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# *Health Issues*

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## **RETHINKING THE UNINSURED**

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### **OVERVIEW**

**N**ew numbers from the Census Bureau have renewed concerns about the uninsured. The latest count has grown to 45 million in 2003 from 43.6 million in 2002.<sup>1</sup> This, despite enormous attention on the issue from all levels of government, the private sector, and academia.

Sometimes when a problem seems intractable, it helps to reframe the question. What to do about the uninsured is such a problem.

The purpose of health insurance is to finance health care services. The goal cannot be merely to put an insurance card in everybody's wallet but to secure needed health care services.

Insurance may not always be (and often is not) the best way to pay for these services. And having insurance is no guarantee of access to needed care.

Further, no insurance plan will ever be able to finance every imaginable health care service, beneficial or not. The most generous insurance program on earth will still leave many services uncovered. Health insurance has an important role to play, of course, but it is only one element of a panoply of ways to finance health care.

Rather than obsessing over the absence or presence of insurance, it is more useful to think about the appropriate role of insurance in relation to all of the other methods of delivering health care services.

## COUNTING THE UNINSURED

The United States has been wrestling with the issue of maximizing insurance coverage for decades, and no clear solutions are on the horizon. Policymakers can't even agree on the dimensions of the problem. The Congressional Budget Office<sup>2</sup> has looked at various attempts to count the uninsured and found none of them satisfactory. Director Douglas Holtz-Eakin testified before Congress that there are three usual methods of counting the uninsured: "One describes those people who do not have coverage for a sustained period (say, one year) – the long term uninsured. Alternatively, another identifies how many individuals have experienced any spell without insurance during a particular period. Finally, the most commonly used measure (a mixture of those two others) counts the number of individuals without insurance on any particular day or in a certain week." Using these different methods, the CBO found in 1999 that between 21 million and 31 million were uninsured all year, 40 million were uninsured at any particular time of the year, and 60 million were uninsured at some time during the year.

Families USA went even further and concluded that 74.7 million Americans were uninsured at some point during the two-year period of 2001-2002.<sup>3</sup> This study broke down the duration of non-insurance and found that nearly 35% were uninsured for less than 9 months but that 24% were uninsured for two years or more.

Breaking out the uninsured into constituent groups, the Blue Cross Blue Shield Association<sup>4</sup> found:

- More than 14 million uninsured are already eligible for public programs such as Medicaid and SCHIP

- More than 15 million have incomes exceeding \$50,000 and likely could afford private coverage if they found value in it
- Approximately 5.7 million are "short-term uninsured," possibly between jobs or recent college graduates.

The study further finds that the fastest growing segment of the uninsured has family incomes of \$75,000 or more and that many of the uninsured who are already eligible for public coverage are concentrated in just three states, California, Texas and New York (5.2 million of the 14.1 million eligible). These data suggest that the problem of "the uninsured" is not a single issue but includes a number of different facets involving different populations.

## INSURED – BUT FOR WHAT?

Not only is it hard to count the number of people who do not have health insurance, but it is not at all clear that even those who have health insurance are always able to access the care they need. People on Medicaid are insured, for example, but often can't find a doctor who will see them. Many people (14 million, according to the Blue Cross Blue Shield study cited above) are not actually enrolled in Medicaid but are already eligible. They would be instantly enrolled if they entered a hospital needing major services, and Medicaid would pay for those costs.

People on Medicare are considered insured but still have to pay nearly half of their health care costs on average out of their own pockets.<sup>5</sup> This amounts to 21.7% of their income on average, according to Karen Davis, president of the Commonwealth Fund. Ms. Davis testified

before Congress that “the average elderly Medicare beneficiary spent \$3,142 on their own health care expenses” in 2000 and projected that figure to rise to \$5,248, or 29.9% of income, by 2025.<sup>6</sup>

Even the privately insured often have trouble paying their medical bills, especially people with chronic conditions, according to the Center for Studying Health System Change.<sup>7</sup>

The uninsured also consume care, \$98.9 billion worth in 2001, according to Jack Hadley and John Holahan writing in *Health Affairs*.<sup>8</sup> Importantly, only one-third of this number (\$34.5 billion) is in the form of uncompensated care; the rest is paid directly out-of-pocket (\$26.4 billion), by private insurance programs (\$24.2 billion), or by public insurance programs (\$13.8 billion). Presumably these uninsured are covered for part of the year, or the insurance “tail” is still running, i.e., they continue to receive benefits for conditions incurred while they were insured. The amount of uncompensated care amounts to 2.8% of the total personal health spending in the United States of \$1,235 billion spent in 2001, according to the article – a trivial portion of overall spending by any standard. The fact that \$38 billion of the care spent on the uninsured comes from public or private insurance sources again calls into question the whole premise of what it means to be uninsured.

The biggest concentration of non-insurance is among young people, especially men in their twenties.<sup>9</sup> For instance in 1998, the rate of non-insurance for males age 21 – 24 was 38.9%. But even these young men usually are insured for the things most likely to happen to them – workplace injuries and automobile accidents. It could probably be argued that these young people are as well insured as people on Medicare, as measured by the percentage of income spent out-of-pocket on health care.

So, this dichotomy that supposes one group of Americans who are insured and another group that isn’t doesn’t seem to work very well. Our society is far more complex and fluid than that. People acquire and lose health insurance coverage all the time. Since most Americans get their coverage through their employers, they are virtually guaranteed to lose their current coverage when they lose or change jobs.<sup>10</sup> Even people who buy their own coverage in the individual market may have to give up their insurance if they move from one state to another, since insurance is state-regulated and a policy approved in one state may be illegal in another.

## REFORMULATING THE ISSUE

**W**e need to reformulate the issue. Instead of thinking about insured versus uninsured *people*, policy makers should be thinking about insured versus uninsured *services*. After all, the whole point of having health insurance is to pay for medical services. The goal is to get the services people need, not just to have insurance for the sake of having insurance.

We all are at least partially uninsured, since insurance can never possibly pay for everything that might be considered health care. The universe of goods and services that is health care grows every year. No insurance program, government or private, can pay for it all. John Goodman, president of the National Center for Policy Analysis, argues, “Advances in medical science have reached a point where we can probably spend the entire GNP on health care – in useful ways!”<sup>11</sup> But as important as health care may be, there are other goods and services that are even more important to most people.

So the more important questions are not *who* should be insured, but *what* should be insured, and what should be paid directly by health care

consumers – and who decides.

## WHO DECIDES WHAT TO COVER?

Some people argue that everyone should have “basic” benefits, others say everyone should have “comprehensive” coverage, and still others maintain everyone should have “catastrophic” insurance. Rarely does anyone clearly define what is meant by these terms.

Attempting to define these terms would open up a hornet’s nest of conflicts. Should family counseling be universally covered? What about sex change operations? How many attempts at in vitro fertilization are appropriate? As Leonard Schaeffer, CEO of Wellpoint, said at a recent conference at the American Enterprise Institute,<sup>12</sup> one of the most vexing issues he encountered as an insurance executive was defining what a month’s supply of Viagra should be.

Those who would support a national health insurance program for all Americans need to consider the debates that House Majority Leader Tom DeLay (R-TX) and Minority Leader Nancy Pelosi (D-CA) would have over these issues. Would anything ever get done? Yet in a single-payer system, it is precisely Representatives Pelosi and DeLay and their colleagues who would decide what to cover. Because their decisions would determine the coverage of 300 million Americans, their decisions would be a matter of financial life-or-death for millions of health care providers. Chiropractors, physical therapists, nutritionists, dieticians, pastoral counselors, psychiatric social workers, and many others would make it an absolute imperative to persuade Congress of the merits of their particular service. Money that could otherwise go toward meeting health care needs would pour into Washington to lobby for coverage.

Consider also the decade-long debate over adding prescription drug benefits to Medicare. A bill was finally enacted but continues to be controversial, with many inside and out of Congress demanding repeal even before most of it has taken effect.

Having Members of Congress define what should be universally included in a health insurance policy may not be a good idea, but having Leonard Schaeffer define it for all Americans at all times isn’t a very good idea either. Mr. Schaeffer is undoubtedly a wise and well-experienced health care executive, but he should not be put in the position of deciding what benefits each American would value.

For that matter, having the owners of print shops and auto dealerships defining benefits for their employees leaves a lot to be desired as well. Such business owners may know a lot about printing or selling cars but next to nothing about health care and even less about the health care needs and preferences of their workers.

An alternative approach would be to let American consumers define for themselves what services are appropriate to be insured. Let individual consumers understand the trade-offs and make the choices. Many people prefer to pay higher monthly premiums to get more services covered by insurance. Many others prefer to have less coverage for a lower premium. Neither choice is right or wrong. Both are made according to the needs, values, and resources of the individual family.

Routine physician office visits, for instance, are not very efficiently financed through an insurance mechanism. Filing a claim for a \$60 office visit imposes administrative costs on both the insurer and the physician, raising health care costs generally. Some people may prefer to pay

cash or use a Health Savings Account for these transactions, rather than passing the dollars through an insurance company. Others may prefer to pay the extra cost to have the service covered. Both are legitimate decisions, based on the values and resources of the individual. But the debate over the uninsured implies that it is inherently better to process that expense through an insurance plan, even though it might be more expensive to do so.

Similar arguments could be made over coverage for vision, dental, prescription drugs, allied health services, even hospital outpatient visits, diagnostic tests and routine childbirth. Being “uninsured” for these services is hardly a social problem if the consumer is able to acquire needed services through some other mechanism. It wasn’t very long ago that the cost of having a baby would be paid off with monthly payments over a period of time. Like buying a car, the new parents would make a deposit and leave the hospital with a baby and a coupon book.

## **ADVERSE SELECTION VERSUS MORAL HAZARD**

**S**ome people will argue that individual choice will lead to “adverse selection” because people will choose the benefits they prefer and shun the benefits they are less interested in. A consumer with back problems might load up on chiropractic benefits, while another person would have little interest in these services, so would opt for vision benefits instead.

But adverse selection already exists. According to EBRI, people aged 21 to 24 are more than twice as likely to be uninsured as are people aged 55 to 64 (34.4% versus 15%). Older people know they are more likely to need health care services and place a higher value on coverage. Younger people often don’t see

as much value in having coverage, especially for services they are unlikely to use. Allowing these younger people to choose the benefits they most value could encourage more of them to become insured.

Moral hazard is the flip side of adverse selection. Where the principle of selection says people are more likely to stock up on coverage they know they will use, moral hazard says that people who are covered will be more likely to consume a service than they would otherwise be. Someone who would not otherwise go to a psychiatric social worker may do so once the service is covered. Both are insurance-induced distortions, but policymakers should be at least as concerned about moral hazard as they are about adverse selection. Avoiding selection means imposing certain benefits on people who may not want them. But once they have the coverage they become more likely to use it, resulting in excessive consumption and costs.

Both principles suggest the value in minimizing the amount of services that are paid through an insurance mechanism. Insurance is important to cover services that would otherwise be unaffordable, but the presence of insurance coverage changes behavior and distorts normal market mechanisms.

## **INSURANCE VERSUS THIRD-PARTY PAYMENT**

**W**hen people discuss “the uninsured” they are not usually speaking of insurance at all, they are talking about third-party payment of health care services. Insurance is a contract between two persons. The contract says that one person will pay a premium so that the other person will pay a benefit when an unfortunate event occurs. This is how life insurance, homeowners insurance,

auto insurance and almost all other forms of insurance operate.

So-called “health insurance” has come to be a very different breed of animal. Most health insurance is based on a three-party arrangement in which a person pays a premium to an insurance company, which pays a physician or a hospital to provide a service to the consumer. It is a triangular relationship that causes great confusion and administrative costs, and results in little accountability between the three parties. It also results in excessive utilization as patients are insulated even from knowing the price of the services they consume. Once the premium has been paid, the services are all free or nearly so. There is no economic constraint whatsoever on consumption of services. The only constraint is imposed by the payer through some form of rationing, which is very expensive to enforce and very intrusive on the relationship between patient and provider.

Our near-exclusive reliance on third-party payment to finance health care services has resulted in our health care system being in a state of perpetual crisis as we lurch between panic about cost increases one year, poor quality the next, and inadequate access after that.

The only way to achieve an optimal balance between the competing demands of cost, quality and access is through consumer choice and decision-making about how to spend resources. Proposals to expand our current system of third-party payment will only compound a problem that has proven to be unsolvable in the past.

## **RISK POOLING VERSUS PRE-PAID HEALTH CARE**

**P**repayment of health care services (“prepaid health care”) is also fundamentally different than insurance

(“pooling risk”). It is a distinction that too often escapes policymakers and too often leads to misguided policies such as “community rating,” mandated benefits, and other forms of social welfare in the guise of insurance coverage. In discussing risk pools, policymakers tend to put the emphasis on “pool” and not on “risk.” In this view, a health insurance company is a big pool of unrestricted money from which people withdraw funds to pay for the services they need. This thinking leads to a “tragedy of the commons” phenomenon where people try to pull as much as possible out of the pool before it runs dry. It is small wonder that health care costs are out of control.

The emphasis in the expression “risk pooling” should be on “risk,” not on “pool.” The thing that is being pooled is risk. A risk is an uncertainty. If we voluntarily pool our uncertainties, some of us will incur a “loss” (the risk of bad outcomes will be realized), but most of us will not. The risk pool provides all its members with protection against a catastrophe, but we are happier if we never have to collect a benefit.

There is no big unallocated pool of money in this arrangement because every dollar held by the insurance company is already contractually obligated. Because insurance is a two-party contract, the premiums are paid to secure a specific benefit. The insurance company is required to hold enough money in reserve to pay all the benefits it is contractually obligated to pay. Because a risk is an uncertainty, the company does not know who will get the money or when it will be released, but it knows from experience that a certain number of customers will have losses, and it is obligated to pay the contracted amount when the loss occurs.

Prepaid health care is something else entirely. It is not “insurance” because there is no “risk” involved. We may know for example that we

are likely to consume \$6,000 in care over the next five years, so we pay 60 monthly premiums of \$100 because it is more convenient to spread out the cost in equal increments. There is an element of cost sharing involved because a few people may consume only \$4,000 while a few others consume \$8,000, but at its core the principle is the same – it is a way of financing known consumption.

In that sense, there is no particular advantage to “pre-paying” for health care services over “post-paying” for the same service. That is, as in our example of normal child birth expenses cited above, one can pay in advance \$100 a month for five years to get a benefit of \$6,000 when the baby is born, or one could have the baby, incur \$6,000 in expenses and pay it back at \$100/month for five years. Providers prefer pre-payment because it saves them the trouble of having to collect a debt, but there is no fundamental difference in the economics of the transaction.

Yet in counting the uninsured, someone with a pre-paid program is considered insured while someone with a post-payment program is not, even though in both cases the patient has to make 60 equal payments of \$100 to cover the \$6,000 expense.

## **PREMIUMS VERSUS BENEFITS**

All health care is ultimately paid for by consumers. Some of it is paid directly, but most is paid indirectly when consumers earn a benefit through their labor, pay a premium to an insurance company, or pay taxes that finance government programs. The source of the funds used by the government, an insurance company, or an employer is the individual American consumer.

Too often in policy discussions, the trade-off between benefits and premium is ignored, but it

will always be the case that the richer the benefit is, the higher the premium will be. It is sometimes argued that lower-income people don’t have the resources to pay high-deductibles or high coinsurance. But this ignores the fact that lower-income people may also not have the resources to pay higher premiums. Even if an employer is paying the premium, the money still comes from the employee’s total compensation. If only low-deductible, high premium policies are available to low-income workers, they may never become insured in the first place. And, of course, that is precisely what happens. There is a near-perfect correlation between family income and levels of coverage, especially for employer-based insurance.

How to subsidize those with low incomes is a separate discussion. We currently have tax-based subsidies available for low-income people in the form of Medicaid, SCHIP, and in some cases, refundable tax credits or vouchers. These subsidized insurance programs are subject to the same dynamics that apply to the rest of the insurance market. The presence of insurance coverage results in higher utilization, and the richer the benefits, the higher the premium or tax cost. There is no particular reason for the subsidy to be aimed at the initial “premium” rather than at the user level. A program for the low-income could as easily have higher deductibles and coinsurance, with financial assistance available to help with those out-of-pocket costs. If such an approach could lead to more efficient utilization of services, we owe it to the taxpayers to test these other models.

## **SOLUTIONS**

The United States already spends a lot of money on health care — \$1.6 trillion in 2002.<sup>13</sup> Critics rightly puzzle over the fact that even with all this money we still have so many people uninsured. But the fact is that the

way we finance health care in the United States is hugely inefficient and unresponsive to the needs of individual consumers. There are a number of steps we could take to secure wider and more appropriate coverage and create a health care system that is more responsive to consumer demands.

### Tax policy

The United States currently tilts tax policy heavily in favor of employer-provided coverage. Every penny without limit that an employer spends on health insurance is excluded from the employee's income and is tax deductible for the employer. That means the value of those benefits is free of all taxes to employers and employees — state and federal, income and payroll. The most recent estimate of the federal cost of this exclusion is \$189 billion in 2004.<sup>14</sup> If health care costs go up 10%, the cost to the government goes up \$18.9 billion — without a single debate in Congress, without a vote, without a word being uttered.

This subsidy is also extremely regressive, with higher-income families getting far more in tax support than lower income families do. According to Sheils and Haught, the average family making over \$100,000 gets a tax benefit of \$2,780, while a family making under \$10,000 gets a tax benefits of \$102. Partly this is because our progressive income tax system requires them to pay higher taxes in the first place, so an exclusion is more valuable to those with higher incomes. But it is also because they are likely to have richer benefits than lower-income workers do, so the amounts that are excluded from income are also larger.

A worker whose employer does not provide coverage gets no tax relief at all, except for a deduction for the amount of health insurance premium that exceeds 7.5% of income — provided he itemizes his tax return. Similarly, money spent directly on health care services

is all taxable unless it exceeds 7.5% of income. A self-employed person may take a simple tax deduction for the cost of premium but still must pay payroll taxes on the money.

The consequence of this policy has been to provide huge incentives for people to turn over decisions about their health coverage to their employers. They only get the generous tax savings if the employer writes the check for the policy. That means that someone else decides the benefits that virtually all employees will have. Even when there is a choice of benefit plans, it is the employer who selects the insurance companies and the benefits offered. If we like chiropractors but our boss doesn't, we don't get chiropractor coverage. If we want better mental health coverage but the employer thinks it's trivial, we don't get mental health.

If policy makers in the United States believe health care is worth subsidizing, they should subsidize the purchase of health insurance outside the workplace, as well as employer-sponsored coverage. The same subsidy could be applied to all forms of health care spending. The subsidy could be capped as a percentage of spending or limited to a fixed dollar amount to limit the impact on the Treasury. But the same subsidy should be available to all Americans regardless of how they finance their health care needs.

The benefits of such a change would be several:

- Workers wouldn't have to rely exclusively on their employers to gain coverage. If the employer didn't act, the worker would have other options to purchase insurance and still receive the tax benefit.
- Employers would be better able to offer employees a choice of health plans.
- The revenue loss to the government would be capped and predictable. It would not be an open-ended entitlement.

- Lower-income workers would not be disadvantaged by the current tax code and would get at least the same dollar amount of subsidy (and probably more) as their wealthier colleagues, making health care more affordable to them.
- Direct payment of services would not be discouraged, creating a more efficient financing system with lower administrative costs.
- Employers who preferred to put more compensation into wages rather than benefits would be free to do so, allowing them to better respond to changing labor market conditions.

### Insurance reform

Over the years state and local governments have piled on a bewildering array of laws and regulations that tend to weigh down on the insurance industry and make innovation difficult. On the federal side alone, we have ERISA, COBRA, HIPAA, the Pregnancy Discrimination Act, the HMO Act, and mandates relating to breast cancer treatment, mental health coverage, and maternity benefits. On the state side, we have 1,818<sup>15</sup> mandated benefits, plus rate restrictions, guaranteed access provisions, market conduct rules, solvency requirements, patient bills of rights, and so on. We also have separate sets of laws for Blue Cross Blue Shield plans, HMOs, commercial carriers, small group, large group, Medigap, and individual insurers.

This system needs to be simplified and coordinated, with an emphasis on solvency protection and full disclosure of the terms and conditions of the insurance policy. Then people could make their own decisions about what sort of policy and which insurance company will work best for their own families. A consumer who thought an insurance company was unresponsive could drop that company in favor of another. Consumers could look for the company that offered the benefits they most

preferred. Further, all forms of coverage could be regulated the same way – employer-sponsored or non-group, fully-insured or self-funded, Blue Cross or commercial.

Consumers should also be allowed to tap into a national market for health insurance coverage. If one state has only one or two insurance companies or a consumer doesn't like the mandates or regulatory structure in his own state, a consumer should be able to apply for coverage with an insurer located in a different state.

The benefits would be considerable:

- Lower compliance costs for insurance companies would translate into lower premiums for consumers.
- Insurance buyers could purchase the coverage that is more precisely tailored to their own needs.
- There could be a single set of laws and a single place to go to file a complaint or grievance.
- Portability between employers or between states could be assured, allowing better continuity of coverage and continuity of care.
- Insurance companies would respond to the demands of the ultimate decision-maker, in this case the individual buyer rather than the employer.

### Public Program Reform

Currently public programs such as Medicare, Medicaid, and SCHIP tend to be clumsy and resistant to innovation. Making changes to the programs involves largely political decisions and political opportunism. The costs of these programs are growing, and it is not at all clear that taxpayers will continue to support the costs.

Medicaid and SCHIP have special problems that Medicare is exempt from.

- Demand is greatest at precisely those times when state budgets are weak,

making it very difficult for the states to respond to changing economic conditions.

- Both programs are stigmatized as “welfare medicine,” resulting in many millions of eligible people refusing to enroll until they absolutely have to.
- There is a lack of continuity of coverage as people’s economic conditions change and they move on and off the programs.
- SCHIP is based on carving children out from the coverage their parents may have. This results in parents having to learn the benefits and procedures for two or more insurance programs, when learning only one is confusing enough.
- Medicaid is challenged by being the primary payer of LTC services at the same time it provides acute care coverage for the poor. It doesn’t seem to make sense to have both activities in the same program.

Rather than having state agencies acting as insurance companies for the poor, it would make sense to simply allow Medicaid and SCHIP funds to be used to buy private coverage for the eligible population. In many cases this may be the same coverage the recipient is getting at work or it may be an individual policy. In either case, the stigma of Medicaid enrollment would be eliminated and the potential for continuity greatly increased. Children could be enrolled in the same program their parents have, and SCHIP funds could be directed at helping parents pay their premium obligation for dependents.

#### Provider Deregulation

Finally, all these financing reforms will have only limited effect if the providers of health care services are unable to respond to changing conditions. What the United States needs now is a burst of innovation in the delivery of health care services. This is not the time to lock into

place a system that is inefficient and increasingly archaic. Just a few of the recommended actions would include:

- Eliminating Certificate of Need and other anti-competitive regulations that act as a drag on innovation.
- Removing criminal sanctions on physician behavior that in any other context would be considered mere civil torts.
- Reforming malpractice laws to eliminate the winner-takes-all lottery we currently have. Steps could include reasonable limits on non-economic damages, the elimination of joint and several liability, and establishment of the “English Rule” in which the loser of a lawsuit pays the court costs of the winner.
- Requiring price transparency for all hospital and physician services so that consumers can shop between providers. Each facility could publish the actual payment received for a service from different payers.
- Focusing evidence-based medicine and “best practices” information on improving the knowledge base of both physicians and patients, rather than on mandatory compliance or discipline of outliers.
- Emphasizing the customization of medicine rather than standardization. Each patient should be able to receive the treatment that is tailor-made to his or her own unique condition and needs.

This list is only the beginning of a needed transformation in health care delivery. Clearly we also need better use of information technology in health care management, greater emphasis on quality safeguards, better communication with patients on follow-up care and treatment compliance, better integration of the treatment of chronic diseases such as diabetes. But many of these changes will come

about as a result of empowered consumers demanding them and aren't likely to require changes in public policy.

## WHAT THE FUTURE HOLDS

**P**olicymakers should focus on the creation of a set of general rules and incentives that will make transformation possible, and then get out of the way as consumers demand specific changes.

Transformative change is, and should be, impossible to predict or control. Witness the growth of personal computers and then their application to the Internet. No one could have foreseen how this would develop even just fifteen years ago. Many ideas have already been attempted and abandoned in that short time. And many ideas in health care will be abandoned in favor of new iterations as we learn from experience. This process has already begun, but we are only at the very beginning and much more lies ahead.

Some of the early baby steps already in the works include:

- A significant movement by the states to roll-back some of the more onerous insurance regulations, such as community rating, guaranteed issue of individual insurance, and mandated benefits.
- The development of Health Reimbursement Arrangements (HRAs) by employers and the enactment of Health Savings Accounts (HSAs) by Congress.
- A growing movement by physicians to reject the rules and regulations of managed care plans and Medicare in favor of direct cash payment by patients.
- Increasing pressure on hospitals to disclose actual prices and to charge self-pay patients reasonable fees.

- Growing interest at all levels of the health care system in using information technology to increase efficiencies.

In the next year or two we should see enactment of additional steps such as:

- Refundable tax credits for people who purchase their own health insurance policies.
- Malpractice reform at the state level, or failing that, at the national level.
- Legislation that would enable a citizen of one state to purchase health insurance coverage from a company in another state.
- Opening the insurance market to allow associations of businesses or individuals to purchase coverage collectively.
- Elimination of some of the anti-competitive regulations such as Certificate of Need.
- Elimination of some of the leverage-based hospital discounts awarded to PPOs.
- Reform, at least on a pilot basis, of Medicaid and SCHIP to provide recipients with a choice of private coverage.
- Greater market penetration of HRAs and HSAs that will empower consumers to demand better service throughout the health care system.
- Far better consumer information and patient support services, both on the Internet and through personal care counselors.

Even these steps are just a beginning. Eventually, possibly in ten years, we will have a system in which consumers control their own resources and make their own decisions. The system will respond to the needs and demands of individual consumers. Innovation and superior quality will be rewarded and mediocrity will be punished – not by some

faceless bureaucracy, but by consumers who will vote with their dollars.

The dichotomy between the insured and the uninsured will disappear as we discover that we are all uninsured for some things and we are all insured for others. Even the low-income will have control over the public dollars we have made available to them. We will invest our insurance dollars in those services that provide the greatest value, and that cannot be financed any other way. And we will pay directly for everything else.

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*The views expressed in this paper are the opinions of the author and do not necessarily reflect the views of the Galen Institute or its directors.*

## ENDNOTES

<sup>1</sup> *News Conference: 2003 Income, Poverty and Health Insurance (CPS Report) and Data from the American Community Survey (ACS)*, U.S. Census Bureau, 2004. Washington, D.C. Available online at <http://www.census.gov/Press-Release/www/2004/2004IncomePov.html>.

<sup>2</sup> Testimony of Douglas Holtz-Eakin, Director of CBO, before the Subcommittee on Health of the Ways and Means Committee, March 9, 2004 (at <http://www.cbo.gov/showdoc.cfm?index=5152&sequence=0>) See also “How Many People Lack Health Insurance and for How Long?” Congressional Budget Office, May, 2003.

<sup>3</sup> “Going Without Health Insurance – Nearly One in Three,” Families USA, March, 2003.

<sup>4</sup> “The Uninsured in America,” Blue Cross Blue Shield Association, February, 2003.

<sup>5</sup> *Program Information on Medicare, Medicaid, SCHIP, and Other Programs of the Centers for Medicare and Medicaid Services*, Centers for Medicare and Medicaid Services, June, 2002.

Baltimore, Maryland. Available online at <http://www.cms.hhs.gov/charts/series/sec3-b1-9.pdf>.

<sup>6</sup> Karen Davis, “Medicare’s Cost Sharing: Implications for Beneficiaries,” testimony before the U.S. House Committee on Ways and Means, Health Subcommittee, May 9, 2001.

<sup>7</sup> Ha T. Tu. *Rising Health Costs, Medical Debt and Chronic Conditions*, Center for Studying Health System Change, September, 2004. Available online at <http://www.hschange.org/CONTENT/706/706.pdf>.

<sup>8</sup> Jack Hadley and John Holahan, “How Much Medical Care Do the Uninsured Use, and Who Pays for it?” *Health Affairs Web Exclusive*, February 12, 2003.

<sup>9</sup> Paul Fronstin, “Sources of Health Insurance and Characteristics of the Uninsured,” Employee Benefit Research Institute, January, 2000.

<sup>10</sup> If they work for an employer with more than 20 employees, they may exercise their continuation of coverage option under COBRA, but very few do since they would have to pay 102% of their employer’s premium at the very time they have lost their income.

<sup>11</sup> John C. Goodman, “To Your Health,” *The Wall Street Journal*, December 26, 2003.

<sup>12</sup> *How Leading Health Plans Are Reshaping Health Care*, American Enterprise Institute Event, April 6, 2004. Washington, DC. Available online at: [http://www.aei.org/events/eventID.770,filter./event\\_detail.asp](http://www.aei.org/events/eventID.770,filter./event_detail.asp).

<sup>13</sup> *National Health Expenditures Aggregate and per Capita Amounts, Percent Distribution, and Average Annual Percent Growth, by Source of Funds: Selected Calendar Years 1980-2002*, Centers for Medicare and Medicaid Services, September 17, 2004. Baltimore, Maryland. Available online at <http://www.cms.hhs.gov/statistics/nhe/historical/t1.asp>.

<sup>14</sup> John Sheils and Randall Haught, “The Cost of Tax-Exempt Benefits in 2004,” *Health Affairs Web Exclusive*, February 25, 2004. Available online at: <http://content.healthaffairs.org/cgi/content/full/hlthaff.w4.106v1/DC1>.

<sup>15</sup> Victoria Craig Bunce and JP Wieske. *Health Insurance Mandates in the States: 2004*, Council for Affordable Health Insurance, July, 2004. Available online at [http://www.hrpolicy.org/downloads/2004/CAHI\\_Mandates\\_2004.pdf](http://www.hrpolicy.org/downloads/2004/CAHI_Mandates_2004.pdf).