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Removing the Middleman: What States Can Do to Make Health Care More Responsive to Patients

By Byron Schlomach, Ph.D., Director, Goldwater Institute Center for Economic Prosperity

EXECUTIVE SUMMARY

It is no secret that the American health care system suffers from high costs, lack of access, and uneven quality. Many, if not most, of these problems stem from a dramatic rise in the cost of health care driven by the “third-party payer” system.

In 1960, Americans paid almost half of their health care expenses directly out of pocket; today less than one-eighth of health care costs are paid out of pocket. As government and private health insurance programs have taken on increasing shares of health care payments, medical prices relative to general prices have risen precipitously.

That means solutions must be targeted toward bringing health care costs down. Measures that encourage a more open health care market will do much to reduce costs and make health care more affordable and responsive to patients. Fundamental reforms needed at the federal level include putting individually purchased health insurance on an equal tax footing with that provided by employers and block-granting Medicaid.

While states are somewhat limited by federal tax and health care policies, they can take positive steps toward bring health costs under control by

- Restructuring health programs to target the most needy by seeking waivers to impose copayments, and establishing Health Savings Accounts (HSAs) for Medicaid recipients
- Allowing greater competition in the health care industry by reducing regulation, requiring greater price transparency and plain-language billing, and allowing pharmacists to prescribe some drugs
- Encouraging greater competition in health insurance by allowing purchasing of insurance across state lines and reducing mandates for lower-income purchasers of insurance
- Removing barriers to private medical charity
- Establishing HSAs for state employees
- Prohibiting hospitals from charging to treat infections contracted in the hospital.

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I N S T I T U T E

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Introduction

The rising cost of health care is undermining our nation's prosperity. It threatens the financial stability of individuals, families, local governments, state governments, and even the federal government. From 1960 to 2006, health care prices rose at more than double the general rate of inflation. Health care expenditures went from 5 percent of U.S. gross domestic product (GDP) to 16 percent. Nearly a quarter of the state of Arizona's General Fund spending is devoted to some type of health care spending, and the upward trend shows no signs of stopping.

Local government budgets are under pressure to cover their employees' medical benefits, the costs of which grow with rising health care prices. Counties and other local entities often help to finance hospitals and other health care services, too. Consequently, other government services are threatened as health care prices rise. Current levels of spending in public education and road infrastructure cannot be maintained if resources have to be diverted to burgeoning health care budgets. It is imperative that health care costs be brought under control.

From a policy perspective, too much of the focus is on making health insurance more available. The real issue,

even for health insurance advocates, is the affordability of health care. Emphasis on insurance generally focuses on figuring out how to pay exorbitantly high health care prices. The emphasis, however, should be on how to bring prices down. This requires a clear understanding of why health care prices have skyrocketed in the first place.

Decades of poor state and federal policies have contributed to the rise in health costs. States are limited in what they can do to mitigate federal policies; however, Arizona can enact some positive measures to move policy in the right direction. Arizona is especially well positioned, given that it already operates its Medicaid program under a federal waiver and thus has more flexibility to act.

The job of a physician is to evaluate symptoms, make a diagnosis, and then prescribe a treatment that will cure whatever illness is causing the symptoms. A similar strategy is employed here. This paper first discusses the symptoms of a health care system in trouble, including its current and rising demands on government budgets. Then it seeks to diagnose the problem and determine its underlying cause. Finally, given this understanding, it recommends actions that can be taken at the state level to mitigate what is fundamentally a federal illness.

Decades of poor state and federal policies have contributed to the rise in health costs.

Symptoms of a Troubled Health Care System

Among aspects of the American health care system that are less than perfect, there are four major areas of concern—symptoms—that indicate the system is flawed:

- 1) Health care prices are rising much faster than inflation.
- 2) Many believe that the quality of health care is inadequate.
- 3) Health care is not accessible enough.
- 4) Health care consumes a large and growing share of our economy.

The first and fourth symptoms contribute to fiscal problems at the state and national levels. The second and third symptoms appear to be related to high health care prices. It is important to understand just how serious each of these symptoms is in order to make a sound diagnosis. Perhaps the United States is no different from any other nation; perhaps the symptoms are just a result of our aging population. As we will see below, some symptoms are more indicative than others.

Symptom 1: The Fast Rise of Health Care Prices

Americans are used to paying directly for services they receive. Nevertheless, it is certainly daunting to contemplate the possibility of bills for tens of thousands of dollars or more to pay for a critical surgery. Such risks can be mitigated through the purchase of catastrophic health insurance policies. However, the rise in the prices of even routine medical procedures has made this option a costly one. The widely acknowledged precipitous increase in health care prices has increased the cost of

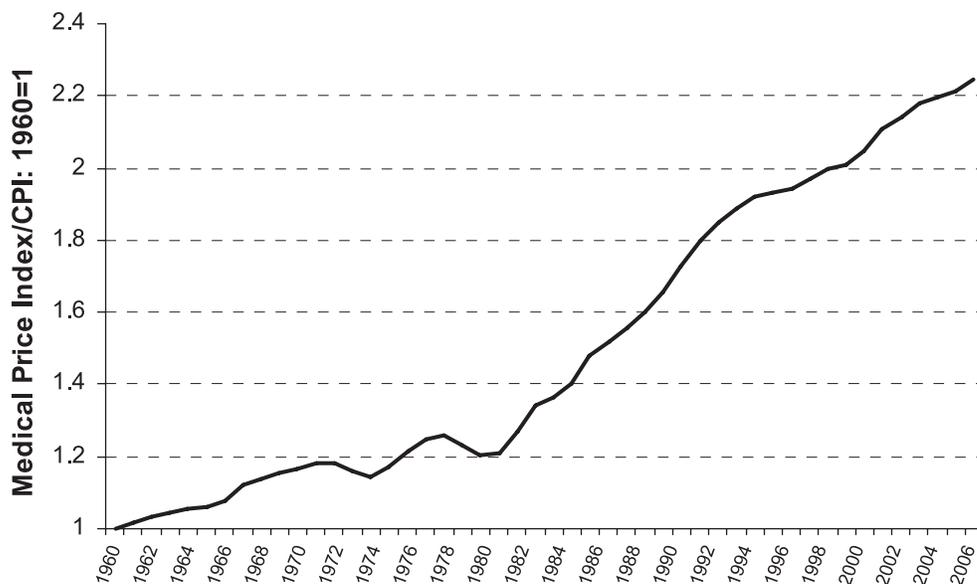
health insurance, making it less affordable (discussed further below) and more difficult for individuals to protect themselves from financial ruin should a health catastrophe strike.

The prices of health care services are especially high in the United States when compared with practices in other nations such as Canada and most of Western Europe where health care can be accessed at taxpayers' expense for little or no out-of-pocket fees. Even so, policymakers around the globe are well aware that people's patience with rising health costs is wearing thin. In Eastern Europe, when fees have been imposed in an effort to bring government budgets under better control, protests have ensued. The fee for seeing a doctor in the Czech Republic is now \$1.85, and it is \$4 a day to stay in a hospital. These modest fees, imposed where there had been no fees before, have angered many (even though they admit to spending more on veterinary care for their pets).¹

Policymakers in the United States should be most concerned about the rapid rise in health care prices. Health care prices have risen faster than the general rate of inflation nearly every year since the mid-1950s, and these rapid increases show no signs of abating. Figure 1 shows the ratio of the Medical Care Price Index (MCPI) and the Consumer Price Index (CPI) from 1960 through 2007. This ratio is normalized to equal one in 1960 in order to show how much medical prices have risen relative to prices in general since then. By 2007, the rise in medical prices had more than doubled the increase in general prices. Over this 47-year period, medical inflation averaged 1.7 percentage points higher than general inflation per year.

Health care prices have risen faster than the general rate of inflation nearly every year since the mid-1950s, and these rapid increases show no signs of abating.

Figure 1: Growth in the Medical/General Price Ratio in the U.S. since 1960



Sources: Bureau of Labor Statistics, MCPI and CPI data, <http://data.bls.gov/cgi-bin/surveymost?cu>; author calculations.

Especially alarming for Arizonans is the degree to which health care spending is growing in their state government.

Economic output is measured in dollars so that we can aggregate everything that is produced and measure it according to its value—the only common, measurable denominator among all goods and services. Consequently, there are two components of output and expenditures: (1) the actual amount, or quantity, of the goods and services produced, and (2) the set of prices of those outputs. Therefore, an unusually rapid growth in a particular sector of the economy could be due either to rapid increases in actual output or to rapid price increases in that particular area.

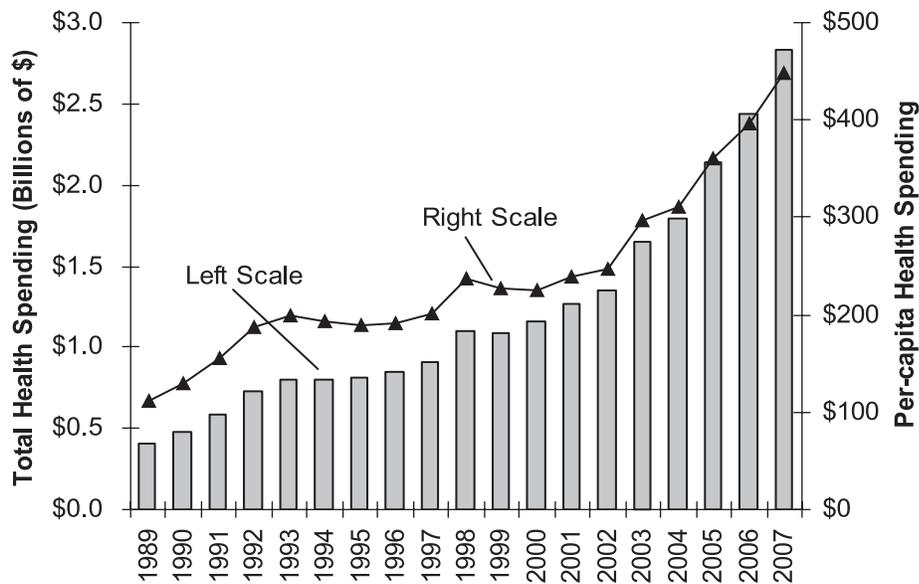
The rapid rise in the health care’s share of the economy (discussed below) is largely due to rising health care prices. Figure 1 illustrates that if medical prices had risen with the general price level reflected in the CPI since 1960, by 2006 medical care would have constituted only a 7.2 percent share of GDP instead of the 16 percent

share it actually has. Instead of health care’s share of GDP increasing by more than 300 percent since 1960, it would have increased a mere 38 percent. Instead of Arizona’s share of GDP devoted to health care increasing over 54 percent from 1980 to 2004, it would have *decreased* 15 percent.

Implications for Arizona’s State Budget

Especially alarming for Arizonans is the degree to which health care spending is growing in their state government. Whether Arizona’s state spending on health care is measured as a total or on a per capita basis, it has grown at a high rate. The bulk of spending in the Arizona Health Care Cost Containment System (AHCCCS), the Department of Health Services (DHS), and the Commission for the Deaf and Hard of Hearing (CDHH) is on health care. Two programs in the

Figure 2: Arizona Health Spending from State Funds



Sources: Joint Legislative Budget Committee, “General Fund Annual Expenditures for Each Agency FY 1979–FY 2008 (8/20/07)” and “Other Fund Annual Expenditures for Each Agency FY 1989–FY 2008 (8/20/07),” both available at <http://www.azleg.gov/jlbc/fiscal.htm>; Stephen Pawlowski, Department of Economic Security.

Currently, nearly a quarter, or 23 percent, of Arizona’s General Fund spending is dedicated to health care.

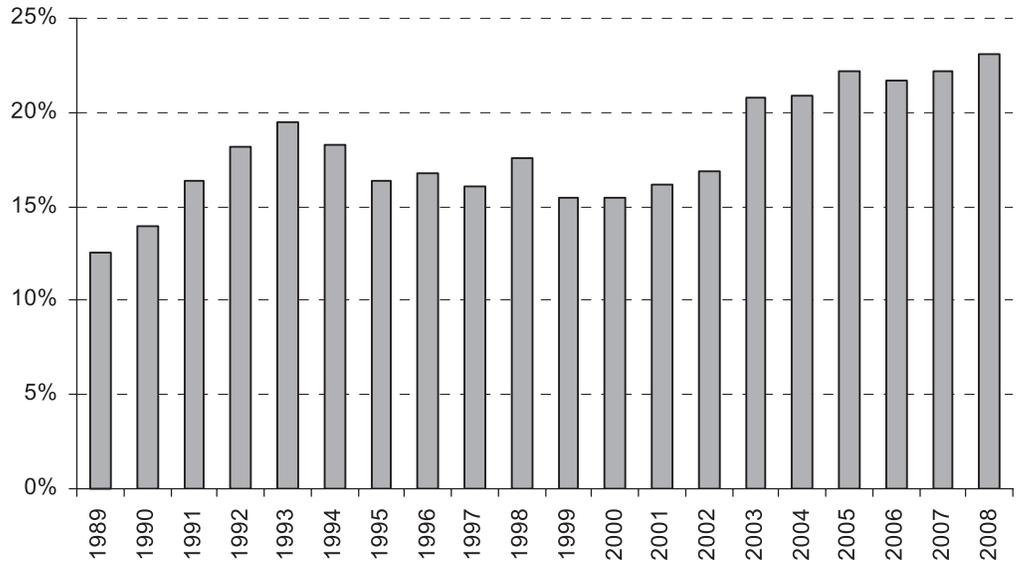
Department of Economic Security (DES), long-term care and developmental disabilities, are also focused on health care. Figure 2 illustrates Arizona’s total General Fund and Other Fund spending in these health care categories, in total and on a per capita basis from 1989 through 2007.²

Arizona’s total state health care spending increased from \$405 million in 1989 to \$2,838 million in 2007, a sevenfold increase over the period, or an annualized average growth of 11 percent per year. Even when accounting for rising population, the growth in Arizona’s state health care spending is remarkable. During this same period, Arizona’s per capita state health care spending grew from \$111 to \$448, a fourfold increase over the period, or an annualized average increase of 8 percent per year.

Figure 3 shows that health care’s share of the budget has also increased markedly in recent years. Currently, nearly a quarter, or 23 percent, of Arizona’s General Fund spending is dedicated to health care. One reason for this is the passage of Proposition 204 in 2001, which required Arizona’s Medicaid program to cover families with incomes as high as 100 percent of the federal poverty level. As late as 1996, Medicaid coverage had been extended only to families at or below 34 percent of the federal poverty level.³ There is a definite jump in the proportion of state funds spent on health care in 2003 as a result of Proposition 204. There is currently no sign that this percentage will peak (as it did in 1993).

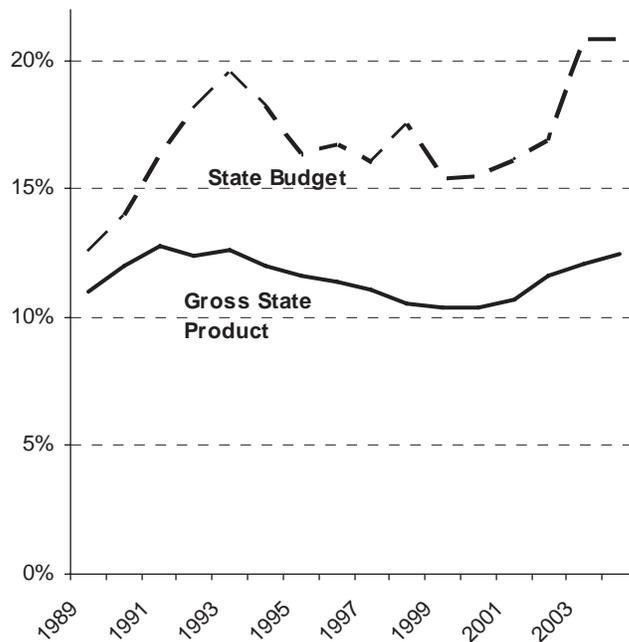
The percentage of Arizona’s budget devoted to health care would be higher

Figure 3: Percentage of Arizona State Funds Spent on Health Care



Source: Author's calculations from fiscal history data by the Joint Legislative Budget Board, available at <http://www.azleg.gov/jlbc/fiscal.htm>.

Figure 4: Percentages of Arizona's Budget and GSP in Health Care



Sources: See Figures 3 and 8.

but for the marked increase in spending across the board in recent years. In real, per capita terms (i.e., adjusting for population growth and inflation), state General and other Fund spending has increased more than 30 percent from 1989 to 2007. Over a third of that increase, however, is a result of increased health care spending.⁴ Clearly, the current trajectory of state health care spending in Arizona is cause for concern. Fully a quarter of Arizona's state budget could be devoted to health care within just a few years. As recent revenue challenges make clear, trade-offs eventually have to be made regarding budgetary priorities. The greater the health care obligations, the more difficult it will be to fund other state needs such as law enforcement functions and education.

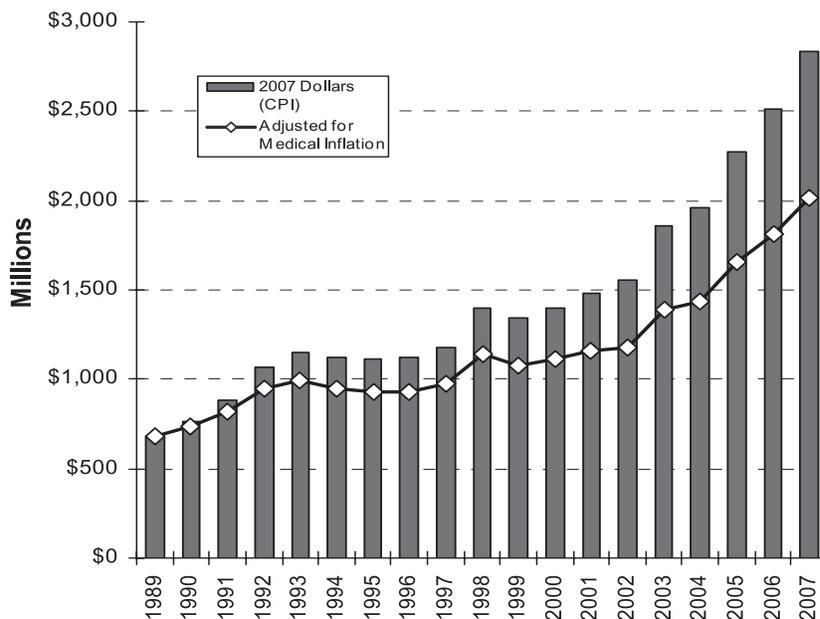
Finally, it is worth noting the possibility

of a relationship between Arizona's state spending on health care and the percentage of the state's economy devoted to health care. Figure 4 (derived from Figures 3 and 8) shows that, since 1989, health care's share of the state's budget and its share of the state's economy have roughly moved together.

The bulk of the health care spending increase illustrated in Figure 2 has been due to high medical inflation. To illustrate this, the data in Figure 2 are adjusted for general inflation and medical care inflation in Figures 5 and 6. Figure 5 shows total Arizona state government medical care spending (not including federal dollars), and Figure 6 shows the same spending on a *per capita* basis. The vertical bars show Arizona's state spending on health care adjusted to 2007 dollars using the

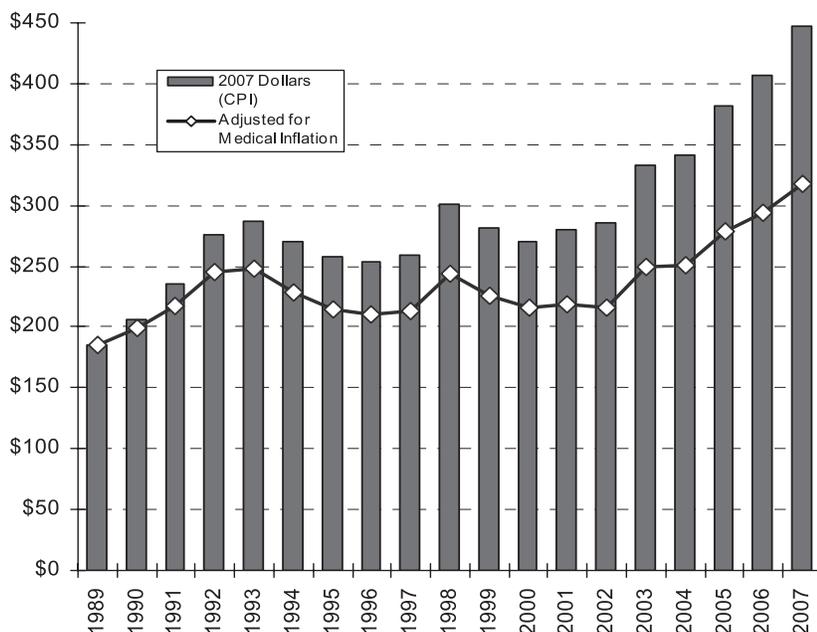
Clearly, the current trajectory of state health care spending in Arizona is cause for concern.

Figure 5: Inflation-Adjusted Total Arizona State Health Care Spending: 1989-2007



Sources: Joint Legislative Budget Committee, "General Fund Annual Expenditures for Each Agency FY 1979–FY 2008 (8/20/07)" and "Other Fund Annual Expenditures for Each Agency FY 1989–FY 2008 (8/20/07)," both available at <http://www.azleg.gov/jlbc/fiscal.htm>; Stephen Pawlowski, Arizona Department of Economic Security; Bureau of Labor Statistics, MCPI and CPI data, <http://data.bls.gov/cgi-bin/surveymost?cu>; author calculations.

Figure 6: Inflation-Adjusted Per Capita Arizona State Health Care Spending: 1989-2007



In 2007, the state spent \$448 per Arizonan, an increase of 142 percent, or 5 percent per year, since 1989.

Sources: See Figure 7; U.S. Census Bureau population estimates; author calculations.

CPI (since spending is denominated in 2007 dollars, the total amount for 1989 is higher than in Figure 2). Despite the general inflation adjustment, spending in Figure 5 still shows a marked increase hardly different from that shown in Figure 2. In 1989, state spending on health care in 2007 dollars stood at \$678 million. By 2007, spending on health care was just over \$2.8 billion, a 318 percent increase (an average 8 percent annual increase) on top of inflation.

Consider what happens when an adjustment is made to account for the disproportionate amount of inflation in the health care sector, assuming every dollar spent by each of the agencies is spent on actual health care. This adjustment reflected in the line in Figure 5 roughly reflects the change in the amount of health care actually being purchased by Arizona taxpayers. Even by this measure,

the amount of health care purchased by the state has increased a great deal—a 198 percent increase, or an average of 6 percent per year. Nevertheless, had medical inflation equaled general inflation from 1989, Arizona could have saved \$800 million in state funds in 2007 and bought just as much health care.

This picture gets even more interesting when inflation-adjusted state health expenditures are adjusted for the state’s population (shown in Figure 6). In 1989, Arizona spent \$185 per Arizonan on state health services. In 2007, the state spent \$448 per Arizonan, an increase of 142 percent, or 5 percent per year, since 1989. However, despite this increased spending, the average Arizona taxpayer was actually buying only 72 percent more health care. When the high level of medical inflation since 1989 is accounted for, the state bought \$318 in health care per Arizonan

in 2007, considerably less than indicated if medical inflation is not taken into account, but still considerably more than in 1989.

From a diagnostic point of view, it is telling that half the growth in real per capita state health care expenditures can be attributed to rising relative health care prices. This is not to say that agency caseloads do not matter. However, monthly caseloads for AHCCCS from FY 2003 through FY 2007 (following the implementation of Proposition 204) have averaged 16.5 percent of the state's population. In FY 2007, average monthly caseload as a percentage of the population stood at 16.2 percent, slightly less than the five-year average, even though inflation-adjusted per capita expenditures were higher than ever. The increase in real per capita spending since 2003 can be attributed mostly to relatively high growth in the caseloads.

Symptom 2: Quality Shortfalls

Qualitatively, our health care system unarguably suffers many imperfections. Of course, the same could be said regarding nearly any market. Nevertheless, health care quality is a widespread concern. Critics attack the U.S. health care system from a number of quarters. In an article in *The New York Review of Books*, Paul Krugman and Robin Wells point out that health spending per capita in Canada, France, and the United Kingdom is lower than that of the United States; yet life expectancy in the United States is lower, infant mortality is higher, and there are fewer hospital beds per capita.⁵ The implication is that inefficiency and lack of quality in the U.S. health care system are to blame for these disparities.

The facts that Krugman and Wells highlight are true, but they are not necessarily indications of quality shortfalls in U.S. health care. Of the 69 nations with populations of 12 million or more compared in the *Statistical Abstract of the United States: 2008*, only 11 have lower infant mortality rates than the United States. Here, 6.4 infants die for every 1,000 live births; the unweighted average of the nations performing better is 4.7.⁶ If infant mortality is measured as a *percentage* of all live births, that is a difference of less than two-tenths of one percentage point.

Every nation with a lower infant mortality rate than the United States' also has a lower fertility rate. There is a well-known positive relationship between infant mortality and fertility rates among nations, although the causal relationship is unclear. A partial explanation for relatively high fertility and the higher infant mortality in the United States is likely its high rate of births among teens, an age group that has a higher infant mortality rate than for other mothers.⁷ The United States has, by far, the highest rate of live births to teens among developed countries.⁸ Every European nation, along with Japan, that has a lower infant mortality rate has a much lower teen birthrate.⁹ In other words, infant mortality in the United States is not just a function of the quality of health care readily available in a nation; there are other significant factors.

The same is true of life expectancy. The U.S. life expectancy at birth is 77.9 years, lower than that of nine other nations. The unweighted average for those nations with a higher life expectancy is 79.9 years.¹⁰ This can be related to any number of demographic factors that are independent of the health care system.

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The United States experiences significantly greater obesity than any of the nations with greater longevity.¹¹ The United States also experiences a higher murder rate than these nations.¹² Both of these factors can be expected to bring average longevity down considerably.

Other critics use different measures to look at health care quality in the United States. In his book *Health Care at Risk*, Timothy Stoltzfus Jost points to a widely cited study that estimates between 44,000 and 98,000 deaths occur every year from medical errors. He cites other studies that show the inconsistency with which effective treatments are adopted and used by health care providers. He hypothesizes a lack of coordination and points to the slowness of the United States in adopting electronic records. Jost also claims that incentives within the health care system to improve health care are weak.¹³ Sounding a similar concern, the National Committee for Quality Assurance (NCQA), a monitor of health care quality, estimates that 45 million workdays are lost each year because of “unexplained variations in care.”¹⁴ Even more frightening, an article in *Forbes* points out that one in 200 patients who spends a night in a hospital will die from a medical error, and one in 16 will pick up an infection.¹⁵

So what do these facts really mean? Despite a lack of electronic records, a credible study can be cited by Jost that estimates the number of deaths from medical errors. That implies a medical system that actually yields a great deal of data. In fact, one only has to access the Kaiser Family Foundation website (www.kff.org) to quickly obtain an overwhelming amount of quality-related data. The NCQA report indicates significant ongoing

improvements in the quality of U.S. health care and an increasing willingness on the part of providers to provide data.¹⁶

Critics of the U.S. health care system often fail to put their statistics into context. Jost, for example, makes no international comparisons except in regard to electronic records. So the large numbers of deaths from medical errors, while pointing to a problem, are unsubstantial in judging the U.S. health care system compared with any other country’s system or even historically with itself. The NCQA statistic on 45 million lost workdays is also better understood when one realizes that with 251 workdays each year and 145 million employed individuals, there are 36 *billion* workdays per year. Therefore, the 45 million lost workdays represents just over one-tenth of 1 percent of all workdays each year. The central theme of the *Forbes* article is how the lack of competition in the hospital industry leads to bad patient outcomes, which is an important context when trying to understand infection statistics.

There are indications that quality in U.S. health care is improving at a rapid clip. In his book *Crisis of Abundance*, Arnold Kling points out that the number of medical specialists has increased exponentially compared with the population as a whole. The same is true of the number of computed tomography (CT) and magnetic resonance imaging (MRI) machines. The United States is virtually alone internationally in the common use of colonoscopy to screen for colon cancer.¹⁷ The NCQA report speaks to the spreading use of beta-blockers to treat patients who have had a heart attack.¹⁸ Procedures that once meant a long stay in the hospital, such as cataract surgery and some knee

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surgeries, can be accomplished safer, faster, and better and have patients sleeping in their own bed within an afternoon. The United States is the world's leader in drug innovation,¹⁹ which is one reason that the odds of survival are significantly better in the United States for one who contracts cancer than if that person is treated elsewhere.²⁰

“Poor quality” as a symptom of illness in the U.S. health care system does not appear to be much of a symptom at all. Proxy measures for quality are too unreliable and can be explained by too many other factors. Human beings who provide health care are certainly fallible, but that is hardly a legitimate criticism of an institutional structure.

The lack of incentives within the health care system to bring about improvement is the one qualitative symptom that should be of concern in a diagnosis. If quality is occurring *despite* incentives, the paucity of incentives should still be a cause for concern.

Symptom 3: Lack of Access

Concerns about access to health care in the United States mostly revolve around the fact that many Americans lack health insurance. In 2005, almost 47 million Americans had no health insurance, and this number had grown significantly in the previous half-decade.²¹ Health *insurance*, as opposed to health *care*, is such a big concern that the first hit under a Google search for “health care cost” is a link to the National Coalition on Health Care. The material focuses on how rising costs have led to less health insurance coverage.²² The second Google hit is to the Kaiser Family Foundation webpage titled “Health

Insurance/Costs.”²³ The Kaiser webpage devoted to health care access is entitled “Health Coverage & the Uninsured: Access to Care.”²⁴ *The Economist* put it well when it said that for many politicians, “the priority in this [2008 presidential] election is not cost but coverage.”²⁵

The problem with the emphasis on insurance as an access indicator is that it obscures the real issue: the rise in health costs. As health costs rise, it is more difficult for the uninsured to afford care when they pay directly, and it is more difficult for them to afford insurance. Rising health care prices affect the bottom line for insurance companies. These companies raise their rates as their health care prices rise; health insurance becomes less affordable; and fewer employers and individuals purchase health insurance, swelling the ranks of the uninsured.

To be sure, there are indications that people without health insurance experience worse health outcomes than those with health insurance. A recent study published in the *Journal of the American Medical Association* (JAMA) reports that the uninsured are less likely to receive initial and follow-up care for accidental injuries and new chronic conditions. Consequently, the uninsured are more likely to report a worsened health situation. Interestingly, the percentage of uninsured who seek medical help overwhelms the percentage of those who do not. In the case of accidental injury, 79 percent of uninsured and 89 percent of insured seek and receive professional medical help. In the case of new chronic conditions, 82 percent of uninsured and 92 percent of insured seek and receive professional medical help.²⁶

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The differences between the insured and uninsured in the JAMA study undoubtedly reflect the fact that out-of-pocket costs matter to people. On average, the uninsured face a higher level of out-of-pocket costs than the insured. Thus, the study confirms that the law of demand is at work in health care just as it is in every other market for every other good or service—that is, the lower the price, the more people tend to consume.

The Institute of Medicine states that “about 18,000 excess deaths among people younger than 65 are attributed to lack of [health insurance] coverage every year.”²⁷ This claim is not presented in a methodological context and therefore cannot be easily verified. However, if it is true, it should be considered in the fullest possible context. In another difficult-to-verify claim, the Committee to Reduce Infection Deaths states that, when compared with the numbers who die from lack of health insurance, “five times as many people die each year from hospital infections, and most of them are insured.”²⁸

This is not to minimize the problem of people going without health care to the detriment of their health, even to the point of premature death. No one would argue that efforts should not be made to minimize premature deaths and maximize individuals’ overall health. Access to affordable health care is certainly a very important ingredient in achieving these aims. However, low-cost access to highly infectious hospitals or those with little access to the latest technologies will not lead to longer and healthier lives.

Access, as a symptom of an ailing health care industry in the United States,

appears to be less strictly an issue of health insurance and more an issue of health care cost or price. The real issue, after all, is access to health *care*, not health insurance. The JAMA study only proves that as the price to the consumer falls, the consumer consumes more health care. Critics concerned about access are really saying that health care costs too much.

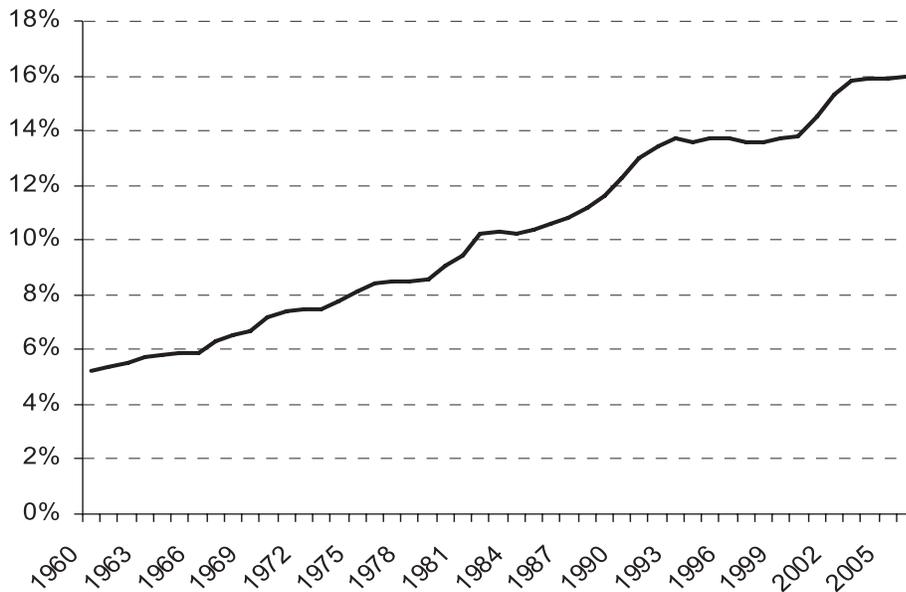
Symptom 4: Health Care’s Growing Share of Gross Domestic Product

Health care now constitutes 16 percent of the U.S. GDP.²⁹ The United States devotes the highest proportion of its economy to health care among nations in the Organisation for Economic Co-operation and Development (OECD). On average in 2006, OECD nations devoted 8.9 percent of GDP to health care, while the United States dedicated 15.3 percent (France’s share of GDP spent on health care was 11.1 percent, Germany’s was 10.6 percent, the United Kingdom’s was 8.4 percent, Mexico’s was 6.6 percent, and Canada’s was 10 percent). The trend for all OECD nations, however, is to spend increasing shares of their GDP on health care.³⁰

While it might be reassuring to know that other nations are similarly seeing the proportion of their economies devoted to health care rising, it is alarming to see how quickly this proportion has risen in the United States. During the 1990s, OECD nations with relatively high levels of health spending at the beginning of the decade slowed the rate of growth in health spending—an exception being the United States.³¹ Figure 7 shows that in 1960 the proportion of the U.S. economy devoted to health care was just over 5 percent. By 1985, this proportion had doubled

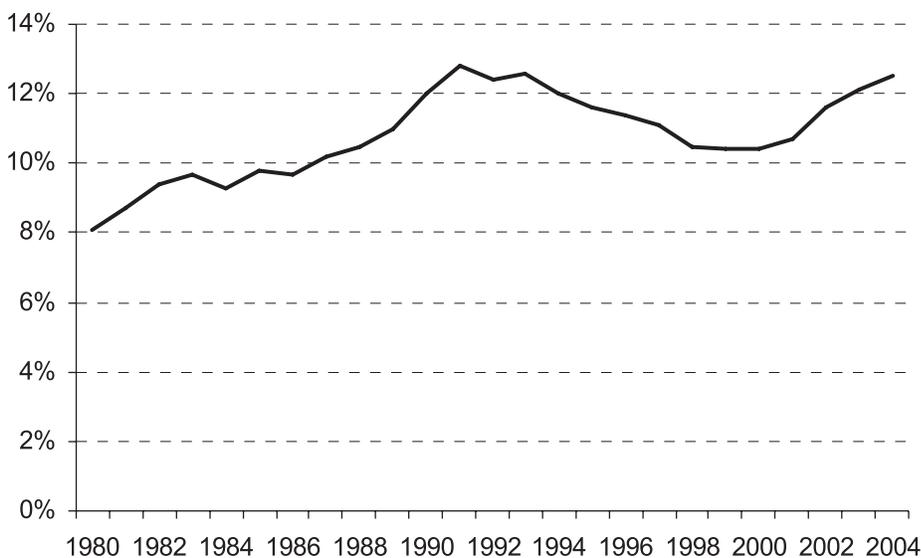
The real issue, after all, is access to health care, not health insurance.

Figure 7: Total Health Care Expenditures as a Percentage of U.S. GDP



Source: Centers for Medicare and Medicaid, “NHE [National Health Expenditures] Summary Including Share of GDP, CY 1960–2006,” http://www.cms.hhs.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp#TopOfPage.

Figure 8: Personal Health Expenditures as a Percent of Arizona Gross State Product



Source: Centers for Medicare and Medicaid, “Health Expenditures by State of Provider: State-specific Tables, 1980–2004 (Final, February 2007),” http://www.cms.hhs.gov/NationalHealthExpendData/05_NationalHealthAccountsStateHealthAccounts.asp#TopOfPage.

compared with 1960. Today, it has more than tripled.

Figure 8 shows a similar pattern for Arizona. Although the Arizona data are not directly comparable with the U.S. data (they leave out some expenditures on health care), the evidence does show that Arizona's economy is also increasingly dominated by health care. Over the 25-year period illustrated, the proportion of Arizona's economy devoted to personal health care expenditures increased by over 54 percent.

Diagnosis

From the four major symptoms from which to deduce a diagnosis of what ails U.S. health care, there is one that stands out as primary—rapidly rising costs.

From the four major symptoms from which to deduce a diagnosis of what ails U.S. health care, there is one that stands out as primary—rapidly rising costs. To an economist, this is very important. Using the basic tools of supply and demand, the underlying causes of price increases can be determined, diagnosed further, and policy adjustments recommended.

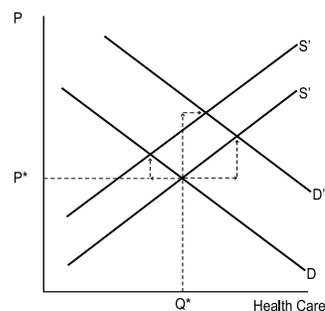
There are only two possible reasons that the price of anything rises relative to other goods and services: (1) consumers have increased their willingness to pay (an increase in demand), or (2) producers have decreased their willingness to sell (a decrease in supply). Supply and demand analysis splits a market into two distinct groups: producers (suppliers) and consumers (demanders). The supply and demand diagram is the most basic, and most powerful, analytical tool economists have at their disposal. With price measured on the vertical axis and quantity measured on the horizontal, causal determinations can be made regarding why prices change (see sidebar).³²

Sidebar: Health Care Supply and Demand

Demand (consumers' willingness to buy) and supply (producers' willingness to sell) are illustrated beginning with the lines labeled D (demand) and S (supply). Demand slopes downward, since people are willing to buy more when price falls, assuming nothing else that affects willingness to buy changes. Supply slopes upward because producers are not willing to sell as much when price falls, assuming nothing else that affects willingness to sell changes. The market price automatically adjusts to where demand (D) and supply (S) cross because any other price results in shortages or surpluses, creating pressure for price to change. The resulting market price is P^* .

If consumers become more willing to buy (willing to pay a higher price for the same amount), the demand line shifts up, illustrated by the D' line. At the old price of P^* , a shortage would result, so consumers bid up the price. The quantity bought and sold in the market also rises as the market moves to the new intersection between D' and S. On the other hand, if producers for some reason become less willing to sell (only willing to sell the same amount at a higher price), the supply line shifts up, illustrated by the S' line. Again, price would rise to the new intersection between S' and D, but the quantity bought and sold would fall.

Figure A: Supply and Demand Related to Quality and Price of Health Care



The distinguishing question is whether rising prices in U.S. health care result from an increased willingness on the part of health consumers to pay or from a decreased willingness on the part of health producers to sell. The test is in the amount of health care being bought and sold. If only demand increased, shifting from D to D' , the amount of health care traded would increase; if only supply were affected, shifting from S to S' , the amount of health care traded would decrease.

Health care costs have risen largely because of increased willingness to buy (i.e., increased demand). The amount of health care bought and sold in the United States has increased even after accounting for general growth in the economy and health care inflation. Even when the much higher medical inflation is accounted for, a higher percentage of the U.S. economy is now devoted to health care. In 1960, health care constituted 5.2 percent of the economy. Today, after accounting for medical inflation, health care constitutes 7.2 percent. In relative terms, the amount of health care produced and sold has increased, suggesting that consumers are bidding up prices.

A two-percentage-point difference in relative health care output may not seem significant, especially when considering the increasing numbers of elderly in the nation. But remember that this is a *relative* increase. Health care output increased along with output in the rest of the nation and then grew some more to expand its share of actual output by at least 38 percent over a 46-year period.

It can be the case that if demand increases significantly, producers can be less willing to sell, and output can still increase. This is illustrated in the supply and demand diagram in the sidebar with a simultaneous movement from D and S to D' and S'. Equilibrium price and quantity adjust from the intersection of D and S to the intersection of D' and S'. The effect is a massive price increase with a modest output increase, since demand shifted more than supply. This is exactly what has happened in the United States. Supply and demand have shifted for exactly the same reason—Americans pay directly for very little of their health care.

The Rise of Third-party Payers and Its Effects

A third-party payer is any person or entity who finances the purchase of a good or service but does not produce or consume it. Parents who finance their son or daughter's college education are an example of a third-party payer. Contributors to indigent charity are third-party payers, since they do not directly produce or consume the products and services charities often provide. Recipients of third-party largesse, including both consumers and producers, alter their behavior compared with what it would be without that largesse. Part of the behavioral change is exactly what third-party payers want. State and federal governments provide Aid to Families with Dependent Children (AFDC) precisely to increase overall consumption by poor families. On the other hand, there can be unanticipated perverse behaviors on the part of third-party recipients. AFDC was radically reformed in 1996 because many of its recipients had become permanently dependent on welfare.

Third-party financing can also affect supplier behavior in perverse ways. If suppliers know that consumers are not particularly sensitive to prices, they will raise prices and compete in other ways. For example, when the airline industry was highly regulated, ticket prices were very high and also regulated. Airlines resorted to competing on the basis of cabin service, meal quality, and a variety of drinks for no extra charge, for example. This increased costs and drove ticket prices even higher. Similarly, programs and policies that have driven up demand for health care have had supply-side effects that exacerbate health care cost increases.

Programs and policies that have driven up demand for health care have had supply-side effects that exacerbate health care cost increases.

Government has now served as a third-party payer and has encouraged third-party payments in health care for decades. Medicare and Medicaid did not exist in 1960 when Congress passed the federal Kerr-Mills Act, a progenitor to the Medicare program. Up to that point, very little federal spending consisted of public health care assistance. Most spending on health care was channeled into research funding, the Department of Defense, and the Veterans Administration. State and local governments spent more than the federal government spent on health care. That began to change in 1965 with an amendment to the Social Security Act, which created Medicare and Medicaid.³³ Today, over a third of all health care spending is financed by Medicare and Medicaid.

When most people use the term health insurance, they are really referring to prepaid health care.

Even before the creation of Medicare and Medicaid, individuals in the United States were becoming less directly financially responsible for their own health care following the advent of prepaid health care. When most people use the term *health insurance*, they are really referring to prepaid health care. There is a distinction to be made between classic insurance and prepaid plans. Car insurance, for example, pays for unforeseen events that tend to be expensive. Prepaid car care would be a maintenance plan wherein a participant makes regular payments to a financial company. The participant would pay little or nothing for routine maintenance such as oil changes, tire changes, and tune-ups, as well as major catastrophic repairs. Oddly, this is very analogous to what we call health insurance today, even though in reality it is a prepaid health care arrangement

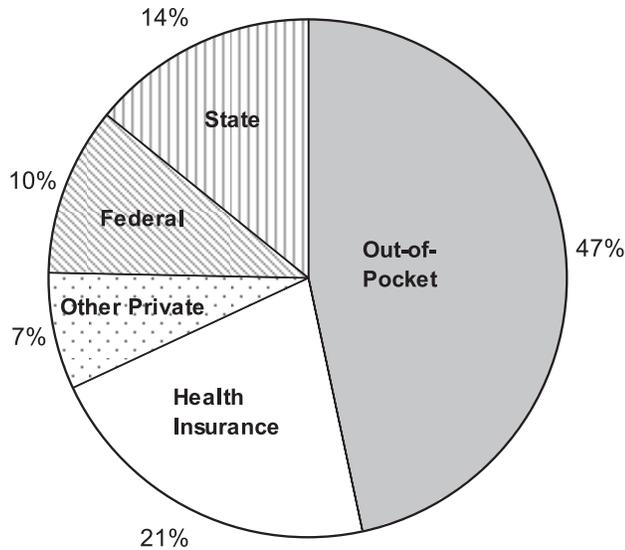
Prepaid health plans were pioneered at Baylor University in 1929. Regulators eventually defined the plans as insurance,

partly because insurance companies recognized prepaid plans' positive cash flow and profit potential. During World War II, wage and price controls prohibited companies from competing for workers by offering higher wages. Companies responded with non-price competition, offering in-kind benefits of various sorts to entice workers. On-site or prepaid health care benefits became one of those common in-kind benefits.³⁴

After wage and price controls were lifted, companies continued to offer prepaid health plans. The Internal Revenue Service (IRS) had decided benefits were not income and were therefore not taxable. Consequently, companies could avoid payroll taxes such as Social Security and unemployment insurance by paying benefits. This was a boon to employees because they did not have to pay the income and payroll taxes that they would have paid on money wages. As a result, by 1960 nearly a third of consumer expenditures for health care were from health insurance. Large employers were further encouraged to provide health benefits in 1973 with the passage of the federal Employee Retirement Income and Security Act (ERISA), which exempts them from most state regulations.³⁵ Today, just over a third of all health expenditures and almost three-quarters of private consumer health expenditures are paid through health insurance, especially of the prepaid variety.³⁶

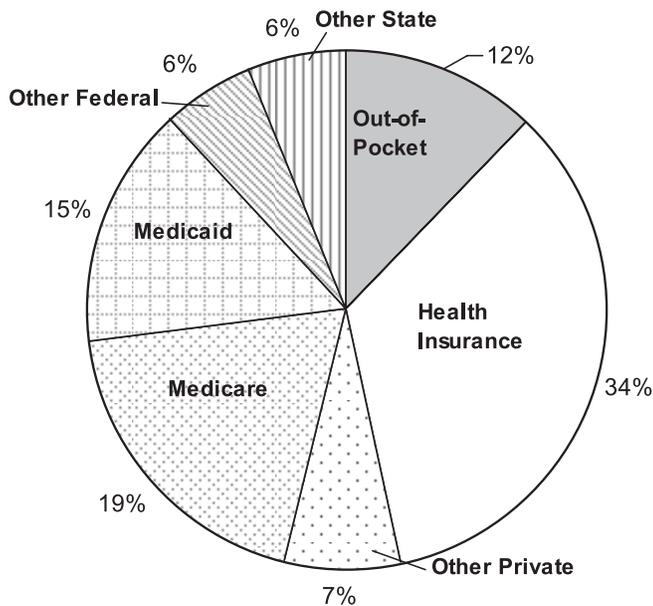
As Figures 10 and 11 show, individuals used to pay a very large proportion of their health costs directly from their own pockets on a fee-for-service basis. In 1960, 47 percent of health care expenditures in the United States were paid directly out of pocket. By that time, private insurance had

Figure 10: U.S. Health Care Spending Sources: 1960



Source: Centers for Medicare and Medicaid Services data. See “NHE Summary Including Share of GDP, CY 1960–2006,” http://www.cms.hhs.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp#TopOfPage.

Figure 11: U.S. Health Care Spending Sources: 2006



Sources: Centers for Medicare and Medicaid Services data. See “NHE Summary Including Share of GDP, CY 1960–2006,” http://www.cms.hhs.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp#TopOfPage.

become common enough that over a fifth of total health costs were paid indirectly by private insurance; less than a quarter of health care was paid by government. By 2006, just 12 percent of health costs were paid out of pocket, over a third by private insurance, and nearly half (46.2 percent) by government. Americans went from paying directly for nearly half of their health care in 1960 to paying directly for less than an eighth of their health care in 2006.

Demand Effects from Third-party Payments

Third-party payment insulates consumers from actual prices, effectively increasing consumers' willingness to consume health care. Consequently, medical care costs have been pushed upward partly because people demand more health care than they would otherwise. The JAMA study on health outcomes for the insured and uninsured (referred to above) helps to make this point. The article states, "These findings are consistent with and reinforce earlier research showing that uninsured individuals *receive* significantly less care than those with insurance and have poorer health outcomes" (emphasis added).³⁷ Correctly stated, the article should read that "uninsured individuals *choose to purchase* significantly less than those with insurance." The statistics in the article make clear that even those with insurance make trade-off decisions. They do not see a doctor at a 100 percent rate when they get hurt or fall chronically ill; on average, they go more often because prepaid-style health insurance has effectively reduced the cost that is apparent to the consumer, even when the total cost of medical services has increased.

The RAND Health Insurance Experiment, completed in 1982, illustrates

the same point. People buy more when the price to the consumer is effectively reduced, even if the actual price paid is much higher. The RAND experiment looked at differences in health services consumed depending on whether health care was provided for free or whether there was "cost-sharing" where the consumer bore only part of the price of his or her health care. The study found that cost-sharing resulted in less usage *and* less waste; needed health care and unneeded health care reductions occurred. Despite the latter result, however, overall health was not different for those who received health care for free and those who had to share in the cost (leading to the question of what "needed" health care was foregone).³⁸

The JAMA article also gives an illustration of how the supply side of the health care market has responded to the rise of third-party payers. The article states, "The finding that there were no differences in the likelihood of having further care [i.e., follow-up visits] recommended *if* a clinician was seen suggests that either there were no differences in severity or, *more probably, that the severity threshold for recommending care is higher for an uninsured person than a person with insurance*" (emphasis added).³⁹ In other words, since the uninsured were less likely to see a doctor in the first place, it is likely that their conditions were generally worse than those who were insured. Yet doctors were no more likely to recommend follow-up visits for the uninsured, despite the increased likelihood of a more serious condition. Doctors were more likely to recommend further treatments when a patient had insurance.

Supply's Response to Third-party Payments

There is, in fact, a great deal of

Third-party payment insulates consumers from actual prices, effectively increasing consumers' willingness to consume health care.

evidence that health care producers have reacted strongly to the increase in demand that third-party payments have enabled. Because consumers with third-party payers do not give much attention to prices, competition among producers has been reduced. Prices have increased even more than the artificially increased demand would seem to dictate. When suppliers raise prices in response to the ready availability of payments by third parties, they have reduced their willingness to sell. It is as if input prices had risen, or the numbers of suppliers had fallen.

A commonly accepted explanation for rising health prices is the development and use of expensive technologies, such as MRI and CT imaging technologies. However, throughout human history, improved technology and its adoption have been accompanied by marked price reductions. Improved technology can only explain higher costs if it is being overused but not making much impact in health outcomes. This is exactly what you would expect in a third-party payer regime and what Arnold Kling describes in his book *Crisis of Abundance*. Kling presents strong evidence that health costs have risen substantially from the practice of “premium medicine,” the heavy use of specialists and expensive technology. Premium medicine makes some, but little, difference in overall health outcomes while adding a very great deal to costs.⁴⁰ If consumers weighed the actual costs with the benefits of premium medicine, there would be much less dependence on such expensive care.

Until recently, MRI and CT scanners were regularly replaced every three years because of the volume of business and their profitability. Now, they are cycled every five years. This change in replacement schedules

has resulted from a reimbursement policy change by Medicare. The city of Pittsburgh has more MRI machines than the entire nation of Canada.⁴¹ Canada probably has too few MRI machines, but it seems fairly reasonable to conclude that the United States might just have too many. Technology, it seems, has become more about adding another billing point than improving patient health. If improved technology is truly the root cause of increased prices in MRI and CT scanners, then why have there been remarkable price declines in other heavily technology-dependent procedures such as LASIK (laser-assisted in situ keratomileusis) corrective eye surgery?⁴²

Medicare, a federal third-party payer, spends much more for oxygen and associated supplies than do people who pay for the supplies themselves. According to a *New York Times* article, Medicare is paying as much as \$8,280 for a basic oxygen setup that can otherwise be had for as little as \$3,500. Oxygen costs Medicare \$1.8 billion per year. Similarly, a pump device available online for \$108 costs Medicare about \$450. Efforts to bring these costs under control, however, are often thwarted by industry communicating to politically active seniors that there are efforts afoot to cut Medicare and that their services will suffer.⁴³

Hospitals are the prime factor in rising costs. A *Wall Street Journal* article notes that nonprofit hospitals enjoy greater pricing power and have seen earnings soar as a result of a series of mergers. Net income of the largest 50 hospitals grew eightfold from 2001 to 2006. Chicago’s Northwestern Memorial Hospital opened a women’s hospital with marble in the lobby, flat-screen televisions in birthing

Medicare, a federal third-party payer, spends much more for oxygen and associated supplies than do people who pay for the supplies themselves.

rooms, 1,000 works of art, and a roof that includes 10,000 square feet of gardens. The former CEO of the hospital received a \$16.4 million payout. The Cleveland Clinic paid a former CEO over \$1 million per year for two years *after retirement*. Many nonprofit hospitals have begun to count their payrolls as part of the “community benefit” that they are obligated to produce for their nonprofit status. Increasingly, their tax benefits alone far outweigh what they spend on charity care.⁴⁴

Hospital billing errors are an all-too-common problem. A *Washington Post* article from 2004 describes how a routine two-hour surgery was billed at over \$25,000. Another patient was charged for a blanket in addition to the room charge. The excuse provided is that too little is standardized with respect to billing for dozens of insurance companies and several government health programs. The article goes on to note that those who review hospital bills for a living find multiple errors in eight of every ten bills.⁴⁵ This grossly high error rate leads one to ask what an “error” truly is. Such a level of systematic “error” indicates purposefulness.

Consider a medical bill audit provided by M-Audits for a 2004 medical bill from a hospital in California. An ammonia plasma laboratory test going for \$13.75 in the wholesale market was billed by the hospital at \$330.88. Numerous Mefoxin (an antibiotic) injections were billed by the hospital at \$91.52 each. The audit allowed only \$9.00 each, which was widely considered usual, customary, and reasonable. Todd Houston of M-Audits noted that the average savings his company can identify just from looking at a bill is between 13 and 20 percent. A CBC (complete blood count) that hospitals

routinely charge \$85 for can be purchased for \$3.75.⁴⁶

J. Patrick Rooney, former CEO of Golden Rule Insurance Company, recently coauthored a book with Dan Perrin entitled *America’s Health Care Crisis Solved*. In the book, the authors point to a study commissioned by the California Public Employees’ Retirement System (CalPERS) and the Pacific Business Group on Health (PBGH). Peter V. Lee, CEO of PBGH, said the study shows that “some hospitals are basing their prices to private insurers and patients on what they can get away with.” A Milliman Inc. report states, “In most private health insurance plans, costs for hospital care have increased at a rate faster than any other component of the health care system, and hospital costs are the largest portion of the price of insurance premiums.”⁴⁷ Hospitals can get away with a lot when people who use their services are not the ones paying for them.

Judging by hospital pricing data compiled from Medicare and compared with Johns Hopkins by the Fairness Foundation, the situation is little different in Arizona. A perusal of the foundation’s website HospitalVictims.org shows low cost/price ratios—estimated actual costs divided by prices charged—that are very common across the states (although wide variations can occur within the same cities or even the same zip codes).

To be fair, economists do not distinguish “fair” pricing. Prices simply are what they are. Admittedly, it is probably not justified to compare every hospital in the nation with a prestigious institution like Johns Hopkins. However, it is quite common to see some uniformity in pricing across the nation in other markets. It is also

Hospitals can get away with a lot when people who use their services are not the ones paying for them.

common to see prices posted, firm charge estimates made and honored, and billing made using plain language. The degree of pricing variation among hospitals and the absence of other generally accepted market characteristics are indicative of a great deal of local market strength on the part of hospitals. Through regulation such as licensing and zoning, government has protected a seller's market in health care. Combined with government's encouragement of health care consumption, it is impossible for a normally functioning market in health care to exist.

The Third-party Payer Distortion

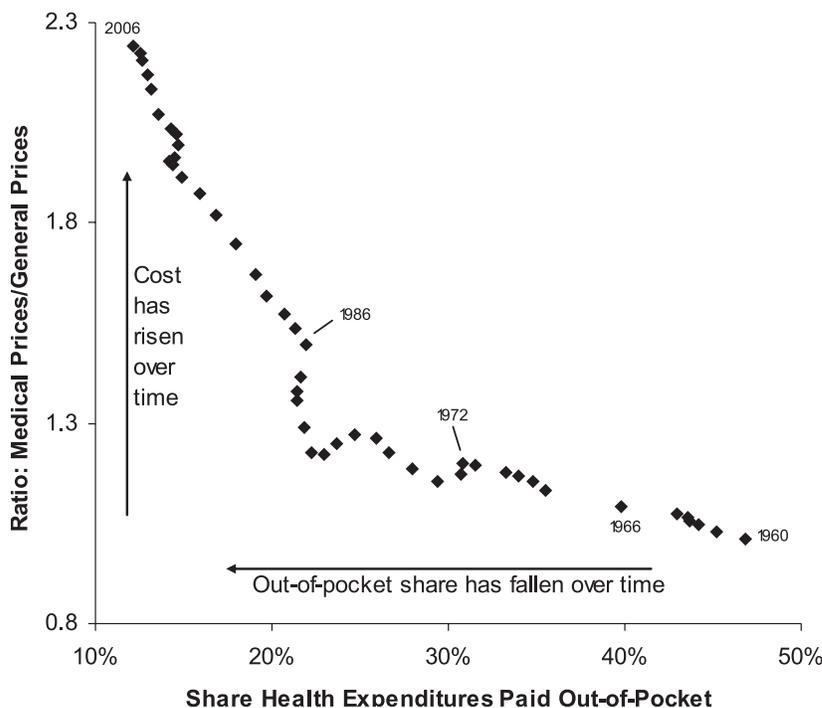
The demand and supply effects from the increasing prevalence of third-party payers in health care have resulted in

fast-rising health care prices. As shown above, the percentage of health care costs paid out of pocket has diminished over time. The relationship between these two phenomena can be seen by looking at a scatter plot using national U.S. data from 1960 through 2006 (see Figure 12). As the proportion of health care costs paid out of pocket has fallen, medical inflation has continually outstripped general inflation, compounding the differential between medical and general prices over time. The ratio of medical and general prices illustrated by the vertical axis in Figure 12 is the same as that in Figure 1.

Americans are paying a great deal more for health care. It is arguable that the reason we are paying more is that we are living longer and have better access to treatments,

Through regulation, government has protected a seller's market in health care.

Figure 12: Medical Prices and the Share of Medical Payments Out-of-Pocket



Sources: Bureau of Labor Statistics, CPI; Centers for Medicare & Medicaid Services, National Health Expenditure statistics; author calculations.

vaccines, procedures, and cures that did not exist just a generation ago. We could, however, get even more for our dollars if not for the distortions caused by the third-party payer system. Studies comparing U.S. health care with other nations' indicate that not only do Americans use more resources than necessary in our health care system, but we pay a disproportionately high price for those resources.⁴⁸

The correct diagnosis, it would seem, for what ails America's (and Arizona's) health care system is remarkably simple: People are not paying for their own health care. Consequently, the market for health care is highly distorted, even to the point of not being a legitimate market. When only 12 percent of consumer expenditures in a market are paid directly by the consumers themselves, this can hardly be considered a true market. Markets occur when buyers and sellers come together. Sometimes, third parties are involved (e.g., buyers and sellers of real estate often never meet, acting instead through intermediaries). However, the health care system is one of suppliers, receivers, and payers. Receivers of and payers for services are usually the same party, known as the consumer, but these functions have been divided in the U.S. health care market.

It could be argued that nations with highly socialized medicine have the ultimate third-party payer system; yet the United States is still unique in the degree to which prices have risen.⁴⁹ This would appear to refute the third-party payer argument. However, nations with socialized health care put government in the role of health care consumer, making decisions on behalf of individuals. In this role, government's purchasing power, its ability to ration care, and price controls have

served to slow the rate of growth in costs. The U.S. system allows receivers of health care to continue making fundamental consumption decisions, but because of the involvement of third-party payers, most of these decisions are made independent of cost considerations.

Americans are in a catch-22. We are afraid to have to pay for our own health care because of rising health care costs, but we could better afford our own health care if more were paying for it themselves. It is certainly understandable that few are willing to venture into the unknown territory of self-paid health care given the current state of medical care pricing. Nevertheless, more than anything this is what is needed. Not only would out-of-pocket costs fall, but so would insurance premiums. Lower health care costs would mean lower premiums. Were medical care prices lower, people would undoubtedly be more comfortable with the idea of moving away from prepaid health care and toward a true insurance model focused on unanticipated, catastrophic health events.

Treatment

The Big Picture

A true health care market, including head-to-head price competition among hospitals and doctors, is badly needed. It means competition in quality as well. A true market is characterized by lots of information with which consumers can make informed comparisons, which is nearly nonexistent in today's health care sector. Individual consumers make their own choices in a market rather than having their insurance and its terms selected for

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them by their employer or government. Markets allow for risk reduction—which is what insurance is all about—but markets do not insulate consumers from the costs of their decisions. Also, competition and profit motive cause the interests of consumers and producers to converge, with competition among producers and competition among buyers rather than between producer and buyer. Having an almost adversarial role between buyer and seller, damaging in any market-like setting, is especially dangerous in health care.

With respect to health care, Americans would like to see improved affordability, quality, and availability, issues that parallel criticisms of the current system. Of particular importance is the mitigation of financial risk. Ideally, no one should have to do without basic health care because of lack of affordability; no one should go bankrupt or without care because of a catastrophic health event; no one should become financially strapped because of the expenses of a chronic condition. It is the mitigation of these financial risks that gave rise to the Medicaid and Medicare programs, as well as the State Children's Health Insurance Program (SCHIP). These programs are intended to insulate the poor (Medicaid), the lower middle class (SCHIP), and the elderly (Medicare) from financial hardships resulting from health care expenses.

Although the mitigation of financial risk appears to be the main goal of modern U.S. health policy, health care quality is certainly important. Ideally, everyone would have unlimited access to the latest and best technologies and the very best personnel. Catastrophic illness and chronic conditions should be quickly and correctly diagnosed and the most effective treatments

applied. Errors should be vanishingly rare. Hospital-induced infections should be nonexistent. Emergency care should be no more than a few minutes away. Specialists for any imaginable malady should be easy to consult, if not at one's bedside. Nurses, rehabilitation specialists, and other trained personnel should be at one's beck and call.

Reality is, and always will be, much different from the ideal. Economic scarcity is very real and continuously present. Trade-offs will always have to be made. John Goodman, whom the *Wall Street Journal* referred to as "the father of Health Savings Accounts," has calculated that if every American requested every available blood test at the same time, it would cost more than all of the U.S. GDP.⁵⁰ Low prices combined with unlimited quantity and superlative quality, at any point in time, do not go together. These are conflicting policy goals in the short run, although technological change and market incentives have demonstrated over and over an ability to simultaneously lower costs and improve quality *over time*. In the short run, one must be sacrificed in favor of the other, however, and policy efforts calculated to obtain both backfire, especially with respect to innovation. This, in turn, makes it *less* likely that low cost and high quality will be simultaneously achieved.

The challenge for the policymaker is to mitigate financial risk while minimizing perverse incentives that policies intended to meet that goal tend to engender. Unfortunately, it appears that many policymakers have either ignored or been unaware of this challenge, creating policies that seem calculated to encourage as much consumption of medical care as possible, regardless of the costs. Indeed, as has

No one should have to do without basic health care because of lack of affordability; no one should go bankrupt or without care because of a catastrophic health event; no one should become financially strapped because of the expenses of a chronic condition.

been demonstrated, because of perverse incentives from government health care finance programs and government's encouragement of prepaid health insurance, the resultant higher medical prices have made it more difficult to reach the financial mitigation goal. In 2000, U.S. public spending on health care alone, about half of all health care spending, constituted 5.8 percent of GDP, nearly equal to that of the United Kingdom (5.9 percent), where government covers nearly all of the spending on health care.⁵¹

Needed Changes in Federal Policy

The third-party payer problem is largely a federal policy issue. Medicare is purely a federal program. Medicaid, though significantly financed at the state level, is a federal program, and federal law determines much of its policy. Income tax policy is also a federal issue. Most state income taxes piggyback on federal policy, and federal income taxes dwarf state income taxes. Consequently, states are hamstrung, significantly limited to mitigating the effects of bad federal policy with respect to health care. That is not to say states have resisted promulgating market-stultifying policies of their own. However, federal policy is the elephant in the room when it comes to health care.

Fix the Tax Code

The federal tax code is largely responsible for the current state of prepaid health insurance in the nation and the distortions of the market that result from such a system. In-kind benefits purchased on behalf of employees (e.g., health insurance) should be taxed as employee income, or individually purchased health insurance plans should be fully tax

deductible whether an individual otherwise itemizes or not. The easiest way to put benefits on an equal tax footing would be to tax them just like any other form of income for wage and salary earners and just like any cash payroll for employers. The effective tax increase could be offset with increased standard deductions. Either way, individuals could decide for themselves how much health insurance to buy and on what terms. It is a good bet that many will opt for cash instead of the in-kind benefit when tax treatment is equalized. Then it will be up to individuals to purchase their own insurance, which will tend to be of the relatively inexpensive, truly catastrophic variety. Insurance will then be individually owned and portable across employers.

Block Grant Medicaid

The Reagan administration first proposed block-granting Medicaid in the 1980s.⁵² The idea is to establish a formula that determines the amounts each state would receive from the federal government. The funds would be used only to provide for medical care for the poor. The formula would be based on variables such as a state's poverty rate and total population.

The main benefit of block-granting Medicaid is that it would grant a finite amount of money to the states, which would no longer have the incentive to chase federal dollars as they do today. This problem is thoroughly discussed in a recent Goldwater Institute policy report, as well as in an American Enterprise Institute report.⁵³ Currently, 66.2 percent of Arizona's Medicaid spending comes from federal dollars. For each dollar that Arizona spends on Medicaid, the federal government matches it with \$1.96. The temptation to chase these federal dollars

Federal policy is the elephant in the room when it comes to health care.

is more than many states can resist. Arizona is one of the few that has resisted taking Medicaid close to its federal limits. However, it is difficult to counter the argument for spending one dollar to bring in nearly two dollars, even if this spending distorts the health care market.

Remove Remaining Barriers to Health Savings Accounts

In 2003, as part of the political calculus that created Medicare Part D, the new prescription drug benefit for seniors, federal law provided for before-tax Health Savings Accounts (HSAs). No income tax is paid on deposits to an HSA, including interest earnings. An individual may use funds from an HSA to purchase qualifying medical expenses (determined by the IRS) without any income tax implications. Currently, though, only those having a high-deductible health insurance plan—\$1,100 for an individual or \$2,200 for a family—can establish an HSA. In addition, there is a maximum yearly HSA contribution limit of \$2,900 for an individual and \$5,800 for a family. These and the deductible amounts are indexed for inflation.⁵⁴

The positive incentives of HSAs are clear. They encourage people to save and build their wealth, providing greater security in retirement. By coupling HSAs with high-deductible insurance (which most individuals would likely do), people become responsible for the costs of their own health care decisions. They come to recognize and account for the costs charged by the health care system, and they act accordingly. In the long run, the inflationary pressures so strong in health care today will subside as a result of people taking on greater financial responsibility. At

the same time, individual HSAs, along with real catastrophic health insurance plans, will provide safety nets for the account holders. HSAs have proven so popular that over 6 million people in the United States are currently covered by such plans. More than 3 percent of all Arizonans enrolled in private health insurance are covered by HSAs coupled with high-deductible plans.⁵⁵

The federal government should remove minimum deductible restrictions on individuals establishing HSAs. It should also remove the maximums on HSA yearly contributions. This will encourage more to begin saving their money. As time goes on and savings build, people will move toward higher-deductible plans. The federal government should also make it easy to deduct HSA contributions on even the simplest income tax return forms. Coupled with policies to free individuals from employer-provided health insurance, HSAs can help to re-create a true market in health care, which will bring down costs for discerning consumers. HSAs can help bridge the interval during which health care prices moderate and then adjust where a true market would dictate.

Needed Changes in State Policy

State Remedy 1: Restructure Medicaid for Those Who Really Need It

Medicaid is the elephant in the room when it comes to state finances and health care. Unfortunately, the federal government limits what states can do and is unlikely to cancel the program. However, there are a few things states can do to limit their taxpayers' liability and still maintain the program. States should push the federal government to grant federal waivers, of

By coupling HSAs with high-deductible insurance, people become responsible for the costs of their own health care decisions.

which the Arizona Health Care Cost Containment System program is one.

Recipients of public-financed health care have little reason to scrutinize the costs of their health decisions. They receive very little or no benefit if they moderate their use of health care, since they pay very little or nothing when they use it. Methods must be devised to provide a functional safety net but also fundamentally alter the incentives Medicaid recipients face. Arizona's managed care system in AHCCCS is one innovation other states should emulate as a way to mitigate demand.

Limit Eligibility

In the 2008 legislative session, the legislature chose to limit Medicaid eligibility to six-month intervals as a cost-saving measure. In the past, eligibility for Medicaid could be established and benefits would be forthcoming for a minimum of one year, regardless of whether the recipient's income grew to an ineligible level during the year. By limiting eligibility to six-month intervals, Medicaid recipients who have become ineligible can be discovered sooner and taken off the rolls. This shorter interval should be maintained, and over the long-term, the state should put systems in place to maintain even more continuous eligibility checks, if they can be implemented in a cost-effective manner.

Impose Copayments

Although federal law limits copayments to a nominal amount of \$3,⁵⁶ Arizona operates AHCCCS under a federal waiver and sometimes specifies slightly higher fees (e.g., a regular doctor visit is \$1, while a nonemergency visit to an emergency

room is \$5). No one can be turned away for inability or refusal to pay. This last provision makes copayments a farce, and it is unlikely that anyone bothers to demand such copayments. Apparently recognizing this, a rule was promulgated to raise copayments for certain services (a nonemergency visit to an emergency room would require a \$30 copayment). However, a federal court has prohibited the enforcement of this rule change.⁵⁷

For a copayment to have an impact and reduce needless use of health services, it has to be more than a nominal amount, especially for optional services such as using an emergency room instead of making a regular office visit. If a true safety net is to be maintained, its abuse leads to dysfunction. The likeliest path to a well-maintained safety net is to keep copayments low for needed procedures but use copayments to give people incentives to make more rational decisions by recognizing the real costs of the services they use.

Establish Health Savings Accounts for Medicaid Recipients

The positive incentives of HSAs are clear. The problem is that Medicaid recipients are, by definition, low income and as such have little discretionary income with which to build an HSA. However, perhaps there is a way to divert some of what is currently spent on Medicaid into establishing HSAs for Medicaid recipients. This is where copayments can help. Some of the money that the state and federal governments save from reduced use and cost-sharing by instituting a system of copayments could be diverted to HSAs for Medicaid recipients.

The federal government has invited

Methods must be devised to provide a functional safety net but also fundamentally alter the incentives Medicaid recipients face.

waiver applications for just such a program under the heading of Health Opportunity Accounts (HOAs).⁵⁸ HOAs for Medicaid recipients would have to be carefully constructed to build the right incentives for the recipients. It would not be wise to seed savings accounts intended for medical expenses and then turn them over to recipients with the optimistic belief that the accounts will only be used for health care. At the same time, if the accounts can only ever be used for health care, we will have the same overuse problem we have now. It is not likely that health care will be denied to those who exhaust their accounts, either. The only way to build an incentive for Medicaid recipients to preserve savings for their own health care is if some or all of those savings can potentially be used for something else.

One possibility could be to provide for matched savings. That is, if a Medicaid-eligible individual saves a dollar, the state could match that dollar with some amount, deposited into the same account. The account could be held in a private trust account. A certain minimum balance could be required before any funds above that minimum could be treated as a regular HSA. So, if the minimum balance were \$5,000, the account's owner could draw only from amounts above \$5,000 for purposes other than health care, subject to income tax. Matching funds would cease once the minimum is reached, and the minimum could increase with age.

Allow Medicaid Recipients to Opt for a Concierge Doctor

Concierge medicine is a growing phenomenon wherein doctors offer their services to patients essentially by subscription. The patient and doctor enter

into a contract that specifies a certain yearly retainer fee that the patient must pay in exchange for the right to see the doctor on a ready basis. Certain limits could be built into the contract, but the patient would have nearly unlimited access to a concierge doctor in his office (subject to appointment availability) and by phone after hours.⁵⁹

Doctors who practice medicine in this financial model do not deal with insurance companies or Medicaid or Medicare. They only answer to the patient. Some doctors charge a relatively high fee, making themselves subject to their patients' beck and call while taking fewer patients. Other doctors accept a lower fee in exchange for patients placing fewer all-hour demands on them.

Combined with an HSA and a high-deductible catastrophic hospitalization plan, a concierge contract with a willing doctor might be a simple finance solution for some Medicaid recipients. The doctor would be more willing to take Medicaid patients because of the reduced administrative hassle. Medicaid recipients would be in greater control of their health care choices by directly choosing their doctors

A similar strategy could be to offer doctors tax incentives to care for low-income patients free of charge. Doctors willing to do so could be placed on a list and receive referrals from AHCCCS. This would keep patients off the Medicaid rolls, and the doctor would not have to deal with the administrative hassles related to finances.

Concierge medicine is a growing phenomenon wherein doctors offer their services to patients essentially by subscription.

State Remedy 2: Free the Health Care Market

Encourage Competition

Hospitals consume a third of the nation's \$2 trillion health care bill. Specialty hospitals, often owned by doctors, have regularly shown high-quality results. However, the hospital industry, "through legally questionable bullying tactics and arduous lobbying,"⁶⁰ has squelched the expansion of specialty hospitals. The claim is that doctors will admit patients too frequently and overprescribe if they own the hospitals. Federal law prohibits doctors from referring patients to hospitals in which they own part interest. Specialty hospitals got through a loophole by being owned entirely by doctors, but a 2003 law prohibits Medicare patients from using such hospitals.⁶¹

The most powerful disciplinary force for service providers is market competition.

To the greatest extent possible, states should encourage the establishment of hospitals and clinics, regardless of who owns them. The most powerful disciplinary force for service providers is market competition. If a mechanic insists that a complete tune-up be performed on a vehicle before it leaves his shop—regardless of why it was brought to him in the first place—he will lose customers to the mechanic down the street. The same discipline can exist in the health care system as long as government resists subsidizing large hospitals and enacting regulations that add costs. Regulation leads to increased consolidation and less competition.

Encourage Price Transparency and Plain-language Billing

A truly functioning market readily provides pricing information. Restaurants,

for example, often post their menus and prices just outside their entry doors. Auto repair shops and other technical service industries give estimates free of charge or for a refundable charge if their services are used. This allows consumers to comparison shop and gather qualitative information regarding the integrity of the service provider and other issues in addition to the pricing information.

The lack of pricing information in health care is a strong indicator that there is not enough competitive pressure in the system, which is largely a result of the third-party payer problem. But even today, there are health consumers who pay out of pocket and others with HSAs who need pricing information.

The health care system, however, currently provides little pricing information, making it difficult for consumers to comparison shop or control costs. Although a 1996 law requires price reporting to the Arizona Department of Human Services, this reporting is not for the benefit of patients who finance their own health care, but for the benefit of the major third-party payers in the state. Further, a 2005 statute exempts certain health service providers from this reporting requirement.⁶²

If policies change to reduce the dominance of the third-party payer system, price transparency is likely to increase as health care providers become more competitive. However, policymakers could consider expediting this process with policies that encourage greater price transparency now.

Every hospital, clinic, and patient has unique circumstances, and it can

be difficult to estimate the full cost of a medical procedure. Consequently, if government decides to require increased transparency, it should not mandate its form. A law requiring pricing information should not go further than requiring medical providers to inform patients of the price of a standard procedure when requested.

The Deloitte Center for Health Solutions has provided a guide for policymakers with respect to price transparency in health care. The authors point out that there is a role for states to play in this area. One possible way to show leadership is to change state employee health benefits to high-deductible plans with HSAs. Then, the state could require price disclosure for state employees, thereby taking advantage of its market position.⁶³

Regardless of the challenges involved in developing this type of system, hospitals should be required to post what they charge for a Mefoxin injection (see above) or a standard x-ray, for example. There are a host of other standard treatments and procedures that can easily be priced and posted. The often-complex language on bills can equivalently be standardized. If a mechanic can estimate the standard time for any given procedure for any given car, surely health care professionals could figure out how to post prices and use plain-language billing. One resource for information on plain-language billing as well as price transparency is the Patient Friendly Billing Project by the Healthcare Financial Management Association.⁶⁴

The recent increase in retail medical clinics demonstrates the possibilities in price transparency. Companies such as The Little Clinic and MinuteClinic post

treatment prices online and in their retail locations.⁶⁵

Allow Pharmacists to Prescribe

Pharmacists generally have more training in pharmacology than do nurse practitioners and physician assistants. Yet, while these latter two professions are often allowed to prescribe drugs, pharmacists are not. Scope of practice regulations generally prevent pharmacists from prescribing, although there are often situations and conditions that do not require a sophisticated diagnosis. The United Kingdom, among other nations, allows pharmacists to counsel patients and sell them drugs without a physician. Easing scope of practice regulations will likely lead to greater access to drugs people need but consider too costly given the current two-step process to get them. Wherever possible, physicians should be eliminated as gatekeepers to needed care.⁶⁶ A good example of where this is already occurring is with in-store health clinics in Wal-Mart, which frequently use nurse practitioners and physician assistants.⁶⁷

State Remedy 3: Encourage Private Companies to Broker Health Services and Hold Hospitals and Doctors Accountable

A major reason people seem more concerned about health insurance than health care is that apparent health care prices are so high. It is no wonder a person who uses health insurance and sees the undiscounted bill is fearful of losing that insurance. The charges often seem unreachable for anyone of average means. However, a conversation with any health professional who handles billing reveals that prices patients see rarely bear much resemblance to those actually paid by health

If a mechanic can estimate the standard time for any given procedure for any given car, surely health care professionals could figure out how to post prices and use plain-language billing.

insurance companies. Few consumers of health care consume it regularly enough to make it worthwhile to take the time necessary to thoroughly research charges. Such information is scant even for those who do take the time.

As a result of the increasing numbers of uninsured looking for alternatives, a new industry has been born. Businesses have begun to profit from the arbitrage between prices hospitals and doctors state on their bills and what they receive from insurance companies. These firms seek out health cost information and, for a fee, promise to lower the bills of uninsured individuals who contract with them. The nonprofit Fairness Foundation, for example, negotiated 29 hospital bills from fall 2006 to fall 2007 whose original total billings of \$717,540 were negotiated to \$219,229, a savings of \$491,310.⁶⁸

Medicaid reimbursement rates should be made public and can serve as a baseline for people and firms that seek to profit from arbitrage.

The Fairness Foundation did not have to charge for its services. However, its example shows why arbitrage in health care presents a large financial opportunity. These companies are generally disliked by insurance companies because they can often operate outside of state insurance regulations, yet they offer an alternative to insurance, especially for those who are relatively healthy. Depending on their business model, arbitrage companies contract with and even assemble PPOs (preferred provider organizations) that guarantee discounts (compared with uninsured billing rates) to contracted patients who carry discount cards. Other companies may simply contract to provide billing audits and provide evidence that billings are too high.

Any time an industry is able to operate behind a thick informational veil, efforts

to pull back that veil will be stymied. The health care industry is no exception. Hospitals and doctors resent outsiders looking under their hoods; insurance companies resent the competition. Just as prepaid health plans were captured and pulled under insurance regulation, the same is happening with discount plans. One company based in Texas, Affordable Healthcare Options, has been placed in legal limbo and has borne extra legal costs as a result of investigations by the Texas Attorney General and the state's Department of Licensing and Regulation. In both cases, the company has been able to continue operating, albeit in a modified form.

There have certainly been instances where people have been swindled by companies promising medical discounts. Part of the problem arises from consumers' wide experience with prepaid health plans associated with insurance but relatively little experience with paying health bills directly.

Government should provide information and be aggressive in prosecuting fraud. Medicaid reimbursement rates should be made public and can serve as a baseline for people and firms that seek to profit from arbitrage. Authorities should default to a hands-off approach, however. Discount cards and audit firms are new concepts to most people, and some consumers will not fully inform themselves, even when businesses disclose everything as honestly and straightforwardly as they can. If government steps in over every complaint, though, health care consumers will have less incentive to become price savvy themselves.

State Remedy 4: Deregulate Insurance

One important way for an individual to protect himself from bankruptcy in the case of a major calamity is to purchase insurance. The availability of insurance covering a reasonably wide spectrum of events at a reasonable cost is therefore a worthy policy goal. Policymakers should be aware, however, that costs of insurance and the comprehensiveness of coverage are related. Coverage for a wider set of more costly events pushes up the cost of insurance.

Insurance of all types suffers from an *adverse selection* problem. Those who are at the greatest risk of calamity feel the greatest need to purchase insurance, while those at low risk see little need to purchase insurance. Consequently, insurance costs more than otherwise because coverage ends up being concentrated among those facing the greatest risk. High costs cause those with low risks to be even more reluctant to buy insurance. However, if they were to participate, they could eventually bring insurance costs down.

Insurance works best when it offers coverage of basic risks whose costs are well known and that are widely faced by many individuals. It also works best when the potential pool of insurance customers is as large as possible. An insurance company limited to selling insurance only in Arizona cannot be as large and cannot spread risk over as many customers (insurance being a risk-sharing arrangement) as one that can sell across the whole country.⁶⁹

Allow Purchasing from Other States

Noah Clarke and Eric Novack recently authored a Goldwater Institute paper

calling for Arizona to allow its residents to purchase insurance from any state. Despite being a direct violation of the Commerce Clause of the U.S. Constitution, states have limited their citizens' options with respect to insurance purchases. There seems to be little justification for this practice except that customers who have disputes with their insurance company potentially have a relatively low-cost recourse in the form of a state's regulatory agency.

There could be some justification for states to have some authority to oversee the actuarial, financial solvency of insurance companies incorporated within their borders. States could even compete on this basis, much as they compete in tax and regulatory policies in other areas. Such competition could lead to lower overall insurance rates and to more complete knowledge regarding companies' financial depth. Alternatively, the insurance industry could police itself with government requiring disclosure of key financial information, much as corporate information is made available to investors today.

With the increased competition resulting from cross-state purchasing of health insurance, consumers could pick an insurance package that more closely fits their personal needs. State regulators would also have to make decisions without being able to take for granted that all citizens in the state are essentially captured customers. Greater competition among providers will benefit consumers and eventually lead to lower prices and better service.

Protests that Arizonans would have little recourse if problems arise with an insurance company chartered and regulated in New York ring hollow in light of other cross-state arrangements. Arizona's

Greater competition among providers will benefit consumers and eventually lead to lower prices and better service.

Department of Insurance could become a clearinghouse for customer complaints, making them publicly available, and out-of-state insurance companies would be disciplined by their reputations. When Arizonans experience a tort, they would continue to have recourse to the courts, just as they do when they buy products from any company not based in Arizona. The idea that insurance is fundamentally different from any other product currently sold across state lines is unreasonable.

Reduce Insurance Mandates

Current practice in health care is to substantially limit choices of individuals and small businesses. Large employers who self-insure, as stated before, can rely on the federal ERISA law and avoid most state regulations. Small employers and individuals, however, must purchase insurance specified by state law. That means that in every state save Utah, a single male must purchase insurance that covers mammograms.⁷⁰ These mandates add to the cost of insurance, often causing employers to drop health insurance as a benefit and leading to fewer having insurance. Currently, about 1 million Arizonans lack health insurance.⁷¹

Mandates add to costs. In 1997, the National Center for Policy Analysis commissioned the actuarial firm Milliman & Robertson (now Milliman Inc.) to analyze a dozen health insurance mandates. The analysis found that if all 12 mandates were included in a health insurance plan, they would add up to 35 percent to the cost of health insurance. To be sure, only a few of these mandates added the bulk of the additional costs, but it is not always clear beforehand how much a potential mandate will cost.⁷²

A new mandate just passed during Arizona's 2008 legislative session requires insurance companies to cover autism beginning in June 2009. The coverage is limited to \$50,000 per year per child up to nine years of age and \$25,000 per year per child from nine to 16 years of age.⁷³ Since autism is often treated with costly one-on-one therapy and diagnoses of autism have skyrocketed in recent years, this mandate is likely to be very costly.⁷⁴

In a competitive market, insurance companies anxious to maximize profits would tend to offer policies that appeal to the widest possible number of people at the lowest possible cost. Coverage of an additional event for everyone would be evaluated on a profitability basis. If enough people would be willing to pay enough more that the costs of the additional coverage were outweighed by the revenues, the coverage would be offered. That is, customers would decide whether the reduced risks were worth paying for.

Government mandates short-circuit this rational process. According to the Council for Affordable Health Insurance, prior to the last legislative session, Arizona imposed 29 health insurance mandates of various types. The autism mandate makes 30, with Arizona joining only 11 other states with similar mandates.⁷⁵ Health insurance mandates should be determined in a market setting rather than according to legislative mandates heavily influenced by the buyer's remorse of people confronting an unanticipated event that was never covered under their insurance policy in the first place.

Conditionally Deregulate Insurance

In 2008, Florida passed a bill that

In a competitive market, insurance companies anxious to maximize profits would tend to offer policies that appeal to the widest possible number of people at the lowest possible cost.

created an insurance alternative with fewer mandates for those who have been uninsured for at least six months. Florida currently carries 50 mandates for health insurance. The claim is that premiums for the “Cover Florida” plan could be as low as \$150 a month for basic and preventive care. The intent is to encourage individuals to buy prepaid-type health insurance that includes a catastrophic plan. Companies that participate are required to offer a plan with catastrophic coverage as well as one without.⁷⁶

In Florida’s case, the logic is clearly that some insurance is better than no insurance at all. Mandates have pushed up the cost of insurance, causing many to drop their insurance or simply to do without. The new law includes provisions to allow small employers to provide scaled-back health insurance plans in addition to the creation of a new state-run central market, of a sort.⁷⁷

The state of Arizona, through AHCCCS, sells a scaled-down insurance plan to small businesses that have not provided coverage for at least six months. This is done through what is supposed to be a self-funded program called Healthcare Group of Arizona (HCG). One of the products it offers, Secure Advantage, is an HMO (health maintenance organization) plan that does not include pregnancy or behavioral health benefits, has limits on inpatient days paid, and has relatively high copays on diagnostic services.⁷⁸ HCG should be privatized (i.e., sold) and the law changed to allow for fewer mandates and larger employers to encourage its expansion. Currently, HCG is a guaranteed issue plan for the self-employed. However, since it adds to the moral hazard problem inherent in insurance and the costs it engenders, guaranteed issue should be avoided.

In both Florida’s and Arizona’s cases, the conditional deregulation is similar to that of the federal government’s ERISA law, which only applies to large, self-insured employers. The Florida law is for individuals who have had no health insurance for six months and for employers with fewer than 50 employees. There are likely to be other sound bases on which to allow some to purchase substantially deregulated insurance policies.

As HSAs become increasingly popular, and savings accrue, it seems reasonable that people with a minimum level of savings should be able to opt out of the heavily regulated health insurance plans. After all, those with savings have more of the wherewithal to handle health issues on their own, and they can use their HSA to purchase added benefits should they choose to do so.

State Remedy 5: Do Not Regulate Charity

An objection to solutions to health care issues that do not include subsidized insurance or a single-payer plan is that individuals who have high-cost health problems will be left out. Even if we were to dismiss the fact that high-cost health problems would become more financially manageable in a true health care market, there could still be those left facing financial ruin or simply without access to lifesaving help. An alternative to building an entire health care system around these relatively rare events is to rely on charity. In fact, there are nonprofit organizations already helping to facilitate mutually charitable health care financing.

One already existing private charity-related strategy is to establish health care sharing among individuals. This could be

Mandates have pushed up the cost of insurance, causing many to drop their insurance or simply to do without.

thought of as a health care cooperative wherein everyone in the co-op contributes to the health care expenses of everyone else in the co-op. Obviously, no one is compelled to join such an arrangement. These types of organizations have run into challenges, though, and have been regulated as insurance companies.⁷⁹

Charity should not be regulated as insurance. In fact, several states specifically exempt charitable health care sharing organizations from insurance regulation. Florida became the 11th state to do so. Arizona has thus far not taken this action.

State Remedy 6: Health Savings Accounts for State Employees

One way to reduce health care costs to the state that is entirely within the state’s policy discretion is to change the nature of state employee health benefits. This can also serve as an important demonstration for further reforms in other health care programs. State employees cannot be treated as mere guinea pigs, though. It is important to remember that Arizona competes in the once relatively tight U.S. labor market. However, current and potential state employees should jump at a change in their benefit package that ultimately benefits them.

HSA’s can do just that. The state could shift away from the defined benefit plan where state employees pay barely more than nominal copayments of \$10 or \$20, depending on the plan they choose, and move toward a defined contribution plan that provides for a high-deductible true health insurance plan. Arizona would immediately realize savings that could be paid to state employees in the form of contributions to their personal HSA’s. The

state could initially set the deductible on the lower end of high-deductible plans and then raise it (and its HSA contribution) over time as savings accumulate. In the future, new employees could be given initial sizable HSA grants that become fully theirs only after a certain number of years of service.

State employees should like this arrangement because HSA’s can be used as supplemental retirement accounts, provided income tax is paid on amounts withdrawn for purposes other than to pay for health care. In addition, an HSA is fully privately owned and controlled, and individuals can use HSA’s for various financial purposes such as collateral. Finally, instead of being paid in-kind with the sickest among them effectively being paid the most, state employees will be rewarded on a more rational basis.

State Remedy 7: Prohibit Hospitals from Charging for Treatment of Infections Contracted in the Hospital

A recent *Forbes* article noted, “Deaths from preventable hospital infections each year exceed 100,000, more than those from AIDS, breast cancer and auto accidents combined.”⁸⁰ Partly because of this fact, Medicare stopped reimbursing hospitals for certain infections in October 2008. Many—perhaps most—infections contracted in hospitals are preventable. Johns Hopkins Medical Center in Baltimore and Sutter Roseville Medical Center in Sacramento, for example, have no bloodstream infections from intravenous needles and other medical devices.⁸¹

Service professionals generally do not charge the customer when an error on their part requires additional work to

One way to reduce health care costs to the state is to change the nature of state employee health benefits.

correct. If a car is dented while undergoing repairs, the onus is on the shop owner to pay for and repair the dent; it is rare that customers have to resort to court action in such circumstances. In a competitive environment, it is crucial for service providers to take responsibility for fixing errors.

However, because of the general lack of competition in the health care system, hospitals can bill patients for items and services that result from a patient contracting an infection in the hospital. In 2000, the U.S. Centers for Disease Control estimated that hospital-borne infections cost the nation's economy \$5 billion per year.⁸² A more recent report from the state of Massachusetts, which has a population comparable to that of Arizona, estimates hospital-contracted infections cost that state \$473 million per year.⁸³ In a true health care market, hospitals would have more incentive to prevent infection. However, in the current system, it is certainly likely that hospitals are taking fewer precautions than they should. Preventing them from charging patients for treatment of infections contracted in the hospital would induce hospitals to more actively prevent infection.

Conclusion

The goal of health care policy at the state and federal levels should be to move toward a true health care market. Critics who claim that the current system proves that a health care market cannot work likely do not understand that a true health care market does not exist in the United States. Markets have historically brought costs down; markets simplify; markets customize to specific consumer wants and needs;

markets provide information; markets sell information when information is not readily available; markets grow in the face of rising prices; markets are innovative.

Health care prices keep rising. Consumers face complicated choices, ranging from which insurance plan to buy to which specialist is most likely to help. Health consumers are only now able to choose a convenient clinic in a large department store. A lot of information about health care is available, but the most important from an economic perspective—price—is almost nonexistent. Despite its high spending per capita, the United States has fewer physicians, on average, than other OECD nations have. But health care innovation is still high in the United States, and we should fight to keep this strength of our system.

Can a private health care system work? One example to look to is Singapore. While Singapore's health system is not fully private, it is certainly more closely market-based than most. Its system also shows that people can afford health care when institutions are not encouraging prices to rise at high rates. People can also be healthy even as they choose not to consume health care at every opportunity due to price consciousness. Life expectancy is four years higher than in the United States and infant mortality is almost four deaths per thousand lower. Nevertheless, Singapore spends just 3.7 percent of its GDP on health care, and only 25 percent of total health care is paid for by the state.⁸⁴

Regardless of the faults that can be found with the American health care system, the worst option would be to move in the direction of a single-payer system like those of Canada and many Western

The goal of health care policy at the state and federal levels should be to move toward a true health care market.

European nations. The entire world benefits from medical breakthroughs made possible by medical innovation investments that mostly occur in the United States. David Gratzner's book *The Cure* notes, "When three hundred leading internists were asked to rank major medical innovations in a survey of the journal *Health Affairs*, eight of the top ten they ranked were developed, in whole or in part, in the United States."⁸⁵ A greater reliance on markets in health care is the most promising way to maintain this record.

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