alternative to such a market-based system is a totally government controlled system, which is the logical outcome of today’s health care policy. Under such a system government is the single payer for all non-elective health services; private health insurance is illegal; patients receive only such care as the government agrees to pay for; hospitals and nursing homes operate on mandatory government-fixed budgets; medical professionals work for the government; doctors, dentists, nurses, and technicians are unionized to protect their interests against a monopoly employer; and the bill for all covered health expenses is sent directly to the taxpayer. Why any reasonable person would favor such a system, variations in which are currently collapsing in Great Britain, Canada, and Russia, is hard to imagine.

Effecting a thorough-going market-oriented reform will require a major rethinking of public policy toward health care, and considerable political courage on the part of elected officials. Both are long overdue.

The Ethan Allen Institute is Vermont’s free-market public policy research and education organization. These proposals are based on the Institute’s report Reviving Health Insurance in Vermont (2000).

Commentary on Health Care Policy in Vermont

Greg Scandlen’s Health Policy Comments


There has been a lot of talk recently about “the perfect storm” of health care problems — the combination of rising costs, rising unemployment, poor sales, and lowered tax revenue that will likely result in more uninsured, more uncompensated care, more cost shifting, and yet higher premiums for those who continue their coverage.

These are all problems, but we tend to use the term “crisis” too easily. Health care has been in “crisis” for as long as I can remember and probably a lot longer than that. Already the economy is rebounding and the current round of premium hikes probably has as much to do with the underwriting cycle as anything else. That means rate increases will moderate, employers will start hiring again, and tax revenues will recover.

More importantly, there is today also a “perfect storm” of solutions. Winston Churchill once said that America can be counted on to do the right thing — after trying everything else. Now we have tried everything else under the sun, and we are approaching, for the first time in my lifetime, a convergence of good ideas that will transform American health care.

Consider some of the trends:

- Employers are wising up to the idea that relying exclusively on third-party payment for all our health care needs doesn’t work. Large numbers are installing some form of cash account to enable employees to make their own value judgments on what is worth spending resources on. These employers are being aided by some of the most innovative thinkers in health care — companies like Lumenos, Destiny, MyHealthBank, Definity, Vivius and others. And now, the old line giants are joining the parade — Aetna, Humana, United Healthcare, even Cigna. This is a powerful movement.

- Employers are also catching on to the idea of making a defined contribution and then allowing their workers to use that money to design their own benefits program. This approach is being made available by companies like WellPoint, Highmark, and UniCare.

- The “use-it-or-lose-it” aspect of Flexible Spending Accounts (FSAs) is finally getting some attention, both from the Bush Administration and business organizations like the Washington Business Group on Health. WBGH has made allowing roll-overs one of its top priorities this year. And about time — could anyone dream up a more anti-consumer, pro-inflationary provision than use-it-or-lose-it?

- Expanding and simplifying Medical Savings Accounts (MSAs) has passed both houses of Congress at some point in the last couple of years. There is widespread support for the idea, but they need to have their feet held to the fire to get the job done.

Refundable tax credits is growing as an issue, with Ways and Means chairman Bill Thomas (R-CA) serving as the champion in the House and support from the White House. Some liberals are skeptical because they don’t like the idea of empowering individuals to buy their own coverage, and some conservatives worry about creating a new entitlement program, especially for people who pay no income taxes. Conservatives have to remember that even people who pay no income tax are still paying nearly 15 percent of their incomes in payroll taxes. A worker with only $10,000 in income has paid $1,500 in payroll taxes (FICA and Medicare). There is no reason a credit can’t be used to offset those taxes as well as income taxes, especially if it gets them off the roles of the uninsured who use publicly financed health care services.

Despite the dot-com bust, the Internet is growing as a source of reliable information on the cost and quality of health care services. As people gain more control of their resources, they will need more information to help them spend those resources wisely, and the market is rising to the challenge.

Finally, the need to roll-back the plethora of costly and nit-picky regulations is becoming more evident. The “administrative simplification” aspect of HIPAA have been delayed for one year on a request basis, but this is only the beginning of a needed campaign to reduce regulatory interference in the health care marketplace.

Taken together, all these trends represent a new wave of pro-market activities, which could all be considered “patient power”. Ten years ago when Dr. Goodman’s book was first published, most of the thinking in Washington and among corporate benefits managers was focused on managed care. The widespread belief was that only sharp-penciled insurance experts could match up consumers and providers in a cost-effective manner. The one crack in that paternalism was the idea of MSAs as laid out in Patient Power.

The MSA demonstration project enacted by Congress in 1996 has not been successful in the market place, largely due to excessive restrictions and complexity. But the concept of people controlling their own resources has slowly seeped into the consciousness until it is heralded today as an obvious truth.

Now, for the first time in memory there is a coherent free-market strategy coming into shape that will affect all Americans – the uninsured, employers and employees, people who buy their own coverage, as well as people currently in public programs.

It is a strategy that will enable consumers of health care services to make their own judgments about quality and cost, to pay more for the most highly valued physicians and services, and less for those less highly valued. It will put insurance coverage back in its place of providing financial protection against unexpected events and allow people to pay directly for routine care.

This is a dramatic transformation, and 2002 will be a pivotal year for it.
Facing Up to Vermont’s Health Financing Problem

Over the past nine years the Governor and legislature alike have bought into the idea that the Holy Grail of health care is a low number of uninsured. Drive that number down – success! See it rise – failure! And so every policy step focuses on driving down the uninsured rate without paying a lot of attention to what is actually happening in the insurance marketplace.

What has happened over the years 1994 to 1998 is this: Vermont’s insurance “reforms” produced a drop of 30 percent in private individual insurance coverage and 24 percent in small group coverage, and nearly destroyed a competitive insurance market in the state.

Individual and small group plans are those used by the self-employed and small businesses with fewer than 50 employees. Because of Gov. Dean’s 1992 “reforms”, a series of new state coverage mandates, and the departure of most of the companies selling such policies, many of the people formerly covered found that health insurance had become unaffordable. Many of them found their way, as intended, into Medicaid, which increased by 26 percent over the same period.

This program, called VHAP, has been expanded to the point that the children in a family of four earning over $50,000 can get “free” health care from the state, and Gov. Dean has petitioned the Federal government to allow VHAP to cover the parents of those children as well.

This transfer of uninsureds to Medicaid means that the Medicaid budget must rise. Last spring the Joint Fiscal Office projected that VHAP will be $42 million in the hole by 2006, even with no new eligibles.

If more and more people are showing up at hospitals and doctor’s offices on the government’s nickel, and the leaders of the government are unwilling to ask for tax increases to pay the bills, what happens? Gov. Dean has vigorously ruled out any tightening of eligibility. The remaining option is to further underpay the providers. The hospitals can’t turn patients away, the state won’t pay their full costs (in some cases, not even half of the costs), so the hospitals have to raise rates for everybody else. This has been the strategy of choice.

Given these facts, it is startling to hear Gov. Dean blame higher Medicaid costs on higher patient utilization. After all, who has been taking credit for sending more people to more providers on the taxpayer’s nickel all these years? Why wouldn’t there be higher utilization, when more and more people are offered services for free?

The Governor’s most recent solution is for hospitals to get tough with people who show up asking for these services! In other words, the government gives itself credit for sending thousands more people to use health care services; the patients pay almost nothing; the government drastically underpays the providers, forcing them to shift the costs to private customers, causing more people to abandon their now-unaffordable insurance; and now the Governor insists that hospitals ration services to bail Medicaid out of a coming fiscal crisis.

There is a lot more to this story, but the outline should be clear. Since 1991 government policies have deliberately destroyed a once-competitive insurance market, shifted thousands of Vermonters from private coverage to taxpayer paid coverage, and sent taxpayers ever increasing bills. The solution is not lecturing hospitals on the need for them to ration health services. The solution lies in backing the government out of the mess it has made, and adopting a new health care policy based on personal responsibility, tax equity, reduced mandates, a high-risk pool, and honest payment for what the state forces providers to deliver.