

Cato Institute Policy Analysis No. 197: Laboratory Failure: States Are no Model for Health Care Reform

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Executive Summary

While the media are focusing primarily on the debate in Washington, an intense battle over reforming health care is under way in America's state capitals.

Nearly every policy debated at the national level is also being debated in the state capitals or is being put in place. Many of the state plans are being hailed as models for national health care reform.

Unfortunately, reforms at the state level have generally relied on increasing government control rather than expanding market choices. A review of nine states' reforms reveals a host of negative consequences: insurance premiums increase; access to medical care is not improved; jobs are lost; spending on Medicaid goes up; insurance companies leave the market; and medical care is explicitly rationed.

Although many of the problems with our health care system can be addressed only at the federal level, there is much the states can do to lower the cost of and increase access to medical care. Specifically, states could take steps to deregulate the health care industry, including eliminating mandated benefits, repealing certificate-of-need requirements, and lifting restrictions on what nonphysician practitioners' are allowed to do.

The debate at the state level and the experience of programs already introduced provide important guidance by showing the failure of many of the concepts most eagerly debated at the national level. Congress should learn from the states' mistakes.

Introduction

Alexis de Tocqueville rightly called American state governments "the laboratories of democracy." Under our federalist system of government, the states are able to experiment with policies on a small scale before those policies are adopted by the whole nation. That has been done on issues ranging from welfare reform to environmental policies. The process is now under way with the crucial issue of health care reform.[1]

State governments have a tremendous stake in health care reform. Health costs are consuming an ever-greater portion of state resources. Medicaid, the federal-state health care plan for welfare recipients, is now the second largest budget item in many states, and it accounts for a nationwide average of over 14 percent of total state expenditures.[2] If current trends continue, state expenditures on Medicare will have increased more than 480 percent from 1990 to the year 2000.[3] Programs for care of the indigent, state employee health insurance, and other health care expenditures are also severely straining state budgets.

States also have an interest in health care reform because the insurance industry has traditionally been state regulated.[4] State politicians are not immune from the media and public demand to "do something" about the problems of access to and cost of health care.

Recently, Robert Reischauer, director of the Congressional Budget Office, said that not only is Congress unlikely to pass health care reform legislation this year, but such legislation is unlikely for many years to come. According to Reischauer:

Even if they push quite hard, it's going to be something that, given the pace at which Congress moves, takes a number of years. . . . The problem is if you decided managed competition in October-- a fantasy--it would probably take a year or two to write the regulations and implement decisions. It'll take another year or two to set up the health care purchasing co-operatives and figure out how they're going to run. You'll probably be out with your first bids in four years or so. But, in the meantime, you might have this other stuff (state experimentation) going along.[5]

State health care reform is indeed "going along." Almost every state legislature is considering some kind of health care reform legislation. Fifteen states enacted at least limited reforms in 1992, and the pace is accelerating this year.[6] Nearly every policy debated at the national level is also being debated in America's state capitals, or is actually being put in place. From "managed competition" to insurance regulation, from full-blown Canadian-style government-run systems to tax incentives, states are discussing, debating, and experimenting.

The expectations for the state plans are truly extraordinary. "Florida Cuts Cost, Expands Service," one headline flatly declared only two weeks after the Florida legislature passed its reform plan.[7] Of course, not a single person has yet been insured under the plan.

The hopes for the state plans are unlikely to be realized. Although state experiments provide a rich source of information, very few state-based reforms address the root causes of out-of-control health care costs and gaps in coverage. Fewer still embrace reforms that would control costs by changing the tax treatment of health care to allow Americans to become health care consumers able to shop around for the best deal.

Growing Interest in Managed Competition

Following in the footsteps of the Clinton administration, reformers in several states have evidenced a growing interest in the concept of managed competition. The National Governors Association has also embraced that approach to health care reform.[8]

Proposals for managed competition are generally being presented as a compromise that would preserve many free-market aspects of health care, while making the market more accountable to government control. The concept is generally considered the brainchild of the "Jackson Hole Group," an ad hoc coalition of health care executives and academic experts led by Dr. Paul Ellwood.[9]

As envisioned under the most common managed-competition proposals, there would be established a system of health insurance purchasing cooperatives (HIPCs) that would act as collective purchasing agents on behalf of employers and individuals.[10] All residents of a state would be enrolled in an HIPC, either through their employer or individually.[11] The HIPCs would negotiate benefits packages for their members with accountable health partnerships. HIPCs would operate much like German sickness funds.[12] The federal government would establish a uniform effective health benefits package as a minimum standard benefits requirement, replacing current state-mandated benefits. Accountable health partnerships would generally be required to community rate all members of an HIPC and to guarantee coverage to all HIPC members.[13]

However, as economic scholar Richard Epstein has noted, managed competition "is not so much a coherent government plan as an oxymoron. It is possible to have either managed health care or to have

open competition in health care services. It is not possible to have both simultaneously." [14] As proposed, managed competition appears to offer a great deal of management and very little competition. Often discussed as a compromise among various health care reform proposals, managed competition borrows many of the worst elements of the other proposals.

As Alain Enthoven, one of the leading proponents of managed competition, admits, it is not "a free-market system." [15] He is certainly correct about that. First, managed competition will severely limit consumer choice--choice of insurer, choice of benefits, and choice of physician. Numerous studies have shown that Americans do not like restrictive managed-care plans that limit their choice of physician. [16] Because managed-competition proposals generally prevent insurers from competing on the basis of their ability to price and manage risk, most traditional insurers would be driven out of the market. The criteria established for accountable health partnerships essentially limit the market to "the Blues"--Blue Cross and Blue Shield--and a handful of large health maintenance organizations (HMOs). [17]

Managed competition also has the potential of severely disrupting the traditional doctor-patient relationship. Managed competition changes insurers from "financial intermediaries with expertise in underwriting risks" to "health care delivery systems . . . organizing, managing and purchasing medical care." [18] In short, advocates of managed competition believe physicians should be responsible to insurers, rather than to their patients. That means limiting a patient's choice of physician to give the insurer increased bargaining power with the doctor. It also means increasing insurer control over the physician's choice of treatment, so that insurers can "apply quality assurance or review of appropriateness." [19]

As Swiss medical philosopher Ernest Truffer has noted, the increasing interjection of third parties between doctor and patient "amounts to a rejection of the medical ethic-- which is to care for a patient according to the latter's specific (medical) requirements--in favor of a veterinary ethic--which consists in caring for the sick animal, not in accordance with its specific medical needs, but according to the requirements of its master and owner, the person responsible for meeting any costs incurred." [20]

Although there is no evidence that managed competition will actually reduce health care costs, its advocates have a tremendous faith in the ability of managed care to control health care costs, which is not surprising considering the close ties between them and the managed-care industry. [21] Indeed, a recent survey indicated that half of the employers who had switched from non-managed-care plans to HMOs said their HMO rates were as high as or higher than their previous rates. [22] Likewise, a Congressional Budget Office report found that shifting Medicare patients to HMOs "had little or no effect on hospital use and costs." [23] In addition, a recent RAND Corporation study indicated that managed-care providers are as likely as fee-for-service providers to perform unnecessary procedures. [24]

It is very difficult to judge whether managed competition can deliver its promised cost savings because no such system currently exists anywhere in the world. However, it is at least worth noting that one of the models for managed competition cited by the Jackson Hole Group is the Federal Employee Health Benefits Program. [25] Despite recent enthusiasm for FEHBP on the part of some conservative groups such as the Heritage Foundation, [26] FEHBP costs have actually risen faster than those of employer-provided health benefits generally. [27]

Beyond the specific problems with the concept, managed competition is unlikely to work because it fails to address the real problems with the American health care system--a regulatory environment that reduces supply and a third-party payment system that stimulates demand. In fact, as envisioned in most state proposals, managed competition would make both of those problems worse. Extending third-party payment to currently uninsured individuals will increase demand still further. In addition, most state proposals contain strengthened regulatory requirements, such as certificates of need, that will further restrict supply.

Insurance Regulation

Perhaps because insurance regulation has traditionally been a state concern, one of the most common state

proposals for health care reform has been changes in the way small- group health insurance is regulated. Some of the insurance market reforms, such as eliminating mandated benefits and abolishing restrictions on so-called fictitious groups, are sensible. However, there are increasing efforts to manipulate insurance laws to require insurers to provide coverage for groups or individuals that they would not normally cover or to equalize insurance rates for healthy and sick individuals. The most disturbing of those proposals are requirements for "guaranteed issue" and "community rating."

Under guaranteed issue, insurers are required to accept all applicants regardless of health status, including those with active illnesses, such as cancer or AIDS.[28] Community rating requires that an insurer charge all insured persons the same rate. In some cases rate adjustments are allowed for age, sex, and geographic area, but not for health status.[29]

Such insurance reforms have a worthy intent, expanding access to insurance to those who find it difficult or impossible to purchase insurance under the current system. However, the reforms may have unintended consequences that will increase the cost of insurance and actually leave more people without insurance.

Insurance is a business of risk allocation, in which the insurer receives payment in exchange for agreeing to cover the expense of certain risks. The cost and scope of coverage are determined by morbidity-mortality statistical analysis.[30] To the degree insurers are prevented from basing their contracts on actuarial values, other policyholders will be forced to absorb the additional costs associated with covering high-risk individuals.

Indeed, studies estimate that, while employers with high-risk employees would certainly notice improved access to coverage under proposed insurance reforms, overall premiums could increase substantially. A recent study by the American Society of Actuaries found that claims costs in the second year of guaranteed-issue policies were 50 percent higher than for standard-issue policies. Claims costs tapered off in subsequent years but still averaged 38 percent higher.[31] The results of that extensive seven-year study confirm earlier studies by Community Mutual Insurance of Ohio and Tillghast Corporation that showed premiums increasing by 25 to 35 percent in a guaranteed-issue environment.[32]

The net result would be to force many small businesses to drop their current insurance coverage. Some currently uninsured workers would move into the insurance market. Others, who now have insurance, would move out. Thus, guaranteed issue would defeat its own *raison d'être*.

Even the liberal advocacy group, Families USA Foundation, estimates that 50 percent of small groups would experience a rate increase if guaranteed-issue and guaranteed-rate restrictions were adopted, and those increases would average 15 percent higher than they would be without changes in the law. Approximately 15 percent of small groups would receive a decrease in premiums, averaging 25 percent. The remainder would see no change in premiums.[33]

The whole theory underlying guaranteed issue and community rating is essentially flawed--that healthy people and sick people should pay the same for insurance. Since sick people inevitably require greater benefits, the cost of insuring them must be subsidized by healthy people. Thus, to provide coverage for a person with AIDS, a person without AIDS must pay a higher premium. Moreover, the additional costs are highly regressive in nature, forcing the highest marginal costs on those least able to afford the increase. For example, if small-group reforms cause the premiums for a family policy to increase by \$1,000, that is a 10 percent surcharge for a family earning only \$10,000 per year but only a 1 percent surcharge for a family earning \$100,000.[34] The subsidization is also regressive because the low-risk persons, who will see their premiums increase, tend to be young and have lower incomes, while high-risk persons, who will be subsidized, tend to be older and have higher incomes.[35]

Finally, we should recognize that community rating and guaranteed issue relieve individuals of the responsibility for unhealthy lifestyles. There is no question that individuals who smoke, drink, use drugs, practice unsafe sex, eat poor diets, and fail to exercise have far higher health costs than do individuals

with healthy lifestyles. In fact, the top 10 causes of death in the United States are all lifestyle related.[36] By spreading the cost over the entire population, community rating and guaranteed issue "socialize" the costs in the truest sense of the word.

The essential unfairness of such subsidization has long been recognized as a matter of insurance practice and law. In fact, insurance companies are generally required by law to make distinctions among risks and classify them in such a way as to assess fair premiums. Those laws, which are based on the Unfair Trade Practices Act developed by the National Association of Insurance Commissioners and enacted in some form in all 50 states, are designed to "protect insured persons from paying excessive amounts to subsidize high-risk policyholders and groups." [37]

Those problems are compounded by the ability of people to "game" the system. Healthy people purchase health insurance because they fear the possible financial consequences of illness. People purchase health insurance while they are well, so that they will have it when they are ill. However, if health insurance becomes available regardless of health status, much of the incentive to pay for health insurance while healthy will be removed. For many people, it will be a rational choice to do without health insurance until the need arises.

Automobile insurance provides a good analogy. If it were possible to purchase auto insurance after an accident had occurred, would people be likely to purchase insurance before they had accidents?

The self-selection process will make the cost situation worse. Since the individuals who will forgo insurance will probably be healthy while those who will purchase insurance will have an increased likelihood of being ill, the overall health status of the insured group will decline, which will increase the ratio of claims costs to premiums. The result will be higher premiums for those remaining in the group. Then, faced with increasing premiums, more healthy individuals will choose to drop their insurance coverage, starting the cycle again.

Preexisting-condition limitations reduce but do not eliminate such "gaming." Generally, claims are limited for conditions for which an individual was treated during the previous 12 months, and the limitation generally extends for only 12 months after coverage begins. That protects against "instant insurance" for some conditions and accidents but still allows gaming for long-lasting conditions such as HIV or cancer. Further, many conditions that may dramatically increase the risk of future claims, such as a heart attack followed by a year with no medical treatment, do not qualify as preexisting conditions.

Lots of Price Controls

Recent state reforms reflect renewed interest in price and expenditure controls, ranging from controls on hospital rates, physicians' fees, and insurance premiums to attempts at global budgeting. Some states, such as Washington, are attempting to limit total health care spending within the state, a practice known as "global budgeting." However, the examples provided by global budgeting in foreign health care systems show that such expenditure limits inevitably lead to the rationing of care.

In Great Britain, a country with a population of only 55 million, the waiting list for surgery is more than 800,000.[38] In New Zealand, a country with a population of just 3 million, the waiting list for surgery now exceeds 50,000.[39] In Sweden the wait for heart x-rays is more than 11 months. The wait for heart surgery can be an additional 8 months.[40] In Canada the wait for hip-replacement surgery is nearly 10 months; for a mammogram, 2.5 months; for a pap smear, 5 months.[41] Surgeons in Canada report that, for patients in need of heart surgery, the danger of dying on the waiting list now exceeds the danger of dying on the operating table.[42] According to Alice Baumgart, president of the Canadian Nurses Association, emergency rooms are so over-crowded that patients awaiting treatment frequently line the corridors.[43] Sometimes the rationing of care is even more explicit: care is denied the elderly or people for whom the prognosis is poor. For example, in Britain kidney dialysis is generally denied patients over the age of 55. At least 1,500 Britons die each year because of lack of dialysis.[44]

Other states, such as Maryland, are experimenting with direct price controls. But the evidence available from this country's experimentation with price controls in the Medicare system indicates that direct price controls also diminish the quality of care and may lead to rationing. For example, economists with the Prospective Payment Assessment Commission found that hospitals frequently discharged Medicare patients prematurely in an effort to reduce costs.[45]

There is no evidence that price or expenditure controls actually succeed in controlling prices. Despite global budgeting and price controls, nearly all the national health care systems of Europe are experiencing a rapid growth in health care costs.[46] Canada's global budgets have also failed to control skyrocketing health care costs that are threatening to bankrupt the country's national health care system.[47]

In this country, experience with price controls has shown that, while such controls do succeed in restraining costs for a short period, prices very soon start rising again.[48] Once again Medicare provides additional evidence. Few government programs have seen as many efforts at price control--from "cost-plus" to diagnosis-related groups, to the Resource-Based Relative Value Scale--yet Medicare spending has increased between 12 and 15 percent each year since 1983.[49] State-level experiments have produced equally poor results. For example, Nevada imposed price controls on hospitals in 1987. But, in reviewing the results, the state's insurance division concluded that there had been "no net savings for insurers to pass along in the form of lower premiums." [50]

Interestingly, some states are trying to combine price controls with managed competition. However, nearly all advocates of managed competition, including Enthoven, say that managed competition and price controls are incompatible.[51] First, because managed competition hopes that price signals will draw consumers toward the most efficient health systems, price controls would interfere with one of the founding principles of managed competition.[52] At the same time, price controls would prevent the health care industry from raising the capital necessary to invest in the new technologies and computer networks necessary to make a system as complex as managed competition work.[53]

State-by-State Review

Connecticut

In 1990 Connecticut became the first state to undertake a major reform of the small-group health insurance market. The law requires that insurers that serve the small-group market must serve the entire small-group market--all groups with 1 to 25 employees.

Self-employed people are their own employees. Therefore, one-person groups must be guaranteed access, and although insurers may continue to offer as many "name-brand" plans as they wish, every carrier must guarantee to issue at least one small-employer health plan or a special health care plan to any small group that wishes to purchase one.

For name-brand health plans, the entire group must be accepted or rejected. Individuals within the plan may not be medically underwritten. (Medical underwriting evaluates an individual's risk on the basis of medical history and health status. An individual with a history of health care claims or a risky health condition--such as diabetes or HIV--might be rejected for coverage or charged a higher premium.) If a group is rejected for a name-brand plan, it must be issued the guaranteed small-group or special health plan if desired.

All new additions to groups must be guaranteed issue, regardless of the plan initially sold to the group. Previously satisfied preexisting condition limits must be credited.

Rates for two groups with similar coverage and group characteristics may not vary by more than 2:1. Rates may not be increased by more than 20 percent per year based on claims experience or the health of the group.

A reinsurance pool was created to spread the cost of high-risk individuals over the whole system. Insurers may "cede" high-risk groups and individuals back to the reinsurance pool, and the cost of that individual or group will be allocated among all insurers based on their market share of the small-group market.[54]

At the time of its passage, the proposal was greeted with widespread applause. The Hartford Courant proclaimed the legislation "a model for the nation" that would "make health insurance cheaper and more accessible." [55] But, two years later, it appears that the reforms have not lived up to those claims.

Far from eliminating medical underwriting, the reforms may actually have intensified the practice. Insurers have become obsessed with determining which groups or individuals should be ceded to the reinsurance pool. The result, according to Carl Temme, vice president of the H. D. Segur insurance agency, has been a "witch hunt," with insurers seeking ever more detailed medical information on current or prospective clients to decide whom to put in the pool. Full medical applications are now routinely required of all employees in the small-group market. Even insurers such as Blue Cross and Blue Shield, which never used to medically underwrite, have established underwriting departments.[56]

The reinsurance pool has become a dumping ground for existing risks, rather than a way to bring risks into the system. As of September 10, 1992, there had been 7,453 people ceded to the reinsurance pool. But only 2,043 (27 percent) were "new business." The remaining 5,410 people (73 percent) were "existing business," dumped by their insurance companies.[57] Temme summed up the opinion of many insurers: "If [carriers are] not actively . . . dumping clients into the pool, they're idiots." [58]

At the same time, premium costs are rising. While rates for new business have increased dramatically, the real impact has been on small-group renewals; some businesses have been hit with premium increases of 40 percent or more. Essentially, insurers are protecting themselves by raising rates to the maximum allowed by law, regardless of individual circumstances. In addition, many groups are for the first time receiving "demographic adjustments" to reflect differences in industry, geography, age, family status, and size of group. Rate limitations have become a hollow shell.[59]

Perhaps the biggest disappointment of Connecticut's experiment has been its failure to significantly increase access to health insurance. In the program's first 14 months, only 10,000 previously uninsured workers were added to the insurance rolls. As of March 1992, insurers had only written about 250 health insurance plans specifically designed for employers that have not had insurance for two years or more. Nearly 300,000 Connecticut residents remain uninsured.[60]

The result, predictably, has been calls for still further regulation. Already, for example, the plan has been amended to reduce the allowable annual rate increase from 20 percent to 15 percent.[61] (As mentioned previously, demographic adjustments and other underwriting changes have largely made rate restrictions irrelevant.) The Health Care Access Commission, successor to the Blue Ribbon Commission that proposed the insurance reforms, is holding public hearings on a variety of additional reform proposals, including a Canadian-style single-payer plan.

Florida

On April 3, 1993, the Florida legislature approved a sweeping health care reform plan that will make Florida the first state to adopt a managed-competition program.[62] The plan creates 11 community health purchasing alliances (CHPAs), the functional equivalents of HIPCs. CHPAs will negotiate with accountable health partnerships for health insurance benefits on behalf of small businesses, the uninsured, and state employees. Accountable health partnerships may include both managed-care and traditional fee-for-service providers. CHPAs must offer enrollees a choice of at least three types of plans. Enrollment in CHPAs is voluntary.[63]

A new program called MedAccess was created to provide insurance for Florida residents who currently lack health insurance and whose family income is below 250 percent of the poverty level. Premiums will be subsidized on a sliding scale according to income. The Agency for Health Care Administration will

contract with managed-care providers for services.[64]

Current Medicaid recipients will also be required to enroll in managed-care programs. Reimbursement to providers under both MedAccess and Medicaid will be according to the Resource-Based Relative Value Scale.[65] That reimbursement scheme has been adopted despite the fact that the scale, currently used for Medicaid, has not only been unsuccessful in restraining costs but significantly underreimburses many physicians.[66]

The act also contains extensive new insurance regulations. All small-group policies must be offered on a guaranteed-issue basis. In addition, modified community rating is required, allowing rate adjustments for age, gender, family composition, tobacco usage, and geographic location, but not for health status or preexisting conditions.[67]

Despite premature claims of success,[68] even supporters of Florida's reform admit that the outcome is far from certain. "This is an experiment," says Doug Cook, director of Florida's Agency for Health Care Administration and one of the plan's architects. "We're going to have to see how it works as we go along. . . There aren't any guarantees."[69]

Hawaii

Hawaii is the only state ever to mandate directly that employers pay for health insurance for their workers. Under Hawaii's 1974 Prepaid Health Care Act, employers must cover all workers who complete at least four consecutive weeks of work, who work at least 20 hours per week, and whose monthly wage is at least 86.67 times the minimum hourly wage. The insurance benefits must equal or exceed a state-defined package of minimum benefits. Employees' premium contributions cannot exceed 1.5 percent of their gross income, and copayments and deductibles also are limited. Each employee must be given the option of purchasing dependent coverage, but the employer is not required to pay for that coverage.

The Hawaii statute grants few exceptions to those general rules. Government employees, seasonal farm workers, and small businesses, comprised of family members, for instance, are exempt from the law. So are employers with fewer than eight employees. Some firms qualify as economic hardship cases and may receive state subsidies to help with the cost of coverage. But the criteria for such cases are extremely narrow, and in practice few companies qualify. The mandated minimum benefits include 120 days of hospital care; outpatient surgical, medical, and emergency care; home, office, and hospital physician visits; most common diagnostic services; and maternity benefits. The Hawaii law was amended in 1976 to add coverage for drug and alcohol abuse treatment to the minimum package. The law has been amended further since 1983, adding to the minimum package coverage for certain child health services, in vitro fertilization, new mental health and psychological services, and, most recently, mammography.

Hawaii's experiment with mandated employer-provided insurance has not achieved its goals of universal coverage and cost control. Nor can the program be credited with the fact that nearly 98 percent of Hawaiian workers now have health insurance. Hawaiian employers have had a long-standing practice of providing their employees with health care, in large part as a way of attracting workers in what has been a very tight labor market. Some 90 percent of all Hawaiian workers were insured before enactment of the 1974 law.[70] By some estimates, Hawaii's Prepaid Health Care Act added just 46,000 individuals to the health insurance rolls.[71]

The other face of America's health care crisis is rising costs. Hawaii's reform has not appreciably controlled costs. In fact, health care costs are rising faster in Hawaii than almost anywhere else in the nation. Between 1980 and 1990, total health care spending in Hawaii rose 191 percent, considerably more than the national average of 163 percent. Per capita health care costs in Hawaii in 1990 were \$2,469; the national average was \$2,318.[72]

Even though the Hawaii program falls far short of meeting its key objectives, some policymakers see it as the model for the nation or for other states. They point to almost universal employer-paid coverage in

Hawaii. Using Hawaii as a model would be unwise, however, for in many respects Hawaii is in a unique situation. First and most important, Hawaii benefits as an island very distant from the U.S. mainland. Its isolation means that it is relatively more difficult for companies to move elsewhere if they feel that the cost of the health care mandate is onerous. That obviously is not the case for other states.

Second, Hawaii's position as a gateway to Asia makes it alluring to business and thus often worth the increased cost of doing business. Third, there were relatively few uninsured workers when the plan was enacted and few employers not already offering insurance. So the mandate was somewhat redundant.

And finally, approximately 80 percent of Hawaiians are insured through one of two insurers, Blue Cross and Blue Shield or Kaiser Permanente. From the standpoint of regulatory authority, that makes the program simple to manage. Even Walter Zellman, a key adviser to President Clinton's health care task force, admits that those special circumstances mean that "Hawaii's system [is not] directly applicable to other states." [73]

Maryland

The centerpiece of Maryland's new health care reform plan is stringent controls on physicians' fees. The legislation established a commission empowered to collect information on the fees and services of physicians practicing in the state. If the commission decides that physicians are practicing "inefficiently" or making "excess profits," it has the power to impose limits on their fees. [74] Those limits--a variation of the Resource-Based Relative Value Scale used to determine Medicare reimbursements--require that fees be in accordance with the "relative value" of a service, taking into account such factors as training, experience, location, office overhead, and use of medical equipment. [75] That aspect of the bill was watered down from the original proposal, which would have given the commission outright authority to set all doctors' fees. [76] However, according to Dick Merritt of the Intergovernmental Health Policy Project, Maryland's law still goes much further than any previous state reform effort in limiting physicians' fees. [77]

Proponents of limiting physicians' fees cite Maryland's experience with a 20-year-old state law limiting hospital fees. However, while it is true that Maryland's hospital costs have risen slightly more slowly than hospital costs nationally, there is evidence that many procedures were simply shifted to outpatient care, driving up the cost for those procedures. [78]

The plan establishes a standard benefits policy for small employers (defined as businesses with more than 2 but fewer than 50 employees). Policies must be offered on a guaranteed-issue basis and community rated. There is a phase-in period for the community-rating provision. [79]

Maryland's reform also places strict limits on insurance company profits, requiring that at least 75 percent of premiums be paid out as benefits (a loss-ratio guarantee). [80]

Massachusetts

Once hailed as part of the "Massachusetts Miracle," the state's attempt to enact a classic "play-or-pay" health care plan is now almost universally regarded as a failure. [81] In 1988 the state legislature passed the Massachusetts Healthcare Plan, and then-governor Michael Dukakis signed it into law. [82] Employers with five or more workers were to pay a "medical security contribution" equal to 12 percent of the first \$14,000 in wages for each employee. Employers might deduct from that amount the cost of an employee's health insurance or other health care benefits. The money paid by the employer went to the state's unemployment and medical security funds. Those funds were to provide health insurance for individuals without employer-provided health benefits.

The Massachusetts Healthcare Plan has never been fully put into place. Though the unemployment insurance fund with its mandated contribution is now functioning, the more important part of the program, the medical security fund, has been repeatedly postponed, most recently until 1995. With current governor

William Weld opposed to the plan, it is unlikely that the program will ever be implemented.

Since it has never gone into effect, there is no definitive empirical evidence of the impact of the Massachusetts Healthcare Plan. However, studies at the time of the bill's passage indicated that the plan would significantly increase employer costs and lead to a loss of as many as 9,000 jobs.[83]

New York

Perhaps no state better illustrates the failures of the insurance-regulation approach to health care reform than New York. On April 1, 1993, New York began to enforce the nation's most stringent community-rating and guaranteed-issue requirements.

The result has been astronomical increases in insurance premiums; in some cases rates have doubled and tripled. The average premium for a 30-year-old male will increase from \$1,200 per year to \$3,240, a 170 percent hike. A family policy for a 30-year-old will jump 91 percent, from \$4,020 to \$7,680, well beyond the reach of most low- and middle- income families. Of course, some will benefit under New York's plan. The elderly will see nearly a 50 percent reduction in their premiums (Table 1).[84]

A spokesman for the New York State Insurance Department admits that "some people will not be able to afford these increases," but, nevertheless, says that "the new system will be more equitable." [85]

Policyholder	Old Premium (\$)	New Premium (\$)	Percentage Change
Family, age 30	4,020	7,680	+ 91
Male, age 30	1,200	3,240	+170
Female, age 30	1,800	3,240	+ 80
Family, age 45	6,300	7,680	+ 22
Male, age 45	2,520	3,240	+ 29
Female, age 45	2,640	3,240	+ 23
Family, age 60	11,640	7,680	- 34
Male, age 60	5,880	23,240	- 45
Female, age 60	4,380	3,240	- 26

Source: New York State Insurance Department.

Even those who could afford the rate increases are liable to be left without insurance. At least nine health insurance companies have abandoned the health insurance market, leaving at least 50,000 New Yorkers without insurance.[86]

Oregon

Oregon's program is significant because it represents the first deliberate attempt by a government body to ration health care services. In amending its state Medicaid law this year, Oregon has guaranteed all state residents under the poverty line a basic level of health care. Currently, only residents with incomes below 58 percent of the poverty line are eligible for services under the Medicaid program. Although the Oregon program will extend coverage to more residents, it will not cover all services currently provided by the state's Medicaid program.[87]

In accordance with the plan, the Oregon Health Services Commission drafted a priority-ranked list of medical services available to Oregonians. Issued this spring, the list ranks 709 health services by cost,

duration of a treatment's benefit, improvement in the patient's quality of life, and community values. Preventative services and diagnostic care are to be available to all recipients and were not included in the list.[88]

With the \$175 million appropriated by the Oregon legislature for the current fiscal year, the program will pay for the first 585 services on the priority list. That means that treatment for swelling of the esophagus is funded; disk surgery is not. Funded, too, are treatment of most childhood illnesses; treatment of most accidental and other injuries; immunizations; services for treatable cancers; and payment for AZT, a drug used in treating those suffering from symptoms of AIDS. Medicaid also will reimburse the costs of preventive care services such as mammograms.[89]

The Oregon plan, if it goes into effect, will not cover some services currently provided by Medicaid. The uncovered items include treatments for illnesses that usually heal slowly without treatment, such as viral sore throats and colds; conditions that respond to home treatment, such as diaper rash and mild food poisoning; and treatments that are considered by public health authorities to be either ineffective or not cost-effective, such as lower back surgery, treatment for severe brain injury, care for very premature babies, and treatment for advanced cases of certain cancers and advanced cases of AIDS.[90]

The Oregon program also contains a play-or-pay health insurance mandate on business. Small businesses will be allowed to institute a basic health benefits package similar to the package that the state delivers to the poor. Businesses failing to pay for health insurance for their employees will be subject to a tax, the amount of which is as yet undetermined, on wages paid starting in 1995.[91]

While deserving credit for having the courage to face up to the rationing implicit in other proposals for government control of health care, the Oregon plan is fundamentally flawed in its assumption that it is possible for a government bureaucracy to determine objectively the value of various health care procedures.[92] The state thus attempts to substitute central planning for the discipline of the marketplace.

But such an "objective" determination is impossible. First, as Joshua Wiener of the Brookings Institution has noted, "For most condition-treatment pairs, there are no empirical data on which to base the judgments of their likely effectiveness." [93] The commission obtained its information primarily by distributing survey forms to health professionals and asking for their best estimate of the effectiveness of health services. The survey was supplemented by a handful of public hearings, community meetings, and telephone surveys.[94]

In addition, political calculations quickly became part of the ranking process, with the program a battleground for interests associated with various disease constituencies and health care specialties. Groups battled with each other to make sure that their needs or services were included in the list of covered services. Even before the program was enacted, legislators bowed to powerful political pressure from senior citizens' groups and exempted the elderly from the program's rationing mechanism.

Since an objective rationing mechanism is impossible, the Oregon program inevitably involves the government in making ethical decisions that are almost certainly the province of the individual. The government must decide who receives care and who does not, who lives and who dies, who should suffer and how much suffering should be allowed. And it makes those decisions on a subjective and arbitrary basis. As Democratic state representative Tom Mason points out, "That is what the Oregon Plan does throughout: It values one person's life over another for subjective reasons, the ultimate act of discrimination." [95]

Moreover, the plan is not even likely to succeed in its stated goal of reducing Medicaid costs. Plans to expand Medicaid to cover an additional 120,000 Oregonians over the next four years will generate costs far in excess of any savings due to rationing. Indeed, Governor Roberts's budget estimates that over the next two years Medicaid spending will increase by 75 percent under the plan. Without the plan, Medicaid spending was only expected to increase by 25 percent (Table 2).[96]

Table 2
Medicaid Spending in Oregon (\$ Millions)

	State Fund	Federal Funds	Total
Current	306.0	502.7	808.8
With Oregon health plan	516.7	824.4	1,341.1
Without Oregon health plan	388.5	627.7	1,016.3

Source: Oregon Office of Medical Assistance.

Note: Numbers may not add to totals because of rounding.

To pay for the increased spending, Governor Roberts has proposed a 2 percent gross receipts tax on health service providers. Since the cost of that \$100-million tax increase would be passed along to privately insured patients, such a tax would simply extend cost shifting. Roberts has also proposed the usual batch of tax hikes on cigarettes and alcohol.[97]

Vermont

In 1992 Vermont enacted a comprehensive program, restructuring and reorganizing the state's health care planning and regulatory systems. The legislation established a new state agency, the Vermont Health Care Authority, vested with both policymaking and "quasi-judicial" authority. The authority was instructed to draft and submit to the legislature by November 1993 two plans for "universally accessible, medically necessary, and preventive health care." One plan is to be based on the concept of a single-payer system and one on a regulated multiple-payer system.[98]

However, Vermont is not waiting for the legislature to choose a final plan. The authority has enormous power starting immediately. For example, it has the power to adopt a unified health care budget. That global budget limits "the total amount of money to be expended annually for all health care services." The budget--and subbudgets for hospitals, physicians, and other services--is voluntary for 1993 but will become binding in 1994. The authority also has been given total approval authority for all capital construction and purchases.[99]

Vermont also has required that all insurance policies be community rated and offered on a guaranteed-issue basis.[100]

Despite expansive claims of success, most parts of Vermont's program have not yet taken effect. However, a letter to the editor of the Burlington Free Press summed up the results of the state's attempt at reform so far.

At the state and local level, I want to thank my elected representatives for giving me the opportunity to pay community-rated premiums for my health insurance. I was paying \$1,719.28 and now, out of the kindness of your well meaning hearts, I will be paying \$4,363.92. I wonder how many of the 60,000 uninsured Vermonters are now going to pay these new rates. Could it be possible that they may have created another 60,000 who will not have insurance when those who could afford the old rates get their new bills. The premium for my son and daughter, who are just starting out, have gone from \$554 a year to \$1,585 on the community rate method. Their solution is we cannot afford this so they will have to take a chance.[101]

Washington

Hillary Clinton has said that recent health care reforms in Washington "mirror essential elements of the national plan." [102] Like its counterpart in Florida, the Washington Health and Medical System Reform Act is based on the concept of managed competition. However, the program goes much further,

establishing a wide variety of mandates and regulations. Under the legislation, there will be established a system of employers' cooperative health care purchasing groups, which will act as collective purchasing agents on behalf of employers.[103] Each purchasing cooperative will negotiate with certified health plans for a benefits package on behalf of its members. Unlike the situation in Florida, enrollment is mandatory. The state will establish a uniform benefits package as a minimum standard benefits requirement.

Certified health plans will be required to community rate and guarantee coverage to all cooperative members, provisions that will almost certainly increase the cost of insurance. Of course, the bill attempts to control insurance costs by capping premiums.

Reimbursement to certified health plans will be solely on a capitated basis. Therefore, all such plans will essentially be equivalent to current HMOs.

The legislation also includes an employer mandate. By July 1, 1997, employers will be required to provide coverage for all full-time employees. Employers must pay at least half the cost of coverage, but no more than 95 percent. A mandate that employers provide health benefits for all fulltime employees will cost jobs. Even the Jackson Hole Group admits that "employer mandates are a form of employment tax." [104] They claim, however, that their explicit taxes would be "fairer" than the current system of allocating costs. But the real result of such a tax increase is likely to be lost jobs. Some estimates place the number of Washington jobs "at risk" because of the mandate as high as 168,000.[105]

Individuals who are not covered through an employer plan will be required to enroll on their own. The purpose of the mandate that individuals purchase insurance is to eliminate the "free-rider" problem. There is no doubt that many currently uninsured individuals have voluntarily chosen not to purchase health insurance. Studies show that, contrary to common belief, a significant portion of the uninsured are not poor. According to Lewin/ICF, in 1990 nearly 22 percent had incomes of more than \$30,000, and 17 percent had incomes of more than \$40,000.[106] The uninsured are, for the most part, relatively young (nearly 60 percent are below age 30)[107] and healthy individuals who have chosen to forgo the purchase of health insurance. They have generally decided--rightly or wrongly--that the benefits of insurance are not worth the cost. The logic behind mandating that all people purchase insurance is based on the same type of reasoning that has long been used to justify government intrusion into our personal lives and decisionmaking, witness seat belt laws and motorcycle helmet laws.

The program will be overseen by a new state agency, the Washington Health Services Commission, which will have extensive powers, including the power to restrict capital expenditures by a process that will be similar to, and expand upon, the current certificate-of-need program.[108] Currently, Washington requires a certificate of need only for new construction, bed conversions and additions, and tertiary services such as open-heart surgery and organ transplants.[109] The legislation extends the certificate-of-need concept to all capital expenditures.

The power of the commission to control reimbursement rates is open to interpretation. As mentioned earlier, all reimbursement will be on a capitated basis. Fee-for-service medicine is dead. In addition, the commission is authorized to "suggest guidelines" for "utilization management, use of technology, and methods of payment." The guidelines are "voluntary." However, if premiums are capped and utilization increases, there will be an inevitable squeeze on reimbursements to providers. The bill also explicitly embraces "global budgeting," a statewide cap on total health care expenditures.[110]

Finally, the plan will establish a computerized state- operated data bank to track all medical encounters, raising concern about the privacy of medical records.[111]

The plan will be enormously expensive. Governor Mike Lowry estimates the cost at \$478 million,[112] but some estimates place the total cost by the year 2000 as high as \$3.5 billion, with yearly state expenditures as high as \$737 million.[113]

Whether the program ever takes effect remains questionable. The start-up date is sufficiently far off to

allow for significant changes. And an initiative campaign to repeal the plan is already under way.[114]

What States Can and Cannot Do

As state legislators struggle with the difficult issue of health care reform, they must remain aware of the limits to what state governments can do. While there are many health care reforms that can be enacted at the state level, some health care reforms will require action at the federal level. In addition, federal action will almost certainly be required to support many of the state-level reforms.

Most important, state governments can have only a very limited impact on the distortions in our health care system that are caused by federal tax policies. Under federal tax law, money spent by an employer on a worker's health insurance is not counted as taxable income to the worker. Thus, even though that money is part of workers' total compensation, they avoid paying any income or payroll taxes on it.

That tax treatment gives American workers and their families very generous tax relief on their medical expenses, but only on two conditions. First, they must obtain their medical care through health insurance. And second, they must obtain their health insurance through their employers.

In many cases, however, it would be more desirable or cost-effective to purchase low-cost or routine medical care directly out-of-pocket rather than file an insurance claim, or to buy a health insurance plan different from the one offered by the employer. Workers are heavily penalized for doing those things because they receive no tax relief.

To make matters worse, workers who have employer-sponsored health insurance, are cost conscious, and seek out providers who offer good quality at good prices are not rewarded, since they cannot pocket any savings. Moreover, physicians who dispense more services, regardless of their benefit, or charge higher prices are rewarded with more income.

Solving those problems will require the adoption of something along the lines of the Medical Savings Account proposed by John Goodman and Gerald Musgrave.[115] States can point the way by adopting versions of that proposal,[116] but federal action will be required for such accounts to be truly effective.

However, there are several positive, free-market reforms that can be undertaken at the state level. There should be a thorough examination of the extent to which government policies are responsible for rising health costs and the unavailability of health care services. We can help lower health care costs and expand access to health care by taking immediate steps to deregulate the health care industry, including elimination of mandated benefits, repeal of the certificate-of-need program, and expansion of the scope of practice of nonphysician health professionals.

For example, having decided that people are not smart enough to choose their own health insurance benefits, every state has laws that mandate that all health insurance contracts in the state provide for coverage of specific disabilities and diseases and the provision of specific health care services. Those mandates add significantly to the cost of health insurance.[117]

Blue Cross and Blue Shield of Maryland estimates that mandated benefits account for 13.3 percent of all claims dollars.[118] In Massachusetts Blue Cross and Blue Shield estimates that mandated benefits add nearly \$55 per month to the cost of a policy.[119] Surveys of small businesses have repeatedly shown that the cost of health insurance is the primary reason those businesses do not offer health benefits. By making insurance more expensive, mandated benefits are contributing directly to the number of uninsured.

In addition, a majority of states continue to maintain regulatory restrictions on health care services, such as certificate-of-need requirements, that act as a barrier to competition. Certificate-of-need requirements are based on the bizarre economic theory that greater supply and increased competition will lead to higher prices. However, studies have repeatedly demonstrated that certificate-of-need programs not only fail to contain costs but may actually lead to increased costs and limit the availability of medical services,

particularly in rural areas. The Federal Trade Commission has concluded that, on a national basis, "Hospital costs would decline by \$1.3 billion per year if states would deregulate their CON programs." [120]

We also need to rethink our medical licensing laws. Studies have repeatedly shown that qualified midlevel non-physician practitioners can perform many medical services traditionally performed by physicians. Yet the medical profession has consistently used licensure and other regulatory restrictions to limit competition. The result has almost inevitably been higher prices for consumers. For example, 37 states continue to outlaw the practice of lay midwifery. In most states nurse practitioners cannot treat a patient without direct physician supervision. Chiropractors cannot order blood tests or CAT scans. Nurses, psychologists, pharmacists, and other practitioners cannot prescribe even the most basic medications. [121] Deregulating the health care industry will reduce the overall cost of health care, making health insurance more affordable and, therefore, easier to obtain.

The current Medicaid system has clearly failed. Costs are skyrocketing. Patients are receiving second-rate care. And providers are being shortchanged. The time is ripe for drastic reform. A voucher system would bring Medicaid recipients into the private insurance system, providing them with the same quality of care everyone else receives. [122]

Finally, states should investigate the advisability of establishing high-risk pools to cover the medically uninsurable. One such alternative is offered by an approach currently being used in approximately 25 states--a high-risk health insurance pool. [123] Health insurance risk pools operate in substantially the same way as automobile insurance pools for high-risk drivers. Both spread the cost of providing coverage for high-risk individuals among a larger population. [124]

Risk-pool insurance covers a broad range of services comparable to those covered by traditional group health insurance plans, although deductibles are usually higher in risk-pool plans than under other group policies. In addition, premiums for risk-pool insurance are higher, often 50 to 100 percent higher, than rates charged for an average individual policy. Generally, to be eligible for a risk pool, an individual must have been rejected for health insurance by one or more insurers. However, in a few states, a person may be eligible if he has been offered only a policy that excludes certain conditions, or a policy with higher than usual premiums. [125]

Because of the high health care costs for individuals who enroll in the risk pools, the premiums charged--even at the enhanced rates--generally do not cover the costs paid out through the policy, making necessary an additional funding mechanism. In most states additional financing is provided through an assessment against insurers participating in the pooling. However, that is likely to increase premiums for other insured people, for many of the same reasons that guaranteed issue increases rates. Other states subsidize pool losses through assessments on hospital revenues, which is also likely to increase overall health care costs. The best course of action appears to be to fund pool losses out of general revenues. If as a society we have made the decision that individuals should, for whatever reason, be subsidized in the purchase of insurance, the cost of that decision should be borne by society as a whole rather than a particular segment of society.

One problem with current state risk pools is that they are designed in a way that maximizes costs. One of the most damaging trends in recent years has been the changing attitude in this country toward the purpose of health insurance. Insurance was originally intended to protect an individual against unforeseen catastrophic events. It was essentially a form of risk management. However, recent trends in health insurance have been toward increasing front-end coverage, providing coverage for routine medical expenses and initial hospitalization, but terminating benefits after a certain time or expense limit. As a result, insurance has become less of a protection against catastrophic events and more of a form of prepaying for health care. Predictably, costs have increased.

Current high-risk health insurance pools follow the trend by providing most of their benefits up front. The cost of those programs could be significantly reduced if the plans reduced coverage for routine treatment

and initial costs and concentrated instead on catastrophic care. That could be done by redesigning the benefits package or requiring a large deductible (\$2,000 to \$3,000, for example). Combined with Medical Savings Accounts and tax fairness, that would make it possible for high-risk individuals to receive health care coverage yet minimize the burden on taxpayers.

A more market-oriented solution that has been suggested would be to allow insurers, on their own or in combination with other insurers, to provide federally qualified high-risk insurance. Such policies would probably cover only catastrophic illnesses. The purchaser would receive a tax deduction worth up to twice the cost of the policy.[126]

Conclusion

While the media have largely focused on the debate in Washington, D.C., an intense battle is under way in America's state capitals over how to reform the health care system.

Driven by an understandable concern about the impact of skyrocketing health care costs on already fragile budgets, state legislators have sometimes reached for drastic solutions, such as rationing or mandating employer-provided insurance, that make matters even worse. The best reforms--such as changes in federal tax policy--can only take place in Washington, while many of the worst ideas--such as increased insurance regulation, price controls, and some forms of managed competition--are being implemented at the state level.

While state legislators should be applauded for taking the initiative on health care reforms, they should nevertheless carefully examine the effects of any reforms on access and quality and consider the economic consequences for businesses, employees, and taxpayers. The debate at the state level and the experience of programs already introduced provide important guidance by showing the failure of many of the concepts most eagerly debated at the national level. Congress should learn from the states' mistakes.

Health care is an emotional issue. Since it accounts for one-eighth of the U.S. gross national product, changes in health care could have a profound effect on the American economy. It is important, therefore, that federal and state legislators pay close attention to the lessons of the reform movement at the state level.

Notes

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[2] National Association of State Budget Officers, State Expenditures Report (Washington: NASBO, 1991).

[3] "Rising Health Costs in America," Families USA Foundation, Washington, October 1990.

[4] The insurance industry is state regulated by virtue of the 1945 McCarran-Ferguson Act.

[5] "Don't Expect Health Care Reform Any Time Soon," USA Today, April 6, 1993. Emphasis added.

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[7] Steve Sternberg, "Florida Cuts Cost, Expands Service with Regional Pools," Atlanta Constitution, April 18, 1993.

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[10] *The Jackson Hole Initiative: A Proposal for Health Care Reform* (Teton Village, Wyo.: Jackson Hole Group, July 23, 1992).

[11] *Ibid.*

[12] For a discussion of German sickness funds, see Bradford Kirkmann-Liff, "Health Insurance Values and Implementation in the Netherlands and the Federal Republic of Germany: An Alternative Path to Universal Coverage," in *Caring for the Uninsured and Underinsured* (Chicago: American Medical Association, 1991).

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[14] Richard Epstein, "Unmanageable Care," *Reason*, May 1993.

[15] Alain Enthoven, "Managed Competition in Health Care Financing and Delivery: History, Theory and Practice," Robert Wood Johnson Foundation, Washington, January 7, 1993.

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An HMO is an organized system for providing prepaid health care that has five basic attributes: (1) provides care in a defined geographic area; (2) provides or otherwise ensures delivery of an agreed-upon set of basic and supplemental health maintenance and treatment services; (3) provides care to a voluntarily enrolled group of people; (4) requires enrollees to use the services of designated physicians, hospitals, and other providers; and (5) receives reimbursement through a predetermined, fixed periodic payment without regard to the amount of actual services provided. See Health Insurance Association of America, *Health Insurance Data Book* (Washington: HIAA, 1993).

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[19] *Ibid.*

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[123] See *Health Insurance Risk-Pools for the Medically Uninsurable*, General Accounting Office, 1988.

[124] Greg Scandlen, "Some Considerations in State Risk Pools," Blue Cross and Blue Shield Association, Washington, 1987.

[125] *Ibid.*

[126] Terree Wasley, *What Has Government Done to Our Health Care?* (Washington: Cato Institute, 1992), p. 143.