

About the Miller Professorship of Health Economics

Wallace (Wally) T. Miller, Jr. earned a master of arts degree in business in 1963 from Ball State University. Miller was CEO and COO of Miller's Merry Manor Corporation, now known as Miller's Health Systems, which operates 31 nursing homes and three assisted living centers across Indiana. Wally also served as an instructor of economics in the College of Business from 1991 until his death in 1998.

Upon his death, Wally's estate donated funds to establish the Phyllis A. Miller Professorship in health economics. Phyllis and Wally Miller were married from June 1961 until her death in February 1987. Phyllis was raised on a farm in Pierceton, Indiana. She became the first female president of the town board in LaGrange (the equivalent of the mayor) and served on the board of Farmers State Bank.

The Phyllis A. Miller Professorship of Health Economics supports periodic conferences and other programs on health economics held at Ball State University.

About this Book

Reforming the Health Care System was held March 18, 2005 at Ball State University as part of a larger conference, Health by Design. *Reforming the Health Care System* featured a debate between Kenneth E. Thorpe, Ph.D. of Emory University and John C. Goodman, Ph.D. of the National Center for Policy Analysis. Their presentations were transcribed and are presented in this booklet.



Reforming the Health Care System

Controlling Costs • Increasing Quality • Improving Access

A debate between

Kenneth E. Thorpe, Ph.D.
Robert W. Woodruff Professor and Chair
Department of Health Policy and Management
Rollins School of Public Health
Emory University

&

John C. Goodman
Founder and President
National Center for Policy Analysis

To launch the

Miller Professorship of Health Economics
Miller College of Business
Ball State University



Ball State University
The Heartland Institute



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Reforming the Health Care System

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Introduction

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Getting More Value from Our Health Care Spending

By Kenneth E. Thorpe, Ph.D.¹

Introduced by John Horowitz²

Our first speaker this morning is Ken Thorpe, the Robert W. Woodruff Professor and chair of the Department of Health Policy and Management in the Rollins School of Public Health at Emory University. Dr. Thorpe was Deputy Assistant Secretary for Health Policy in the U.S. Department of Health and Human Services from 1993 to 1995. In that capacity he coordinated all financial estimates and program impacts for President Clinton's health care reform proposals. It is my pleasure to present Ken Thorpe.

Presentation by Kenneth E. Thorpe

Thank you, John, for the kind introduction. Today is an important day for the university, and I'm proud to be here to share it with you.

I'm going to begin by focusing on an issue that touches all Americans—that is, the affordability of health care.

Our health care system suffers from a variety of maladies, one being the fact that on a typical day we have about 45 million people who have no health insurance. But we also have issues with respect to value—and not good value—in health care. That is, our spending on health care is rising faster in many cases than the increase in

¹ Kenneth E. Thorpe, Ph.D. is the Robert W. Woodruff Professor and chair of the Department of Health Policy and Management in the Rollins School of Public Health at Emory University.

² John Horowitz is associate professor of economics at Ball State University. He organized and moderated this debate.

health care benefits we receive.

Why is that the case? To get at that question, we need to step back and try to understand what's driving the increase in health care spending in the first place. Then we need to develop appropriate interventions to attack the problem.

Unfortunately, that is not always how we proceed. We often propose solutions to problems even when we don't understand what the problems really are. Then we discover that our solutions are not very effective—largely because we missed the boat on identifying the problems accurately.

With this in mind, my role today is to sketch out an explanation of what's driving growth in health care spending. Then I will discuss the options we have for trying to improve the value of our health care dollar.

I'll start by summarizing what health care economists have had to say about this issue.

What Drives Health Care Spending?

Over the past 25 years, economists have identified four factors as forces that drive growth in health care spending. I will argue later that these four factors explain very little of the current growth in health care spending, but they provide, nonetheless, an important starting point for the discussion.

The first of these factors is rising real income. We know that richer countries spend more of their domestic product on health care than poorer countries. We also know that higher-income households spend a higher share of their income on health care than do lower-income households. As incomes rise over time, as people get more disposable income, they spend more money on health care. So rising real income in the United States is important. Still, it accounts for only about 5 percent of the growth in health care spending we have seen over the past 25 years.

The second factor is aging. It comes in for a great deal of discussion. But the demographic composition of the population doesn't change much over a 10-year period. The growth in total

population has a big impact on total spending, and in the United States we've had substantial growth in total population since World War II. But the age distribution of the population—while it seems likely to be very important in 2050 and 2070—has accounted for only 7 percent of our growth in health care spending over the past 25 years.

The third issue has to do with health insurance. Over the past 25 years, the number of people who have health insurance has increased. Over the same time period, the portion of health care costs that people pay directly, out-of-pocket, has declined. Taken together, these two developments account for about 10 percent of the growth of spending.

These three factors—rising real income, aging, and insurance coverage—explain relatively little of the growth in health care spending. (Joe Newhouse and Victor Fuchs are among those who have quantified the effects in question.) A massive residual remains to be explained. Many analysts have sought to explain it by reference to the ongoing march of science and improvements in medical technology. We have new medications and new hospital equipment, for example, and these things are expensive. But researchers tend to oversimplify the picture by placing many different residual factors into this technology basket. We can do a better job of disaggregating the particulars that have made a difference.

Of these particulars, one has to do with the relationship between changes in out-of-pocket spending and growth in spending on private health insurance. Looking at expenditures from 1980 to the present, we observe a steady downward progression in what Americans pay directly, out-of-pocket, for health care services. In 1980, we spent about 27 percent of our health care dollar out-of-pocket, through co-pays, deductibles, and payments for non-covered services. Today the figure is a little more than 15 percent. That marks a substantial decline in direct, out-of-pocket payments.

The analysis would be more precise if I had stated the numbers in terms of dollars adjusted for inflation. My numbers are stated only in nominal dollars. Even so, if you look at the nominal dollars and do a simple correlation, one telling sign stands out: There is little

relationship over time between the trends in out-of-pocket expenditures and the year-to-year changes in private health insurance premiums. In fact, in the 1990s—the era of managed care, when we saw a precipitous decline in what people pay out-of-pocket for health care—we had a substantial reduction in the growth in health insurance premiums. It occurred because we tried to manage our health care system on the supply side. We were emphasizing incentives to providers in utilization controls, for example. We weren't managing the health care dollar on the demand side.

Beginning in 1999 or 2000, the data show that managed care was effective. Nonetheless, many people felt conflicted about managed care programs because these programs restricted choice. Physicians felt conflicted because managed care amounted to an imposition on their professional autonomy. As a result of these concerns, the structure of the managed care industry has changed substantially. We now find broader, looser networks for managed care, providing more choices and less control. And since 1999, health insurance premiums have gone back up again. (See Figure 1.)

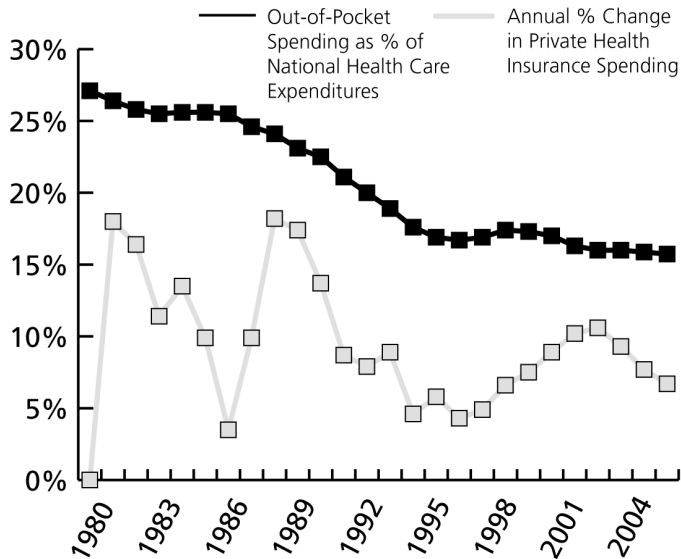
I want to add another set of issues to the previous list of topics. What is missing from the previous list is the rise we have seen recently in certain population risk factors. Before about 1980, this was not a notable omission; until then, these risk factors basically had not changed. It is not surprising, therefore, that they were generally excluded from economists' analyses of spending increases. They were excluded because they weren't factors driving year-to-year increases.

Since 1990, however, we have seen dramatic changes in many risk factors, including obesity, stress, and indoor-outdoor particulates. These changes have played an important role in driving health care spending upward. Moreover, the changes interact with new developments in technology. Together, the changes and the interactive effects now play a dominant role in explaining year-to-year growth in health care spending.

We now face an obesity epidemic marked by dramatic changes in the weight distribution of children, young adults, and adults. From 1960 through 1980 the proportion of young people and adults

Figure 1

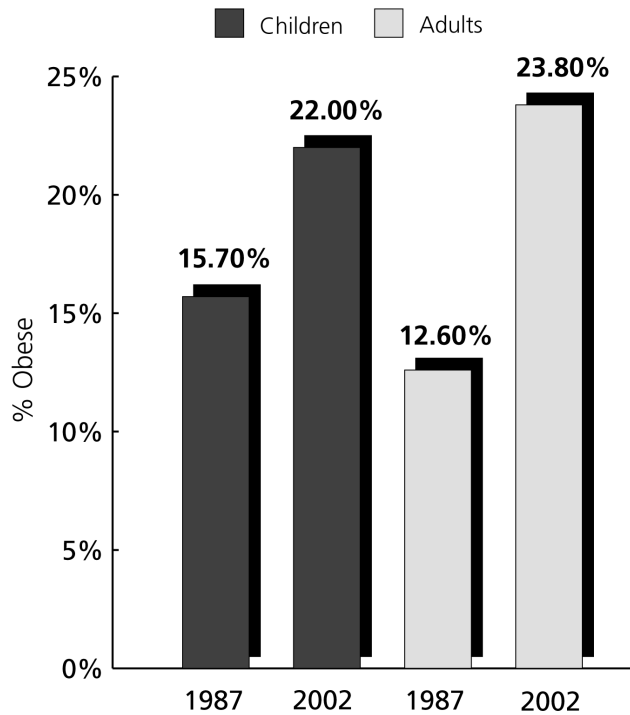
Out-of-Pocket Spending as a Percentage of National (Personal) Health Expenditures and Annual Percentage Change in Private Health Insurance Spending, 1980-2003



classified as overweight or obese didn't change at all. But obesity today is population risk factor number one. Clinical data based on actual observation—weighing and measuring people—show that 30 percent of American people are now obese, according to the Centers for Disease Control and Prevention (CDC). Data based on self-reporting (see Figure 2) put the figure (for adults) at about 24 percent. Obesity has risen by about 10 percentage points in a decade, and the trend can now be observed among children. Nearly a quarter of our children, according to CDC definitions of obesity, are now overweight or obese.

Stress is another risk factor that bears on health care spending. While our measures of stress are not as reliable as obesity measures, the available evidence does show an upward trend in rates of stress. Stress affects the biology of humans. It is therefore an important

Figure 2
Rapid Rise in Obesity Prevalence
Among Adults and Children
At Least a Quarter Now Obese



predictor, affecting some medical conditions such as hypertension and heart disease.

A third set of risk factors affecting health care spending are environmental risk factors such as ozone. In the past 20 years we've seen an explosion in pulmonary disease (bronchitis and asthma) in this country. We see the increase in children and in young adults. The treated incidence of asthma, bronchitis, and other pulmonary conditions has more than doubled in 20 years, and that is not merely a result of improved diagnoses and technology. Pediatricians are increasingly concerned about what they see as an absolute explosion in a variety of pulmonary conditions and diseases.

As doctors treat more and more medical conditions, medical practice interacts with new technologies. For example, new technologies and pharmaceutical innovations now enable us to control blood pressure, treat high cholesterol, and deal with heart disease. This interaction of more medical cases and technology is an important part of the story I want to tell. The numbers indicate that obesity among adults has gone up by more than 10 percentage points since 1987. Among children, it has gone up by about 6 percentage points. Numbers based on clinical observation would be even higher, but the trends are the same in each case.

Similar trends can be observed in many parts of the world, although not everywhere. In France, for example, 8 or 9 percent of adults were obese in 2002—up from about 6 percent since 1982. In the United Kingdom, about 15 percent of adults are obese—an increase of 8 percentage points over the past decade. We see similar trends in other OECD and European Union countries. On the other hand, there has been no increase in obesity rates in certain countries such as Japan, South Korea, and Switzerland. Where that has been the case, there has been an important damping effect on health care spending.

One way to gauge the importance of the risk factors I have reviewed is to reflect on discussions we have had over the past 30 years about smoking. Think of a smoker 30 years ago who found himself transported magically into today's world—a world of warning labels, no-smoking zones, and so on. He would think he had landed in an alternative universe. How did the changes occur? They occurred largely because we drew explicit clinical links between smoking and lung cancer. There were many skeptics early on, contending that no such link had been established. Establishing the link was really step one. Step two was raising awareness about the link. In step three, we attacked smoking on several fronts including government policy, workplace policy, school policy, and restaurant policy.

With respect to diet, nutrition, exercise, and weight management, we are on the cusp of a similar development as we begin to debate the significance of obesity rates. We have reached phase one, which is to

establish clinical links between measures of obesity and the likelihood that people will suffer from certain chronic health care conditions. We can now report that people with a high body mass index (30 and above is the point at which people are usually said to be obese) face a high probability of developing certain chronic conditions. There is no question about the link between obesity and an increased risk of heart disease, and the obese are 15 to 34 times more likely than those of normal weight to develop type-2 diabetes, other factors held constant. In children and young adults, clinicians, internists, and pediatricians now report an alarming increase not in rates of juvenile diabetes but in rates of type-2 diabetes.

The numbers related to hypertension, obesity, diabetes, and some heart disease problems indicate a pattern of increasing risk among young adults—our next generation of workers. Obesity clearly has an impact on high blood pressure, cholesterol, back problems, stroke, and arthritis. And research from the American Cancer Society over the past 20 years has shown that obesity is linked to about 20 percent of cancer cases. There has been an explosion in the number of people being treated for these chronic health care conditions over the past 20 years.

Medical researchers have used various adjusted-odds ratios to determine how the treated prevalence rates in question have changed over time. We have seen an increasing prevalence rate since 1987 in people who are severely overweight.

Once someone becomes 150 to 200 pounds overweight, the number of medical conditions for which he or she will simultaneously receive treatment also increases. A new term for that condition has come into the literature: *metabolic syndrome*. The combined problems of diabetic patients, patients with heart disease, hypertension, and high blood pressure, are thus packaged as one collective set of medical conditions. In 1987, among the seriously overweight adult population, about 13.6 percent were being treated simultaneously for six or more medical conditions; today, about 25 percent of the seriously overweight population are being treated for six or more medical conditions. As more people become morbidly obese, the number of medical conditions treated for obese patients

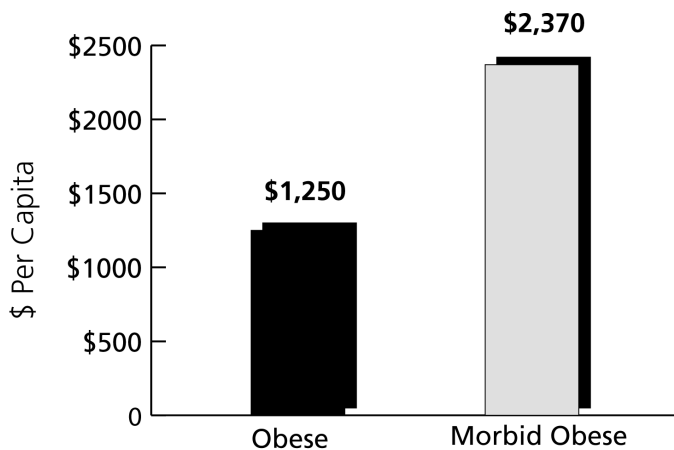
continues to rise, as does health care spending. So we find a compounding effect as we look at distributional changes over time.

Some analyses of attributable spending (i.e., spending linked to smoking or obesity holding other factors constant) follow the same methodologies that the CDC uses to analyze attributable spending related to smoking. The analyses are basically statistical, standardizing all the factors you can think of that affect health care spending—age, demographics, health insurance coverage, race, ethnicity, education, region of the country, and so on. Information represented in Figure 3 shows that for a given person who is obese, with other factors standardized, *additional* health care spending of about \$1,250 dollars per year (in 2002 dollars) will be required, compared to spending on a person of normal weight. The difference comes to about 35 percent higher. For a morbidly obese person (marked by a BMI of 40 or above), the rate of additional spending (almost \$2,400 more per year) doubles.

We can reduce the severity of some of these conditions by lowering cholesterol rates, lowering blood pressure rates, and doing

Figure 3

Obesity Health Care Economics:
Increased Private Health Insurance
Spending Linked to Obesity (2002\$)



a better job of managing diabetes. As indicated earlier, outside of residual costs, the most important factor driving growth in health care spending is the rise in the share of people who have health insurance and the reduction in what people pay in terms of out-of-pocket spending over a 25-year period. Those factors account for about 10 percent of recent growth in health care spending, according to work by Victor Fuchs, Joe Newhouse, and others.

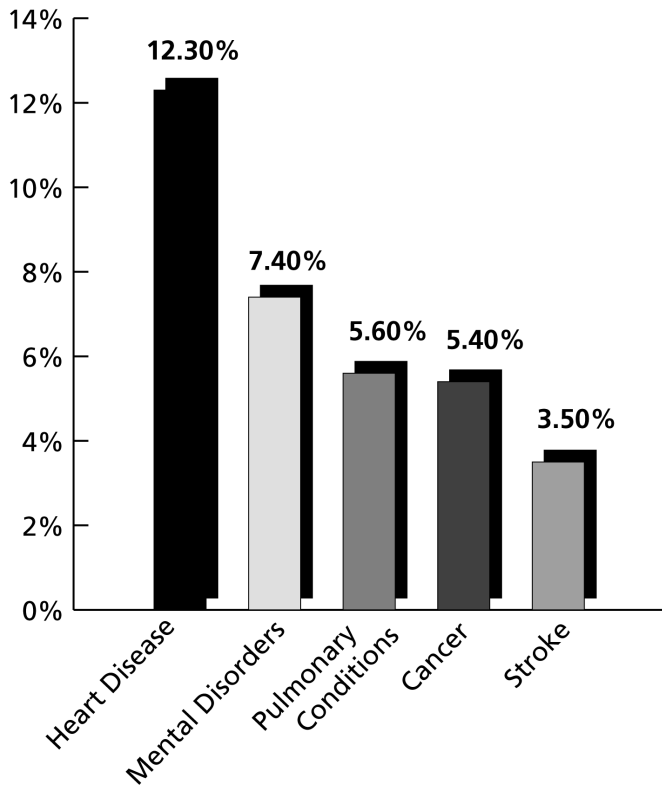
Regarding obesity, about 30 percent of recent growth in health care spending is linked to a rise in the number of people who are overweight as well as the rising cost of treating obese adults. As people become overweight, their likelihood of developing diabetes, heart disease, and hypertension rises. We have new treatments for these conditions (the wonders of Lipitor and so on). If you look at the rise in obesity prevalence alone, apart from new treatments, you find that about 11 percent of recent growth in health care spending since 1987 is accounted for by the rise in obesity prevalence. If you look at the interactive effect for a person who is obese or morbidly obese and is being treated for more medical conditions with more technology, the cost per person accounts for about 16 percent of the growth. In combination, more obesity plus more treatment and technology accounts for nearly 30 percent of the rise in spending.

Looking back at our original list of the drivers of health care spending, we find that obesity dominates by far. It is the leading cause of increased spending in the privately insured population and in the Medicaid population (not counting pregnancy-related spending). Several questions are raised by these observations. What are the medical conditions that are driving this? Where are the spending increases coming from? What are the characteristics of the patients that we are moving through the medical system today?

If you take the top five medical conditions influencing health care spending today (see Figure 4) and look to see how they have contributed to growth in spending, you find that many conditions are linked to obesity. Heart disease is number one. Mental disorder broadly describes number two, but this case is a little bit different. We think that the underlying prevalence of depression and anxiety disorders probably hasn't changed much in 25 years. Three things are

Figure 4

Rise in Spending Over Time
 Role of Chronic Disease:
 Expensive Chronic Illnesses Primary Culprit in Rise in Spending



going on here: (1) patients are doing a better job of recognizing the symptoms; (2) health care providers are doing a better job of recognizing the need for treatment; and (3) more pharmaceutical treatments and other interventions are available—and all increase spending. The other three factors influencing spending are pulmonary conditions (such as asthma), cancer, and stroke. These five conditions alone account for about 34 percent of the growth in health care spending. Patients suffering from these conditions are chronically ill. They are also expensive. Average individual expenditures during a year of treatment reach well into the range of \$10,000 to \$20,000.

These expenditures are driving growth in health care spending and account for most of our health care spending at any point in time.

What Can Be Done?

What can we do about the problems I have summarized? I started this discussion by saying it is difficult to have a dialogue about how to increase the value of our health care dollar, and get control of health care spending, unless we step back and do a clear diagnosis of what the problem really is. I hope I have conveyed some sense of the role played by the rise in treated disease prevalence because it is the dominant factor driving health care spending upward.

If we are going to get at the problem, we need to do three things.

First, we need to find ways at least to freeze current trends in the distribution of risk factors. The best place to start would be in the schools. That's where the next generation of workers will come from. Even if some adults don't want to change their behavior, most parents want to do what's best for their kids and would be likely to support efforts to get at this issue in the schools and at home. In order to do it, we have to go back and look at what we did with smoking. We have to raise awareness so that people can at least understand the links between diet and exercise, nutrition, and the probability of chronic illness.

Second (and this is a tough one, because changing behavior is not easy), we need to develop effective models that show how it actually is possible to make people excited about learning, and changing their behavior, with respect to risk conditions. We need to provide people with real options for reducing risk. It is not enough simply to point the problems out. And we need to provide incentives for people to change their behavior. I don't believe that blaming and trying to force people to change is the right approach. That's not going to work. People don't change unless it's something they want to do.

Third, we need to recognize the fact that most of our health care spending now goes to pay for treatment of chronically ill patients. These are the same patients I have discussed in connection with heart disease, diabetes, and so on—patients with metabolic syndrome. One sad thing to note here is that these patients account for a great deal of

health care spending, yet the *quality* of care we provide for them is really substandard. They get, on average, about 50 percent of the clinically recommended medical care services they should be getting. Diabetic patients should be having their hemoglobin A1C checked two, three, or four times a year, but only about half of them get it checked at all. Managing sugar levels in insulin in diabetics is something that is easy to do. We need to build the delivery systems and the structures to do it. This means we've got to change the way we pay for health care services in this country—particularly for elderly, chronically ill patients—and not worry solely about benefit design issues. We need to get these patients into managed care settings where we can provide them the best available clinical care. We also need to provide the appropriate financial remuneration to physicians and other providers, giving them an incentive to build new structures, and we need to make sure we hold them accountable for results.

In order to change along these lines, I believe we need to use competition to help us get at the things that matter most. We need to focus on value and outcomes—how well health care systems provide health care on a quality basis. Many of these outcomes we can easily measure. We can measure the share of diabetics that get all the clinically recommended care. We can compare what it costs different providers to provide health care services for diabetics. We need to get that sort of information out. We need to reward providers who really provide state-of-the-art care to diabetics, and drive competition around those metrics.

But competition as it is structured today emphasizes the wrong issues. Thus it is hard for health care plans to compete. They all have the same set of hospitals, the same set of physicians and providers. How does a consumer choose among different health care plans? You'll look at the premium, perhaps, but it's virtually impossible to get any information on what you're buying in terms of quality and value. If we provide better ways for people to determine who is doing a good job and who is not, that will drive competition of the right sort.

Finally, let me leave you with this note. In our approach to

REFORMING THE HEALTH CARE SYSTEM

reform, we need a two-part benefit design. Today we structure health insurance for health care savings accounts, fee-for-service plans, or preferred provider organizations, and those are all fine. It is great to give people a broad choice among different types of health care plans. At the same time, once patients present themselves in a plan and show up with diabetes, heart disease, or high blood pressure, we need to switch them into a different type of a structure. At that point the issue is not making people cost-conscious on the margin. The issue at that point is management. These are patients who have a chronic disease, and we need to do a better job of managing their care both in terms of the costs and outcomes.

In a two-part benefit design, the patient would be enrolled in a state-of-the-art program that (1) meets certain clinical standards for quality of care and (2) provides incentives so that health care providers get paid more if they do a better job of managing patients. In a dual system of this sort, there would be a set of health care plans for the very, very low-cost folks who don't drive much of our total health care spending. It is important to give them choices among a variety of plans. For other patients—those who really are driving costs upward—let's make sure we get them enrolled in systems that do a better job of providing health care services and do it on a better value basis. Thank you so much.

Perverse Incentives and Distorting Choices

By John C. Goodman, Ph.D.³

Introduced by John Horowitz⁴

Our second speaker is John C. Goodman. Dr. Goodman is the founder and president of the National Center for Policy Analysis (NCPA). *The Wall Street Journal* has called Dr. Goodman the father of medical savings accounts. Dr. Goodman is the author of *Patient Power: Solving America's Health Care Crisis*, the condensed version of which sold 300,000 copies and is credited with playing a pivotal role in the defeat of the Clinton administration's plan to overhaul the U.S. health care system.

In a conversation I had with Dr. Goodman before today's session, he mentioned that he and Dr. Thorpe participated in the only two debates that were conducted on the Bush and Kerry health care plans during the past presidential campaign. We are pleased that Dr. Goodman and Dr. Thorpe can continue their discussions with us today.

Presentation by John C. Goodman

Thank you, John. I think I won those debates, by the way. We will hear from Ken in a minute, I know.

³ John C. Goodman, Ph.D. is founder and president of the National Center for Policy Analysis.

⁴ John Horowitz is associate professor of economics at Ball State University. He organized and moderated this debate.

Doctors have a rule—the “Do No Harm” principle. It means that before you begin to treat a patient, you want to make sure you are not causing the patient any harm. At the National Center for Policy Analysis (NCPA), we think the same principle ought to apply to public policy. Applied to public policy, it would mean that before we ask the government to enact a new program or enact a new reform, we ought to make sure that government is not the cause of the very problem we are trying to solve.

With that in mind, analysts at the NCPA have examined our health care system in an effort to identify ways in which government policy is causing many of the problems most people want to see solved. We discovered there are quite a few of these. They have to do with ways in which government distorts the decisions that people have to make, causing them to engage in perverse behavior. To jump to the bottom line, we discovered that if we could keep government from causing harm—if we could keep government from being the cause of the very problems we want to solve—we would have a pretty good health care system even if we did nothing else. This is the contention I will present in the remarks that follow.

Consider first what it means to eliminate a perverse incentive. Imagine that you have to choose between two options, a good thing and a bad thing. At the very least, we don’t want the government to encourage the bad choice. At a minimum, we seek a goal of neutrality. Between good choices and bad choices, we want government at least to be neutral. When government is being neutral, it is not doing anything that is good, but on the other hand it’s not causing any harm.

Choices We Make

With that point in mind, I want to present five choices people need to make, five ways in which government policies distort those choices in perverse ways, and five needed reforms.

Choice 1. I will begin with what may be the most important health care choice people have to make today—the choice of being insured or being uninsured. Here the key point is that if you choose

to be uninsured today, you're not really uninsured. If you receive medical care and the bills are so high that you can't pay them, other people in the community are likely to pay them—through higher taxes, higher health insurance premiums, or higher fees. So what we are really talking about, for many people, is a choice between purchasing private insurance and relying, directly or indirectly, on a public safety net.

How does government policy influence this choice? The Texas State Comptroller's Office conducted a study five or six years ago and concluded that in Texas we spend about \$1,000 per year on health care for every uninsured person in the state. Subsequently, a national study by the Urban Institute reached the same conclusion (when you include the value of uncompensated physician care). Nationwide, we provide about \$1,000 per uninsured person per year for health care. Of each \$1,000, \$250 goes to pay doctors for services; the other \$750 is money we spend through federal programs, state programs, or volunteer charities. In one way or another, the rest of the community bears this burden.

One thousand dollars per person comes to \$4,000 dollars for an uninsured family of four. In many Texas counties you can buy reasonably good private insurance for \$4,000. Moreover, these numbers are several years old. If I were to update them, we are probably talking about \$1,500 for an uninsured person today, or \$6,000 for an uninsured family of four. That is a great deal of money. In some ways the prospect it offers amounts to an attractive option, if you consider the alternative costs of private insurance.

Now let's turn to the other option. What does government do for you if you buy private insurance? The answer depends crucially on how you get your private insurance. If your employer provides health insurance instead of paying higher wages to you, the premiums paid on your behalf are not counted in your taxable income. So you get a nice tax subsidy. What does it amount to? If you are a taxpayer in a middle-income family, there is a 25 percent federal income tax you don't have to pay on those dollars. There is a 15 percent FICA (Social Security tax) you don't have to pay. And then (let's say) another 5 percent state tax. This adds up to a 45 percent subsidy for

middle-income taxpayers; in some states the subsidy goes as high as 50 percent. In these cases, government is paying for half the costs of health insurance for many families who get their insurance through an employer.

But suppose you work for an employer who doesn't do that. He just pays you higher wages, and you're expected to buy your own insurance. In that case you're down at the other end of the graph (see Figure 5), and you get virtually no tax relief when you buy your insurance.

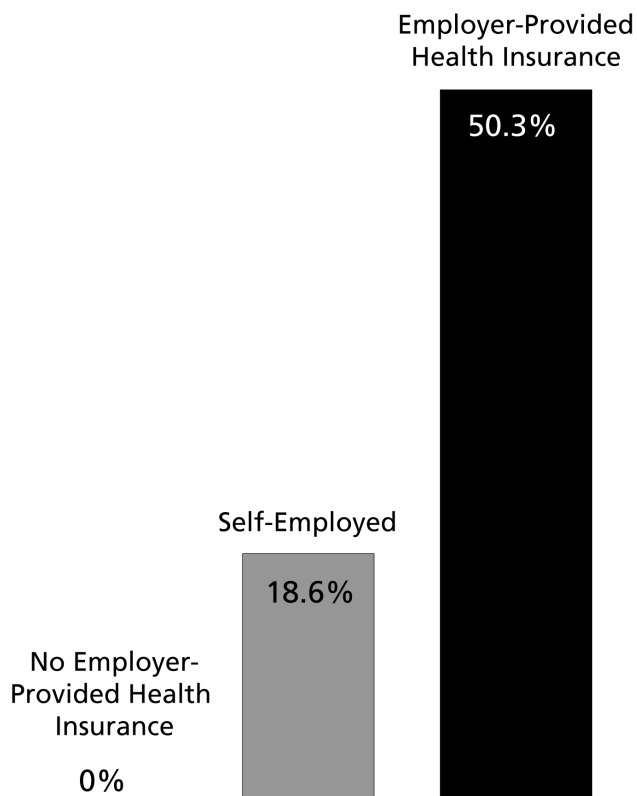
What is the significance of this? Consider the question in light of the \$4,000 I mentioned a minute ago. If an employer purchases health insurance for you, you have to work and produce \$4,000 worth of goods and services for your employer in order to cover the cost of that insurance. But if you are working for an employer that pays only wages, so that you have to take those wages and buy insurance on your own, then you have to pay taxes first. In this case you have to earn \$8,000 for a family that is in the 50 percent tax bracket. After you pay \$4,000 in taxes, you have enough left over to buy health insurance.

The reality, in other words, is that the after-tax cost of health insurance for many uninsured people is twice what it is for most people who have health insurance. Most people who are uninsured have no option to get insurance through an employer. So we are saying to families who rely on the safety net that they can count on about \$4,000 worth of free health care versus earning twice that amount to be able to pay the taxes and buy private insurance with what's left over.

Granted, these two cases are not exactly comparable. Free care is often delivered at large city hospitals where there are long waits in emergency rooms. Patients there don't always get the best care and don't always see the best doctors—but the care they receive is free. Many people regard this prospect as their insurance. Where I live in Dallas, Texas, Parkland Hospital is the place where most uninsured patients go for free care, and they regard Parkland as providing their insurance. It's a free care system.

What I've described is one way in which government encourages

Figure 5
Federal and State Tax
Subsidies for Health Insurance



millions of people to be uninsured. What would it mean for government to be neutral with respect to this choice? It would mean something like this: If government is going to spend \$1,000 per uninsured person on free health care, we should be willing to provide \$1,000 to the people in question regardless of the choice (to buy private insurance or not to) they make. If they choose to buy private insurance, they should get a \$1,000 tax credit to apply to their private insurance premiums. For those relying on the safety net, we should place the \$1,000 in the community where they live.

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That would be a neutral policy. That would be government saying to every citizen in the country: We care what happens to you. How much do we care? The amount is \$1,000. For a family of four, the amount is \$4,000. Where we will put the money depends on the choice you make. The money will follow the family. If you choose to rely on the safety net, your prospects may not be very attractive. There may be rationing. There may be waiting. You may not have the best doctors. But then we really don't want people to be over there and make that choice anyway. We want people to be in the private sector. But at least on the financial side, government policy would be neutral.

If we were handling health care in this way, we would be integrating the tax side of public policy with the spending side. Right now the two sides are not integrated at all. There is no relationship between how government encourages insurance through the tax system and how it spends money on people's health care. We're never going to solve the problem of uninsurance in the United States unless we integrate these two sides of public policy. And the approach I have described is basically the way to do it. If we followed that approach, we would not need to put more money into the health care system.

We continue to hear proposals about how to insure the uninsured, and about how much it would cost to do so. But if you do it right, it won't cost anything. The money is already there, in the system. We just need to rationalize it. We need the money to follow the individuals.

The mirror image of a tax subsidy is a tax penalty. If the government offers you \$1,000 to buy private insurance, you may decide not to buy the insurance. And since we are handling all this through the tax system, declining to buy private insurance will mean that your taxes will be \$1,000 higher. If you turn down the government's offer, you won't get the subsidy and you will pay \$1,000 more in taxes. Then what the government should do is turn around and put that \$1,000 into the safety net. One way to think about this is that if we had a rational system, we would penalize people who are uninsured. They would pay higher taxes. And those

higher taxes would subsidize the safety net for health care in case they needed subsequently to rely on it.

Interestingly, in today's system, people who are uninsured already pay higher taxes. They don't get the subsidies we looked at a moment ago—so they pay higher taxes than insured people do, other things equal. The problem is that their higher taxes go to Washington, and the free care is delivered locally. There is no relationship between the two.

But the money should not stay in Washington; it should go to the localities that provide free care services. Let's take an extreme example.

Suppose everybody in Muncie decides they don't want to be insured. They all want to rely on the safety net. In that case there will be a lot of extra tax dollars going to Washington that should come back to Muncie to fund the safety net.

But now consider a different extreme example. Think of all the people who are now relying on free, safety-net care in Muncie; suppose they all decided to get private insurance. Then you wouldn't need the Muncie safety net anymore. All the money that would otherwise be spent on the safety net could be used to subsidize private insurance. This would be a way to solve a lot of problems by rationalizing the money that's already out there. Let the money follow people. And make sure that government at least is not encouraging people to be uninsured.

Choice 2. Many people have a choice between private insurance and public insurance. By public insurance I mean the Medicaid program, which is our national program of insurance for low-income families, administered by state governments. I refer also to our S-CHIP program, a special program for low-income children. Choosing between private and public insurance under the current system means this: If the government is spending \$1,000 on someone in the Medicaid program in almost every state in the country, there is almost no way to take that \$1,000 and move it over to private insurance. So we have people getting subsidies if they join Medicaid, but getting nothing if they purchase private insurance. In this way, public policy encourages people to be on Medicaid. Similarly, public

policy encourages parents in low-income families to put their children on S-CHIP instead of getting private insurance.

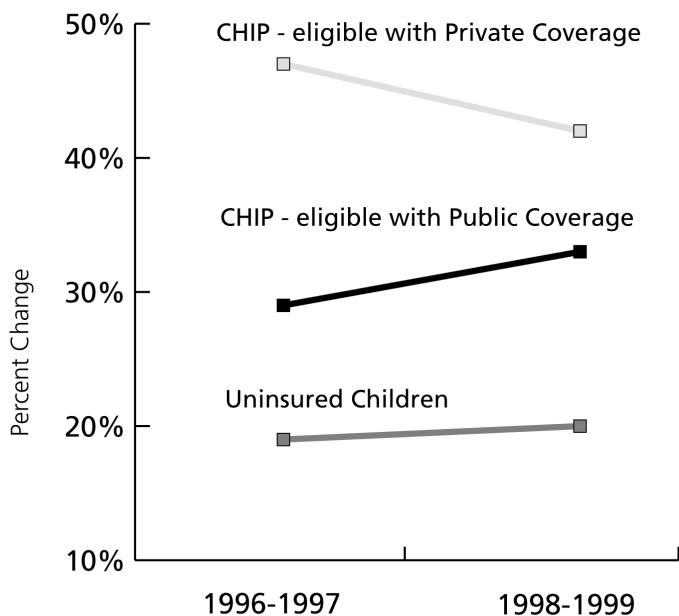
In response, many people would claim that this public insurance is better than no insurance. But because we are encouraging people to drop their private coverage and go to the public sector, we generate a new problem. In the later part of the 1990s we created the S-CHIP program, administered by the states, to provide highly subsidized insurance to low-income children. If you look at the numbers (see Figure 6), you see that participation in S-CHIP is going up; we are enrolling more and more children in this program. And if you looked *only* at enrollment numbers, you might say that we are doing a good job; we are insuring children. But when you look at private coverage, you see that it's going down in exactly an off-setting way. The expansion of public coverage that we have engineered is crowding out private coverage. To put it differently, people are dropping their private coverage to take advantage of free public coverage. So the number of uninsured, or the percent of children uninsured, doesn't change at all.

Mark McClellan, who is now in charge of running the Medicare and Medicaid programs for the federal government, did the most interesting study of all on this point. He concluded that every time we spend an extra dollar on Medicaid, the private sector contracts its spending on health care by somewhere between 50 and 75 cents. We spend a dollar in the public sector and the private sector contracts. What does that mean? Every time someone joins Medicaid or S-CHIP, taxpayers pick up that cost. Taxpayers are spending a lot of money because of this, but at the end of the day we haven't accomplished anything. The number of uninsured as a percent of the population is about where it was 10 or 15 years ago.

We are not accomplishing anything because federal policy is not neutral. It is encouraging people to choose public insurance. Neutrality would mean this: If we are going to spend \$1,000 on you, let's be just as generous (at least) whether you join the private system or the public system.

Figure 6

Children Eligible for CHIP



Choice 3. The choice I'll discuss here is one we don't usually make as individuals, although some people do. But it's certainly a choice we have to make for society as a whole: Do we want people who have private coverage to get it through an employer or do we want them to get it on their own? To put it differently, do we want the insurance that people have to be primarily employer-sponsored insurance or do we want insurance to be individually owned?

This question has been the focus of a national debate over the past several years, and I expect it to continue. People who favor employer provision point out that employers have a unique ability to group people. You can get certain advantages from economies of scale via group purchasing. A large group can purchase insurance more cheaply than an individual can.

On the other hand, employer insurance means that people have

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insurance from an employer only so long as they work for that employer. Those who leave and go to another employer must go on a new plan—or maybe there is no new plan. If there is a plan, maybe it's different—a different set of doctors, a different set of benefits. If you are healthy, this shifting around may not bother you much; but if you are sick, or a member of your family is sick, it may mean no continuity of care and it may mean new costs. In light of these problems, the concept of portability is becoming increasingly important. Individually purchased insurance is portable in the sense that you pay the premiums and the insurance is yours; you own it. You can take it with you from job to job, employer to employer. I predict that portability of insurance will be the next big issue of health care policy over the next 10 years.

What is government doing to influence people in this third area of choice? I have already pointed out that government is very generous in the case of insurance purchased by an employer, providing tax subsidies that equal up to half of the costs of the insurance. But for people who are on their own there is virtually no subsidy. Public policy thus encourages people to get health insurance through an employer and discourages them from getting insurance on their own. In terms of portability, public policy encourages people to have non-portable health insurance and discourages them from obtaining the portable kind. Neutrality here would mean a level playing field—we would be as generous to one form of insurance as to the other.

Currently, the tax code is shaping and molding the whole health care system. Congressional tax-writing committees determine what kind of health insurance you and I have. I know a lot of the people who serve on those committees. You would be surprised how little they know about health care. Many of them may not even be aware that in passing a tax bill Congress affects the whole health care system. But that is what happens.

By contrast, I'm proposing a neutral policy whereby the kind of insurance one has would be determined in the marketplace. Employers would compete. If an employer offered better health insurance than employees could get on their own, that advantage

would be a part of the compensation package used to attract workers. For employers not offering anything better, no such advantage would come into play—though of course employers not paying for workers' insurance premiums might compete by offering higher salaries. In either case, the marketplace would determine the type of insurance people would have, not the tax-writing committees of the U.S. Congress.

If we wanted to encourage private insurance through the tax system, how could it be done? As noted, employer-provided insurance is excluded from employee income. However, the benefit you get from it depends on your tax bracket. When an employer provides you with a benefit and you don't have to pay taxes on it, the benefit is greater insofar as your tax bracket is high. If you are in a lower tax bracket and you have no income tax liability, then your subsidy is only the 15 percent FICA tax. If you are a taxpayer from an upper-middle-income family, your subsidy is closer to 50 percent. That's why you get a graph that looks something like Figure 7.

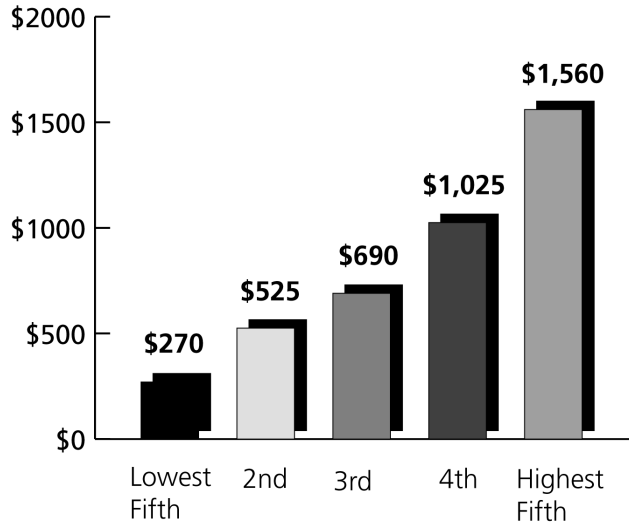
The federal government each year spends more than \$150 billion on tax subsidies for private health insurance—an enormous amount of money. But look where the \$150 billion goes. Families in the highest fifth of the income distribution get a subsidy of \$1,560 each; for families in the lowest fifth, the subsidy is only \$270. So we are spending through the tax system five or six times as much on high-income people as we spend on low-income people. And high-income people probably are more likely to buy insurance whether we subsidize them or not. It is people at the other end of the income scale who have the problems, and we are not doing much to solve them.

As to how health insurance should be subsidized, most health economists, and the Bush administration as well, prefer a fixed-sum flat-tax credit. A credit of \$1,000 was proposed by the Bush administration in the 2000 election: \$1,000 per person, \$3,000 per family. Under the proposal, low-income families would get a dollar-for-dollar write-off, up to \$3,000. Everybody would get the same credit. It wouldn't matter what your family income is.

The Bush proposal scales down the subsidy as income increases, however. I think that is bad. Society has as much interest in the

Figure 7
Current System

Average Benefit for a Family from
Tax Subsidies for Health Insurance



\$100,000 family that doesn't insure as in the \$10,000 family. Under the Bush plan, the subsidy dribbles down to zero by the time the family starts making \$80,000 dollars. I also think the \$1,000 number is too low. The \$1,000 number is something we came up with in the year 2000, and now we are in the year 2005. The subsidy now probably ought to be \$1,500 per person and \$4,500 for family coverage. But apart from such details, we need to change the structure in order to make sure we are achieving the socially desirable objective of getting a return on our tax dollars.

Choice 4. We have to choose between how much we want to rely on third parties to pay medical bills and how much we want to rely on our own savings. You have already heard Professor Thorpe say that in our health care system today, third parties pay about 85 percent of every medical bill. When you or I go into the medical

marketplace and spend a dollar, we are spending, on the average, only 15 cents out of our own pockets. As an economist looking at this situation, I do what economists do: I ask what the economic incentives are. It's not rocket science. The economic incentives are for us to go out and keep spending until we reach a point at which the things we are buying for a dollar are worth only 15 cents—because that's all we are paying. But when we spend a dollar on health care that is worth only 15 cents, and society is paying 85 cents for it, we have a great deal of waste. And that's what is happening right now in the health care system.

How do we waste money? About half the trips we make to primary care physicians are not needed; they are totally unnecessary. We get drug prescriptions filled and we throw the pills away and don't take them. And we waste money in the way we buy drugs. The vast majority of us don't shop for drugs intelligently. It is often possible to reduce drug costs by 90 percent through the use of practices that many shoppers routinely apply in buying groceries or household appliances—by comparing prices, for example. The possibilities for doing so have been enhanced by the Internet. Online shoppers need not be limited to suppliers in their own communities. Discounts are available, moreover, through organizations such as the American Association of Retired People (AARP), which now offers its own mail-order drug services. And by buying in bulk, shoppers can benefit from more reductions in cost. Pill-splitting is another option; many, many pills can be split. In the pharmaceutical market, a 100 milligram pill sells for about the same price as a 50 milligram pill. If you get your doctor to order the stronger dose, you can take the pills home from the pharmacy and cut them in half. Then you have also cut your drug costs in half. And it isn't always necessary to have brand-name drugs. For many patients, the generic version will work just as well. You can also find therapeutic substitutes. There are Web sites that will tell you how to find the generic substitutes and therapeutic substitutes.

These are some of the many cost-cutting measures all of us could be employing. But most of us are not doing so, including those who are on Medicare and Medicaid. Why? Because for the most part it's

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not our money we are spending. How much time are you going to spend to save your employer a lot of money? How much time are you going to spend on the Internet to save the government a lot of money? If you are like most people, the answer is, not much. That's the fix we are in.

The problem under the current system is that we do not have policy neutrality. All dollars paid to an insurance company by an employer are excluded from an employee's income. So your employer sends premium payments over to Blue Cross, and none of that gets taxed. But if your employer tries to put money into a savings account for you, all of those dollars, unless you have a tax-qualified Health Savings Account, are taxed. If you are a taxpayer in a middle-income family, the government takes half of the money paid by employers before it gets into the account. So the whole tax system is set up to encourage us to give money to the insurance companies and none to the self-management of dollars on our own.

That is a poor system, and it leads to a great deal of waste. In effect, this is a system that encourages the HMO form of health care delivery. With an HMO, you give all the dollars in question to the HMO, and it rations your care. It is set up to discriminate against individuals who want to make their own health care decisions.

We need a neutral tax system, one that encourages people to make deposits into medical savings accounts just as strongly as it encourages third-party payments. Between 1996 and 2004, we had a pilot program with tax-free medical savings accounts for small businesses and self-employed workers. As of January 2004, anybody under age 65 may have a tax-free health savings account, provided the insurance plan has at least a \$1,000 deductible. You have to have a qualified plan, but at least the law has changed. My belief is that the new law is still too rigid. We need complete flexibility here. Still, the Bush administration has been very good on this. The president held a news conference announcing that he had a health savings account himself.

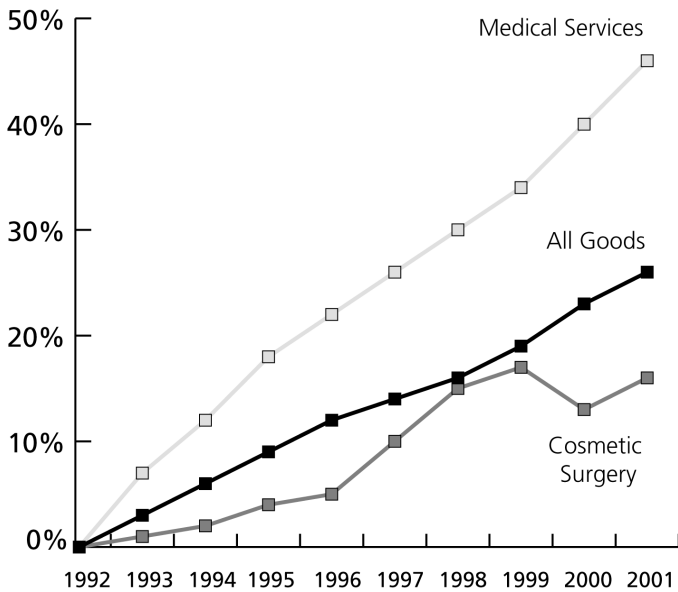
What do people do when they are managing their own health care dollars? What do they do when they have a \$1,000 deductible and \$1,000 in a health savings account? How does their behavior change?

They do exactly what common sense would tell you they would do. They cut down on trips to primary care physicians. They cut down on the money they spend on drugs. They make other spending cuts. And they appear to do a good job of managing their health care dollars.

Where could all the money go? Figure 8 shows the market for cosmetic surgery. In that market, there aren't any third-party payers—not private, not public. People buying cosmetic surgery spend their own money. Thus the cosmetic surgery market differs greatly from the market for other kinds of surgery. For most elective surgeries, patients can't find out in advance what the surgery is going to cost. And if you can't find out in advance what it's going to cost, you can't compare prices. You can't make intelligent economic decisions about where to get your care.

In the cosmetic surgery market there is no such thing as a procedure with an unknown cost. Prospective patients find an up-

Figure 8
Price Increases for Medical Services
and Cosmetic Surgery



front price for cosmetic surgery, and it covers everything—the doctor, the nurse, the clinic. Patients thus can compare prices. It is not a perfect market by any means, but at least it is a market that acts like a real market. And prices charged in the cosmetic surgery market have been low compared to the consumer price index. The real price of cosmetic surgery actually went down in the 1990s, while prices for other medical services exceeded the general inflation rate.

In the cosmetic surgery market there was a huge increase in demand over the decade of the 1990s. The number of cosmetic surgeries performed increased by four times. Supply expanded to meet demand. Technological innovations allow doctors to do procedures today that they couldn't do 15 years ago. Recall Professor Thorpe's comment earlier: People want to blame technology for all the increases we have seen in health care costs. But in the case of cosmetic surgery, technological innovation has been very important, and costs are going down. The whole health care system might be evolving in this direction if we had patients, instead of third-party payers, managing their money.

Choice 5. Here I want to draw attention to the market for risk. I won't be referring to any particular choice that individuals make. Rather, I'll focus on a choice that policymakers at the state level often make for large numbers of people.

During the 1990s, state governments increasingly passed laws preventing insurers from discriminating against people based on their health condition. Yet, Census Bureau numbers from 1990 showed that only 1 percent of the U.S. population had been denied health insurance because of a health condition. But if you are a member of the legislature or Congress, from whom do you hear? You hear from that 1 percent. It is a noisy 1 percent because the people who constitute it have a problem, and for them it is a serious problem. They have large medical bills; they don't have insurance; they don't have enough money to pay their medical bills; and they want coverage. They complain. They seek help.

In attempting to help this 1 percent, politicians screw up the market for everybody else. They pass laws requiring insurers to accept all comers regardless of health conditions. And they pass

community-rating laws requiring insurers to charge the same premium to everybody regardless of the likelihood that a given individual is going to incur costs.

The results of these efforts to help the uninsured illustrate the point that well-intended actions can have unforeseen consequences. The 15 states that did the most in the 1990s to try to help uninsured people—that is, the ones that passed the most laws—are states that saw subsequent increases in the number of uninsured. In the 15 states that didn't do anything to try to help uninsured people, uninsurance rates actually fell. Doing nothing actually was a better way to help the uninsured than trying to do something helpful.

People can't make rational decisions about risk if risk is not priced. The information prices convey can cause people to change their behavior. But if insurance prices are unrelated to the risks at stake, then people are not going to change their behavior. It is almost impossible for politicians to make intelligent decisions in any market for risk, and they are certainly not making them in insurance markets.

Conclusion

To conclude: I have been proposing and defending a “do no harm” approach to public policy. Before we enact new programs, let's make sure that government isn't the cause of the very problems we are trying to solve. To get where we want to be in the five problem areas I have discussed, we need government at least to be neutral—neutral with respect to several choices people need to make:

- Neutral between being insured and uninsured, giving equal encouragement to both choices.
- Neutral between private insurance and public insurance, giving equal encouragement for people to be privately insured or enrolled in a public program.
- Neutral between employer-purchase and individual-purchase of health insurance, providing a level playing field in the

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employment market.

- Neutral between self-insurance obtained through a health savings account and insurance obtained through premiums paid to an insurance company.
- And, finally, neutral in the market for risk.

What if we attained an environment of policy neutrality in these five areas? If we could keep government from being a source of our problems, we could have a better health care system. It wouldn't be perfect, but it would have many attractive features. It would be a system of universal coverage, one in which government commits a certain amount of money for each individual. The money would follow the individual according to his or her choices. If you wanted to be in the private market, the money would go there. If you wanted to be in the safety-net market, the money would go to the safety net. In such a system, people would not be trapped in public programs; they would be free to take the money and go to the private sector if they wanted to. We would not force an insurers' role on employers—a role that many of them, especially smaller employers, are not very good at playing. We would create a level playing field in which the manner of offering health insurance would be determined by the marketplace, not by tax law. People then could determine the extent to which they want to control their own health care dollars instead of having their dollars controlled by an insurance company or an employer. And people could transfer risk to other parties, which is what you do when you buy insurance, but at real market prices.

This would not be a perfect system, but it would be a lot better than the system we have now. Thank you very much.

Kenneth E. Thorpe, Ph.D.



Kenneth E. Thorpe, Ph.D. is Robert W. Woodruff Professor and chair of the Department of Health Policy & Management, in the Rollins School of Public Health of Emory University, Atlanta, Georgia. He was a Vanselow Professor of Health Policy and director, Institute for Health Services Research.

Professor Thorpe received his Ph.D. from the Rand Graduate School, an M.A. from Duke University, and his B.A. from the University of Michigan. He was previously professor of health policy and administration at the University of North Carolina at Chapel Hill, associate professor and director of the Program on Health Care Financing and Insurance at the Harvard University School of Public Health, and assistant professor of public policy and public health at Columbia University. Dr. Thorpe also has held visiting faculty positions at Pepperdine University and Duke University.

Most recently, Professor Thorpe was deputy assistant secretary for health policy in the U.S. Department of Health and Human Services. In that capacity, he coordinated all financial estimates and program impacts of President Clinton's health care reform proposals for the White House. He also directed the administration's estimation efforts in dealing with Congressional health care reform proposals during the 103rd and 104th sessions of Congress.

As an academic, he has testified before several committees in the U.S. Senate and House on health care reform and insurance issues. In 1991, Professor Thorpe was awarded the Young Investigator Award, presented to the most promising health services researcher in the country under age 40 by the Association for Health Services

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Research. He also received the Hettleman Award for academic and scholarly research at the University of North Carolina and was provided an “Up and Comers” award by *Modern Healthcare*.

Dr. Thorpe has authored or co-authored more than 60 articles, book chapters, and books and is a frequent national presenter on issues of health care financing, insurance, and health care reform. He also serves as a reviewer for several health care journals.

John C. Goodman, Ph.D.



John C. Goodman, Ph.D. founded the National Center for Policy Analysis in 1983 and has served as president since the center's inception. *The Wall Street Journal* called Dr. Goodman "the father of Medical Savings Accounts," and *National Journal* declared him "winner of the devolution derby" because his ideas on ways to transfer power from government to the people have had a significant impact on Capitol Hill.

Dr. Goodman is the author of seven books, including *Economics of Public Policy*, a widely used college textbook, and *Patient Power: Solving America's Health Care Crisis*, the condensed version of which sold 300,000 copies and is credited with playing a pivotal role in the defeat of the Clinton administration's plan to overhaul the U.S. health care system.

He has authored numerous editorials in *The Wall Street Journal*, *USA Today*, *Investor's Business Daily*, *Los Angeles Times*, *The Dallas Morning News*, *Houston Chronicle*, *The San Diego Union-Tribune*, and other papers.

Dr. Goodman regularly appears on television news programs, including the PBS program *Debates*, *The NewsHour* with Jim Lehrer, and *The Wall Street Journal Report*. He has been a debater on several of William F. Buckley Jr.'s *Firing Line* shows, and has appeared on a number of two-hour prime-time debates, including debates on the flat tax, welfare reform, and Social Security privatization.

He regularly briefs members of Congress on economic policy issues and frequently testifies before congressional committees.

He is author/co-author of more than 50 published studies on such topics as health policy, tax reform, and school choice.

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Dr. Goodman has an active speaking schedule and has addressed more than 100 different organizations on public policy issues.

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Dr. Goodman received a Ph.D. in economics from Columbia University. He has taught and done research at several colleges and universities including Columbia University, Stanford University, Dartmouth, Southern Methodist University, and the University of Dallas.